FOSTERING HEALTH: AN AUSTRALIAN HEALTH POLICY AND SYSTEMS STUDY OF HEALTH ASSESSMENT FOR CHILDREN AND YOUNG PEOPLE IN OUT-OF-HOME CARE

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ABSTRACT

This thesis reports on the first multi-centre health policy and systems study of the complex problem of health assessment for children and young people in Out-of-Home Care (OOHC) in Australia. The study has been conducted within a context of poor uptake of routine health assessment recommended by medical colleges. Analysis of the research literature around OOHC in Australia revealed that the implementation of routine health assessment had not been investigated in any systematic way. A national symposium held as part of this study confirmed the knowledge gap and identified a community of interest who supported research in this area.

RESEARCH AIM

The study aimed to identify systemic and policy factors which enabled or inhibited the work of health professionals in health assessment for children in OOHC.

METHODOLOGY

Guided by soft systems methodology I developed a series of conceptual models in which I imagined the elements of systems for each key step of care and then used these models as tools for comparison with experiences in the social or real world. Each of the models was built on a discrete theoretical purpose related to health assessment. The five purposes were to:

I. Collect and maintain child health histories;
II. Provide initial or preliminary health assessments at entry to OOHC;
III. Provide comprehensive health assessments;
IV. Develop individual child health management plans;
V. Monitor the provision of assessment and treatment services and child health outcomes.

In order to explore experiences in the social world, I undertook an embedded case-study to collect data from 9 organisations (incorporating 12 geographical sites) across two states of Australia with large OOHC populations. Case study data comprised my analysis of policy and
procedural documents from state jurisdictions and local sites, observations from site visits and analysis of recordings from 47 semi-structured interviews with health professionals and policy advisors spanning 10 disciplines.

RESULTS

The outcomes demonstrated that a lack of agreement about central concepts, such as how health is defined hampered consistency of assessment processes. Similarly I uncovered disparate ideas about the purpose of health assessment in OOHc, underpinned to some extent, by variable appreciation of child abuse and neglect as health determinants. At a systemic level, I found a synergy between conceptual models of systems of care associated with health assessment and the steps which health professionals both value and strive to implement in everyday practice. The results provide a compelling illustration of systemic complexity and interconnectedness. Across all steps of care the study results show that much hinges on the efficacy and effectiveness of the first step of collecting and sharing child health histories. In this step health professionals find themselves in a dependent relationship with staff from the child protection sector whose roles include gate-keeper, referrer, family liaison officer, child case manager and corporate parent. This dependence exemplifies a recurring theme in the everyday experiences of health professionals: the contrast between usual processes of patient care and the greater complexity of health assessment steps in OOHc. I argue for rethinking health policies which have been premised on minimalist approaches involving either usual, universal health care or “tweaking” usual health care processes. Minimalist interventions, such as giving children in OOHc priority in the queue for assessment cannot by themselves bring about the extent of systemic changes desired by health professionals. Of critical need are permanent and accessible health records for children who have experienced maltreatment.

This thesis demonstrated that the health policy and system approach has broad utility in improving our understanding of what has been problematic about health assessment in OOHc in Australia and what changes are desirable in assessment approaches. A key strength of the study was that multi-centre and multi-disciplinary recruitment across two legislative jurisdictions enabled me to capture health professionals’ views and experiences from multiple contexts. This added richness to the data and rigour to the generalizability of the study results.
IMPLICATIONS

As a result of this study I formed a view that professional purposes, judgement and volition among health professionals are individual matters, more influenced by peers, training and clinical experience than by public policy. Not only do doctors have a unique role to play in clinical governance in OOHC but their knowledge and skills, their professional roles and identity and their beliefs about the consequences of their work are important influences in bringing about quality improvement in health care. Messages from research and the recommendations of medical colleges in Australia, U.S. and U.K. were clear that health professionals believed individualized, systematic health assessment was warranted in OOHC, notwithstanding the cost. Furthermore, doctors in this study demonstrated sufficient power and professional autonomy to stop, start, block, enhance or lead initiatives to improve health assessment in OOHC.

Analysis of the steps of care associated with health assessment in OOHC revealed a deeply complex web of inter-connected activities which rest on sophisticated clinical decision making by doctors. The results of this thesis indicate that health professionals are aided in their work when governments and child protection agencies appreciate this complexity and sophistication.

The results of this study suggest areas where change is desirable in order to break the impasse of poor implementation of health assessment. A more congruent common understanding of the concept of health in OOHC is essential i.e. what is being assessed. Alongside this a more careful alignment of theoretical and practical purposes in health assessment is needed. I argue that in the context of Australia’s moral and civic obligations under the 1989 United Nations Convention on the Rights of the Child, purposes of health assessment must be more coherently aligned around reparative health care, and responsive to the impacts of child maltreatment on life-course health outcomes.

More widespread appreciation of maltreatment as a health determinant is required in order for policy advisors and health practitioners to better align health assessment policies and practices.
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DECLARATION

This is to certify that:

i. The thesis comprises only my original work towards the degree of Doctor of Philosophy;

ii. Due acknowledgement has been made in the test to all other material used;

iii. The thesis is fewer than 100,000 words in length, exclusive of tables, maps, bibliographies and appendices.

Signed:

SUSAN MARGARET WEBSTER

Date: 16 May 2014
ACKNOWLEDGEMENTS

This research study was triggered by a ‘corridor’ conversation in 2007 with a colleague, the late Dr Peter Waxman. Peter and I had been shocked to learn at a meeting earlier that day that our state government Department of Human Services (DHS) lacked a suitable system for examining the health needs of children in out-of-home care (OOHC). We found this incredulous in the 21st century. As General Practice Adviser to DHS, Peter had a vital interest, not only in clinical issues, but in the quality of health service systems. DHS, at that time, had responsibility both for child protection services (including placement of children in OOHC), and for public hospital and community health services for Victoria. Peter was determined that this situation in OOHC must be addressed, and that actively engaging health professionals would be a key element in bringing about change. That brief conversation set in train a research quest to explore how this situation came about and the contributing factors which might support such engagement. Peter was the spark. He flagged this as an important issue for the health sector and supported my application for a Primary Health Care Research and Evaluation Development (PHCRED) Fellowship which marked my first step into this field. The Fellowship became a Master of Primary Health Care Research study, which examined factors affecting general practice involvement in health assessment in OOHC in Victoria. That research revealed a large and complex national problem in Australia which enticed me into the PhD study reported in this thesis.

During the early scoping phase of the study, I opportunistically and individually consulted with a small group of people who had direct experience in the field in other Australian states and in New Zealand. Dr Maree Crawford, Yvonne Darlington, Janet McCormick, Tia Lockwood and Nicola Atwool graciously shared with me some of their insights at a time when I was still developing research questions.

I am indebted to Bill Newton, the former Chief Executive Officer of General Practice Victoria (GPV) for his wise counsel and his appreciation of the value of academic research. His personal commitment to the study and contribution of organizational and financial support helped to make possible the national symposium which was the key strategy in testing the need for, and feasibility of further health policy and systems research around health assessment in OOHC. Sonya Tremellen, Debra Clayton and Eliza Sanneman from GPV provided great support in administrative preparations for the symposium and were important members of the planning advisory committee. I am indebted also to Bernie Geary, Victoria’s...
Commissioner for Children and Young People and his staff members, particularly Ray Carroll and Yildiz Araz who made a substantial financial and administrative contribution to the symposium and have remained supportive. Yildiz Araz, who represented the Commissioner on the symposium planning advisory committee, provided a wealth of insight which helped to smooth the collaborative pathway between our health and child welfare sectors.

Geoff Jende and Tony Lunken, formerly with the Victorian Department of Human Services, patiently increased my appreciation of the enormous challenges facing both the staff at the front line of child protection and children and young people who enter out-of-home care in situations of crisis. Tony’s contribution to the program advisory committee, along with that of Karen Scobell from the Centre for Excellence in Child & Family Welfare, helped to ensure the development of a rich and diverse program and a successful event.

From the academic sector I received positive support and encouragement from Prof. Jane Gunn and Assoc. Prof. Lena Sanci in the Department of General Practice at the University of Melbourne who generously gave their time and energies to co-chair the national symposium. Graham Vimpani, Professor of Community Child Health and Head of the Discipline of Paediatrics and Child Health at the University of Newcastle similarly gave substantial time and energy. His finely focussed keynote presentation addressed an essential threshold question which had arisen for me from opinions I had heard expressed in the child welfare field. That question was:

*Is it really worth the effort and expense to improve health needs assessment and health service access for children and young people in out-of-home care in Australia, especially when most kids seem healthy enough on a day-to-day basis and can just be taken to a doctor if they feel sick?*

Dr Maree Crawford, Dr Hubert van Doorn, Adjunct Assoc. Prof. Annette Jackson and Assoc. Prof. John Tobin also provided keynote papers, bringing perspectives from a wealth of experience in paediatrics, law, general practice and psychology. Their ideas, along with those of 17 others who presented papers, were valuable in shaping this study.
Three other people contributed more than they would know in the design phase. Dr Delwyn Goodrick, whose short course on qualitative design methods helped me to delve below a surface understanding of research methodologies, John Molyneux whose introduction to soft systems methodology gave me the confidence to learn more and Prof James Hathaway whose roundtable on international human rights respectfully challenged my “undue reverence” for the power of the 1989 United Nations Convention on the Rights of the Child.

I wish to particularly acknowledge the 47 health professionals and policy advisors in this study who placed trust in me when they allowed me to visit them in their workplaces and interview them about their experiences. I appreciate how valuable their time was and the significance of being allowed to enter this field as an ‘outsider’.

The privilege of an attentive, and inspiring PhD supervisory panel sustained me through the four years of this study. Anne Smith, Medical Director of the Victorian Forensic Paediatric Medical Service at the Royal Children’s Hospital in Melbourne was always positively encouraging and introduced me to some new threads of knowledge, including the history of medical care of children of the state, a subject I developed a fascination with. I have been inspired through witnessing how Assoc Prof Lena Sanci has incrementally built a body of knowledge and far-reaching research collaborations in young people’s health. Prof Cathy Humphreys lit a fuse when she astutely suggested I might find complexity science and soft systems methodology worth considering in the study design phase. Assoc Prof Meredith Temple-Smith, my principal academic supervisor through the Master’s study and PhD has taught, mentored, supported and encouraged me on a weekly basis. I am deeply appreciative of her commitment to my studies, her faith in my ability and her constancy in fostering my scholarly development. Meredith patiently guided me back to the research question when I sometimes risked losing my way down some riveting but peripheral rabbit burrows. She has been my critic and my cheerleader, in appropriate measure. Her wise guidance in academic writing has helped me to weave a great tangle of ideas into a pleasing fabric.
Finally I gratefully acknowledge the financial support I received from the following sources.

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DEDICATION

For my inspirational Brigitte, for Peter who is my rock, and for Tim who helped me reach the end with his reminder at the most strategic of times that “a good thesis is a finished thesis”.
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SYSTEMIC RECOMMENDATIONS FROM MEDICAL COLLEGES AND ASSOCIATED PUBLIC POLICIES

STATE POLICIES AND PROCEDURES

FIELD OBSERVATIONS OF DOCUMENTATION

FIELD OBSERVATIONS THROUGH INTERVIEWS

Determining minimum data requirements
Collecting medical information
Verifying information and recording information accurately
Storing information securely and sustainably
Protecting information privacy
Sharing information effectively
UPDATING INFORMATION CONTINUOUSLY

SYSTEMIC ANALYSIS OF STEP ONE

STEP TWO – INITIAL HEALTH ASSESSMENT

SYSTEMIC RECOMMENDATIONS FROM MEDICAL COLLEGES AND ASSOCIATED PUBLIC POLICIES

STATE POLICIES AND PROCEDURES

FIELD OBSERVATIONS OF DOCUMENTATION

FIELD OBSERVATIONS THROUGH INTERVIEWS

Identifying an appropriate health professional
Ensuring child attends with responsible adult/s
Providing appropriate consents and health history
Physical examination, screening and review of history
Making clinical decisions
Sharing written records of initial health assessment

SYSTEMIC ANALYSIS OF STEP TWO

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SYSTEMIC RECOMMENDATIONS FROM MEDICAL COLLEGES AND ASSOCIATED PUBLIC POLICIES
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<td>American Academy of Pediatrics</td>
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<td>AGPN</td>
<td>Australian General Practice Network</td>
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<td>AHMAC</td>
<td>Australian Health Ministers’ Advisory Council</td>
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<td>AIHW</td>
<td>Australian Institute of Health and Welfare</td>
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<td>AMA</td>
<td>Australian Medical Association</td>
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<td>APA</td>
<td>Australian Postgraduate Award</td>
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<td>Australian Population Health Principal Committee</td>
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<td>APO</td>
<td>Australian Policy Online</td>
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<td>ARACY</td>
<td>Australian Research Alliance for Children and Youth</td>
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<tr>
<td>ARC</td>
<td>Australian Research Council</td>
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<td>COAG</td>
<td>Council of Australian Governments</td>
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<td>CPS</td>
<td>Canadian Paediatric Society</td>
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<td>CRC</td>
<td>Committee on the Rights of the Child</td>
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<td>Department of Communities, Child Safety and Disability Services (Queensland)</td>
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<td>DCSF</td>
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<td>Commonwealth Department of Families and Housing, Community Services and Indigenous Affairs</td>
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<td>General Practitioner</td>
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<tr>
<td>MOU</td>
<td>Memorandum of Understanding</td>
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<tr>
<td>MJA</td>
<td>Medical Journal of Australia</td>
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<tr>
<td>NHMRC</td>
<td>National Health and Medical Research Council</td>
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<tr>
<td>NICE</td>
<td>National Institute for Health and Care Excellence (United Kingdom)</td>
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<tr>
<td>NPHP</td>
<td>National Public Health Partnership (Australia)</td>
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<tr>
<td>NSW</td>
<td>New South Wales</td>
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<tr>
<td>OCSC</td>
<td>Office of the Child Safety Commissioner (Victoria)</td>
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<tr>
<td>OOHC</td>
<td>Out-of-Home Care</td>
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<tr>
<td>PHCRED</td>
<td>Primary Health Care Research and Evaluation Development strategy (Australia)</td>
</tr>
<tr>
<td>QCCYPCG</td>
<td>Commission for Children and Young People and Child Guardian (Queensland)</td>
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<tr>
<td>RACP</td>
<td>Royal Australasian College of Physicians</td>
</tr>
<tr>
<td>RANZCP</td>
<td>Royal Australian and New Zealand College of Psychiatrists</td>
</tr>
<tr>
<td>SCRGP</td>
<td>Steering Committee for the Review of Government Service Provision</td>
</tr>
<tr>
<td>Acronym</td>
<td>Description</td>
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<tr>
<td>SDQ</td>
<td>Strengths and Difficulties Questionnaire</td>
</tr>
<tr>
<td>SSM</td>
<td>Soft Systems Methodology</td>
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<tr>
<td>UNCRC</td>
<td>United Nations Convention on the Rights of the Child</td>
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<tr>
<td>U.K.</td>
<td>United Kingdom</td>
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<tr>
<td>U.S.</td>
<td>United States of America</td>
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<tr>
<td>WHO</td>
<td>World Health Organisation</td>
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### GLOSSARY

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition/Description</th>
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<tr>
<td>CARER</td>
<td>A person who provides care in their private household for a child who is living apart from his or her natural or adoptive parent(s). The term includes kinship carers who are family members other than parents. It also includes foster carers who have undergone relevant screening and selection processes, who are authorized by a relevant government department or child welfare agency to have a child placed in their care and for whom reimbursement is available for expenses incurred in caring for the child.</td>
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<tr>
<td>CATWOE</td>
<td>Mnemonic developed by Smyth &amp; Checkland (1976) commonly used in Soft Systems Methodology</td>
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<tr>
<td>CHILD</td>
<td>A Child or young person aged 0-17 years of age.</td>
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<td>CHILD MALTREATMENT</td>
<td>Child maltreatment refers to any non-accidental behaviour by parents, caregivers, other adults or older adolescents that is outside the norms of conduct and entails a substantial risk of causing physical or emotional harm to a child or young person. Such behaviours may be intentional or unintentional and can include acts of omission (i.e., neglect) and commission (i.e., abuse). In this thesis, the terms &quot;child abuse and neglect&quot; and &quot;child maltreatment&quot; are used interchangeably. Child maltreatment is commonly divided into five main subtypes (1) physical abuse, (2) emotional maltreatment, (3) neglect, (4) sexual abuse, (5) the witnessing of family violence (Australian Institute of Family Studies 2012).</td>
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<tr>
<td>HEALTH PROFESSIONAL</td>
<td>A Health Practitioner registered to practice with one of 14 National Registration Boards for health professions which are part of Australia’s National Registration and Accreditation Scheme under the Health Practitioner Regulation National Law Act 2009.</td>
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<tr>
<td>HEALTH POLICY AND SYSTEMS RESEARCH</td>
<td>Health Policy and Systems Research is a field of research that seeks to understand and improve how societies organize themselves in achieving collective health goals, and how different actors interact in the policy and implementation processes to contribute to policy outcomes. It is interdisciplinary research that draws a comprehensive picture of how health systems respond and adapt to health policies, and how health policies can shape and be shaped by health systems and the broader determinants of health (Alliance for Health Policy and Systems Research 2011).</td>
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<tr>
<td>HOLON</td>
<td>A term used in Soft Systems Methodology as an alternative to the word ‘system’ to describe the concept of a whole.</td>
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<tr>
<td>INDIGENOUS</td>
<td>Includes children of Aboriginal or Torres Strait Islander descent who are identified as an Aboriginal or Torres Strait Islander.</td>
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<tr>
<td>Term</td>
<td>Definition</td>
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<tr>
<td>LOOKING AFTER CHILDREN</td>
<td><em>Looking After Children</em> practice, planning and review materials for OOHC developed and introduced in the U.K. in the 1990s (Ward 1995) and subsequently adapted for use in Australia (Wise 1999).</td>
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<tr>
<td>NON-GOVERNMENT ORGANISATION</td>
<td>Any non-government organisation that provides services to the community on a non-profit making basis.</td>
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<tr>
<td>OUT-OF-HOME CARE</td>
<td>Out-of-Home Care is a program provided to children and young people aged under 18 who are in need of care and protection. Home-based OOHC is provided in the home of a carer who is reimbursed (or who has been offered but declined reimbursement) for expenses for the care of the child. Home-based OOHC includes care with family members other than parents, or with volunteer foster carers</td>
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<tr>
<td>WELTANSCHAUUNG</td>
<td>A German word, often translated as 'worldview'. A central term in Soft Systems Methodology</td>
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CHAPTER 1

FOSTERING HEALTH: AN AUSTRALIAN HEALTH POLICY AND SYSTEMS STUDY OF HEALTH ASSESSMENT FOR CHILDREN AND YOUNG PEOPLE IN OUT-OF-HOME CARE

Health care is a functional aspect of society. Attention to the maintenance of good health and care of the sick and disabled have been an element of group life throughout recorded history and in all likelihood long before. As a social activity, such care is interlocked in various ways and in differing degrees with the structure of group living of which it is a part - with the family, religion, the economy, government, the value system and other elements. Furthermore, not only is the structure of health care inseparable from the general organisation of society, but its reality cannot be fully discovered from static, cross-sectional analysis. Like any other social institution, medicine experiences both continuity and change so that its past differs from its present and it will be something different in the future, and yet for good or ill what happened in the past influences the present and the future. (Rosen 1974 p. 44).

The link between a child's experiences of maltreatment and child health inequalities is an intellectual and policy frontier which Australia has yet to successfully traverse. Australian medical researchers and paediatric specialists with a particular interest in child abuse and neglect have built an understanding of the link. Their political, economic and social policy colleagues however have only recently begun to make the connection. The link demands timely and sustained attention to child health needs after maltreatment if the risks to health are to be mitigated. The thesis explores this frontier territory from the perspectives of health professionals involved in assessing the current health needs of children and young people entering home based out-of-home care (OOHC) in Australia. While the study captures a point in time in Australian history, it will be argued that past societal expectations and past roles of health professionals have shaped the present and are salient in re-thinking the future.
HEALTH ASSESSMENT IN OUT-OF-HOME CARE

Placement in OOHC is an intervention of last resort in Australian child protection systems. In 2012 more than 90% of all children in care were subject to legal care and protection orders as a consequence of substantiated abuse or neglect. More than 12,000 children, the majority aged 9 years or younger, entered care in 2011-2012. Nearly 40,000 children (or 7.7 per 1000 children in Australia) were in care on 30 June 2012 (aihw 2013).

THE PROBLEM SITUATION

The United Kingdom and North America have crossed interdisciplinary divides in their linking of child maltreatment with child health inequalities (Landsverk, Garland, Reutz, & Davis 2011, National Institute for Health & Clinical Excellence 2010). Medical professionals have successfully argued that the health needs of those living in OOHC warrant systematic screening and assessment on entry to care, regular ongoing review and facilitated access to therapeutic and restorative services (American Academy of Pediatrics 2002, Mather, & Batty 2000). Government legislation, regulations and practice guidance have assigned specific health assessment responsibilities to designated organisations or professional groups (United States Congress 2008, Department for Children, Families and Schools 2009). In contrast, Australia lacked a national government policy in this area at the time the study commenced. Matters of child health in OOHC rested, and still remain, in the hands of eight, geographically and politically independent state and territory government child protection authorities. A plethora of state-level child protection inquiries have criticised governments for failing to adequately identify or address child health needs in OOHC (Auditor-General Australian Capital Territory 2013, Auditor-General Tasmania 2011, Ombudsman Victoria 2010, New South Wales Office for Children 2009, Wood 2008, Mullighan 2008, Forde, 2007, Auditor-General Victoria 2005, Layton 2003). Australian medical colleges were also critical, and issued policies advocating more systematic responses (RACP 2006, RANZCP 2009). Despite medical advocacy, and statutory scrutiny, systematic health assessment in OOHC has been more of an aspiration than achievement.

The context of this study is multi-layered and complex. As a result the study was deliberately limited in two respects. Firstly, health needs assessments may depend on types of OOHC accommodation, or a child’s demographic grouping. In Australia, assessment can be offered in therapeutic residential OOHC care, or in secure welfare settings which have salaried staff and an institutional accommodation base. Indigenous health, refugee health, or disability services provide specialised assessment settings for some children in OOHC. Assessment
arrangements in each instance may have unique features which differentiate them from the way services are usually provided through Australia’s universal health care system. Specialised arrangements were therefore not the focus of this study.

Secondly, the study focus was limited to health assessment arrangements for the majority (93%) of children, being those placed in home-based OOHC (AIHW 2013). Health assessment for these children has usually been sought through universal health services. Universal health services in Australia consist of primary health care by general practitioners (GPs) or specialist medical care through public or private paediatric services. Children in OOHC who are permanent Australian residents would usually be eligible for health care subsidies for such services, under the Medicare national health insurance scheme.

Many voices clamor for attention in research conversations around OOHC. Law and justice, human ethics, human development, social planning, child protection, economics and politics are merely the loudest in the field. The thesis is limited in that it predominantly reports the voices of health professionals and, to a more limited extent, of policy advisors in Australia who collaborate on health assessment matters.

**RESEARCH AIM**

This thesis describes an Australian health policy and systems research study, conducted from 2010 to 2014, by a doctoral student. The study aimed to explore factors that influence how health professionals in Australia provide comprehensive health assessment for children and young people living in home-based OOHC.

**CONCEPTUALISING CHILD HEALTH**

The wide use of the word ‘health’ in everyday language can give the impression of shared meaning. People ritually raise glasses at social occasions to toast another’s health, often accompanied by wishes for good fortune, happiness or a long life. In popular culture, books, television and radio programs, and websites are devoted to ideas about health. Lay perceptions about health rest both on negative concepts, such being free of disease or sickness, and on positive concepts, such as wellness, fitness, or healthy diets (Bowling 2011).
Children as young as six years of age can understand and report on their own health and how it affects their lives (Stevens 2010). Children's level of happiness with their health has been shown to be significantly associated with their overall sense of wellbeing and a positive self-identity (Rees, et al., 2012).

In contrast to lay understandings about human health, health professionals' understandings face academic and professional challenges. Loosely framed and contested definitions, varied theoretical models, evolving knowledge and new discoveries (Alonso 2004, AIHW 2011) can be found at every turn. Ongoing health research and practice use fluid and complex concepts of health, disease, illness, sickness, wellness, health determinants and resilience (Yuill, Crinson, & Duncan 2010).

The ability to describe and measure health is important, both for healthcare organisations, and for health research (Godlee 2011). Developing operational measures of health, or assessment of individual health, rests firstly on a definition of health and the complexity with which health is defined. Interest in this thesis was confined to how health definitions affected health needs assessment in OOHC. However, listening in to conceptual conversations around the broader question of defining health proved important, serving to anchor the thesis within the territory of health professionals.

**DEFINING HEALTH**

Health can be understood as a state of being. A commonly used definition in Australian primary health care, for example, comes from the World Health Organisation (WHO) whose constitution states that "health is a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity" (WHO 1946 p.100). The WHO definition has endured for more than 60 years, notwithstanding criticisms that it is more aspirational than functional (Law, & Widdows 2007, Huber, Knottnerus, Green, Van der Horst, Jadad, Kromhout, Leonard, Lorig, Loureiro, Van der Meer, Schnabel, Smith, VanWeel, & Smid 2011, Smith, O’Grady, & Jadad 2009, Godlee 2011). Australia's Indigenous communities have similarly defined health as a state of being, but with physical, mental and social dimensions subsumed within an overarching state of "cultural and spiritual well-being" (NACCHO 2011, Wilson, & Neville 2009, McMahon, Reck, & Walker 2007).
Law and Widdows (2007) explored ideas about health as an ability to cope, a capability, citing Bircher (2004), who defined health as “a dynamic state of wellbeing characterised by a physical, mental and social potential which satisfies the demands of a life commensurate with age, culture and personal responsibility…” (Law, & Widdows 2007 p. 38). The idea of a dynamic state has gained traction. International health experts, meeting in 2011 to revise the WHO definition, moved away from the precision of a definition, and towards the idea of a health framework based around dynamic interactions that enable humans to adapt and self manage (Huber, Knottnerus, Green, Van der Horst, Jadad, Kromhout, Leonard, Lorig, Loureiro, Van der Meer, Schnabel, Smith, Van Weel, & Smid 2011). The suggested framework has been criticised as being too reductionist, more a definition of survival than of health. Notwithstanding such criticisms, there has been support for a health definition based on adaptability. The U.S. National Research Council and Institute of Medicine defined child health as:

...the extent to which individual children or groups of children are able and enabled to a) develop and realize their potential, b) satisfy their needs and c) develop the capacities that allow them to interact successfully with their biological, physical and social environments (National Research Council 2004 p. 33).

The idea of capacities has been expanded to include functionality, capability, and agency or autonomy as components of wellbeing, of what is required for a healthy life (Alkire 2005). Halfon and Hochstein (2002), drawing partly from similar ideas about capabilities and autonomy, developed a conceptual framework for defining health, based on a life course perspective. The framework is built on ideas about multiple determinants of health, the development of health as an adaptive process, the effect of risk and protective factors on health trajectories and the influence of the timing and sequence of determinants on human development. At the heart of the framework is a scientific understanding of the process of embedding, through which the effects of interactions with the external environment affect the way individual biological and behavioural systems develop. This understanding has provided new guidance for social services and health service programs for children, by beginning to augment knowledge about psychopathology, developmental deficits and negative environmental factors with ideas about what shapes child resilience in the face of adversity (Fraser 2004). Wetherington (2005) cautioned that some studies based on the life course approach dwell more on cumulative risk, than a balanced assessment of the competing positive and negative influences over time.
HEALTH ASSESSMENT IN OUT-OF-HOME CARE

Public health professionals have suggested that notions of child rights, equity, health determinants, and both community and individual health must be incorporated for a satisfactory health definition (Bradshaw, Hoelscher, & Richardson 2007, Shilton, Sparks, McQueen, Lamarre, & Jackson 2011). This clearly moves beyond ideas confined to a state of being. Life course perspectives continue to marry the influences of social context and biological development on health (Yuill, Crinson, & Duncan 2010).

A challenge in this thesis was to locate health definitions within multiple theories, not only in the area of child health, but also of child welfare. Contemporary Australian child protection practice has a multi-theoretical basis which has implications for how child health and wellbeing are viewed. Robyn Miller, the Principal Practitioner for Child Protection and Family Services in the Victorian Department of Human Services, identified separate and distinct theoretical perspectives in her conceptual overview of the principles of the "best interests of the child". Miller argued that child abuse and neglect is such a challenging and complex area that no single theoretical model is sufficient to address the breadth of concerns (Miller 2006). A gendered approach, for example, considers health particular to either girls or boys. Social exclusion theory generates concern about children's peer relationships and sense of belonging. Trauma theory has taken into account the neuro-physiological effects of past traumatic experiences. Attachment theory has been influential in child welfare in adding understanding about the link between the quality of primary caregiving relationships and links with self-regulation in children (Bowlby 1982).

1 The principles of the best interests of the child are articulated in the 1989 UN Convention of the Rights of the Child and provide an important underpinning of the most recent child protection legislation in Victoria, the Children, Youth and Families Act 2005. The principle states that “the best interests of the child must always be paramount”, and must be at the heart of all decision making and service delivery.
ECOLOGICAL THEORY OF CHILD DEVELOPMENT

Ecological theory of child development (Bronfenbrenner 1979) gained considerable traction in the child protection field. Ecological theory rightly encouraged consideration of a wide range of factors beyond disease that influence human health and wellbeing. Over time, objective and subjective measures across a wide range of domains have been used to assess child wellbeing. Beyond physical health, the inclusion of social measures as broad as poverty, housing and schooling opportunities along with measures of emotional factors such as resilience, happiness and life satisfaction serves to illustrate some of the breadth (Statham & Chase 2010). In my view, adoption of the ecological view in assessment frameworks for children unwittingly served to blur ideas about health within notions of wellbeing, and arguably distracted attention from the health of the individual child. Although the domain of child health has been found to be more strongly correlated to overall child wellbeing than any other factor (Bradshaw 2009), some child and family assessment models in the child protection field used diagrams where health was illustrated as a factor quite separate from the child (Department of Health 2000). The resulting concentration on environmental factors external to the child was contrary to Bronfenbrenner’s intent (Bronfenbrenner 2005). From the ecological perspective, a child’s exposure to maltreatment, their geographical isolation from health services, the cultural beliefs and norms of their community, bureaucratic decisions about eligibility for services and so on would all be important elements in a picture that captures a child’s experience of wellbeing over their life-course. While factors in the child’s environment undoubtedly interact to shape the child, Bronfenbrenner came to realise that “in place of too much research on development out of context, we now have a surfeit of studies on context without development”, and a failure to address the reciprocal interplay, between the influence of the external context on child development and the instigative characteristics within the child (Bronfenbrenner 2005 p. 95). He explained this failure partly as a product of his own strong emphasis on ecological factors in earlier writing, and partly as a result of policy makers and practitioners lacking awareness of subsequent research from disparate disciplines, which provided new perspectives for understanding the interplay.

Taken separately and together, different theories about child health and development have provided key starting points for a range of interventions aimed at improving child health (Vimpani 2003). Another type of definition adds ideas about receipt of health services to those about health as a state of being. The Australian Research Alliance on Children and Young People (ARACY), for example, used the following:-.
HEALTH ASSESSMENT IN OUT-OF-HOME CARE

Healthy children and youth have their physical, developmental, psychosocial and mental health needs met. They achieve their optimal developmental trajectories. They have access to services which support their optimum growth and development and have access to preventive measures to redress any emerging health or developmental concerns (ARACY 2013 p. 14).

The inclusion of health service receipt is evident in conversations about health measurement data. It has been argued that to understand health, there must be sufficient information about health care practices to make a connection between these practices and health outcomes (Brown, Zaslow, & Weitzman 2006). David Lewis, an English GP responding to an academic debate about health definition (Jadad, & O’Grady 2008), also argued for a definition of health that takes service availability and social infrastructure into account.

Health is created when individuals, families and communities are afforded the income, education and power to control their lives, and their needs and rights are supported by systems, environment and policies that are enabling and conducive to better health (Lewis 2011)

Similar ways of seeing health as a product of service systems have been evident among other researchers. Mallon, & Hess (2005) describe receipt of adequate services to meet physical and mental wellbeing needs as a variable of child wellbeing, along with the capacity of parents to provide for the child’s needs. It is at this point that the line blurs between defining the nature of a healthy state of being, articulating health determinants and studying the ecology around the child.

DETERMINANTS OF HEALTH

Since the 1970s, there has been a growing interest in health determinants, i.e. a range of personal, social, economic and environmental factors which determine the health status of individuals or populations (Lalonde 1974, WHO 2013). Discussions of determinants of health have tended to either clarify or distort conversations about defining health. For example, Graham, & Kelly (2004) summarised public health thinking, originating in the 1970s, arguing that too much attention had been given to genetic and biological influences as health determinants, and too little attention to the influence of social policies and social determinants. In the same year the National Research Council in North America argued that
biological factors, in addition to behavioural and environmental factors, act as key
determinants of child health and require closer attention. The argument for inclusion of
biological factors has been that “an individual's genetic endowment is considered an influence
because in most instances gene expression interacts with other factors before it causes disease
or impairment in functioning” (National Research Council 2004 p. 20). In particular, researchers
have come to recognise the great importance of biological and genetic factors in
Health Development Framework described the fluid, interwoven nature of these factors,
interacting with behavioural, social and economic contexts. The framework refers to individual
bio-behavioural regulatory systems that underpin adaptive processes as a developing child
undertakes multiple transactions with their environment. The framework points to critical and
sensitive periods of child development, when the balance of risk and protective factors may
have greater or more long-lasting health effects. Life-course perspectives have been adopted
in a variety of disciplines, including medicine, psychology, public health and sociology
(Wethington 2005). The slowness in updating measures of health determinants in child welfare
settings (Axford, & Berry 2005, O’Brien 2010) suggests that newer knowledge about the deep
significance of risk and protective factors has not yet been widely appreciated.

More recently, an 'ecobiodevelopmental' framework has been proposed that draws
collectively from neuroscience, molecular biology, genomics and the social sciences (Garner,
Shonkoff, Siegel, Dobbins, Earls, McGuin, Pascoe, & Wood 2012). An important longitudinal
research study in Australia, currently examining whether there are common predictors for
social-emotional adjustment, physical health and learning competencies in childhood,
indicates developing recognition of the complexity of association between health outcomes,
family structures, parenting capabilities and child temperament (Sanson, Smart, & Misson
2011).

Bradshaw, Hoelscher & Richardson (2007) made a connection between definitions,
determinants and child rights to health. They argued that, while child health and wellbeing are
the product of dynamic processes, with outcomes depending on the personal background,
situation, strengths and capacities of the individual child, “from a rights perspective, wellbeing
can be defined as the realisation of children’s rights and the fulfillment of the opportunity for
every child to be all she or he can be” (Bradshaw, Hoelscher, & Richardson 2007 p. 135).
CHILD MALTREATMENT AS A DETERMINANT OF HEALTH

At the extreme, child maltreatment can be fatal (De Silva, & Oates 1993). Although the true incidence of deaths as a result of maltreatment is unknown, several countries have developed local Child Death Review approaches to examine and learn from suspected cases (Jenny, & Isaac 2006). Maltreatment can result in injury or disease, or even the fabrication of illness. Child neglect can result in failure to treat disease or illness or a failure of growth and development. Cumulative neglect has been found among families where a child fails to thrive. Such cases occur within the caseload of emergency and forensic physicians. But child maltreatment can be a less immediately visible determinant of health (Briere 1992, Oates 1996).

Knowledge and new theories have been emerging about biological embedding of adversities during sensitive development periods. Maltreatment has been found to affect brain development in early childhood and hence, longer-term neuropsychological functioning (De Bellis 2005, De Bellis, Woolley, & Hooper 2013). It has been associated with dysregulation of a young child's psychological and physiological stress response systems. In physiological terms, this is referred to as an allostatic load, or accumulated stress mechanism. Such activation may be a precursor of lifetime impairment of learning capacity, and of physical and mental health. (De Bellis 2005, Harris, Lieberman & Marans 2007, National Scientific Council on the Developing Child 2012, Delima, & Vimpani 2011). New knowledge about the neurobiological impacts of child maltreatment (National Scientific Council on the Developing Child 2010) has confirmed what C. Henry Kempe believed from his experience of multiple cases (Kempe, & Kempe 1978). Child maltreatment can result in persistent fear, anxiety and trauma which remain determinative of child health long after a child is moved out of the way of physical harm or past neglect. Placement in OOHC by itself has been shown to be an insufficient intervention to alter the health trajectory. Remedial activity is required.


Having accepted that maltreatment is a determinant of health, scientists are currently concerned with understanding the determinative mechanisms more clearly (De Bellis 2005, Gilbert, Widom, Browne, Ferguson, Webb, & Jansen 2009). What are the sequelae of chronic, compared with isolated, maltreatment? What are the mechanisms through which neglect acts as a determinant, compared with the mechanisms of physical abuse or other forms of maltreatment (Glaser 2002, Jonson-Reid, Drake, & Zhou 2013, Widom, Czaja, Bentley, & Johnson 2012). Why does child maltreatment determine negative health outcomes for some children but not others? Such questions have spurred interest in ideas about individual resilience (Crittenden 1985, Hunter 2012, Nasvytiene, Lazdauskas, & Leonaviciene 2012, Toth, & Cicchetti 2013).
While the concept of resilience still lacks operational definition, and agreed measures, it has been understood as both a personal trait, and as the result of a complex interaction between risks and protective factors. Interaction models view resilience not as a fixed attribute, but as one that can change over the life-course, and vary between areas of individual function (Hermann, Stewart, Diaz-Granados, Berger, Jackson, & Yuen 2011). Ongoing research in developmental psychopathology has increased knowledge and continually challenged ideas about adaptation and mal-adaptation after child maltreatment (Toth, & Cicchetti 2013).

Lack of consensus in defining and measuring child abuse and neglect has hampered research effort to understand maltreatment as a health determinant (Fontana 1973, Wolock, & Horowitz 1984, AIHW 2006, McSherry 2007, Gilbert et al., 2009, Barron, & Jenny 2011, Tonmyr, Draca, Crain, & McMillan 2011 Norman, Byambas, De, Burchart, Scott, & Vos 2012). Research definitions and child protective services or legal definitions of abuse and neglect are not always congruent (Runyan, Cox, Dubowitz, Newton, Upadhyaya, Kotch, Leeb, Everson, & Knight 2005). Frameworks to guide protective practice continue to evolve and become more refined, as demonstrated in Danya Glaser’s research on emotional abuse and neglect (Glaser 2011, 2002). Greeley has argued (2012) that the complexity of intra and inter-disciplinary research leads to many considerations in the diagnosis of child abuse. There is no gold standard test for abuse. While research communities have been developing and debating definitions, measures, mechanisms and best-value approaches, child protection systems have been overwhelmed by their own primary task; that of keeping children safe from harm. Despite the available evidence about the health impacts, child abuse and neglect have been seen more as a social and criminal phenomena that as a health issue (Corby 2006).
HEALTH ASSESSMENT IN OUT-OF-HOME CARE

It is not surprising then that in the 21st century, Australian national child public health policies have struggled to articulate the nature and effects of child maltreatment as a health determinant. Australia's National Public Health Partnership (NPHP) found child protection was mentioned in some state and territory public health policies in relation to ensuring safe environments for children (NPHP 2003). However, in its’ national public health strategy, the NPHP failed to acknowledge child maltreatment as a health determinant (NCHP 2005). The rate of children aged 0-12 years who were subject of child protection substantiation in a given year was adopted in 2006 as one of 19 national headline indicators of child health, development and wellbeing. However, this was included as an indicator of child safety and security, or how well service delivery systems were performing, rather than of child health (AIHW 2008). A lack of consistency in inter-jurisdictional definitions and prevalence measures for child abuse and neglect has limited the utility of the indicator (AIHW 2011). Australia's headline indicator is not conceptually or operationally linked to indicators of child health outcomes consequent to child maltreatment. In more recent recent reports on population health in Australia which addressed social determinants of health (AIHW 2012, Senate Community Affairs Reference Committee 2013) arguments were variously and separately made that:

a. injury or trauma is one of the many factors that can impinge on human health, or;

b. child abuse and neglect can lead to disadvantage and people facing disadvantage can experience health effects, or;

c. people who experience social exclusion such as those leaving orphanages may experience poorer health.

However no explicit link acknowledging child maltreatment in itself as a health determinant has been made in such reports and as a population group maltreated children are poorly recognized as bearing health risks.
HEALTH ASSESSMENT IN OUT-OF-HOME CARE

OOHC AS A DETERMINANT OF HEALTH

Living in OOHC has been found to influence important, service-related health determinants for children in OOHC (Simms, Dubowitz, & Szilagyi 2000, McCarthy 2002), including access to health services (Kinard 2002, Jaudes, Bilaver, Goerge, Masterson, & Catania 2004), continuity of care (diGiuseppe, & Christakis 2003, Mekonnel, Noonan, & Rubin 2009), the availability of current and accurate medical records (Risley-Curtiss, & Kronenfeld 2001) and financial resources for health care costs (Leslie, Kelleher, Burns, Landsverk, & Rolls 2003).

The extent to which living in OOHC acts as a determinant of child health requires further research (Jones, Everson-Hock, Papaioannou, Guillaume, Goyder, Chilcott, Cooke, Payne, Duenas, Sheppart, & Swann 2011). While many studies have found significantly more health and developmental problems among children in OOHC, experiences prior to entry to care, such as instability or disruption of primary caregiving at critical developmental stages (Casanueva, Dozier, Tueller, Dolan, Smith, Webb, Westbrook, & Harden 2011) are likely to have been key determinants. The lack of baseline data at entry to OOHC has meant the impact of care on child health cannot be measured (Poertner 1998, Dunne, & Kettler 2006). While removal to OOHC may increase protection from direct harm, the nature of the OOHC experience may not necessarily enhance child health and development if, for example caregiving by foster parents is not sufficiently committed or optimal for the child’s needs (Lawrence, Carlson & Egeland 2006, Lloyd, & Barth 2011, Dozier, Zeanah, & Bernard 2013). Placement instability, for example, has been correlated with emotional and behavioural problems, physical and mental health outcomes and with risk-taking (Everson-Hock, Jones, Guillaume, Clapton, Goyder, Chilcott, Payne, Duenas, Sheppard, & Swann 2011). For some children a positive association has been found in Australia between very disrupted family histories, high levels of child psychological pathology and high incidence of disrupted placements (Osborn, Delfabbro, & Barber 2007). On the other hand, OOHC may contribute to improved child development and adaptation (Horwitz, Ballestracci, & Simms 2001). Living in OOHC can be considered as a sentinel event, signalling an opportunity to intervene to assess and respond to the impacts of risk factors affecting a child both before and during an OOHC placement (Zlotnick, Tam, & Soman 2012).
MEASURING CHILD HEALTH

The diversity of definitions of health is matched by a diversity of health measures. Health-related quality of life, different health domains, and milestones in child development have commonly been chosen for individual health measurement (Fattore, Mason & Watson 2007). Surveys and administrative data sets provide measures, including health care receipt, socio-emotional and intellectual development, family functioning and parental health, used for child population health. To be of value for research, it has been argued that such data sets should include longitudinal measures, a breadth of high quality and age-appropriate measures, measures drawn from nationally representative samples and sampling that allows stratified analysis across particular sub-populations. (Brown, Zaslow, & Weitzman 2006). The Growing up in Australia Longitudinal Study of Australian Children (Sanson, Smart, & Misson 2011), for example, has been following a representative sample of 10,090 children since 2004, using a variety of measures to examine domains of development. The Strengths and Difficulties Questionnaire (SDQ) has been adopted as a measure of socio-emotional adjustment. Four standardised screening scales have been used to examine child learning competencies:

i. Peabody Picture Vocabulary Test

ii. Academic Rating Scale of Language and Literacy

iii. Matrix reasoning - a subtest of the Wechsler Intelligence Scale for Children IV

iv. ARS Mathematical Thinking

Physical health has been measured with six different instruments

i. Global health rating by parents

ii. Health care needs screener

iii. Health problems index

iv. Body Mass Index

v. Paediatric Quality of Life Inventory

vi. Gross motor coordination scale
HEALTH ASSESSMENT IN OUT-OF-HOME CARE

Measuring the health of broad populations in this way is time consuming and expensive. This Australian study has been made possible through Commonwealth government funding and a sustained, collaborative effort between several research institutes, government bodies and individual researchers.

Given that definitions of health as shown earlier are contested, so too are concepts related to measurement contested (Hartnett, & Bruhn 2006, Lou, Anthony, Stone, Vu, & Austin 2008, O'Brien 2010, Stevens 2010). Administrative processes, such as being seen by a doctor or dentist within a nominated time-frame, have been used as proxy measures to draw conclusions about child health in OOHC (Mason, Urquhart, & Bolzan 2003, Axford, & Berry 2005). However past OOHC system performance measures in North America and Australia have largely ignored child health (Brown, & Zaslow 2006, Tilbury 2006).

More than 269 different tools have been identified for measurement across the physical, psychological, cognitive, social and economic domains of child health. However, comprehensive instruments, that address multiple domains, are limited and have not been well-tested on child welfare populations. Some tools are intended for population surveys rather than for individual assessment or clinical decision making. (Lou, et al., 2008). There has been an historical emphasis on measuring child deficits to the exclusion of strengths and competencies (Altshuler, & Glesson 1999). The resulting risk is that the capabilities of vulnerable and disadvantaged children can be overlooked (Eloff, Ebersohn, & Viljoen 2007).

Child health measures must be tailored across ages and stages of child development; there can be no one-size fits all approach. In practical terms, the demands of child welfare and health sectors mean that for individual child assessment, measurement tools need to be inexpensive, available, relatively brief and easy to administer and score. Standardised health measures have value as baseline indicators of health status, as a means of identifying service needs, and as a tool for collaborative planning towards improved child health outcomes (Lou et al., 2008).
CHILDREN’S SELF-MEASUREMENT OF HEALTH

Less emphasis has traditionally been evident on measuring health or health service experiences from children’s perspectives (Winter 2006). While health is a concept which children identify as impacting on their overall well-being, they may express ideas about what constitutes health differently to adults (Stanley 2007). A growing body of evidence that children can reliably and accurately report on their own health (Juniper, Guyatt, Feeney, Griffith, & Ferrie 1997, Riley 2004, Bevans, Riley, Moon, & Forrest 2010) has encouraged the development of paediatric self-report tools. Varied theoretical frameworks and measurement purposes have given rise to a range of tools measuring a cross-section of health and well-being dimensions such as physical functioning, pain and discomfort, sleep, cognitive and sensory functioning, emotional functioning, self-image, behavior and attachment to others (Prosser, & Corso 2007).

Some child and adolescent self-report tools such as the Child Behaviour Checklist (Achenbach, & Ruffle 2000) measure functional health and well-being. Others, including the Child Health Questionnaire (Landgraf 1999), the Pediatric Quality of Life Inventory (Varni, & Limbers 2009) and Kidscreen (Ravens-Sieberer, Gosch, Rajmil, Erhart, Bruil, Power, Duer, Auquier, Cloetta, Czemy, Mazur, Czimbalmos, Tountas, Hagquist, & Kilroe 2008) measure health-related quality of life. More recent research has produced preference-based measures for health-related quality of life such as the Child Health Utility 9D to enable economic evaluation of health care (Stevens, & Ratcliffe 2012). Research into paediatric self-report instruments has in part been encouraged by a broader focus in the U.S. on patient-reported outcomes and in part by research investment by the European Commission.

There has been a growing interest in measurement within health domains identified by children as important to them (Rees, Goswani, Popple, Bradshaw, Deung, & Main 2012) and recent studies have generated tools based on children’s ideas, rather than relying solely on adaptation of instruments designed for adults (Stevens 2010). Children have described health-related quality of life in terms of emotional factors such as feeling worried, unhappy and angry or in pain because of health difficulties, feeling weak or tired, or jealous of others who did not share the same difficulties. Stevens (2010) found children were more likely to use emotional than functional measures. In other studies children have spoken to being comfortable with their personal appearance, being physically and mentally well and being respected and valued in their own right as measures of health (Children’s Society 2012). Child well-being studies
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have captured other dimensions including autonomy and agency, being able to “be myself”, feeling safe, secure and valued and being involved in activities which give a sense of mastery and achievement (Fattore et al 2007). Greater attention has been given to child and adolescent participation in instrument development through focus groups, cognitive interviews and other types of qualitative research. Self-report survey design has been adapted to include pictorial, web-based and other age-appropriate devices to increase the efficiency and effectiveness of data collection and reliability of data (Bevans et al 2010).

While self-measures of health-related quality of life are now advocated as a gold standard in health research (Morrow, Hayen, Quinne, Scheinberg, & Craig 2011) there remain a number of difficulties in implementation for children. Firstly, as discussed earlier in this chapter, a consensus view is lacking as to how to define child health. Secondly, although disease-specific self-report tools are now available (Solans, Pane, Estrada, Serr-Sutton, Berra, Herdman, Alonso, & Rajmil 2008), a gap has been identified in relation to tools that adequately capture the health impacts of child maltreatment (Prosser, & Corso 2007, Tarren-Sweeney 2007). Thirdly, as no single tool has been developed to enable reliable self-report for children and adolescents of all ages a variety of instruments are necessary, including proxy measures for very young children or those with incapacities which make self-report impractical. Research has identified that perceptions of child health status and health-related quality of life can vary between children and proxy reporters including parents or carers and health professionals (Morrow et al 2011) and that particular attention should be paid to self-measurement for children who experience emotional distress or chronic pain where health impacts may be under-reported by proxies.

THEORETICAL STANCE

While acknowledging the complexity of definitions and frameworks applied to the concept of child health, this study sat within, but did not seek to necessarily encompass, all of this complexity. Similarly, while acknowledging cultural and spiritual health as overarching concepts for Indigenous Australians, the study did not have a particular focus on this important and over-represented population within OOHC.

There have been no experts when it comes to defining child health (Smith, O’Grady, & Jadad 2009). Consequently, no particular theory or framework was privileged. Rather, the study was built on the premise that child health is a complex, multi-dimensional construct. For
study purposes, an assessment of child health was considered comprehensive if it incorporated information across several domains, including at a minimum each of the three domains in the WHO definition. The study included an exploration of which dimensions are included by health professionals in their assessment of child health in OOHC.

Theoretical ideas about the nature of health needs were taken from the work of Wright, Williams & Wilkinson (1998) and Stevens & Gillam (1998). Needs assessment theory encompasses both individual health needs, and how these manifest when aggregated at a population level. The study drew on the American Academy of Pediatrics (AAP) definition of medical necessity as a useful perspective in judging need for health services (American Academy of Paediatrics 2005). The concept of health need is discussed more fully in Chapter 2.

Four different theoretical perspectives supported the scaffolding and influenced the scope of the study. Firstly, as described above, a broad view was taken of child health, informed by the WHO. Secondly, theoretical ideas about health need and medical necessity were adopted. Thirdly, a human-rights based approach placed the study in the context of enactment of health-related rights under the United Nations Convention on the Rights of the Child (UNCRC) 1989 (Office of the High Commissioner for Human Rights (OHCHR) 1990). Complexity theory provided the fourth pillar in the scaffolding.

The study acknowledged a universal consciousness about child neglect and abuse, expressed most recently on behalf of governments and modern, civil societies through the UNCRC. The Convention provides both a guide and an accountability framework for advancing child protection, which combines minimum and aspirational standards (Bennett, Hart, & Svevo-Cianci 2009). As a signatory to the Convention since 2000, the Australian government reports every five years to the United Nations Committee on the Rights of the Child (United Nations Committee on the Rights of the Child 2012) on compliance with the Convention.

The Convention recognises and affirms children’s right to protection from violence and maltreatment as a universal, legal and moral imperative. It also introduces the belief that in all actions concerning children, the ‘best interests’ of the child should be a primary consideration, and defends the right of each child to healthy development. This last right is addressed in several ways, most noticeably through reference to access to health care and to rehabilitation following abuse or neglect or other trauma:
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Article 24 - States Parties recognize the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health. States Parties shall strive to ensure that no child is deprived of his or her right of access to such health care services... (OHCHR p. 7)

Article 39 - States Parties shall take all appropriate measures to promote physical and psychological recovery and social reintegration of a child victim of any form of neglect, exploitation or abuse, torture or any other form of cruel, inhuman or degrading treatment or punishment, or armed conflicts. Such recovery and reintegration shall take place in an environment which fosters the health, self-respect and dignity of the child (OHCHR p.11).

Article 3 of the Convention ties protection from harm to care for each child’s well-being, and binds governments to ensure that all institutions, services and facilities responsible for care or protection of children would meet standards set by competent authorities, particularly in relation to safety and health.

The key concept in the Convention, in the context of a rights-based approach, is children’s right to the highest attainable standard of health. (Tobin 2006). Of particular relevance to this study was Article 24(1) which calls for states to "ensure" the provision of necessary medical assistance and health care (OHCHR 1990 p.7). Tobin explains the way the CRC has interpreted the right to health, which should not be understood as a right to be healthy, but as ensuring a system of health protection which provides equality of opportunity to enjoy the highest attainable standard of health. This interpretation directs states to attend to the availability, accessibility, acceptability and quality of health services for children.

The human rights-based approach (UNICEF 2003) provided an underpinning for the study. However this study did not seek to replicate or anticipate the CRC reviews of Australian compliance, nor did it seek to evaluate organisational performance. Rather, health professional’s ideas and experiences were central. They have unique roles in the enactment of children’s health-related rights.

The research sat within the context of societal planning and service system problems in child protection and health which are complex and generally seen as highly problematic. Such problems are characterised as ‘wicked’ (Rittel, & Webber 1983). For this reason, systems
theory provided the fourth scaffolding support for this study. Originating from the General System Theory of the biologist Von Bertalanffy (1972), systems theory has been adapted and developed across many disciplines, including the social and health sciences. It is fundamental to contemporary organisational theory. Systems theory has provided this study with a framework for testing whether the problem is truly 'wicked'. This, in turn, has influenced the choice of a methodology, developed by Checkland (2000), to improve understanding in complex societal systems and 'wicked' problem situations.

THESIS OVERVIEW

This thesis continues in Chapter 2 with a brief exploration of the concept of health need and a review the current evidence about health assessment in OOHC in Australia. Knowledge from Australian research about issues for health professionals in conducting health assessments in OOHC is compared with that found in U.K. and North American studies. I highlight problems with the availability of robust data and research which impact on the current state of knowledge about Australian OOHC. I also summarise the knowledge I gained from a national research symposium I initiated as part of this study and locate this thesis within the current academic conversation in Australia about health in OOHC. Further information about the symposium is in Appendix A. In Chapter 2 and in subsequent chapters I list the source for any dissemination of results from this research I have undertaken through journal publications or conference presentations. Each peer reviewed journal article is reproduced in full in Appendix D.

Chapter 3 outlines the nature and complexity of the problematic situation for Australian health professionals, including historical and contemporary contexts. The inclusion of the historical context adds a new interpretation to the nature of the interface between child protection and health professionals in Australia.

Following on from this background, Chapter 4 introduces the methodology and research design. I explain my choice of Peter Checkland's soft systems methodology (SSM) and the case study approach along with implementation challenges, including experiences with complicated national, multi-centre ethical and research governance review processes. Appendix B includes a case-study research protocol and forms associated with recruitment to the study.
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The study results begin to unfold in Chapter 5 which provides a contextual analysis for each of the cases in the study and situates the researcher as an actor in the research process. A picture begins to emerge of the influence of geography, public policy, economic and other factors which give a flavour of the Australian study settings.

The subsequent three chapters unpack case findings. Two key conceptual issues which emerged from the research are discussed in Chapters 6 and 7. In Chapter 8, I then offer a detailed examination of health professionals’ experiences of critical steps of care in health assessment processes. Appendix C provides a window into the cerebral mechanics of applied soft systems methodology which sat behind this detailed examination.

A central argument of the thesis is that further thinking about some fundamental conceptual challenges lies at the foundation of any quality improvement in health assessment systems for OOHC in Australia. The key study findings are summarised in Chapter 9 where implications for policy and practice are discussed.
OVERVIEW

Recorded knowledge about health assessments for children and young people living in out-of-home care in Australia can be traced back to the early 1800s when ships' surgeons and superintendents of orphan schools kept detailed records to report on the growth, health and mortality of children in public care in the colonies (Gandevia, & Simpson, 1978). More than two centuries on, a key goal of this study was to review current recorded knowledge in the academic literature and to identify gaps.

In designing the knowledge review for this study I drew on Huff’s notion of the academic “conversation” (2009 p. 3) as a metaphorical description of scholarly work. Each conversation has its own impetus, threads of ideas and audience and may continue over time. While tuning in to current conversations I listened for key concepts and their origins, some of which were buried in the past.

I begin this chapter by exploring ideas about child health need at both individual, and population health levels. The weft in the thesis fabric incorporates current Australian medical recommendations for child health needs assessment in OOHC. These are in part a product of the legacy of ideas from England and North America which I delve in to briefly. Australia and North America were both colonised by the English, who brought with them a strong influence of Poor Law thinking. In social policy and planning, along with scientific thought these origins continue to have a strong contemporary influence in Australia.

I then describe the two approaches used to study the contemporary academic conversation about health assessment in OOHC in Australia. The first approach, a traditional search of academic literature, followed by hours of reading under the desk lamp, engendered a curiosity to hear the current "live" conversation. I thus convened a two-day conversation at the university, bringing more than 100 people together from around Australia. This chapter tunes in to the key elements of the conversation I heard.
DEFINING AND ASSESSING CHILD HEALTH NEEDS

I outlined theoretical concepts about health in the previous chapter. Child health and health needs, rather than the more commonly discussed social and environmental needs of children in OOHC, have been at the heart of the conversations of interest to this study. Ideas about the nature of health needs and how they are determined are contested and rest on conceptual, political, ideological and political considerations (O’Brien 2010, Bowling 2011, Harrison, Young, Butow, & Solomon 2013). Indeed, a long unresolved question has been whether the health needs of maltreated children are medical or social problems (Markel, & Golden 2005, Winter 2006). In order to move forward, I took the view that a child’s health needs are highly relevant to health services, and that providing the means to meet those needs is a social planning problem. Planning that flows from health needs assessment can critically inform health resource allocation (Harrison, Young, Butow, & Solomon 2013).

Health need in OOHC is where a child’s health or development might be at risk of being impaired without some remedial action (Axford 2009). It can also be expressed in terms of comparative need (Bowling 2011), and of equity when considering the higher than average incidence of chronic and complex health conditions found among children in OOHC. In thinking about health can be defined, I have taken these notions of risk and equity along with those of Wright, Williams, & Wilkinson (1998) about need as the capacity to benefit from a health service intervention such as health education, disease prevention, diagnosis, treatment, rehabilitation or even terminal care.

POPULATION HEALTH NEED

At a population level, health needs assessment is a systematic approach to ensuring health service resources are used to improve the health of a population in the most efficient way (Wright et al., 1998). Information from systematically collected individual health needs assessments can be pooled to:

- provide epidemiological data to inform the design of effective health service delivery for particular populations;
- better enable evidence-informed policy and improved service system design to meet health care needs in the most effective, efficient and equitable ways, at the local level;
- inform inter-agency collaboration, research or funding priorities.
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The nexus between individual and population health needs assessment is crucial. Collated data from systematic health needs assessment in OOHC care enables patterns of disease and illness to be compared over time and with other populations. Data can highlight areas of unmet health need and add to knowledge about the felt priorities of children and their carers.

INDIVIDUAL CHILD HEALTH NEED

Individual health needs assessment can lead to improved detection of health concerns (Jee, Szilagyi, Ovenshire, Norton, Conn, Blumkin, & Szilagyi 2010, Horwitz, Ownes, & Simms 2000), and improved health service provision for individuals (Cooper, Morrison, Melville, Finlayson, Allan, Martin, & Robinson 2006). At the individual level, assessment can establish the nature and extent of health risks and health conditions, and determine unmet health care needs. Assessment can identify where ineffective, inefficient or inappropriate health care has been provided, and can determine potential individual benefits of health care. These benefits may not be limited to a change in current health status, but might also include illness prevention, diagnosis, continuing care, rehabilitation, palliative care, and/or education, reassurance or support to carers (Stevens, & Gillam 1998).

MEASURING POPULATION AND INDIVIDUAL HEALTH IN OOHC

Over the long-term, measurement serves as the handrail of policy, keeping efforts on track towards goals, encouraging sustained attention, giving early warning of failure or success, fuelling advocacy, sharpening accountability, and helping to allocate resources more effectively (UNICEF 2007)

Ideas about the purpose of measuring health need in OOHC have not always been crystal clear (Butler, & Payne 1997). In practice, lack of agreement about specific measures, together with a lack of data and inadequate information management systems have hampered broader ideas about child health and health outcomes being operationalised in OOHC (Poertner 1998, Leslie, Gordon, Lambros, Premji, Peoples, & Gist 2005, AIHW 2011, Skouteris, McCabe, Juller-Tyszkiewicz, Henwood, Limbrick, & Miller 2011, Ferry, Ireys, Foster, Devers, & Smith 2012). Resistance has also been noted in the child protection sector to measurement of child health and other child outcomes.
At a practical level, measures need to be purposefully incorporated into child welfare administrative databases, and then collected from the time a new case is opened. Historically, this has not been the practice (Poertner 1998). It has been hypothesised that the underlying reasons for resistance to measurement include aggregated data being undervalued and underused for decision making, staff feeling overwhelmed when measures showed the level of unmet needs among children, and fears that data would be used to demonstrate poor practice (Shackelford, Harper, Sullivan, & Edwards 2007). However, where staff valued standardised measures and were able to relate their value to specific cases, issues were more likely to be related to the time taken to complete standardised measures or perceptions about further training needs (Whyte, & Campbell 2008).

Child protection researchers have described specific aspects of wellbeing as worthy of measurement in OOHC populations, including the concepts of resilience and coping, behavioural disturbance, school performance, trauma experiences, safety and permanency and attached relationships between children and significant adults. (Altshuler, & Gleeson 1999, Strand, Sarmiento, & Pasquale 2005, Wulczyn 2008, Meiser-Stedman, Smith, Bryant, Salmon, Yule, Dalgleish, & Nixon 2009). At the same time, there have been calls for more careful, critical analysis of motives for “judging, measuring and comparing” children in OOHC, particularly in the context of screening, assessment and checklists which take a focus away from the less tangible work of forming meaningful, helpful relationships with children (Garrett 1999 p. 43) and appreciating the broader context of children’s lives (Knight, & Caveney, 1998, Folman 1998).
Since the 1990s, local authorities in both England and North America have been challenged to find new ways of measuring health for children in OOHC. Early efforts focussed on the extent of OOHC health assessment policy development and compliance to assess the extent of health measurement activities (United States General Accounting Office 1995, Cameron, Macdonald, & Daniels 2010, Department of Education 2012). The introduction of the Adoption and Safe Families Act in 1997 increased North American interest in compliance by mandating regular assessment of child welfare service outcomes for children (Wulczyn, Barth, Yuan, Harden, & Landsverk 2005). A national system of Child and Family Services State Reviews has audited states against their performance in ensuring children in OOHC received adequate services to meet their physical, dental and mental health needs.

The extent to which children in OOHC have received comprehensive health needs assessments has been measured in the US (Leslie, Hurlburt, Landsverk, Rolls, Wood, & Kelleher 2003. Ryan, Logosso, Armstrong-Coben, Ganz, & Holochwost 2005, Risley-Curtiss, & Stites 2007, Brown, & Bascetta 2009, Schneiderman, Leslie, Arnold-Clark, McDaniel, & Xie 2011) and the U.K. (Department for Education 2012, Mooney, Statham, Monck, & Chambers 2009, Rodrigues 2004, Hill, & Watkins 2003, Williams, Jackson, Maddocks, Cheung, Love, & Hutchings 2001). However, at an operational level, assessing compliance is complex when there is lack of uniform policies (Leslie et al., 2003) and lack of clarity or consensus about which health dimensions and which outcomes are to be assessed (Poertner 1998, Garwood, & Close 2001). Identifying reliable and achievable health indicators has been complex (Hartnett, & Bruhn 2006).

Systematic and periodic assessment of the health needs of children in OOHC can uncover more health needs than isolated examinations (Szilagyi 2012), particularly when assessment addresses all aspects of health (physical, developmental, emotional, behavioural, dental and educational). The use of standardised screening tools can lead to better identification of children’s developmental needs (Jee, Szilagyi, Ovenshire, Norton, Conn, Blumkin, & Szilagyi 2010).

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Paediatrics, child psychiatry and child psychology have a particular focus on child health as a dimension of child wellbeing. Measures in the medical disciplines have included:

a. physical health and illness (Sneddon 2003, Sullivan, & VanZyl 2007, Ringeisen, Casaneuva, Urato, & Cross 2008, Widom, Czaja, Bentley, & Johnson 2012);


d. intellectual abilities (Strathearn, Gray, O’Callaghan, & Wood 2001, Garwood, & Close 2001, Budd, Felix, Poindexter, Naid-Polan, & Sloss 2002);

e. physical and behavioural development (Leslie, Gordon, Ganger, & Gist 2002, Lawrence, Carlton, & Egeland 2006, Zimmer, & Pankov 2006, Lloyd, & Barth 2011);

f. health-related quality of life (Prosser, & Corso 2007);


h. prescription of psychotropic medications (Zito, Safter, Sai, Gardner, Thomas, Coombes, Dubowski, & Mendez-Lewis 2007, Raghavan, Lama, Kohl, & Hamilton 2010).

MEDICAL RECOMMENDATIONS FOR HEALTH ASSESSMENT IN OOHC

The early history of health need assessment for children and young people cared for 'on the public common' is discussed in the next chapter. North American and English OOHC health assessment recommendations have influenced medical thinking in Australia (Carter 1983, Murphy 2011) and provide an important context for the contemporary health assessment conversation.

MEDICAL RECOMMENDATIONS IN U.S.

The American Academy of Pediatrics (AAP) recommendations on health care for children in OOHC (American Academy of Pediatrics 1994) called for:

- initial health screening before or immediately after placement in care;
- comprehensive health assessment by a paediatrician within 30 days of placement;
- developmental and mental health evaluation;
- monitoring during an OOHC placement.

These recommendations were revised in 2001 and 2005 to include dental assessment and continuity of primary care in a "medical home" (AAP 2005). American Board of Pediatrics certification in the sub-specialty of Child Abuse Pediatrics, first approved in 2008, recognised the additional knowledge requirements of paediatricians involved in comprehensive health assessment and treatment after child maltreatment (Christian 2008, Giardino, Hanson, Hill, & Leventhal 2011).

By 2008 key components were broadly adopted in US federal legislation resulting in a significant flow of federal reimbursement to states under the Social Security Act for health expenditure on foster children. Implementation has been monitored through analysis of

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3 The figurative expression 'on the public common' is used in this thesis for illustrative purposes. It draws on the image of common land, a notion inherited from English land management systems since the early Middle Ages when there were no owners of land, use being common to all. Common land provided what was essential for people's survival; food, water and fuel. English legislation of 1235 established the rights of use of common land, notwithstanding debates about formal ownership. (Association of Commons Registrations). Authorities Retrieved October 7, 2013 from www.acraew.org.U.K/index.php?page=History) Debates, disputes and fluid arrangements through history about entitlement to use common land resonate with debates, changing values and changeable arrangements for care of children requiring, metaphorically, to share in the use of common land when separated from the protection of their own family. Figuratively speaking children affected by uncertainty about who is taking responsibility for them on behalf of the Crown or of the State could be imagined as being left wandering on the public common.

4 S. 205 of the US Congress Fostering Connections to Success and Increasing Adoptions Act (2008) amended S. 422(b) of the Social Security Act to required states to consult with pediatricians to develop health oversight and coordination plan for any child in a foster care placement which "will ensure a coordinated strategy to identify and respond to the health care needs of children in foster placement"
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Medicaid data (Geen, Sommers & Cohen 2005) and audits of state compliance. Notwithstanding federal legislative support for the AAP recommendations state level implementation remained problematic (Mekonnen, Noonan, & Rubin 2009) as many states struggled to comply (U.S. Department of Health and Human Services 2011).

**MEDICAL RECOMMENDATIONS IN U.K.**

The then Medical Group of the British Agencies for Adoption and Fostering had supported health assessment in OOHC for many years (Mather, & Batty 2000) before a parallel to the North American recommendations was put in place in England, through the Children Act 1991. Associated statutory requirements to that Act were designed to ensure that all children would be assessed by a registered medical practitioner before, or shortly after, their entry into OOHC (Secretary of State for Health 1991). Statutory requirements for health assessment have been the subject of ongoing revision in England (Mooney et al., 2009, DCSF 2009, 2010) and of national compliance reporting (Department of Education 2012). As in the U.S. progress in implementation of the medical recommendations has been slow (Simkiss 2013).

Intercollegiate roles and competencies for health professionals assessing children in OOHC were first agreed in 2012 (RCN, RCPCH, & RCGP 2012).

**MEDICAL RECOMMENDATIONS IN AUSTRALIA**

More than two decades after the initial North American recommendations, the Royal Australasian College of Physicians called for routine, comprehensive and collaborative health assessment and systematic health monitoring and service planning in OOHC in Australia (RACP 2006). The Royal Australian & New Zealand College of Psychiatrists subsequently also released a position statement specifically recommending greater attention to the mental health needs of children in OOHC (RANZCP 2009). It took another five years from the time of the RACP’s recommendations until the first national Australian out-of-home care standards, implemented gradually from 1 July 2011, signalled national recognition by governments of the desirability of health needs assessment in OOHC. The standards called for preliminary health checks and then comprehensive assessments, covering physical, developmental, psychosocial and mental health needs (Department of Families, Housing, Community Services and Indigenous Affairs 2010). The Commonwealth Department of Health and Ageing developed a complementary National Clinical Assessment Framework for Out-of-Home Care (APHPC 2011) designed to:
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- improve the consistency of OOHC health assessments and services provided by state and territory governments;
- provide advice about the role of clinicians and appropriate assessment tools;
- encourage jurisdictions to develop appropriate policies to enable early detection of child health needs by health professionals.

One explanation for the time lapse between international precedents and Australia’s initiatives was the reluctance of the Australian government to interfere in child protection and health matters. These both fell within the purview of state and territory governments which had individual jurisdiction over hospitals and community services and their own individual child protection legislations. Within this federated system, the Commonwealth government remained at arms-length. Its two key functions were distribution of taxation revenue to states and territories for expenditure on health-related services (Parliamentary Education Office 2013) and the national universal health insurance scheme, Medicare (Palmer, & Short 2010). While the Commonwealth provided funding for local primary health care organisations known as Medicare Locals to encourage GP-led initiatives in population health, child protection and OOHC have never been the subject of nationally targeted population health initiatives or funding through these organisations.

A second explanation for Australia being slow to respond to medical recommendations about health assessment in OOHC was that although Australia ratified the UNCRC in 1990, it did not take the Convention into law (Rayner 1994, Tobin 2006). Rather than following their international cousins by taking legislative or regulatory action, the Australian government took a soft, collaborative approach with states and territories. It was nine years after Australia’s ratification of the UNCRC that a National Framework for Protecting Australia’s Children was agreed between the respective governments (Council of Australian Governments 2009). The Framework had no legislative force, but attempted to articulate a shared agenda between the jurisdictions, and identify goals for collaborative approaches. National Standards for OOHC (Department of Families, Housing, Community Services and Indigenous Affairs 2010) and the National Clinical Assessment Framework for OOHC (Australian Population Health Principle Committee 2011) were both by-products of the collaborative agenda. Criticism from the UN for failure to honour the health-related rights of children affected by maltreatment certainly urged the Australian government to take action on child health needs in OOHC, but beyond moral censure there were no sanctions for failure to act.
A third likely explanation is that national conversations about OOHC provision in Australia were hampered by lack of knowledge. It was not until 1989 that Australia began to collate child protection data at the national level (AIHW 1993) and a broad picture about OOHC slowly emerged. At the same time, Australia lacked the research and technical capacity to study maltreatment-related child health and development disorders to the same extent as North America. This placed Australia in the position of needing to extrapolate from overseas evidence, in order to identify children at risk who would benefit from targeted health screening and assessment (Delima, & Vimpani 2011). It was not until 2013 that the Commonwealth created a new position of National Children’s Commissioner to promote discussion and awareness of the human rights of children in Australia, particularly those who were vulnerable or at risk (Australian Human Rights Commission 2013).

AUSTRALIAN IMPLEMENTATION OF MEDICAL RECOMMENDATIONS

What had been the Australian research conversation about health assessment in OOHC at the time this study commenced? The audio signals seemed weak. In an invited presentation to the Queensland Child Protection Symposium in 2000, Adam Tomison, then Senior Research Fellow at Australia’s National Child Protection Clearinghouse, argued that “there does not appear to be a clear, coordinated, dedicated research program operating across the nation.” (Tomison 2000, p.2). Acknowledgement of the research gap around OOHC was not a new phenomenon. Boss’s (1986) report on systems for managing child maltreatment identified diverse, inconsistent and uncoordinated child protection data collection systems which prohibited national analysis across Australian jurisdictions. He called for wide research in the field. However, the multi-jurisdictional nature of Australian child protection systems was complex and opaque (Bromfield, & Higgins 2005a). Twenty years after Boss’s assessment, notwithstanding concerted efforts in national collation of child protection data, the Australian Institute of Health & Welfare (AIHW) found that little could be learned about health and wellbeing in OOHC from existing administrative data sets in Australian states and territories (AIHW 2006).

A single research study had found health assessment rates in OOHC in one Australia state were poor (Gilbertson, & Barber 2004). Reports from Commissions of Inquiry and public audits made similar findings in other states (Commission for Children and Young People and Child Guardian 2010, NSW Office for Children 2010, Wood 2008, Mullighan 2008, Ford 2007,
HEALTH ASSESSMENT IN OUT-OF-HOME CARE


While there was disquiet in public administration about how health was being addressed, health had still barely permeated the research focus in the child protection sector. In an audit of a decade of Australian research on OOHC, commissioned by the Child and Family Welfare Association of Australia and the Association of Children’s Welfare Agencies (Cashmore, & Ainsworth 2004) health had not been among the search terms. That audit formed the basis of a more comprehensive research review (Bromfield, Higgins, Osborn, Panozzo, & Richardson 2005) commissioned by the Australian Government. The review characterised health as child wellbeing which was just one of several reported outcomes studied in OOHC, along with placement stability, permanency planning, educational needs and family contact. Among 21 publications identified in the audit which addressed outcomes in OOHC, a total of six addressed psychosocial and behavioural adjustment (Barber, & Delfabbro 2003, 2004, 2005, Osborn, & Delfabbro 2006), or mental health problems (Tarren-Sweeney 2006, Tarren-Sweeney, & Hazell 2005, 2006). One further publication, a state audit in Victoria, concluded that most children in OOHC were in good physical health (Victorian Department of Human Services 2002). At the same time that the RACP (2006) was reviewing its’ policy on health assessment in OOHC, the OOHC sector was working from a limited research base. It seemed then that the most which had been learned from the research audit in OOHC was that children in OOHC showed exceptionally poor mental health and social skills and resembled clinic-referred children in the scope and severity of their problems (Tarren-Sweeney, & Hazell 2006) but that psychological functioning could improve over time in OOHC (Barber, & Delfabbro 2005). The prevalence of aberrant eating among children in OOHC was found to be much higher than anticipated (Tarren-Sweeney 2006) and between 14% and 20% of children in care may have intellectual or physical disabilities (Victorian Department of Human Services 2002). The ongoing gaps in knowledge were evident and were felt more broadly in the child protection field, even if there seemed a low level of appreciation of the need to examine child health.

There is a limited evidence base in the field of child abuse and neglect, which is difficult to reconcile with increasing demands for evidence-based practice in child and family services and highlights the urgent need for a national research agenda (Bromfield, & Arney 2008 p.13).
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AUSTRALIAN RESEARCH AND PRACTICE REVIEW

When I commenced this PhD study in 2010, it became clear to me that the past Australian research conversation had been in muted tones. In order to listen attentively to the current dialogue, I adopted two approaches:

(1) I initiated a national symposium of health professionals and policy advisors with experience of health assessment in OOHC;

(2) I reviewed published literature in Australia from 2006 to 2010.

REVIEW APPROACH I: NATIONAL SYMPOSIUM

After review of the published literature, and reflection on the theoretical frameworks and underpinnings, it was clear that there were gaps in the information needed to create a satisfactory blueprint for the PhD study. Were the emerging questions the right and the only questions in the Australian context? Was there other relevant data? Were there additional themes that might be important to consider? Was it possible to tap the unpublished wisdom and experience of key people grappling with health assessment questions in their everyday practice? Was there further, as yet unpublished Australian research on foot? Had important literature been missed? I developed an idea about holding a small one-day symposium which could bring together up to 20 people for a discussion around these questions.

SYMPOSIUM IN CONTEXT OF NATIONAL POLICY DEVELOPMENT

Unexpectedly, in July 2010 the Commonwealth government released new draft national standards for out-of-home care (Department of Families, Housing, Communities and Indigenous Affairs 2010). The draft standards proposed comprehensive health assessments for all children and young people entering OOHC and addressed ongoing health service provision and health record management. This provided an important 'hook' and I was able to engage two collaborating bodies and the university in my idea for convening a larger, national symposium and inviting clinicians, child protection professionals and policy makers to the table.

SYMPOSIUM FUNDING AND AIMS

I brokered a funding partnership agreement between the University of Melbourne General Practice and Primary Health Care Academic Centre, General Practice Victoria and the
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Office of the Child Safety Commissioner Victoria which enabled the two-day symposium to be conducted without registration fees for participants. A Call for Papers was posted for the event, titled “Health, hope and resilience: Fostering better health for Australian children and young people living in out-of-home care”, which was subsequently held in October 2010 at the University of Melbourne.

A primary aim of the symposium was to enable sharing of the best available evidence from Australian research and everyday practice about health systems in OOHC, including systems for comprehensive health needs assessment, models for improving continuity of health service and methods of managing child health records.

SYMPOSIUM PARTICIPANTS AND PRESENTATIONS

An initial invitation list was developed through a search for:

- authors of Australian research on child or adolescent health and well-being in out-of-home care;
- clinicians working in the area of child protection, including paediatricians, general practitioners, psychiatrists and psychologists;
- policy or senior program managers responsible for child health in child protection in Commonwealth, state and territory government departments;
- organisations with statutory responsibilities in advocacy and representation for children in out-of-home care.

This search resulted in an invitation list of 226 people. Funding partners suggested additional names, leading to a final list of 260. Emails were sent to each person on the invitation list giving details of the symposium and the Call for Papers. The Call for Papers was also advertised through national newsletters and email bulletins of Australian Policy Online (APO), the Australian Research Alliance for Children and Young People (ARACY) and the Australian Institute of Family Studies National Child Protection Clearing House. Details were circulated through the Australian General Practice Network (AGPN) and the national network of Children’s Commissioners and Guardians.

Advertising attracted 23 abstracts, which were double-blind reviewed by the principal PhD Supervisor, Associate Professor Temple-Smith and 6 members of a Planning Advisory
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Written review summaries were completed by all reviewers, using a standardised format. Three PhD students in the General Practice and Primary Health Care Academic Centre also reviewed the abstracts and provided written reviews. The Planning Advisory Group met to compare reviewer ratings and made a final selection of 18 papers for inclusion in the symposium program. One author subsequently declined the offer to present, due to competing commitments.

The symposium program was widely advertised and attracted more than 100 participants, coming from most Australian states and from New Zealand, far exceeding my initial expectations.

SYMPOSIUM THEMES

The final program included invited keynote and peer-reviewed paper presentations, and three small group discussion segments, in addition to the opening address and policy presentations. A printed guide provided to each participant, contained the program, paper abstracts and speaker details.

A keynote paper addressed the vital question for this research study of whether comprehensive health assessment for children and young people in out-of-home care was warranted in Australia, given the current evidence. Of the 17 peer-reviewed papers in the program, 10 were unpublished. Peer-reviewed papers addressed a range of themes including health assessment program implementation, health service access and equity in rural settings, interagency communication, the health status of children OOHC and spiritual health in Indigenous children.

Two papers were based on published reports from statutory Children’s Commissioners and Guardians. Three academic papers were in press, and one had been, in part, the subject of a previous academic journal article, which covered a broader topic.

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5 The Planning Advisory Group was comprised of representatives from the partnership organizations, as well as the Victorian Department of Human Services and the Centre for Excellence in Child and Family Welfare in Victoria.
Unpublished research was presented around some important themes such as the development of new, standardised screening tools, and their particular value for this cohort.

Newly published work emerged in several ways. Importantly, some relevant work, on health assessment for refugee and immigrant children had not emerged in the literature search as it was not specific to children in OOHC and was only just published. Secondly, a key researcher, who was not able to attend, provided details of a forthcoming special edition of a leading journal which contained relevant material and was therefore promoted in the symposium program. Thirdly, presenters provided details of their own forthcoming or new publications and referred to other new work. Fourthly, themes emerged which were additional to, or further developed than those evident from the literature search. These included the formation of therapeutic relationships with a child as therapy in itself, the need to develop consistent language to describe health needs assessment, and the potentially powerful role of independent advocacy in the Australian context. The symposium also confirmed that the previously identified themes which shaped the program were highly relevant.

**SYMPOSIUM OUTCOMES**

The symposium created a link to a broad, interdisciplinary community of researchers, practitioners and policy makers, who shared an interest in the Australian academic conversation and supported the aims of this study. It clearly demonstrated that no state or territory claimed to have a robust, sustainable and comprehensive system in place to assess the health needs of children and young people in OOHC, or to consistently provide appropriate treatment and therapy to meet known needs. This confirmed the value of undertaking research to better understand factors that limit or enhance the development of such systems.

The symposium program along with a published overview and summary of the outcomes are provided in Appendix A of this thesis.
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REVIEW APPROACH II - NARRATIVE LITERATURE REVIEW

A previous Australian OOHC research review (Bromfield, Higgins, Osborn, Panazzo, & Richardson 2005, Bromfield, & Osborn 2007) indicated a paucity of research about health assessment in OOHC. I used that review as my starting point and concentrated the literature review for this study on the period from 2006.

SEARCH STRATEGY

Between April and December 2010 I searched six academic databases (Web of Science, EBSCO, Informit, PsycArticles, SCOPUS, PubMed) for any journal article published between 2006 and 2010 reporting research on any aspect of child or adolescent health in OOHC in Australia, including physical, mental, emotional, behavioural, cultural or developmental health. Research on health care systems or health decision making in out-of-home care were included, as were relevant editorials, letters to the editor and critical analyses. Search terms used, as derived from the CSA Thesaurus, Medical Subject Headings (MeSH) and key words in relevant articles already identified, are listed in Table 1. To avoid duplicating a systematic review of research about residential and specialised models of care (Osborn, & Bromfield 2007), and given only 6% of children and young people in OOHC in 2010 were in residential care (AIHW, 2011), my literature review focused on home-based OOHC (i.e. foster and kinship care). I also subsequently searched potentially relevant references from the Systematic Map of the Out-of-Home Care Literature 1995-2008 provided by a fellow PhD student, Belinda Mayfield from University of Queensland (Mayfield 2010). This helped to confirm the search strategy, as only one additional reference was located from the Map.

This chapter reports the results of my Australian research review completed in December 2010 and subsequently published in 2011. Up to the time of completion of this thesis I became aware of only one publication which was not captured in the literature search. That research paper, by Tarren-Sweeney (2010c), which described a further aspect (abnormal pain responses) arising from his Children in Care study in New South Wales is not reported in the analysis here as it did not inform my thinking at the time of the study design.
Table 1  Search terms selected for literature review re Australian research on health needs of children in Out-of-Home Care in Australia 2006-2010.

<table>
<thead>
<tr>
<th>Key Term</th>
<th>Key Term</th>
<th>Key Concept</th>
<th>Key Concept</th>
<th>Key Concept</th>
</tr>
</thead>
<tbody>
<tr>
<td>FIELD</td>
<td>Child Abuse</td>
<td>Out-of-Home Care</td>
<td>Child Health</td>
<td>Health Needs Assessment</td>
</tr>
<tr>
<td></td>
<td>Child neglect</td>
<td></td>
<td></td>
<td>Good practice guide for health care in child protection</td>
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<td></td>
<td>Child maltreatment</td>
<td></td>
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<td></td>
<td>Battered child</td>
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<td></td>
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<tr>
<td></td>
<td>Safeguarding children</td>
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<tr>
<td></td>
<td>Child abandonment</td>
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<td></td>
<td>Child welfare</td>
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<tr>
<td>SYNONYMS</td>
<td>Child protection</td>
<td>Looked-after children</td>
<td>Child well-being</td>
<td>Health check</td>
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<tr>
<td></td>
<td>Child neglect</td>
<td>Foster care</td>
<td>Health outcomes</td>
<td>Multi-disciplinary assessment</td>
</tr>
<tr>
<td></td>
<td>Child maltreatment</td>
<td>Kinship care</td>
<td>Adjustment</td>
<td>Medical examination</td>
</tr>
<tr>
<td></td>
<td>Battered child</td>
<td>Residential care</td>
<td>Mental health</td>
<td>Well child check</td>
</tr>
<tr>
<td></td>
<td>Safeguarding children</td>
<td></td>
<td>Emotional health</td>
<td>Health examination</td>
</tr>
<tr>
<td></td>
<td>Child abandonment</td>
<td>Foster child*</td>
<td>Behaviour</td>
<td>Promoting health</td>
</tr>
<tr>
<td></td>
<td>Child welfare</td>
<td>Development</td>
<td>Development</td>
<td>Fostering health</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Health needs</td>
<td></td>
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<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MeSH</td>
<td>Child abuse</td>
<td>Foster home care</td>
<td>Child health services</td>
<td>Physical examination</td>
</tr>
<tr>
<td></td>
<td>Child abuse, sexual</td>
<td>Fostering Kinship care</td>
<td></td>
<td>Needs assessment, healthcare</td>
</tr>
<tr>
<td></td>
<td>Shaken baby syndrome</td>
<td>Care, foster home Care, kinship</td>
<td></td>
<td>Assessment of healthcare needs</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Outcome and process assessment(Health Care)</td>
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<td></td>
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<td></td>
<td></td>
<td>Patient care planning/organization and administration</td>
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<td></td>
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<td></td>
<td></td>
<td>Primary health care Physicians, Family</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td>Quality assurance, health care</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Pediatrics/standards</td>
</tr>
<tr>
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<td></td>
<td></td>
<td>Comprehensive health care/standards</td>
</tr>
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<td></td>
<td></td>
<td></td>
<td>Child health services/standards</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Child health services/organization &amp; administration</td>
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<td></td>
<td></td>
<td>Medical records systems</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td>Patient care planning</td>
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<td></td>
<td></td>
<td>Clinical governance</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td>Standards of care</td>
</tr>
</tbody>
</table>

I screened all articles by title and excluded those which were not about the health or health care of children or young people in OOHC. Abstracts were reviewed to exclude studies which were not Australian or not relevant. Articles about types of OOHC accommodation, carer needs, or parent health were excluded if they did not include an examination of the health or health care of children or young people. I reviewed and analysed the full text of the remaining articles.
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None of the papers specifically addressed the research aim in this PhD study which was to explore what may assist or hinder health professionals in undertaking comprehensive health assessment in OOHC. However, as my research aim was subsumed within an overarching interest in the Australian research conversation about health in OOHC, I undertook a narrative review which allowed me to surf the channels on which that conversation took place, confident that this would enrich my appreciation of the context for my study.

PUBLICATION ANALYSIS - METHOD OF ANALYSIS

The search identified 53 publications, which included 44 research reports, relating to 34 different studies. As the literature was varied, I used the Medical Journal of Australia (MJA) typology to categorise publications. The relative involvement of different disciplines and research groups, and the types of journals where research was published were of interest, as were research topics and methods.

PUBLICATION ANALYSIS - PUBLICATION TYPES

In Table 2 I describe my categorisation results, based on the MJA typology. All but two of the publications were articles in peer-reviewed academic journals, the exceptions being peer-reviewed conference papers. The first, (Reynolds, & Casey 2008) reported important secondary data from an out-of-home care health assessment clinic in an Aboriginal Health Service. The second (Mendes 2010) was a further paper, in relation to an ongoing study. Paediatricians wrote three of the four editorials retrieved, with the fourth coming from the discipline of psychology. These are listed in Table 3. Tarren-Sweeney’s (2010) introductory article as guest co-editor of the international journal Child Psychology and Psychiatry was categorised as a Review. Three critical analysis articles came from the disciplines of psychiatry, psychology and social work, two in international journals published in the U.K. A detailed retrospective reflection, after more than 30 years as a community paediatrician in the child protection field was also included (Packer 2008), as was a letter to the editor from a community paediatrician. While it was clear that these types of publications indicated an inter-

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disciplinary commentary on the issues. What was missing from within the MJA typology were 
Clinical Updates.

Table 2  Number and percentage of published articles (2006-2010) relating to health/health care for children aged 0-17 years living in Out-of-Home Care in Australia, listed by Medical Journal of Australia typology, 2010.

<table>
<thead>
<tr>
<th>Type of Article</th>
<th>Number</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Editorial</td>
<td>4</td>
<td>7.5 %</td>
</tr>
<tr>
<td>Research</td>
<td>44</td>
<td>83 %</td>
</tr>
<tr>
<td>Review</td>
<td>3</td>
<td>5.5 %</td>
</tr>
<tr>
<td>Clinical Update</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Personal Perspective</td>
<td>1</td>
<td>2%</td>
</tr>
<tr>
<td>Letter to the Editor</td>
<td>1</td>
<td>2%</td>
</tr>
<tr>
<td>TOTAL</td>
<td>53</td>
<td>100%</td>
</tr>
</tbody>
</table>

Table 3  Australian editorial authors, writing on health in Out-of-Home Care, 2006-2010, categorised by discipline and name of publication.

<table>
<thead>
<tr>
<th>Author/s</th>
<th>Discipline</th>
<th>Journal</th>
</tr>
</thead>
<tbody>
<tr>
<td>(2009) Winterton, P.M.</td>
<td>Paediatrics</td>
<td>Medical Journal of Australia</td>
</tr>
</tbody>
</table>

The 44 research reports were categorised according to studies generating original data or using secondary data. Table 4 indicates the number of studies in each category.
Table 4  Number of Australian research papers 2006-2010 relating to health needs and/or health care for children in Out-of-Home Care in Australia, categorised by first author, use of original or secondary data and number of studies.

<table>
<thead>
<tr>
<th>First Author</th>
<th>Papers reporting Research generating Original Data</th>
<th>Papers reporting Research using Secondary Data</th>
<th>Number of Studies (*does not equal number of papers)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bromfield L</td>
<td>2007, 2005</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Carbone JA</td>
<td>2007&lt;sup&gt;a&lt;/sup&gt;</td>
<td></td>
<td>-&lt;sup&gt;2&lt;/sup&gt;</td>
</tr>
<tr>
<td>Cashmore J</td>
<td>2006</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Chambers M</td>
<td>2010</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Champion R</td>
<td>2009</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Drake T</td>
<td>2008</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Dunne E</td>
<td>2006</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Fernandez E</td>
<td>2009, 2008, 2007</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Frederico, M.</td>
<td>2008</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Jackson, A.</td>
<td>2009</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Kaltner, M.</td>
<td>2010</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>McGlade, A.</td>
<td>2010</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>McMahon, A.</td>
<td>2007</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Milburn, N.</td>
<td>2008</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Moss, M.</td>
<td>2009</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Nathanson, D.</td>
<td>2009, 2007</td>
<td></td>
<td>2</td>
</tr>
<tr>
<td>O'Donnell, M.</td>
<td>2010</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Reynolds</td>
<td>2008</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Sawyer, M.</td>
<td>2007</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Sheehan, R.</td>
<td>2010</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Tregeagle, S.</td>
<td>2010</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Webster, S.</td>
<td>2010</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Wilson, S.</td>
<td>2009</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Zhou, A.</td>
<td>2010</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>TOTAL</td>
<td>27</td>
<td>17</td>
<td>[34&lt;sup&gt;a&lt;/sup&gt;]</td>
</tr>
</tbody>
</table>

<sup>a</sup> While 19 studies generated original data, two papers were written for one study by different first authors from different disciplines (Carbone 2007, Sawyer 2007). For the purposes of this table, both papers are included but the study is counted only once.
HEALTH ASSESSMENT IN OUT-OF-HOME CARE

PUBLICATIONS ANALYSIS - RESEARCH FUNDING

The review identified 34 relevant research studies published between 2006 and 2010, which contrasted with only seven published in the previous 10 years (Bromfield et al., 2005). While I found no published data about the quantum of research funding, where available I considered the funding sources to gauge the level and type of research investment in Australia (Table 5). In 23% of studies, each by a principal researcher holding a senior academic or clinical post, no funding source was disclosed. Research higher degree students completed 20% of studies. State government funding accounted for 29%. In 17% of studies the principal researcher was an employee of the organisation in which the research took place. Only 15% appeared to have been specifically commissioned from universities. (Jackson, Frederico, Tanti, & Black, 2009, Frederico et al., 2008, Milburn, Lynch, & Jackson, 2008, Tarren-Sweeney, & Hazell 2006, Cashmore, & Paxman, 2006). The Australian Research Council (ARC) funded 8% of studies. Of these, one (Fernandez 2009, 2008) was supplemented by a charitable trust. Another included an Australian Postgraduate Award (APA) Industry Scholarship (O’Donnell, Nassar, Leonard, Mathews, Patterson, & Stanley 2010). The third fell within a larger ARC Linkage project on foster care (McMahon, Reck, & Walker 2007).

Table 5 Number of Australian research studies (2006-2010) relating to health needs and/or health care for children in Out-of-Home Care, categorised by research funding source.

<table>
<thead>
<tr>
<th>Funding Source</th>
<th>Research generating Original Data</th>
<th>Research using Secondary Data</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHMRC</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>ARC Linkages</td>
<td>1</td>
<td>-</td>
<td>1</td>
</tr>
<tr>
<td>ARC Linkages + RHD</td>
<td>-</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>ARC + Charity</td>
<td>1</td>
<td>-</td>
<td>1</td>
</tr>
<tr>
<td>Criminology Research Council</td>
<td>-</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Australian Housing &amp; Urban Research Institute + Charity</td>
<td>-</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Australian Rotary Research Fund</td>
<td>1</td>
<td>-</td>
<td>1</td>
</tr>
<tr>
<td>Charitable trust only</td>
<td>3</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>Research Higher Degree Studies</td>
<td>4</td>
<td>2</td>
<td>6</td>
</tr>
<tr>
<td>State governments</td>
<td>7</td>
<td>3</td>
<td>10</td>
</tr>
<tr>
<td>No funding disclosed</td>
<td>2</td>
<td>6</td>
<td>8</td>
</tr>
<tr>
<td>TOTAL</td>
<td>19</td>
<td>15</td>
<td>34</td>
</tr>
</tbody>
</table>
It appeared from my analysis that more studies were funded by charities (12%) than through national competitive research rounds (8%). Researchers not only tapped into more usual charitable sources such as the Australian Rotary Health Research Fund, but also called upon less likely benefactors, including Gourmet Traveller Wines and the Returned Services League.

Notwithstanding an increased number of studies over the previous decade, a closer analysis suggested there had been, at best only a modest level of financial investment. This was noteworthy when compared to expenditure through the National Health & Medical Research Council (NHMRC) for health conditions with a comparable impact on child health.\(^7\)

**PUBLICATIONS ANALYSIS - DISCIPLINE-BASED RESEARCH**

Among the 34 research studies I identified the discipline of the first authors in research published at the time of the literature review (Table 6). Social workers were first authors for 44% of studies and psychologist for 24%, thereby accounting for the majority of studies. Only 12% of published studies were in paediatrics (all funded by charitable trusts). Psychiatrists were first authors for 6% of studies. It was striking that only one research study (Webster, & Temple-Smith) came from the primary health care discipline, considering that general practice is at the front line of health care for children in OOHC.

---

Table 6
Number of Australian research studies (2006-2010) relating to health needs and/or health care for children in Out-of-Home Care, categorised by first author’s academic discipline.

<table>
<thead>
<tr>
<th>Academic Discipline of First Author</th>
<th>Number of Research Studies generating Original Data</th>
<th>Number of Research Studies involving Secondary Data</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child Protection Policy</td>
<td>-</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Health Informatics</td>
<td>-</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Law</td>
<td>1</td>
<td>-</td>
<td>1</td>
</tr>
<tr>
<td>Paediatrics</td>
<td>3</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>Primary Health Care</td>
<td>1</td>
<td>-</td>
<td>1</td>
</tr>
<tr>
<td>Psychiatry</td>
<td>2</td>
<td>-</td>
<td>2</td>
</tr>
<tr>
<td>Psychology</td>
<td>3</td>
<td>5</td>
<td>8</td>
</tr>
<tr>
<td>Social Work</td>
<td>10</td>
<td>5</td>
<td>15</td>
</tr>
<tr>
<td>Statistics / Economics</td>
<td>-</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>TOTAL</td>
<td>20</td>
<td>14</td>
<td>34</td>
</tr>
</tbody>
</table>

* Although 19 studies generated original data, one study produced two papers by different authors from different disciplines (Carbone 2007, Sawyer 2007) and is recorded twice.

PUBLICATIONS ANALYSIS - THE AUDIENCE

Over the 5 years, researchers from the 34 studies generated 42 publications in a variety of academic journals across disciplines and interest areas, as summarised in Table 7. Papers were predominantly written for medical and clinical audiences (36%) and social work (31%). Child development journals published 19% of papers and child protection journals a further 12%. Only one article, pointing to the fact that existing performance measures in child protection ignored child health and well-being, was particularly written for a public policy audience (Tilbury 2006).
HEALTH ASSESSMENT IN OUT-OF-HOME CARE

Table 7  The number of papers appearing 2006-2010 in Australian and international journals about Australian research into health needs and/or health care in Out-of-Home Care in Australia.

<table>
<thead>
<tr>
<th>Field of Interest</th>
<th>Journals</th>
<th>No. of Papers</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Medicine and clinical services</strong></td>
<td>Australian Journal of Primary Health</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Current Opinion in Psychiatry</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>International Health Information Management Journal</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Journal of Abnormal Child Psychology</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Journal of Clinical Child Psychiatry &amp; Psychology</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Journal of Paediatrics &amp; Child Health</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>Medical Journal of Australia</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Pediatrics</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Quality of Life Research</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td><strong>SUB-TOTAL</strong></td>
<td><strong>15</strong></td>
</tr>
<tr>
<td><strong>Social Work</strong></td>
<td>Administration in Social Work</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Australian Social Work</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>British Journal of Social Work</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Child &amp; Family Social Work</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>Family Matters</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>International Journal of Social Welfare</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Journal of Family Studies</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td><strong>SUB-TOTAL</strong></td>
<td><strong>13</strong></td>
</tr>
<tr>
<td><strong>Child Protection</strong></td>
<td>Child Abuse Review</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Child Maltreatment</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Developing Practice: the Child, Youth &amp; Family Work Journal</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Vulnerable Children &amp; Youth Studies</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td><strong>SUB-TOTAL</strong></td>
<td><strong>5</strong></td>
</tr>
<tr>
<td><strong>Child Development</strong></td>
<td>Child &amp; Youth Services Review</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>Children Australia</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Youth Studies Australia</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td><strong>SUB-TOTAL</strong></td>
<td><strong>8</strong></td>
</tr>
<tr>
<td><strong>Policy</strong></td>
<td>Australian Journal of Public Administration</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td><strong>SUB-TOTAL</strong></td>
<td><strong>1</strong></td>
</tr>
<tr>
<td></td>
<td><strong>TOTAL NUMBER OF PUBLISHED PAPERS</strong></td>
<td><strong>42</strong></td>
</tr>
</tbody>
</table>
Recommendations flowing from research have been directed at a range of audiences, including child protection practitioners, people looking after children in out-of-home care, government departments with statutory responsibilities, politicians, clinicians, other health care providers and public health planners and practitioners.

It was not clear from the publication pattern how policy makers, child protection professionals working in government and community organisations, and carers might have learned about health researcher’s recommendations, particularly considering the listed journals in the medical and some other disciplines are not on open access. Research had predominantly been in the three largest Australians states: Queensland, NSW and Victoria. There were limited examples of research summaries circulated for a non-academic audience e.g. the National Child Protection Clearinghouse Issues Papers, and NSW Department of Community Services Research Notes. Professional practice guides, such as those provided by the NSW Children’s Guardian, also provided a synthesis of research-based evidence. Notwithstanding these examples, the systematic and universal promotion of research evidence to inform policy and practice about health assessment in OOHC appeared to have been somewhat fragmented.

**PUBLICATIONS ANALYSIS -TOPICS OF RESEARCH**

The research study topics largely encompassed a variety of dimensions of child health status, and the impacts of health assessment on subsequent health care provision.

**TOPIC (I) DIMENSIONS OF CHILD HEALTH RESEARCHED**

Research studies varied in the extent to which they took a comprehensive approach across dimensions of child health and well-being. One qualitative study sought to define what health and well-being means in Indigenous Australian cultures (McMahon, Reck, & Walker 2007). Studies situated in hospital-based paediatric clinics tended to involve multi-disciplinary approaches and examine physical, developmental and psychological health. Studies in the psychiatry and social work disciplines were generally focused on mental health, and social and emotional adjustment, rather than physical health. In other studies, health was one variable considered along with issues such as employment, training, housing and independent living skills. Table 8 summarises the aspects of health examined.
HEALTH ASSESSMENT IN OUT-OF-HOME CARE

Table 8  Domains of child health examined in Australian research studies in Out-of-Home Care published 2006-2010.

<table>
<thead>
<tr>
<th>Domain</th>
<th>Aspect</th>
<th>First Author</th>
</tr>
</thead>
<tbody>
<tr>
<td>Definition of wellbeing</td>
<td>Defining well-being for Aboriginal, Torres Strait and Pacific Islander children in out-of-home care</td>
<td>McMahon 2007</td>
</tr>
<tr>
<td>General Health</td>
<td>Cumulative harm and chronic maltreatment</td>
<td>Bromfield 2007, 2005</td>
</tr>
<tr>
<td></td>
<td>Experiences and impact of abuse prior to child protection referral</td>
<td>Frederico 2008</td>
</tr>
<tr>
<td></td>
<td>Well-being in care</td>
<td>Fernandez 2009, 2007</td>
</tr>
<tr>
<td></td>
<td>Health-related quality of life</td>
<td>Carbone 2007</td>
</tr>
<tr>
<td></td>
<td>Health of children presented to Children’s Court for child protection who have parent in prison</td>
<td>Sheehan 2010</td>
</tr>
<tr>
<td>Mental Health</td>
<td>Predictors of mental health problems</td>
<td>Tarren-Sweeney 2008</td>
</tr>
<tr>
<td>Emotional &amp; Behavioural</td>
<td>Self-esteem, connectedness with family, identity</td>
<td>Moss 2009</td>
</tr>
<tr>
<td></td>
<td>Social/emotional problems of children in kinship care</td>
<td>Dunne 2006</td>
</tr>
<tr>
<td></td>
<td>Patterns of aberrant eating</td>
<td>Tarren-Sweeney 2006</td>
</tr>
<tr>
<td></td>
<td>Problematic sexualized behaviours</td>
<td>Tarren-Sweeney 2008</td>
</tr>
</tbody>
</table>

TOPIC (II) RESEARCH ON OUTCOMES

In 21% of studies, researchers examined health or health service outcomes for children in OOHC, as shown in Table 9. Among these, 12% of studies followed what had happened in relation to children's health care and health needs several months after they had received a comprehensive assessment. One study considered the outcomes of a type of therapeutic treatment and another explored health outcomes as part of a longitudinal study with OOHC.
HEALTH ASSESSMENT IN OUT-OF-HOME CARE

care leavers. It was of interest to me that among the outcomes research 71% came from the medical disciplines.

Table 9  Types of outcomes of health assessment in OOHC examined in Australian research studies 2006-2010, by first author and year of publication

<table>
<thead>
<tr>
<th>Types of Outcomes Studied</th>
<th>First Author / Year of Publication</th>
</tr>
</thead>
<tbody>
<tr>
<td>Longitudinal impacts on children of comprehensive assessment in an out-of-home care multi-disciplinary clinic</td>
<td>Chambers 2010</td>
</tr>
<tr>
<td></td>
<td>Nathanson 2009</td>
</tr>
<tr>
<td></td>
<td>Reynolds 2009</td>
</tr>
<tr>
<td>Outcomes for children in a therapeutic response service</td>
<td>Jackson 2009</td>
</tr>
<tr>
<td>Longitudinal study of outcomes for care leavers</td>
<td>Mendes 2010</td>
</tr>
<tr>
<td></td>
<td>Cashmore 2006</td>
</tr>
<tr>
<td>Concordance of mental health impairment and service use</td>
<td>Tarren-Sweeney 2010</td>
</tr>
</tbody>
</table>

PUBLICATIONS ANALYSIS – METHODS OF RESEARCH

I also reviewed two aspects of research methods; the types of research informants and the extent and types of standardized tools administered to collect research data.

METHODS (I): RESEARCH INFORMANTS

In assessing child health, information from sufficient, independent sources is needed to enhance the quality of the information (Barber, & Delfabbro 2000). Parents, child protection case managers, clinicians and allied health professionals, foster and kinship carers and teachers were used as informants about the health status of children and young people. In some studies, self-report measures completed by young people or qualitative interviews were also used (Mendes 2010, 2008, Fernandez 2009, 2008, 2007, Moss 2009, Milburn, Lynch, & Jackson 2008, Carbone 2007, Sawyer, Carbone, Searle, & Robinson 2007, Cashmore 2006). The type of informant appeared influential, as researchers reported that:

a. carers tended to underestimate the health problems of children in care when compared to clinical assessment findings (Kaltner, & Rittel 2010) and were sometimes unwilling or unable to provide information (Chambers, Saunders, New, Williams, & Stachurska, 2010);

b. the criteria used by carers to assess child health and wellbeing in Indigenous communities could be culturally diverse and they may have lacked opportunities to record their views in ways that were meaningful to them (McMahon et al., 2007);

c. child protection case managers were not always able to code maltreatment
histories accurately (Tarren-Sweeney 2008, Bromfield, & Higgins 2005) and were not always able to retrieve child health records efficiently from child protection records (Nathanson, Lee, & Tzioumi 2009, Tarren-Sweeney 2006, Tilbury 2006);

d. health conditions detected by paediatricians at entry to out-of-home care health assessment may have been previously undiagnosed or poorly managed (Nathanson, & Tzioumi 2007);

e. parents may be unable or unwilling to provide accurate information about the child because of low literacy levels, concerns about privacy, embarrassment or bad feelings, or fear of social disapproval about recording adverse information, such as parental substance abuse (Tregeagle 2010);

f. although carer and teacher ratings may have been congruent for child health problems below clinical thresholds, they were less reliable for problems in the clinical range (Fernandez 2008).

The emerging picture suggested that the quality and reliability of child health history information for children in OOHC can be variable and this may be an issue for health professionals conducting assessments.

METHODS (II): STANDARDISED TOOLS USED IN RESEARCH

One third of the 34 studies involved collecting data through the use of standardized assessment tools which may have been administered to the children’s carers or to children themselves. The uses of each category of tools are discussed below.

a) Standardised Tools Administered to Adults: Fifteen tools administered to adults with knowledge of the child or young person are listed in Table 10. Two of the tools used are of particular importance having been developed in Australia for the cohort of children being studied. The Assessment Checklist for Children (ACC), developed by Tarren-Sweeney for an initial study published in 2006, is a behaviour rating scale for children in foster, kinship and residential care. It was designed to measure a range of problems not included in standard parent-report checklists, including attachment-related difficulties, anxiety and dissociative responses to trauma, age-inappropriate sexual behaviour and self-harm. This scale was subsequently used by Chambers, Saunders, New, Williams, & Stachurska (2010).

The Harm Consequences Assessment tool was developed in 2004 by a collaborative team, comprising Victorian researchers at La Trobe University and the Berry Street Victoria Take Two program, to describe the experiences and impact of abuse prior to child protection referral (Frederico, Jackson, & Black 2008). It was
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designed to be completed by child protection professionals to capture their perception of cumulative, harmful experiences and their consequence for individual children. The domains covered were abandonment or no appropriate carer, physical harm and injury, sexual abuse, emotional and psychological harm and developmental and medical harm. The tool was revised in 2008.

Table 10 Standardised health assessment tools used to collect information from adult informants about children in Out-of-Home Care in Australian research studies published 2006-2010.

<table>
<thead>
<tr>
<th>Screening /Assessment Tool</th>
<th>First Author</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ages and Stages Questionnaire (Bricker &amp; Squires)</td>
<td>Chambers 2010</td>
</tr>
<tr>
<td>Australian Developmental Screening Test (Burdon 1993)</td>
<td>Nathanson 2007</td>
</tr>
<tr>
<td>Child Health Questionnaire Parent Form CHQ-PF50 (Quality Metric)</td>
<td>Carbone 2007</td>
</tr>
<tr>
<td>Depression Scale CES-D (Centre for Epidemiological Studies)</td>
<td>Sawyer 2007</td>
</tr>
<tr>
<td>Hare Self-Esteem Scale (Shoemaker 1980)</td>
<td>Fernandez 2007</td>
</tr>
<tr>
<td>Harm Consequences Assessment (Thomas et al 2004)</td>
<td>Frederico 2008</td>
</tr>
<tr>
<td>ICD Diagnostic Classifications</td>
<td>Milburn 2008</td>
</tr>
<tr>
<td>Interpersonal Parent and Peer Attachment Inventory (Armsden &amp; Greenberg 1987)</td>
<td>Fernandez 2007</td>
</tr>
<tr>
<td>Social Network Map (Tracey &amp; Whitaker 1990)</td>
<td>Jackson 2009</td>
</tr>
<tr>
<td>Strengths and Difficulties Questionnaire (Goodman 1997)</td>
<td>Milburn 2008</td>
</tr>
<tr>
<td>Trauma Symptom Checklist for Children (Briere 1996)</td>
<td>Jackson 2009</td>
</tr>
<tr>
<td>Youth Risk Behaviour Surveillance System Questionnaire (National Centre for Chronic Disease Prevention and Health Promotion)</td>
<td>Sawyer 2007</td>
</tr>
</tbody>
</table>

b) Standardised Tools for Completion by Children or Young People: Two of the tools used in research studies were administered to young people aged 13 years and over and one was completed by children from age 7. Three tools completed by young people are listed in Table 11.
Seventeen different screening tools were used in Australian research, along with the ICD Diagnostic Classifications. Only two were used in multiple studies; the Assessment Checklist for Children (ACC) and the Child Behaviour Checklist.

Table 11  Standardised assessment tools used to collect information from children assessed in Out-of-Home Care in Australian research studies published 2006-2010

<table>
<thead>
<tr>
<th>Assessment Tool</th>
<th>First Author/Year of Publication</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child Health Questionnaire Child Form CHQ-CF7 (Quality Metric)</td>
<td>Carbone 2007</td>
</tr>
</tbody>
</table>
SYMPOSIUM AND LITERATURE REVIEW FINDINGS

FINDING A: LEVEL OF ASSESSED HEALTH NEED

A threshold question related to the need for this PhD study was whether the health needs of the contemporary OOHC population in Australia warranted the same comprehensive approaches as those recommended by medical colleges in the U.K. and U.S. Similar levels of chronic and complex health conditions to those found overseas were evident in the 12 Australian studies which identified health needs of individual children in OOHC (Chambers et al., 2010, Kaltner, & Rissel, 2010, Sheehan 2010, Tarren-Sweeney 2006, 2008a, 2008b, 2010, Fernandez 2009, 2008, 2007, Jackson et al., 2009, Frederico et al., 2008, Milburn et al., 2008, Reynolds, & Casey 2008, Carbone, Sawyer, Searle, & Robinson, 2007, Sawyer, et al., 2007, Cashmore, & Paxman, 2006).

Importantly, five studies compared the extent of health needs within their sample with the broader Australian population. Overall, prevalence of health problems was much higher in children in out-of-home care than in the Australian population, comparable to that in North American and U.K. studies (Fernandez 2008, Milburn et al., 2008, Nathanson, & Tzioumi, 2007, Carbone et al., 2007, Sawyer et al., 2007). The prevalence of mental health problems, for example, was two to five times greater in children in OOHC (Jackson et al., 2009, Fernandez 2008, Sawyer et al., 2007). Children in Australian OOHC were also more likely to have complex health concerns at entry to care than the general population, with 70% to 90% requiring multiple referrals for further assessment and treatment (Kaltner & Rissel 2010, Carbone et al., 2007, Nathanson, Lee, & Tzioumi 2009). Table 12 summarises the type and frequency of health problems.
Table 12  Types of health problems identified, and range of frequencies among children aged 0-17 years in Out-of-Home Care research published in Australia 2006-2010.

<table>
<thead>
<tr>
<th>Health Problem</th>
<th>Range of Frequency</th>
<th>First Author / Year of Publication</th>
</tr>
</thead>
<tbody>
<tr>
<td>Immunisation not up to date</td>
<td>24% to 53%</td>
<td>Kaltner 2010</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Reynolds 2008</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Nathanson 2007</td>
</tr>
<tr>
<td>Vision</td>
<td>18% to 33%</td>
<td>Chambers 2010</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Nathanson 2007</td>
</tr>
<tr>
<td>Hearing</td>
<td>24% to 26%</td>
<td>Chambers 2010</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Kaltner 2010</td>
</tr>
<tr>
<td>Growth abnormalities</td>
<td>14%</td>
<td>Nathanson 2007</td>
</tr>
<tr>
<td>Eating disorders</td>
<td>24%</td>
<td>Tarren-Sweeney 2006</td>
</tr>
<tr>
<td>Language delay</td>
<td>57%</td>
<td>Chambers 2010</td>
</tr>
<tr>
<td>Emotional/behavioural</td>
<td>48% to 62%</td>
<td>Jackson 2009</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Milburn 2008</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Sawyer 2007</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Tarren-Sweeney 2006</td>
</tr>
<tr>
<td>Psychotropic medication used</td>
<td>16%</td>
<td>Tarren-Sweeney 2010</td>
</tr>
<tr>
<td>Multiple referrals needed for further assessment and treatment</td>
<td>70% to 90%</td>
<td>Kaltner 2010</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Nathanson 2009</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Carbone 2007</td>
</tr>
</tbody>
</table>

The incidence, complexity and effect of health problems in OOHC in Australia significantly reduce health-related quality of life, with comparable effects to diabetes, asthma or cystic fibrosis (Carbone et al., 2007).

Some studies used standardised tools, allowing identification of health conditions severe enough to warrant treatment (Fernandez 2008, Tarren-Sweeney 2006). Notwithstanding that such data showed severity rates were higher among study children than the wider community, the use of tools was repeated only occasionally across studies. Medical guidelines in Australia recommend the systematic use of screening tools in OOHC health assessment (RANZCP 2009, APHPC 2011). If implemented, further comparative evidence may become available about child health status.
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In their review of the neurobiology of maltreatment, Delima and Vimpani concluded that while Australia lacks the research and technological capacity to extensively study maltreated children, evidence extrapolated from international studies supports targeted assessment and screening (Delima & Vimpani 2011).

In summary, children in Australian OOHC were found to have significant levels of complex health concerns and health needs which are unlikely to be adequately identified and addressed through opportunistic health care alone.

FINDING B: CURRENT THREADS OF THE ACADEMIC CONVERSATION IN AUSTRALIAN RESEARCH

Articles providing critical analyses, editorials and letters to the editor along with conclusions and recommendations of individual research studies provided the tone and tenor of the current conversation. While listening, I reflected on the content, the speakers and the silences. I heard four main threads of ideas about future directions.

CONVERSATION THREAD (1) SUPPORT FOR SYSTEMATIC HEALTH ASSESSMENT IN OOHC

Justification for the cost of systematic individual health needs assessment is an important theoretical issue in population health. Stevens and Gillam (1998) argued that individual assessment is most appropriate when case loads are light, the cost per patient is high, there are few potentially hidden patients, and there is high variability among cases. All of these conditions apply to OOHC population. The case load of children in OOHC for an Australian general practitioner (GP) would normally not exceed three each year but the cost in doctor time to complete an OOHC assessment is high compared with that of usual, standard consultations (Webster, & Temple-Smith 2010). Similarly, in specialist paediatric services, the time needed for comprehensive health assessment for OOHC significantly exceeds that of a usual paediatric consultation (Piper, & Ryan 2010). Children in OOHC (except for those in informal kinship care) are known to the state; hence there is a low potential for hidden children. Research indicates both the complexity and multiplicity of conditions experienced by children and their varying ages and stages of development assure high variability among cases (Sawyer et al., 2007, Nathanson, & Tzioumi 2007, Tarren-Sweeney 2006, 2007, 2008, Frederico et al., 2008, Fernandez 2008, Jackson et al., 2009, Chambers et al., 2010)
Australian researchers called for more systematic measurement of health needs, arguing that children required pre-emptive, population-based assessment of all aspects of their health at entry to care (Crawford 2006, Tarren-Sweeney 2010). Further, different assessments were called for, depending on the child’s developmental stage. Infants and young people leaving care, for example, were seen to have particular but different monitoring needs (Milburn et al., 2008, Zhou, & Chilvers 2010). Some sub-populations warranted additional assessment, monitoring and research e.g. children with intellectual disabilities, Indigenous, immigrant and refugee children (Davidson, Skull, Chaney, Frydenberg, Isaacs, Kelly, Lampropoulos, Ramon, Silove, Buttery, Smith, Steel, & Burgner 2004, Walsh, & Paxton 2010, Raman, Reynolds, & Khan 2011, Tarren-Sweeney 2010, Tilbury 2009).

Australian research since 2006 indicated no significant doubt that health problems experienced among children in OOHC are important, frequent and can have a high impact on children’s lives. Evidence of the outcomes for children after comprehensive health needs assessment was confined to three, single-site studies. These revealed that although multiple health needs were identified through comprehensive assessment in OOHC populations, complex referral processes, health service waiting lists, lack of financing for private health services and difficulties faced by carers and child protection case managers in navigating health systems resulted in less than optimal outcomes (Chambers et al., 2010). Lack of continuity of OOHC placement and of case manager, along with poor record keeping about child health also adversely affected the implementation of health recommendations after comprehensive assessment (Nathanson et al., 2009, Reynolds, & Casey 2008).

Difficulties in addressing health needs does not undermine support for systematic health assessment activities. Rather assessment is theoretically driven by the potential to benefit, not whether every outcome will be favourable (Stevens, & Gillam 1998). The American Academy of Pediatrics’ definition of ‘medical necessity’ for children (American Academy of Pediatrics 2005) illuminated the notion of ‘potential to benefit’ more clearly. According to that definition, necessity can be assured where health interventions:

- are intended to promote normal growth and development and prevent, diagnose, detect, treat ameliorate or palliate the effects of any condition, injury or disability, be appropriate for the age and stage of the child and reflect current bioethical standards;
b. -can be reasonably expected to produce the intended results and have expected benefits which outweigh potential harmful effects, and where there is insufficient scientific evidence, be judged on the basis of professional standards or consensus paediatric expert opinion;

c. -can be judged in terms of effectiveness on the basis of value for children, not on lowest price.

In the absence of gold-standard scientific evidence, this definition alone supported the necessity for individual health assessment as an intervention in OOHC.

The UN Committee had been critical of the Australian government’s failure to ensure adequate medical care was provided to children in OOHC and recommended that this be strengthened (UN Committee on the Rights of the Child 2005). In response, the Australian government advised that this would be addressed within a new national framework for child protection 2009-2020 and had referred the matter of exploring healthcare options to the Child Health & Wellbeing subcommittee of the Australian Population Health Development Principal Committee of the Australian Health Ministers’ Advisory Council (AHMAC). That Council had been considering the matter since at least 2006 when the RACP first made recommendations for national action on health in OOHC (RACP 2006).

At the time this study commenced the conversation among Australian health professionals strongly supported comprehensive health assessment in OOHC but the Commonwealth government had been slow to join the chorus, notwithstanding pressure to act from the UNCRC.

CONVERSATION THREAD (2) A NEED FOR IMPROVED TRAINING FOR HEALTH PROFESSIONALS.

A second thread in the conversation was a call for improved training for health professionals. Factors associated with child abuse and neglect can be among the most difficult conditions that paediatricians deal with (Cooper, & Hewson 2002). High quality health services for children who have experienced abuse and neglect depend on well trained staff with specialist skills to lead clinical services, training and research (Kistin, Tien, Leventhal, & Baucher 2011). The lack of adequate opportunities for paediatric training in community child health in Australia (Smith, & McDowell 2006) and lack of a consistent and recognised curriculum about
child abuse and neglect for doctors has been noted (Packer 2008) although the way forward to remedy these problems has been contested (Vimpani 2006). Problems have also been noted in paediatric skills and training in the assessment of child development (Beggs, Sewell, Efron, & Orken 2005). Tarren-Sweeney joined Smith and McDowell (2006) in urging that health professionals need particular clinical competencies to assess the OOHC cohort and Australia should build professional frameworks for clinical specialisation in child welfare and OOHC. Tarren-Sweeney argued that acute-based services were a poor match for these children, who needed greater continuity and certainty of care than hospital care provided (Tarren-Sweeney 2010).

In the US, family medicine training has tended to provide less attention and resources to child abuse and neglect than is offered in paediatric training (Starling, Heisler, Paulson, & Youmans 2009) General practitioners were at the front line of health care for those in OOHC in Australia. While GPs with special interests in child and adolescent health were motivated to provide assessment and continuity of care to children in OOHC, they too needed additional support to enhance their clinical skills and case-based knowledge (Bannon, Carter, Jackson, Pace, & Thorne 2001, Webster, & Temple-Smith 2010).

CONVERSATION THREAD (3) A NEED FOR FOCUSED AND SUSTAINED CLINICAL RESEARCH

A third thread of the Australian conversation concerned an identified need for further research into methods of assessment and assessment outcomes.

Tarren-Sweeney’s research had gone beyond measurement of prevalence to examine the complexities of the health problems found in OOHC, such as aberrant eating behaviours, problematic sexualised behaviour and mental health difficulties (Tarren-Sweeney 2008a, 2008b, Tarren-Sweeney, & Hazell 2006). He argued that many children exhibited complex problems which were unlikely to respond to usual treatment for single conditions such as depression. He found that professionals showed “considerable diagnostic disagreement and uncertainty” in framing the complex psychopathology seen in OOHC, and that international mental health classification systems were inadequate for this group (Tarren-Sweeney 2010 p. 615). His research on the development and initial validation of the Assessment Checklist for Children (ACC) represented a new attempt to screen for the wider range of the clinically significant mental health problems which could be expected in the OOHC cohort (Tarren-Sweeney 2007).
Paediatricians lamented the low level of Australian research in the field of community child health (Smith & McDowell 2006). Both clinicians and researchers argued for more systematic measurement of the outcomes of assessment in OOHC, both in terms of health service access and response to treatment or therapy (Chambers et al., 2010, Tarren-Sweeney 2010, Ronan, & Feather, 2009, Tilbury 2006). Several researchers argued for further clinical research in Australia into the characteristics and meaning of complex attachment-related and trauma-related disturbances (Tarren-Sweeney 2010, Jackson et al., 2009, Fernandez 2009, 2008, Milburn et al., 2008, Sawyer et al., 2007, Bromfield & Osborn, 2007, Bromfield, & Higgins, 2005a). Clinical research on parents’ health and children’s birth histories was also of interest in order to further understand biological factors affecting child health (Chambers et al., 2010, Frederico et al., 2008, Ingall 2006, Tarren-Sweeney 2006). Why some children in care have good mental health despite adversity was not well understood and further research on resilience mechanisms was needed.

Overall, Australian researchers were calling for further research to support evidence-based assessment and interventions (Ronan, Canoy, & Burke, 2009). While Australian rates of maltreatment appeared to be increasing, systematic, long term implementation of evidence-based services had been slow to develop (Ronan, & Feather 2010). Increased evaluation of the effectiveness of interventions and longer term perspectives in research and service innovation were needed.

**CONVERSATION THREAD (4) SYSTEMIC CHALLENGES**

Local and national system issues were interwoven in the fourth thread of the academic conversation about health assessment in OOHC. Researchers noted systemic problems including:

a. variable recognition by statutory guardians of the duty of care owed to children in relation to health (Tarren-Sweeney 2010);

b. difficulties in engaging carers in health assessment processes (Chambers et al., 2010);

c. poor collection and retrieval of child health records (Nathanson et al., 2009, Crawford 2006);

d. geographic and other barriers to health service access and lack of monitoring of child health needs (Smith 2008).

A significant systemic shortcoming reported by researchers and practitioners was the limited capacity to address health for each and every child, despite the rate of clinical problems in the OOHC population warranting systematic, universal assessment. Clinical
researchers argued that Australian authorities could not meet best practice standards without a significant service delivery expansion (Tarren-Sweeney 2010, Crawford 2006).

There seems to have been a "chicken and egg" situation at play among authorities with statutory responsibilities for OOHC in Australia. On the one hand, until recently there has been limited epidemiological evidence about the extent of chronic and complex health needs in the out-of-home care population. Following the 2005 national research audit a conclusion was accepted that most children in OOHC in Australia were physically healthy and their psychological functioning improved over time in OOHC, notwithstanding that a significant minority experienced complex psychological and behavioural problems (Bromfield, & Osborn 2007). The conclusion about physical health was based on one descriptive study, in one state, which used carer reports as the only data source about child health status (Victorian Department of Human Services 2002). The conclusion was inconsistent with the position put a year earlier by the RACP that “clear evidence from overseas studies showed children entering OOHC have a high prevalence of acute and chronic health problems and developmental disabilities and subsequently have a broad range of health care needs” (RACP 2006 p. 14). Osborn and Bromfield’s conclusions from Australian OOHC research may have discouraged any sense of urgency in the child welfare sector about establishing health needs in OOHC. At the same time state-level efforts to provide health assessments for individual children in care had been unsystematic, had reached few children and had poor follow up, resulting in less than desirable attainment of recommended health services (Wood 2008, Auditor-General Victoria 2005, Children’s Commissioner Queensland 2010). At the same time, accountability measures in child protection systems in Australia excluded measures related to health care management (Tilbury 2006). Consequently, the low level of individual assessment continued to limit the epidemiological data available. Given the absence of data, it fell to the medical colleges to advocate for systematic health assessment and improved research effort (RACP 2006, RANZCP 2009).

While available research and specialist medical opinion support systematic, universal health needs assessment in OOHC, there is scant Australian research evidence to indicate the factors affecting the engagement of Australian health professionals in assessment activities. An exhaustive review of international research was outside the scope of this study, particularly considering the inter-country differences in health service governance, funding and workforce composition that may affect health professionals. However decades of international
experience of health assessment in OOHC has revealed some factors that may resonate in Australia, notwithstanding the different contexts.

I turned to the consensus framework from Michie, Johnston, Abraham, Lawton, Parker, & Walker (2005) for studying the implementation of evidence-based practice in health settings which was developed to help researchers more adequately understand the behaviours of health professionals. I found this a useful framework to analyse international research about implementing medical guidelines for health assessment in OOHC.

**FINDING C: FACTORS AFFECTING HEALTH PROFESSIONALS**

Susan Michie and her colleagues identified the following twelve theoretical domains which help explain health professionals’ behaviours: (1) knowledge, (2) skills, (3) social/professional role and identity, (4) beliefs about capabilities, (5) beliefs about consequences, (6) motivation and goals, (7) memory, attention and decision processes, (8) environmental context and resources, (9) social influences, (10) emotion regulation, (11) behavioural regulation and (12) nature of the behavior (Michie et al., 2005 p. 30-31). From OOHC research I reviewed I was not able to draw links with factors affecting health professionals and domains such as their memory, emotional regulation or the nature of behavior. Rather, the research suggested links in the following five domains:

I. Knowledge;
II. Skills;
III. Social/professional role and identity (self-standards);
IV. Beliefs about consequences (anticipated outcomes/attitude);
V. Environmental context and resources (environmental constraints).

For my purposes, it was feasible to collapse the domains of knowledge and skills together. In the next section I compare constructs arising from research in the US and the U.K. against each domain and draw a connection to Australian research where I found any potential resonance.
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FACTORS AFFECTING HEALTH PROFESSIONALS: KNOWLEDGE AND SKILLS

As discussed in the previous chapter, medical professions claim particular kinds of knowledge and understanding about child maltreatment and its impact on child health. They also have discipline specific schemas for representing health disorders or illness, albeit that these might involve opposing views (Tarren-Sweeney 2013). Similarly each medical discipline has particular procedural knowledge. Recognition by medical colleges of the special medical skills and competencies needed to assess and manage the health of maltreated children has been relatively recent in the US and the U.K. Such skills encompass knowledge of the law (Payne 2008, Rees 2011) collaborative practice with child welfare agencies and advocacy skills (Szilagyi 2012) and knowledge and skills in developmental assessment (Beggs, Sewell, Efron, & Orkin 2005). Health professionals who lack case experience may be unfamiliar with the severity and complexity of health conditions presented by children in OOHC (Byrne, & Lyddiard 2013).

Training and education were among several critical and interdependent components of promising approaches identified from a review of 144 separate program and activity evaluations relating to improving health care in OOHC in the U.S. (McCarthy 2002). Major gaps have been reported between the numbers of trained health professionals with expertise in child maltreatment compared with the numbers of children requiring health assessment and management (Jaudes, Bilaver, Goerge, Masterson, & Catania 2004, Bennett, Plint, & Clifford, 2005, Carter, Bannon, Limbert, Docherty, & Barlow 2006, Mathews, Payne, Bonnet, & Chadwick 2009, Mekonnen et al 2009, Lane, & Dubowitz 2009, Giardino, Hanson, Hill,& Leventhal 2011, Everson-Hock, Jones, Guillaume, Clapton, Goyder, Chilcott, Payne, Sheppard, & Swann 2011). The lack of accredited training for Australian health professionals in the care of children affected by maltreatment has been noted in Australian research (Packer 2008, Tarren-Sweeney 2008, 2010, Webster & Temple-Smith 2010) and was discussed in symposium presentations (Blanchard, Preston, & Rich 2010, Tremellen, & Van Doorn 2010, Crawford 2006, Lawrence, Henderson & Foster 2010).

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FACTORS AFFECTING HEALTH PROFESSIONALS: SOCIAL/PROFESSIONAL ROLE AND IDENTITY

Within the social/professional domain, Michie and colleagues (2005) included constructs of social and group norms, alienation versus organisational commitment, professional identity, boundaries and roles. When viewed through this lens, further issues emerged which may impact on health professionals involved in health assessment in OOHC.

In respect of personal boundaries some of the recognised difficulties for health professionals have been professional discomfort, ambivalence and gaze aversion to child maltreatment found in the US (Theodore & Runyan 1999, Leventhal 2003, Jenny 2007, Giardino, Hanson, Hill & Leventhal 2011), the U.K. (Carter 2007) and in Australia (Oates 2014).

Secondly, considering alienation versus organisational commitment, a study among multi-disciplinary staff in child protection programs based in paediatric, academic health centres identified burn-out as an issue, which reportedly stemmed from time pressures, inadequate workforce, long hours of work, being involved with the emotional distress of patients and uncertainty over future funding for their centre. Frustration in dealing with child welfare and law enforcement agencies and limited training in child protection issues contributed to the stress (Bennett, Plint, & Clifford 2005). That study resonated in the U.K. where a community paediatrician, Professor David Hall from the University of Sheffield speculated on additional factors which probably made working with child protection matters more stressful than other aspects of paediatrics. Clinical uncertainty is often present. Paediatricians can lose control of decision making when child welfare or legal authorities have case management responsibilities (Hall 2005). U.K. paediatricians reported that parental complaints, pressure by lobby groups, adverse media exposure, fear of General Medical Council disciplinary consequences and workload pressures left them vulnerable to anxiety and stress from child protection cases (Mathews, Payne, Bonnet, & Chadwick 2009). Similar factors were reported in a more limited study of paediatric sub-specialists in the U.S. (Flaherty, Schwartz, Jones, & Sege 2013). The usual doctor-parent relationship can be different and less satisfying in this area of work. Clinical uncertainty and the implications of medical judgments weigh heavily, as do adversarial legal processes which question clinical judgment while costing doctors scarce time and money.

Reliance on medical histories is a strong norm in health care. Difficulties in obtaining, recording and sharing child health history information posed a particular problem for health
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professionals where the impact weighed heavily. (Ward, Jones, Lynch & Skuse 2002, Leslie, Hurliburt, Landsverk, Rolls, Wood, & Kelleher 2003). Both the provision and reliability of child health records can be problematic. Simmonds eloquently described the fate of professionals left to rely on a range of information about a child where it is not possible to confirm the validity or significance of that information.

*Becoming involved as a professional can feel like being sucked into a nightmare of distortions and misunderstandings where the ground threatens to fall away at every turn. Retaining any sense of objectivity, rigour or indeed hope in the face of such complexity is extremely difficult* (Simmonds 2010 p. 607).

Each of the issues described above could negatively impact on an individual’s sense of their professional role and identity. However, counterbalancing these stresses were the interest generated by clinical challenges which motivated interested paediatricians to keep up with literature and participate in research. Support networks of trusted colleagues were seen as a valuable resource both for managing stress and providing a collegiate, learning culture which could be fulfilling (Flaherty et al., 2013). The teaching, research, advocacy and leadership roles of paediatricians with a special interest in child maltreatment have not only been recognised but indeed have been seen as vital in the implementation of medical professional standards (Smith, & McDowell 2006, Bailey 2008, Mekonnen, Noonan, & Rubin 2009, Szilagyi 2012).

Consistent with the importance of professional identity, respect from others for the value and importance of the roles of health professionals in clinical governance and as clinical coordinators emerged as a factor. Health professionals have developed and evaluated integrated care pathways and specialist assessment service models although these have not been as widely or uniformly implemented by responsible authorities as doctors would wish (Giardino, Montoya, & Leventhal 2004, Leslie, Gordon, Lambros, Premji, Peoples, & Gist 2005, Risley-Curtiss, & Stites 2007).

Professional roles and identity are influential in inter-agency collaboration and coordination. Normative models have tried to blend a central role for child protection agencies in facilitating health assessment and treatment processes with the important health sector role of coordinated clinical management of child health (Halfon, Inkelas, Flint, Shoaf, Zepeda,
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Lack of organisational support for systems of care developed and recommended by health professionals may affect health professionals' willingness to engage. It can be indicative of a power struggle that health professionals do not like to lose. This power differential underpins a debate around the level of evidence that integration and coordination are essential elements for achieving positive outcomes for children in OOHC (Taylor, & Corlett 2007, Dickinson 2006). A fundamental inter-sectoral question has been whether successful collaboration can be built on non-hierarchical, mutually respectful relationships rather than on "a pecking order deeply rooted in the superiority of the medical profession" (Taylor, & Corlett 2007 p. 315) or the "self-importance of the tall hats" (Frost & Robinson 2007 p. 195).

Professional socialisation and clinical decision-making responsibility can create barriers in engaging doctors in shared responsibility with other professionals (Whitehead 2007). This debate represents just one aspect of inter-disciplinary difficulties in recognising the respective contribution and expertise of health and child welfare collaborators (Glendinning, Rummery, & Clarke 1998, Reder, & Duncan 2003, Luckock 2007). From a health professionals' viewpoint facilitating factors in inter-agency partnerships included a shared, long-term vision, effective monitoring and feedback about progress and a strong evidence-base for decision-making. These factors needed to be sufficiently robust to counter-balance the financial and workload costs of participation and to overcome previous negative experiences (Kendall, Ehrlich, Young, Muencherger, Wilkie, & Rushton 2009). The expanding clinical gaze on child maltreatment in the last decade (Peckover 2009) has renewed interest in ideas about professional roles, identity and boundaries.

Evaluation of collaborative quality improvement demonstration programs for health care improvement in OOHC in the U.S. showed that improvement cannot begin unless health sector organisations can successfully engage with child protection agencies in change processes (Leslie, Gordon, Lambros, Premji, Peoples, & Gist 2005, Allen, Pires, & Mahadevan 2012). Similarly, close attention to supporting inter-sectoral working on steps of care in OOHC health assessment can produce significant quality improvement (Eichler 2011). Recent
organisational changes to the National Health Service in the U.K. have caused concern that without direct incentives for collaborative work, even the informal collaborative arrangements which have been widespread between health and local authorities may be torn apart in the bid to meet savings targets in the national health bill (Simkiss 2013).

Systems for health assessment in OOHC necessarily involve the push-pull of special clinical interests versus clinical stress and uncertainty and of clinical governance versus inter-agency co-ordination. Taken together, issues related to professional role and identity could be expected to impact on health professionals involved.

**FACTORS AFFECTING HEALTH PROFESSIONALS: BELIEFS ABOUT CONSEQUENCES**

The domain of beliefs about consequences includes constructs of expected outcomes, reinforcement, incentives or rewards, ideas about anticipated regret, negative consequences and perceived risk, and notions about the value, probability and salience of expected outcomes. Research raises several issues around health assessment in OOHC which fall within this domain. Anticipated negative consequences associated with failure to provide health histories or to maintain continuity of health care for children in OOHC affect health professionals in their relationship with child welfare agencies (McCarthy 2002, AAP 2005, Tarren-Sweeney 2010). Failure to ensure that health management plans are properly developed and implemented has been widely discussed in the literature (Hill & Watkins 2003, Burns, Phillips, Wagner, Barth, Doldo, Campbell, & Landsverk 2004, Stahmer, Leslie, Hurlburt, Barth, Webb, Landsverk, & Zhang 2005, Stanley Riordan, & Alaszewski 2006, , Mooney Statham, Monck, & Chambers, 2009, Brown, & Bascetta 2009, Dickson, Sutcliffe, Gough, Statham, & Morris 2010, Reeve, & VanGool 2013). Consistent with overseas research, Australian studies of outcomes after health assessment reported unacceptable rates of health recommendations being enacted (Nathanson et al., 2009, Chambers et al., 2010). Health professionals’ beliefs that their recommendations following health needs assessment may not be enacted could be a factor affecting their engagement in assessment in OOHC.
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FACTORS AFFECTING HEALTH PROFESSIONALS: ENVIRONMENTAL FACTORS AND RESOURCES

Financing, facilities, competing tasks and time constraints fall within this domain. Constraints faced by OOHC health assessment services in the U.K. included OOHC being sidelined from the main agendas in paediatrics (Mather, & Batty 2000), designated specialist staff positions being left unfilled or under-resourced (Care Quality Commission 2009, Royal College of Paediatrics & Child Health 2012) and inadequate clinical supervision when assessment tasks were delegated to nurses (Mooney et al., 2009). Designated doctors for child protection reported that their contracted time was inadequate for these roles (Dale, Harrison, Humphreys, & Spencer 2001, RCPCH 2012). A sense of strong professional identity may be effected if doctors feel their role is under-valued and under-resourced. Financing has been problematic where special child protection units have been established in public hospitals in the U.S. (Giardino, Hanson, Hill, & Leventhal 2011). Financial incentives for health care providers affected engagement in assessment in OOHC in the US (Simms, Freundlich, Battistelli, & Kaufman 1999, Leslie, Kelleher, Burns, Landsverk, & Rolls 2003), and in Australia (Webster, & Temple-Smith 2010). An overarching factor affecting resourcing has been the paucity of financial data to underpin policy and planning (Knapp, & Robertson 1989, Segal, & Dalziel 2011, Fang, Brown, Florence, & Mercy 2012).

While a detailed analysis of health care delivery and financing in Australia was well beyond the scope of this thesis, some review of health care delivery systems seemed warranted, particularly in broad comparison with US and U.K. Funding arrangements, medical workforce characteristics and government controls over health delivery systems have been compared periodically by the Organisation for Economic Cooperation and Development (OECD 2013). The most recent comparison using data from 2011, shows Australia generally falling at or near the OECD median, as shown in Table 13. Using measures such as the number of doctor consultations per capita (7 per year) this put Australian rates ahead of those in the U.K. (5.5) and USA (5) with more practicing doctors per 1000 population. Specialist doctors in general practice and in paediatrics were accorded key roles in state government approaches. GPs\textsuperscript{10} are usually the first medical specialist a person sees for health care and at the time of this study

\textsuperscript{10} GPs are medical specialists with unique training and service characteristics. The majority of GPs in Australia worked in private practice. General practices provide individualised, coordinated, comprehensive primary care for individuals and families within their communities (RACGP 2014). GPs qualify by attaining fellowship from either the Royal Australian College of General Practitioners (RACGP) or the Australian College of Rural and Remote Medicine (FACRRM).
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made up the largest proportion of the medical workforce in Australia. A referral from a GP is usually required to see a paediatrician in Australia.

Table 13: Key aspects of Australian medical workforce, frequency of population use of doctor visits and health service financing in Australia compared with UK, US and the median for OECD countries in 2011 (OECD 2013).

<table>
<thead>
<tr>
<th>Measure</th>
<th>Australia</th>
<th>U.K.</th>
<th>U.S.</th>
<th>OECD Median</th>
</tr>
</thead>
<tbody>
<tr>
<td>No. of practicing doctors per 1000 population</td>
<td>3.3</td>
<td>2.8</td>
<td>2.4</td>
<td>3.2</td>
</tr>
<tr>
<td>No. of doctor consultation per patient per year</td>
<td>7</td>
<td>5.5</td>
<td>5</td>
<td>6.3</td>
</tr>
<tr>
<td>Per capita expenditure from public expenditure in US $</td>
<td>3800</td>
<td>3000</td>
<td>4000</td>
<td>3322</td>
</tr>
<tr>
<td>Health expenditure as % of gross domestic product (GDP)</td>
<td>8.9%</td>
<td>9.4%</td>
<td>17.7%</td>
<td>9.3%</td>
</tr>
<tr>
<td>% of all health expenditure funded by general government financing</td>
<td>68%</td>
<td>83%</td>
<td>6%</td>
<td>35%</td>
</tr>
<tr>
<td>% of all health expenditure financed by private out-of-pocket expenditure</td>
<td>20%</td>
<td>3%</td>
<td>12%</td>
<td>20%</td>
</tr>
</tbody>
</table>

Four aspects of the GP workforce were relevant to the context of this study, given that in each case GPs were the preferred provider of initial health assessment in OOHC. Firstly, there were significant and ongoing GP workforce geographical misdistribution and shortages (Health Workforce Australia 2012) with reduced availability of GP services in rural and remote areas (SCRGSP 2013). Secondly, health professionals, including GPs, may have received no special training or professional development in dealing with child abuse or neglect, or have reported that their training had been inadequate (Raman, Holdgate, & Torrens 2011, Webster & Temple-Smith 2010). Thirdly, capacity to provide multi-disciplinary assessment for children in OOHC within a single general practice was limited. While the majority of GPs employed primary care nurses, less than half of GP practices had other health providers co-located in their practice. Where co-location occurred, psychologists or physiotherapists were most likely to be part of the multi-disciplinary service (Britt, Miller, Henderson, Charles, Valenti, Harrison, Bayram, Zhang, Pollack, O’Halloran, & Pan 2012). While health assessments were an uncommon activity in general practice, accounting for less than 0.6% of all types of care for which Medicare rebates were available (Britt, et al., 2012), more than 97% of GPs did make use of specific Medicare billing items associated with chronic disease management (SCRGSP 2013). These items provided Medicare rebates for the development of health care plans and for case
conferencing with other service providers for health planning purposes. This is important as the National Clinical Assessment Framework (APHPC 2011) established that where there was a clinical need, such Medicare rebates, already familiar to GPs, would be available for the care of children in OOHC. At the same time, limited dissemination of the framework may have left GPs unaware of this option. Lastly and most significantly, the majority of GPs were operating in private practices (SCRGSP 2013) where decisions as to whether to collaborate in any way with child protection authorities in respect of children in OOHC were entirely at the professional discretion of individual doctors.

Similarly, as paediatricians were the preferred provider to lead comprehensive health assessment in OOHC (RACP 2006) the paediatric workforce was important. There was a significant gap in the geographic distribution of the general paediatric workforce in Australia. Additionally, there were particular unmet specialist medical workforce needs for community child health, developmental paediatrics and child protection (Health Workforce Australia 2012). The small scale of the specialist child protection workforce was highlighted in the results of a self-report survey of those working in the 15 Child Protection centres in tertiary hospitals across Australia and New Zealand (Cruickshanks & Skellern 2007). Just 45 paediatricians were identified by the researchers as potentially eligible for the study. Among the 71% who responded, only 12% were involved in child protection work for more than 30 hours a week. The average among respondents was 12.8 hours per week in this specialty area. Of this time, only 12.7% of the working hours spent in child protection were spent on providing medical follow-up for children entering OOHC and only half of respondents monitored the development and behavioural progress of those children for longer than 6 months. Importantly, 34.4% had received no child protection training prior to working in the field, while the average length of child protection training among respondents was 5 months (ranging from 2 to 24 months). As thousands of children enter OOHC each year in Australia it is clear that the specialist child protection paediatricians could not meet demands for comprehensive

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11 General paediatrics is a multi-disciplinary specialty concerned with the diagnosis and management of undifferentiated and complex conditions for children and young people aged 0-19 years. Trained through the Royal Australian College of Physicians (RACP), paediatricians may follow one of 22 sub-specialties. Some sub-specialties in particular may relate to child abuse or neglect, including paediatric emergency medicine, general paediatrics and community child health. Community Child Health is the sub-specialty with particular expertise in child development and behaviour, child population health and child protection. A Community Child Health Chapter of the RACP supports specialist doctors with expertise in aspects of community child health (RACP 2014).
assessments for each and every child. This makes the preparedness of GPs and generalist and community health paediatricians critical.

In Australia pilot specialist Child Protection Clinics faced constraints without sustainable funding for scaling-up when the complexity of the assessment task became apparent and additional resource needs were revealed (Chambers et al., 2010). Similarly, pilot assessment projects in primary health care lacked a sustainable funding based (Tremellen, & Van Doorn 2010). In the area of mental health services. Clinical practice models for mental health services for OOHC have been largely piecemeal, initiated in the main by “a small number of visionary clinicians” and insufficient capacity has been a major shortcoming in existing public health responses (Tarren-Sweeney 2010 p. 614). Environmental restraints have a present and future context when taking into account findings about the long lasting health care costs resulting from child maltreatment (Fang, Brown, Florence, & Mercy 2012, Reeve, & Van Gool 2013).

Overall, research from the US and U.K. suggested that health professionals’ beliefs about consequences of involvement in assessment in OOHC were important. Respect for their professional role and the tools and resources required for their task may be an influence. Health professionals may impose personal boundaries in the face of stresses attached to caring for maltreated children. Variable levels of tolerance or otherwise could also be expected in relation to environmental constraints outside of their control. These ideas formed part of the tapestry of this study and had an influence on the research design.

CONCLUSION

My aim in this chapter was to explore the academic conversation in Australia and determine where, as a PhD candidate I could usefully build on or challenge ideas. The literature review provided a primary justification for research in the area of health assessment in OOHC in Australia. I was satisfied firstly that levels of chronic, complex and unmet health care needs were similar in Australia to those found in the U.K. and US and secondly that the reasons for poor implementation of health assessment were not well understood. Further, I was able to confirm through the symposium that a critical mass of professionals and organisations endorsed the principle of systematic and comprehensive health needs assessment in OOHC and welcomed further research.
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The Australian evidence which had identified some of the challenges for health professionals was limited to a handful of studies in individual sites. These studies had a primary focus on child health status or health interventions. There had been no multi-site studies of systemic issues from a health professionals’ perspective.

The fragmented nature of Australian research about health in OOHC suggested a complexity of inter-disciplinary and inter-sectoral knowledge relevant to the environments where health professionals were working. In particular I was interested to understand the complexity of linked ideas about child maltreatment, social care and health more fully in order to develop a worthwhile and achievable study. However I was yet to realise the depth of that complexity which the next chapter reveals.

DISSEMINATION

Although entry to the academic conversation was an important aim of this thesis there was likely to be a significant time lapse between conversations in the field and thesis publication. I made a deliberate effort to disseminate new learning in accessible formats during the course of the PhD study on the basis that timely knowledge exchange and key messages from research are valued in practice and policy. In relation to this chapter, findings from the review of Australian research literature were first presented in a peer-reviewed paper


In response to the national symposium I was invited to coordinate a special edition of the Association of Child Welfare Agencies journal, Developing Practice. Meredith Temple-Smith was guest editor of the 2012 (Summer) edition where the results of my review of research literature was published, along with nine articles originating from the symposium.

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Following the national symposium, I submitted a report to the Medical Journal of Australia. In response, an editorial was invited addressing the broad issues of health care needs in OOHC which was published as follows.


Building on these publications, I was invited to submit a paper to the Australian Family Physician about the implications in general practice and primary care.


Material presented at the Health, Hope and Resilience: Fostering better health in out-of-home care symposium has been held and maintained on the University of Melbourne website since 2010 (www.gp.unimelb.edu.au/FosteringHealthSymposium). Audio-recorded proceedings, along with the program and a symposium report, have been available for download from the site. The program and report are at Appendix A. The symposium proceedings webpages attracted more than 660 hits up to May 2014.

My student webpage on the Department of General Practice, University of Melbourne website has provided updated details of all presentations, publications and policy submissions arising from this PhD study. That webpage is at:

OVERVIEW

Prior to 2010 public reports abounded of limited outcomes in the implementation of professional and state government policies on health assessment in OOHC in Australia. Previous chapters explained why this situation was considered important and explored some the key concepts around child health, health need, child rights to health, as well as child abuse and neglect as health determinants. A broad review of research about issues related to child health in OOHC in Australia established that patterns of health need appeared similar to those found in English and North American studies. In the face of an identified lack of relevant health policy and systems research in Australia, ideas were extracted from a wider range of research publications, and from symposium presentations, about factors which might be relevant to health professionals in Australia who are working to implement health assessment policies. This chapter explores the problem situation more fully.

The PhD study sat within the relatively new, multidisciplinary field of health policy and systems research (HPSR) which focuses on questions about the architecture and oversight of health systems, systemic interventions at an organisation level, and the decisions and behaviour of individuals involved in health service provision (Sheikhk, Gilson, Agyepong, Hanson, Sengooba, & Bennett 2011). The field:

...seeks to understand and improve how societies organize themselves in achieving collective health goals, and how different actors interact in the policy and implementation processes to contribute to policy outcomes. By nature it is inter-disciplinary, a blend of economics, sociology, anthropology, political science, public health and epidemiology that together draw a comprehensive picture of how health systems respond and adapt to health policies, and how health policies can shape - and be shaped by - health systems and the broader determinants of health (Gilson 2012 p.21).

My key interest was in understanding systems for health assessment in OOHC, and the ways in which health professionals interacted with and shaped these systems in practice.
Comprehensive health assessment for all children in OOHC was the central, social health planning system of interest.

Health systems and policies can be defined by what they seek to do i.e. their goal (Gilson 2012). Health assessment policies were the starting point. Health policies and systems are social and political constructions. They are not fixed and measurable phenomena, amenable to study using the investigative methods of the natural and physical sciences (Gilson, Hanson, Agyepong, Ssengooba, & Bennett 2011). Rather, systems and policies are created as a means to allocate resources, to make choices between competing interests and ideas, and to address problem situations, while achieving a politically determined public good (Bell 2010, Althaus, Bridgman, & Davis 2007). In some problem situations in society, cause and effect are relatively well understood, and the way forward is clear for policy formulation. For example, the spread of common diseases among under-immunized children is a phenomena that is relatively well understood. Such understanding has supported a public policy commitment to immunisation programs. Other problem situations, however, are more complex to define and delineate. The very nature of the problem is less clear and often contested. Problems of gender, race or age discrimination are examples. This type of ill-structured social problem has been termed a 'wicked problem'. This chapter explains how health assessment in OOHC fell into the category of a 'wicked' social planning problem. The typology had an important influence on the choice of study design, which is outlined in Chapter 4.

‘WICKED’ PROBLEMS

In this section I discuss the concept of the wicked problem and the key characteristics which distinguish this from other types of human problems. I then explore the ways in which these characteristics manifest in the problematic situation of child abuse and neglect and the consequences for research in this field.

When Rittel and Webber introduced their notion of ‘wicked’ social planning problems in 1973, they could well have used the problem of how to conceptualise health needs assessment for neglected or abused children as their illustrative case. In their landmark paper, for the American Association for the Advancement of Science, they introduced the notion of social problems that defy definitive description as ‘wicked’ problems. The characteristics of wicked problems are summarised in Box 3.1.

1. Every wicked problem is essentially unique.
2. The choice of problem explanation determines the nature of the problem’s resolution.
3. There is no definitive formulation of the problem, or definitive solution. The problem cannot be understood without knowing its context, or having ideas about potential solutions.
4. Every wicked problem can be considered to be a symptom of another problem.
5. Solutions are not true or false, nor good or bad. Many parties may be equally equipped, interested or entitled to judge the solutions. Solutions are expressed as better or worse, not good or bad.
6. There is no immediate or ultimate test of a solution to a wicked problem.
7. Every solution to a wicked problem is a one-shot operation. There is no opportunity to learn by trial and error, as every trial will leave a trace that cannot be undone.
8. There are no criteria which enable one to prove that all solutions to a wicked problem have been identified and considered.
9. The aim in dealing with a wicked problem is not to find the truth, but to improve some characteristics of the world where people live.
10. Wicked problems have no stopping rule: there are no criteria for sufficient understanding of the problem, as there are no ends to the causal chains that link intersecting, open systems. The social planner stops when resources, time or money are used up, or when a “good enough” point is reached.
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Rittel and Webber (1973) argued that, in response to wicked problems, our inability to hold undisputable ideas about what is the social or “public good” means there can be neither correct, nor false solutions to such problems. Social policies evolve from pluralist thinking about a planning problem. Resolution depends on how a problem is characterised in the first instance. Ideas vary about the contexts in which a problem occurs, and the potential solutions. No empirically ‘correct’ solution is available for wicked problems.

CHILD ABUSE AND NEGLECT AS 'WICKED' PROBLEMS

Academic literature has reported on the complexity and ‘wickedness’ of the problems of (a) defining child abuse and neglect, (b) reducing their prevalence, and (c) ameliorating their long term consequences. (Pugh 2007, Forrester, & Harwin 2008, Spratt, & Devaney 2009, Stevens, & Cox 2008, Devaney, & Spratt 2009). Earlier researchers noted that any notions they had of policy in this field as fixed, or identifiable, were soon dispelled. Instead, they found a fluid, multi-dimensional environment where social planning policy was “something that often appeared ghostly and insubstantial, in outline and detail” (Packman, Randall, & Jacques, 1986 p. 13).

In the following discussion I argue that child abuse and neglect present social planning problems that demonstrate several of Rittel and Webber’s (1973) wicked characteristics which have implications for understanding and solving such problems.

1. EVERY WICKED PROBLEM IS UNIQUE

Firstly, child abuse and neglect are unique and distinct human behaviours. They present societies with complex social planning tasks around how to respond when such behaviours are judged to be outside of an accepted norm. They centre on relationships and behaviours between parent and child, which are particular in the human species. The problems are culturally situated. What is defined as abuse in one culture, might be acceptable behaviour in another. Genital cutting of boys is a contemporary case-in-point.
2. PROBLEM EXPLANATION DETERMINES PROBLEM RESOLUTION

Diverse understandings of a problem affect ideas about possible solutions. For centuries, child abuse and child neglect have continued to defy consensus about definitions, causes and solutions (Sealander 2003). One approach has been to study abusive and neglectful parents, in order to explain why maltreatment occurred. Over time, abuse and neglect have been alternately understood as a product of parents being unfortunate, poor (Parton 2005, Schene 1998, Grell, Cunningham, & Jutte 2002), cruel (Schene 1998, Lamont, & Bromfield 2010, Radford, Corral, Bradley, Fisher, Bassett, Howard, & Collishaw 2011), feeble-minded (Caradog Jones 1927, Blacker 1937, Starkey 2001), or pathologically-disturbed (Wurfel, & Maxwell 1965, Kempe, & Kempe 1978). U.K., U.S. and Australian societies have each made such characterisations, and have attributed parents with a varying degree of culpability for their situation. Ideas about entitlement to public care, both for parent and child, were for centuries linked to perceived parental culpability. By the late 20th century, the medical view theorised that a complex combination of psychological and social factors shaped parenting capacity, and could precipitate maltreating behaviours (Oates 1989). Most ideas about solutions have focused on long-term economic, moral, legal or social outcomes (Carter 1974).

The association of child maltreatment with poverty placed maltreated children low on a scale of social importance (Parker 1976, Wolock, & Horowitz 1979). An active, social dislike and disdain of the poor affected the consistency of health service availability (Elmer 1981). The same disdain was reported in Australia (Penglase 2007). Only very recently have ideas about solutions turned to the childhood needs of abused and neglected children (Mason, & Gibson 2004).

Historical characterisations of abused or neglected children have been a second approach in the search for meaning. Characterisation of maltreated children as waifs and strays (Ramsland 1986, Cannon 1991, Thorpe 1994), trouble children, uncontrollable, delinquent, (Packman, Randall, & Jacques 1986), or damaged children, (Spence 1907, Harris, Lieberman, & Marans 2007), shaped the provision of orphan schools, industrial schools, juvenile prisons, asylums and foster care. By the early 20th century, influenced by theories of eugenics, such children were seen as defective; the offspring of social problem families (Curtis 1999, Levine, & Levine 1990).
These ideas led to widespread psychological screening, and segregation (Van Kriekan 1991). Quasi-official child health assessment became more common, connected with goals of social control. While the conversation moved on from eugenics after the 1960s, murmurs and echoes of eugenics thinking remained audible in later research (Sharma, & Sutherland 1988, Illett 1988).

From the 1970s, challenging ideas about 'residual', unwanted children developed, tied in with the theoretical psychopathology of abusive or neglectful parents (Kempe, & Kempe 1978, Lindsey 2004). Relatively recent thinking about children as bearers of rights under the UNCRC has the potential to profoundly change how societies view the problems of child abuse and neglect.

3. WICKED PROBLEMS HAVE NO DEFINITIVE FORMULATION

Lack of definitive formulation is another pertinent characteristic of wicked problems. It has been argued that no definitive understandings have been reached about child abuse or neglect (Sealander 2003, Hearn 2011). Polarised positions have been debated about whether scientific, medical approaches can improve understanding of these problems, (Oates 1996) or whether these must be completely rejected, on the basis that child abuse and neglect are not primarily individual health phenomena, but are social phenomena (Hassall 1997). Parton has argued that academic appreciation of these problems using a disease model is flawed, and that thinking about child abuse is "still at a primitive level ...whose magnitude, roots and solution remain undefined" (Parton 2005 p. 133).

4. EVERY WICKED PROBLEM IS A SYMPTOM OF ANOTHER PROBLEM

Child health need assessment after abuse or neglect is just one issue within a complex hierarchy of contemporary abuse and neglect issues, many of which have been of interest to health professionals. My illustration in Figure 1 of health assessment as a nested problem shows one way of understanding this hierarchy from a health perspective. Health assessment in OOHC is found relatively lower down in the hierarchy of social planning problems around child abuse and neglect. Higher order problems begin at the very broad level of societal expectations of parents in relation to children, and societal recognition of children's rights. From these, flow 'big ticket' social questions including the social, legal and medical definitions of abuse and neglect, the epidemiology of abuse and neglect, how abuse can be prevented,
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the proper role of the state in stepping into the sacred relationship between parent and child and so on.

At the next systemic level, some of the answers to such questions inevitably lead to identification of children who have been harmed or are at risk and decisions about the most desirable responses. The illustration at Figure 1 places health assessment within a cluster of health problems which flow from identification of child abuse and neglect. Among this cluster, in which both the United Nations Committee on the Rights of the Child, and medical professional bodies have a particular interest, are:

a. the nature and impact of abuse or neglect as determinants of health
b. individual health needs after abuse or neglect
c. treatment and other therapeutic interventions
d. enactment of children's rights to treatment and rehabilitation after abuse or neglect
e. economic and social cost/benefits

Other, related clusters are:

i. Protecting children from abuse and neglect; where community responses to substantiated cases of abuse or significant risk of abuse are framed and enacted.

ii. Providing out-of-home care for children at risk or who have been harmed; where thresholds for removal into care, the availability, design, acceptability, efficacy and efficiency of care are paramount issues.

Australia may be an island continent but it has not been an island of thought and knowledge. The international conversation between England, North America and Australia has been important in shaping health professionals' ideas within the hierarchy. Medical thinking about maltreated children found on the public common has tended to be more strongly rooted in long-standing disciplinary values, knowledge, learning and debate, than in public policy of the day. As in other countries, health professionals in Australia have continuously contributed to the development of new knowledge, across a variety of issues in the hierarchy. However,
the extent of health professionals' influence on inter-disciplinary conversations has historically waxed and waned (Sealander 2003).

Against a background of mumbling in the 1970s about doctors becoming agents of social control or “moral entrepreneurs” (Newberger, & Bourne 1978 p. 597), the medical profession periodically searched its’ collective soul about their roles in relation to child abuse cases. Since Kempe and his colleagues named the “battered-child syndrome” (Kempe, Silverman, Steele, Droegemueller, & Silver 1962) paediatricians have advocated for their roles in diagnosis of “maltreatment syndrome” (Fontana 1973 p. 780), careful monitoring of child development after abuse or neglect (Hobbs, & Wynne 2002), maintenance of long-term follow-up as part of a “therapeutic plan” for the child and his parents (Kempe, & Helfer 1972 p. 163), “feisty advocacy for systemic change”(Dubowitz 2007 p. 606) and provision of a medical home for children in care (Szilagyi 2012). Cruickshanks and Skellern (2007) summed up the role of the modern tertiary child protection paediatrician as encompassing child advocacy, multi-agency decision making, child behaviour and development and forensic medicine. Child protection has now become a recognized sub-specialty in paediatrics in the US, a move applauded in other countries (Jenny 2009).

Historically, opposition to the medical paradigm could be found (Thorpe 1994) as commentators from other disciplines argued variously around:

- a covert, professional self-interest of the medical profession in claiming the territory of child abuse (Pfohl 1977);
- the medical profession’s maintenance of a “myth” about child abuse and neglect as psychodynamic rather than predominantly sociological and poverty-related problems (Pelton 1978 p. 30-31);
- whether physicians in effect colluded with governments in focusing policy on physical abuse of children at the expense of facing issues of child neglect because physical injuries best fit what doctors observed first-hand in hospital settings (Nelson, & Humphrey 1982);
• the power and prestige of the medical profession who defined child abuse as a clinical problem being strong enough to limit the weight given to exploring alternative explanations for a complex societal problem (Wolcock, & Horowitz 1984);

• the failure of the medical model to recognize child abuse as a social and moral issue, more akin to slavery or racism than a technical issue which medical experts can address (Hassall 1997);

• whether health professionals have failed to focus sufficiently on understanding contributing social issues, such as poverty or unwanted pregnancy, in the medical assessment of child neglect cases (Gelles 1973, Pelton 1978, Nelson, & Humphrey 1982, Hearn 2011)

• the confusion for child welfare services in knowing which strands of medical opinion to pay heed to about systematic health assessment and which health professionals to collaborate with in child health assessment in OOHC (Bywaters 1996).

In North America, early medical research about child abuse and neglect was not always embraced within the health professions (Helfer 1985). Australian medical research has met with mixed responses since the first official government inquiry into the veracity of medical claims about cases of child abuse in Victoria (Whatmore, Petty, & Southby 1969, Smith, & Meyer 1980). Early government skepticism was matched by disbelief from medical colleagues in Australia, as it had been in North America (Oates 1996, Scott, & Swain 2002), flagging a lack of consensus views which remains a characteristic of complexity in the field.

5. NO DEFINITIVE SOLUTIONS

A challenging characteristic of wicked problems is that solutions are elusive. Althaus argued that solution is an inappropriate goal for social planning problems as the function of public policy, and of planning and service systems, is to manage, rather than solve, wicked social problems (Althaus et al., 2007). In complex problems, unexpected changes occur which also have to be managed. The introduction of mandatory reporting of children at risk of abuse or neglect was an example. When laws were introduced from the 1970s no-one in North America or Australia predicted the rapid growth in the number of child protection notifications
to authorities. As a consequence, governments failed to provide adequate funding for child protection services (Kempe, & Helfer 1972, Mendes 2001).

In the absence of definite solutions, social planning is suspended when resources, time or money are used up, when efforts are judged to have been 'good enough' (Rittel, & Webber 1973), or when a problem is judged intractable (Althaus et al., 2007). In the problem of child abuse and neglect, there has been no "golden age" of social planning (Munro 2010 p. 9).
An illustration, as imagined by Webster, S.M. of Health Assessment as a nested problem within the broader range of problems surrounding child abuse and neglect in Australia in 2010.
PROBLEMS
- Child abuse and neglect cases are increasingly identified
- Child abuse or neglect can lead to chronic and complex health difficulties for a child

SOCIETAL GOALS
1. Prevent child abuse and neglect and stop maltreatment re-occurring
2. Establish child health needs after abuse or neglect
3. Ameliorate harm done to child

INEQUITIES
- Health needs not assessed for all children affected by abuse or neglect
- Effects of maltreatment not ameliorated for all children

WICKED PROBLEMS
Wicked problems are commonly found “...at the juncture where goal-formation, problem-definition and equity issues meet.” (Rittel & Webber 1973, p. 156). A simplified picture of the intersections of problems, goals and equity issues surrounding health assessment after child abuse or neglect is given in Figure 2. The apparent simplicity of the picture is deceptive. The literature relating to these intersections reveals a labyrinth of issues, ideas, debates and ideals. The remainder of this chapter is an exploration through the labyrinth; a journey into complexity. The journey attempts to trace three pathways which have been of interest to health professionals involved with health assessment in OOHC, namely:

I. problem definition from the perspective of health professionals

II. goal formulation from the perspective of health professionals

III. equity issues from the perspective of health professionals

HEALTH PROFESSIONALS’ PERSPECTIVES ON PROBLEM DEFINITION

Problems can be described as discrepancies between the state of affairs as it is, and the state as it ought to be. The process of resolving the problem starts with the search for causal explanation of the discrepancy (Rittel, & Webber 1973 p.165).

Earlier chapters introduced the academic conversation, where doctor’s voices have described an ideal world in which every child in OOHC (or on the edge of OOHC) ought to undergo systematic health screening and assessments, in accordance with the recommendations of professional bodies. Children ought to receive planned treatments, ongoing monitoring and health care coordination by a competent health professional. A comprehensive epidemiological knowledge base ought to have developed from health assessment data and health research in OOHC (Oates 1996, AMA 2004, AAP 2005).

This vision of the ideal rests on currently accepted medical wisdom about the burden of chronic and complex health difficulties after maltreatment. Among those health professionals determined not avert their gaze from child maltreatment, the vision has seemed logical and self-evident, and has been congruent between countries. The UNCRC (1989) supports this vision, where each child who has been maltreated receives reparative health care to address
the impacts of abuse or neglect, and to enable them to achieve the highest attainable level of health.

A PROBLEM WITHIN A PROBLEM

These ideals, about the way health professionals think things ought to be, are not an isolated vision but are nested within the broader, complex hierarchy of issues and theories relating to child abuse and neglect, introduced earlier in this chapter. As has already been described, clinical leaders and health researchers have taken a keen interest in issues in this hierarchy. Two of these issues in particular provide valuable context for considering contemporary health assessment approaches. These are (a) health professionals’ interest in definitions, determinants and identification of child abuse and neglect and (b) their interest in child protection, OOHC and health.

I have delved into the history books in the belief that contemporary ideas have strong historical associations which contribute to an understanding of medical and other paradigms that compete in the search for meaning. A foundation issue in the problem situation is how abuse and neglect have been defined. This has implications for legal thresholds for state intervention, as well as for studying the epidemiology and economic and social costs of abuse and neglect. Definitions also inform study of child abuse and neglect as a determinant of health.

The scientific inquiry methods embedded in the battered child and maltreated child conversations of Tardieu, Caffey, Kempe, Fontana, Oates, Tarren-Sweeney, Sawyer and others have shaped a medical dialogue about child abuse since the 20th century (Caffey 1946, Kempe et al., 1962, Fontana 1973, Oates 1996, Roche, Fortin, Labbe, Browne, & Chadwick 2005, Tarren-Sweeney & Hazell, 2006, Sawyer et al., 2007). In the 1970s, child maltreatment had been labelled as a disease affecting both the parent and the child (Fontana 1973). By 1976 Kempe and Helfer had amended the term child abuse to incorporate neglect, and legislation in North America, which was influenced by Kempe, recognised different types of maltreatment. Definitions, particularly of neglect, have been continually contested (Oates 1982, Leventhal

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12 In North America, national intervention began with 1974 Child Abuse Prevention and Treatment Act (CAPTA), followed by the 1980 Adoption Assistance and Child Welfare Act. CAPTA definitions of abuse included mental injury, sexual abuse or negligent treatment, as well as intentional physical injury. (Sealander 2003)
In the search for meaning, others have promoted the alternative view, that abuse and neglect are social phenomena, and strongly rejected the disease label (Pelton 1978, Wolock, & Horowitz 1984, Parton 2005). In international terms, definitions of maltreatment are more widely understood as culturally situated (Mapp 2011).

Legislators and judges have taken distinctive paths in the labyrinth, enacting widespread law reform in the U.K, U.S. and Australia, using a myriad of definitions of abuse and neglect. The House of Commons heard evidence at its review of child protection in England that after 40 years of research and practice, neglect remained ill-defined and that civil and criminal definitions still needed clarification. Professor Eileen Munro cautioned the House of Commons Education Committee about the difficulty of finding legal definitions which captured the complexity of cases seen. Judge Crichton summed up the wicked nature of the problem in his evidence to the Committee when he said that defining neglect "... is a bit like describing an elephant. It is not easy...to describe them, but my God, if one comes through the door I know one when I see one. Neglect is in that category" (House of Commons, Education Committee 2012 p. 21).

From a socio-legal viewpoint, maltreatment has been understood to be about the actions or omissions of parents, or substitute parents, and where these acts fit on a continuum of social acceptability. The health and wellbeing of affected children has been a secondary consideration (Scott, & Swain 2002). In contrast, from a medical viewpoint, maltreatment definitions have been more likely to rest heavily on physical signs and symptoms in the child, which support a diagnosis of maltreatment. Fontana (1973) promoted the importance of drawing on the diagnostic ability of the physician to identify maltreatment, in order to prevent further exposure of the child to the risks of trauma. His "Physician's Index of Suspicion" (p.781) for maltreatment included 24 items, encompassing the medical history, the physical examination, differential diagnosis and radiologic manifestations. Hobbs & Wynne (2002) listed an extensive range of clinical features which may indicate a diagnosis of neglect. By 2013, the English physicians guide to the alerting features of possible maltreatment had grown to 17 pages (NICE 2013). In the medical paradigm, the reason, or cause, for the parents’ actions has become a secondary consideration (Dubowitz, & Bennett 2007). In defining child
maltreatment, a focus on acts of omission resulting in failure to meet children’s developmental needs has now been incorporated (Barlow, & Calam 2011). Here lies complexity.

Exploring the entirety of ideas about the phenomena of maltreatment was well beyond the scope of this thesis. For the purposes of this study, it was valuable however, to glimpse ideas held in Australia at the turn into the 21st century, as new typologies of abuse and neglect were continuing to emerge.

A Commission of Inquiry into abuse of children in Queensland institutions (Forde, Thomason, & Heilpern 1999) was concerned about complex definitions and sought to clarify the meanings of emotional, sexual and physical abuse, as well as neglect. In each instance the Commission drew from several sources to form its own definitions. Importantly, the commission included ‘systems abuse’ among the types it defined. Arising from the socio-legal field (Cashmore, Dolby, & Brennan 2004), systems abuse is "preventable harm done to children in the context of policies or programs which are designed to provide care or protection" (Forde, Thomason, Heilpern 1999 p. 12). The commission described how systems abuse may occur when a child’s needs are simply not considered, because of conflicting policy interests, or lack of knowledge.

Research conducted at the Australian Institute of Family Studies (Bromfield, & Higgins 2005) resulted in the proposal of a new typology for repeat-victimisation and multi-type maltreatment; the Chronic Maltreatment Typology. Their prospective, eight year study of a random sample of 100 children in one region of Australia found chronic maltreatment was much more common than isolated maltreatment. The researchers identified an important issue which resonates with health professionals; the need to re-think how maltreatment is legally defined given the potential for cumulative harm to the health of children exposed to chronic abuse or neglect.

At the time of this study, the Australian Institute of Health & Welfare (AIHW 2012a) adopted simplified definitional categories to synthesize varied jurisdictional data about substantiated cases of child maltreatment in Australia. These categories were physical, sexual or emotional abuse or neglect. Each category included actual harm or significant risk of harm. These simplified categories mask some of the legislative complexity found in different jurisdictional definitions of a child’s need for care and protection.
FAILURE TO MEET A CHILD’S EDUCATIONAL OR HEALTH CARE NEEDS, PROPOSED GENITAL CUTTING OF GIRLS, EXPOSING A CHILD TO RISK OF SERIOUS DEVELOPMENTAL IMPAIRMENT, FAILURE TO PROVIDE PROPER SUPERVISION AND CONTROL OVER A CHILD OR ENSURE SCHOOL ATTENDANCE, EXPOSING A CHILD AS A WITNESS TO DOMESTIC VIOLENCE, PORNOGRAPHY, PROSTITUTION OR OTHER ACTS OF A SEXUAL NATURE ARE AMONG THE GROUNDS FOR LEGAL INTERVENTION IN AUSTRALIAN STATES. ONE JURISDICTION SPECIFICALLY ENABLED INTERVENTION WHEN A CHILD WAS AT RISK AS A RESULT OF DRUG USE BY A PARENT. IN SUCH A CASE, A PARENT COULD BE ORDERED TO UNDERGO TREATMENT AND PERIODIC TESTING FOR DRUG USE. SOME JURISDICTIONS DIFFERENTIATED BETWEEN EMOTIONAL ABUSE AND PSYCHOLOGICAL ABUSE, WITHOUT EXPLAINING THE DIFFERENCE BETWEEN THESE IDEAS (AIHW 2012A). AUSTRALIAN CHILD PROTECTION LEGISLATION HAS NOT YET REFLECTED SOME OF THE NEWER POLICY ISSUES NOTED IN ENGLAND, SUCH AS INVOLVEMENT IN ABUSE RELATED TO FAITH OR BELIEF (SIMON, HAUARI, HOLLINGWORTH, & VORHAUS 2011), CHILD TRAFFICKING OR FORCED MARRIAGE (LONDON SAFEGUARDING CHILDREN BOARD 2011).

It is important to reinforce that the medical paradigm around child abuse and neglect issues has been debated (Pfohl 1977, Sealander 2003, Parton 2005). Within scientific, legal, economic, social and moral paradigms, societies have formed definitions of abuse and neglect. These definitions have been inextricably linked to expectations about parental responsibilities. Laws and policies have followed, shaping systems of state intervention, although precise and proper boundaries for state invention have long been contested (McGowan 2005).

Complexity lies in how ideas about the acts or omissions of parents are interwoven with ideas about actual or likely harm to the child. In reality, assessing parent behaviour requires a completely separate approach to assessing actual or likely harm to a child. Kempe and Helfer (1972) argued that in every case examination of the actual and likely impact on the physical, developmental, emotional, psychological and sexual health and wellbeing of a child warranted a paediatrician-led, multi-disciplinary assessment.

The findings of recent research into the neurobiological effects of child trauma and early deprivation have called into question whether current legislative and administrative definitions of neglect are adequate:

...taking into account the less immediately visible but highly threatening long-term consequences of excessive deprivation that can lead to lifelong problems in learning, behaviour and health. Indeed, science tells us that many young children who are identified
by the child welfare system as meeting the criteria for reportable neglect may not exhibit evidence of physical harm, yet they may have already sustained disruptions of their developing brain circuitry (or other developing organs and metabolic systems) that could have serious lifelong consequences (National Scientific Council on the Developing Child 2012, p. 2).

Returning to my illustration in Figure 1 of health assessment in OOHC as a nested problem, I will explore the second layer of issues in the hierarchy of problems around child abuse and neglect; the layer where health professional’s interest in child protection, OOHC and health are to be found. Although this study is about health assessment in OOHC I have drawn a figurative line between OOHC and health. Abuse or neglect act as determinants of health, independently of placement in OOHC. The health of any child, regardless of placement in OOHC, may be affected by abuse or neglect. Living in OOHC is a separate health determinant. This separation of the two issues reflects the urging of clinicians, from Kempe and Helfer (1972) to Rees (2011), that alternative parenting to achieve protection from harm is a necessary, but insufficient remedy for the inter-related developmental, emotional, behavioural and physical consequences of child abuse or neglect. The medical ideal is not confined to health assessment in OOHC, but includes ongoing, multi-disciplinary care from health professionals providing continuity of therapeutic relationships with children and their carers and parents. The ideal promoted by the AAP is a designated 'medical home' for each child affected by abuse or neglect (Sanchez, Gomez, & Davis 2010).

Health professionals’ ideas, goals, values and beliefs about abused and neglected children have not arisen from a vacuum, and are not confined to the sub-population in OOHC. Rather, they are historically situated, and have been cross-pollinated by a range of professional experiences. Within paediatric medicine, community paediatricians have had a particular interest and role since the 1970s in the care of children after abuse or neglect (Oates 1980). Tertiary child protection paediatricians now have multiple roles, including forensic examinations and provision of evidence to courts, assessment of children entering the child protection system, ongoing monitoring of child development, research, multi-agency decision making in child protection and advocacy on behalf of children. Many combine these roles with general paediatrics (Cruickshanks, & Skellern 2007). Clinical and research experiences with children in OOHC have shaped ideas about the appropriate dimensions of child health assessment, the distinctive nature of potential clinical findings after abuse experiences, and
the provision and evaluation of therapies after health needs assessment (Oates 1989, 2000, Tarren-Sweeney 2008, Gilbert, Widom, Browne, Ferguson, Webb, & Jansen 2009, Ronan, & Feather 2009, Rees 2011). Medical research and practice in England and North America have contributed significantly to the ideas of health professionals in Australia, in ways which will be discussed further in the next section of this chapter.

In contrast child protection systems have been slow to make child health and wellbeing in OOHC a key purpose. Courtney (2009) identified three contributing factors. Firstly, a fear of being held accountable for being unable to reverse the effects of neglect or maltreatment on child health, especially given the uncertain length of time a child may be in OOHC. Secondly, child protection authorities have turned to Health departments to be accountable for health care. This sharing of accountability has been difficult to achieve, given that child protection authorities have retained parenting responsibility for children in the care of the state. Thirdly, child protection services have been stretched by ever increasing demands. As a result they have rejected being held to account for matters outside their strict, legal obligations.

An alternative explanation for why health has not been addressed in OOHC lies in cause attribution for a child’s placement in care. If the parent or family is seen as the underlying cause then attention may have been systematically deflected away from the child (Bromfield, & Higgins 2005, Fernandez, & Barth 2010).

This brief overview of the problem definitions illustrates the challenge for this study to make sense of planning for health assessment in OOHC while the broader issues remained ill-defined and unstructured. The next challenge in navigating the labyrinth was in the pathways related to goal setting or purpose.

HEALTH PROFESSIONALS’ PERSPECTIVES ON GOAL FORMULATION

Just as problem definitions have historical and disciplinary origins which influence contemporary thinking, so too does goal formulation.

*Understanding the historical development of medicine can ...make clear ideas and beliefs which act as invisible hands or bonds in stimulating or constraining what we think and what we do. How can we hope to effectively change the behaviour of institutions or people through private actions or public policies without appreciating the circumstances*
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of the past that have made them what they are? Knowing where we have been can help direct us to where we want to go (Reiser 1983, p. 320).

English history can give a glimpse of the invisible hands which have shaped Australian thinking about health needs and health assessment in OOHC. Following colonisation by the English in 1788, Australia’s ancient Indigenous history was irrevocably interrupted. English thinking intruded powerfully on the lives of colonists and first peoples, and on future generations (Castle, & Briggs 1982).

Doctors have assessed the health of children in charitable and public institutions in Australia since early colonisation. The primary goals of assessment included saving lives, controlling infectious diseases, ensuring fitness for education, protecting the health of the future workforce, stopping infanticide, diagnosing physical abuse, preventing further abuse, treating disability, and providing advice on appropriate accommodation to meet health care needs. Public and charitable organisations have placed doctors in semi-public roles involving inspection, assessment, certification and treatment. Doctors have also conducted health assessments for research. A brief review of the goals of such activities makes it possible to tune in to some long-term conversations which still resonate today.

HEALTH ASSESSMENT GOAL FORMULATION IN ENGLISH HISTORY

At the time of Australia’s colonisation in 1788, England’s then Poor Law had been in force for more than 166 years. The Poor Law Act 1621 provided that children not able to be kept and maintained by their parents were to be cared for by their local parish and financially supported from community taxation. England’s poor laws enacted ideas about how societies should provide for children who were found, metaphorically speaking, on the public common.

General medical care was sparse before the mid-18th century, and consequently, children rarely received medical attention in the broad community (Lane 2001). However, health care had been part of poor relief systems in Europe and England at least since the 16th century, following the humanist tradition of Juan Luis Vives (Spicker 2009). Surgeons, bone-setters and apothecaries employed by local parishes or benevolent organisations provided health care for children in the almshouse, workhouse or foundling hospital where children were accommodated under Poor Law provisions. Preventing or reducing child mortality, disease control, ensuring fitness for education and training and promoting healthy
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development to adulthood (Nichols, & Wray 1935, Hart 1979, McClure 1981) were important to the parish fathers. The need to preserve a class of ‘working poor’ to protect the political and economic strength of the state was a strongly felt imperative (Hanway 1759, Rosen 1974).

Health providers’ goals, however, were not always limited to those of the parish. At one extreme of the health workforce were the eminent, wealthy and benevolent, like Sir Richard Mead, physician to the Queen, who was a founding governor and gave honorary services to Thomas Coram’s Foundling Hospital in London (Hattie 1928, Nichols, & Wray 1935, Lawrence 1996).

The foundlings received his personal attention. Riding in a gilt carriage, drawn by six horses and accompanied by two footmen, he came to Hatton Garden to examine the first children taken in and to advise what treatment should be given to those who were ill. (McClure 1981 p. 212)

For some physicians the motivation was more heavily weighted to academic interest and career ambition than benevolence. William Cadogan, a Leyden and Oxford educated physician, described as the “eighteenth century Spock”, originally wrote his revolutionary Essay upon Nursing and the Management of Children in 1748 as a handbook for the care of infants in the same foundling hospital where Mead was benefactor. (Ross 1957 p. 658). The essay brought Cadogan fame and led to his election to Fellowship of the Royal Society and then appointment as a Physician to the Foundling Hospital. In this role, Cadogan not only provided health care but conducted research on new methods for inoculating against smallpox, using the foundlings as subjects. This paediatric writing, work and study helped him to build a successful career and achieve appointment to the College of Physicians (Rendle-Short 1960).

At the lower end of the medical hierarchy, Poor Law Medical Officers, appointed by the local parish, may have had less lofty career ambitions but took on semi-public, parish appointments to earn a regular income. These were the apprenticeship-trained surgeons and apothecaries. Poor Law Medical Officers worked in almshouses and workhouses where they assessed children’s health needs on a regular basis and advocated to institutional governors, organisations and governments about child health. The range of parish surgeon duties expanded in 18th C. to include child abuse and infanticide as reporting became more common (Thorpe 1994). Medical Officers led campaigns to improve nutrition, disease control, and
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health care conditions for pregnant women and children (Hurwitz & Richardson 1989). Partly in response, the Poor Law Amendment Act 1834 recommended that local authorities provide separate workhouse accommodation for children (Lane 2001). Dr Joseph Rogers, a young workhouse Medical Officer in Soho campaigned so successfully, under the umbrella of his Association for the Improvement of London Workhouse Infirmaries, that the Metropolitan Poor Act 1867 forced local authorities to open separate infirmaries. (Ayres 1971, Lane 2001).

Although campaigning cost him his Medical Officer post he went on to form the Poor Law Medical Officers Association (Hurwitz, & Richardson 1989) and continued to press for reforms. Such campaigns, along with protests about poor medical pay and conditions, were a feature of a long history of animosity with local authorities, centered on competing goals (Hanway 1759, Navarro 1978, Harris 1995).

From 1895 in England Poor Law Medical Officers were required to regularly inspect all children cared for under Poor Law services, whether they were reported as well or ill (Woodward, & Jute 1995). Child inspection and medical assessment continued through the 20th century. Psychiatrist Dr Hilda Lewis, who went on to establish the Medical Advisers Group of the British Agencies for Adoption and Fostering organisation, provided a detailed account and longitudinal review of child assessment at Mersham Reception Centre, where children entering OOHC came into temporary residence. The residential nature of assessment proved controversial, but was strongly defended by Lewis. She agreed with the Home Office that "in order to obtain the fullest possible knowledge and understanding of a child’s health, personality, conduct, intellectual capacity, emotional state and social history" sustained observation by skilled staff was vital. She rejected criticisms of residential assessment as "ill-informed and naive, unless the professionals involved were negligent or untrained" (Lewis 1954 p.128-129).

In these glimpses we see a legacy of medical thinking about goals; assessing and treating the neglected child found on the public common, improving the quality of health practices in children’s institutions, improving population health, promoting preventive care, extending medical knowledge through research, and advocating to public officials on behalf of children in charitable care.
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Like Ambroise Tardieu in 1860, (Labbe 2005) and C. Henry Kempe a century later (Helfer 1985), English doctors of influence were prepared to go against prevailing societal and professional opinion in their identification, treatment and care of neglected and maltreated children. Mead encouraged benevolence in health assessment of the previously shunned foundling. Cadogan recommended radical health care practices, including wet-nursing to 12 months, and ceasing administration of opiates or alcohol to infants. Rogers defied parish governors to the extent of losing his posting, and harnessed support from his workhouse medical officer colleagues in London to agitate for improved conditions for sick workhouse inmates, including children. Lewis defended the professionalism of doctors and the assessment of health needs of children in OOHC against what she perceived as naive and ill-informed criticism.


HEALTH ASSESSMENT GOALS TRANSPORTED TO AUSTRALIA

The same traditions of institution-based individual health assessment, treatment and medical advocacy on behalf of children were transported to Australia. At the time of colonisation in 1788, children were not counted separately from their convict mothers, and were not officially provided for on voyages from England. When children of convicts were orphaned on the convict ship Boddington, it was the ship’s surgeon Dr Richard Kent who sought official permission to feed the children so they would not perish (Gandevia, & Simpson 1978). By 1801, women convicts accommodated in Female Factories could keep their children only until the age of 3 when children were transferred to the Orphan School (Ramsland 1986).

In the early 19th century two-thirds of the child population were illegitimate and there were an increasing number of orphans and abandoned children living vagrant lives. Children transported to Australia in juvenile ships as punishment for crimes were cared for firstly by ship’s surgeons, who applied the prevailing standards of naval medicine. These same naval standards were used by doctors who stayed in the colonies, where they provided health assessment and treatment to colonists, convicts, soldiers and the child waifs and strays alike.
These former ship’s surgeons also became public health inspectors. The first of a great volume of official inquiries into the care of children in Australia was conducted in 1826 by the Chief Surgeon and two assistant surgeons who were commissioned to examine problems of eye disease in children at the Female Orphan School. While there, the doctors investigated not only eye disease, but all aspects of the children’s health care, and went on to provide months of treatment for the problems they found. Their recommendations extended well beyond their original purpose when they criticised diet, hygiene and accommodation and looked closely at education provision and financing. (Gandevia, & Simpson 1978).

The number of orphan schools, and later Industrial Schools, grew in line with expanding need, and continued operating until the 1880s, ante-dating conventional children’s hospitals. Initiatives to establish new orphan schools and foundling hospitals were frequently led by doctors (Gandevia, & Simpson 1978). From the 1820s such institutions were conducted by charitable and religious organisations with support from public funding. By the late 19th C. some institutions accommodated several hundred children. Overcrowding, financial restraints, the poor health of children on admission and the lack of trained nursing staff severely taxed the medical officers trying to ensure child survival. (Squires, & Slater 2006). Scabies, eczema, whooping cough, ophthalmic conditions, diarrhea and chilblains were prevalent, along with debility from other diseases such as gastric fever. Typhoid and scarlet fever were also present. Children were commonly in poor or emaciated condition on admission and doctors fought high mortality rates. At a new Infant Home opened in 1874 in Ashfield, New South Wales, for example, child mortality was 52%. Against these odds, by the late 1800s the medical supervision in Industrial Schools in Victoria, the second largest colony, appeared to be good.

The records indicate that the medical care was of a high standard in the context of the times and that medical officers took pride in the health status of the children and in an acceptable mortality record. Certainly, medical attention was more readily available in the institutions than to children of the poor outside. Excess morbidity in the institutions is attributable to overcrowding and inadequate hygiene (Gandevia & Simpson 1978. p. 121).

Colonial surgeons took an interest in child mortality. As in England, Australian doctors were concerned about baby farming and infanticide (Gandevia, & Simpson 1978, Scott, & Swain 2002). Inquests have been conducted into infant deaths at least since the 1860s. A Melbourne medical journal in 1863 demonstrated that in 25% of inquests on children under 3,
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depth could be attributed to neglect, ignorance or maltreatment. Concerns persisted through the 19th C. Twenty four inquests were conducted in 1890-91 related to cases of infanticide (Dickey 1979).

Improving child health by decreasing institutional exposure to infectious diseases, increasing time spent in fresh air and improving dietary variety was a primary goal for the move from institutional care to foster care which began with the 1881 New South Wales State Children Relief Act (Govan 1951). As in England and North America, many children were moved from orphan schools or large institutions to small foster family homes from the late 19th c. Children were then less visible to medical providers than had been the case in institutional settings. Notwithstanding that foster care became the officially preferred option, institutional care remained equally or more common in Australia until the 1970s. Unfortunately, many OOHC institutions, mainly conducted by religious bodies with inadequate and untrained staffing, were unregulated. Contemporary records paint a dark picture of common health practices in some institutions, including harsh sexual health examinations, medical experimentation, the questionable use of psychotropic medication for behaviour control and medical neglect (Forde et al., 1999, Australian Senate 2004, Penglase 2007). Little is recorded about health needs assessment for children who were placed in home-based OOHC in Australia.

A more recent English influence on health needs assessment was the importation by several Australian states of the English "Looking After Children" (LAC) approach to OOHC case management records, which was based on ideas about how the state might act as an "ordinary" or "reasonable" parent (Ward 1995). While it may have been seductive for Australian child protection staff to feel the LAC provided adequate guidance and coverage on health issues in OOHC, LAC was premised not only on 'ordinary parenting' but on the availability of the statutory system for regular health assessment of children in OOHC in England. No such system was in place in Australia. Australian critics around the turn of the century concluded that only those child health needs which were most urgent were being addressed (Butler 2004), and case management in general was in disarray (Auditor-General Victoria 2005, Scott, & Swain 2002). Unlike England, Australia had no national policy or clear agenda, and no national standards around child protection or addressing health needs in OOHC (Rayner 1994, AMA 2004, Cashmore, Scott, Calvert 2008).
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It was not until 2006 that the RACP proposed the introduction of systematic, comprehensive health needs assessment in OOHC, notwithstanding that it had been promoted and enacted in statutory guidance for more than two decades in England.

In summary, Australia was strongly influenced by England's Poor Law values and practices around the health of children in OOHC. The diversity of goals held by medical professionals, which were often at odds with those of government officials, highlights one of the characteristics of wicked problems identified by Rittel and Webber (1973) i.e. there is no definitive formulation or definitive solution.

**U.S. INFLUENCE ON AUSTRALIAN GOAL SETTING IN THE 20TH CENTURY**

Some influences on Australian medical thinking can be traced more directly to North American research than to the English heritage. Forensic and epidemiological study of cases involving child maltreatment, ideas about doctors being mandated to report maltreatment, interest in multi-disciplinary hospital-based Child Protection Clinics, professional advocacy by paediatricians and standards setting for health in out-of-home care have all been influenced by professional opinion and research in North America.

Claims that child abuse and neglect was not a matter of medical interest in North America until the 1960s (Lewis 1981, Nelson 1982, Antler 1981, Yule 1999) have tended to overlook earlier interest in the significant numbers of children already in OOHC. The then Executive Director of the Child Welfare League of America, Howard Hopkirk believed it was inexcusable in an age when rigorous medical examinations and efficient health services had become the norm for military, other work-related purposes, and life insurance, that the same expectations were not widespread in relation to children in care.

The backbone of good work for children often is adequate health service. A community's neglected and dependent children arrive...with greater accumulations of physical neglect than are common among children in the general population...in the familiar cycle of illness, unemployment, poverty and dependency poor health in families usually seems to have been the most powerfully destructive force. It is well to keep this in mind when prominent citizens object to giving better medical attention...than they provide for members of their own families...because the handicap is so great we must work
overtime in helping those who are dependent to become independent (Hopkirk 1944 p.146).

In 1939 the Child Welfare League published Dr Florence Brown’s *Health Program for Children in Foster Care*, which outlined a model health record format and health assessment schedule (Hopkirk 1944). It is likely that such guidance was informed by medical interest, widespread in North America and England, around assessment, institutionalisation and sterilisation as methods of separating and controlling people deemed deviant, dysfunctional or deficient (Levine and Levine 1990, Proust 2003). One goal was to limit the inter-generation transmission of traits which might be associated with unfit parenting and child maltreatment. Doctors had a key role in health assessment to “certify” both children and adults in relation to eligibility for institutional care or particular types of treatment (Curtis 1999). These ideas had resonance in Australia from the earlier 20th century, but when the intellectual tide in North America turned away from institutionalisation in the 1970s, Australia followed (Scott & Swain 2002).

Landmark research in the 1960s from North America around the “Battered Child Syndrome” (Kempe et al., 1962) sparked ideas about a possible new goal on the medical horizon. While many in the medical professions carefully averted their gaze (Helfer, 1985, Thorpe 1994, Oates 1996, Yule 1999) a small number of doctors began to assess children with injuries which were inconsistent with parent explanations, and to study such cases with fresh, forensic eyes. C. Henry Kempe’s first goal had been to develop a new understanding about a phenomena he witnessed in children’s wards; children with inadequately explained injuries (Kempe, Silverman, Steele, Droegemueller, & Silver 1962). Building on Caffey’s demonstration of the value of new x-ray technology to examine suspicious fractures, Kempe and his colleagues at the University of Colorado used a controlled, multi-site, epidemiological study to compare clinical signs in children, and added psychological examination of parents to the picture. With this work, Kempe began a loud, new conversation. His 1962 article has generated more than 3030 academic citations in the ensuing 50 years. Subsequent research led to identification and classification of five types of family dysfunction believed to significantly impair child development; physical abuse, neglect, sexual exploitation, verbal abuse and

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North American advances influenced subsequent research by a young Sydney paediatrician, Kim Oates, who took a particular interest in Kempe’s research, visiting Kempe in the US in 1974, and meeting him again at the first Australian Congress on Child Abuse in 1975 and the 1982 International Congress on Child Abuse and Neglect in Paris. In 1993, while on sabbatical from the New Children’s Hospital in Sydney, Oates spent a year as the acting director of the C. Henry Kempe National Centre for the Prevention and Treatment of Child Abuse and Neglect in Denver, Colorado (Kempe 2007). In 1996 Oates published a well-received text book *The Spectrum of Child Abuse: Assessment, Treatment and Prevention* and in the same year wrote in defense of the application of medical science to the field of child abuse and neglect (Oates 1996). While acknowledging criticisms of the ‘medical model’, Oates argued for accurate data collection, more emphasis on epidemiology, controlled studies, rigorous evaluation of treatments and long-term follow up of cases. He promoted a belief that medical professionalism had something important to offer in improving the quality of work in the child protection field. Oates has been one of Australia’s more prolific medical researchers in the child maltreatment field, and active in the International Society for the Prevention of Child Abuse and Neglect since its’ formation by C. Henry Kempe. These dual involvements reflected an enduring conversation between North America and Australia.

North American trials of health assessment and treatment had generated a growing enthusiasm among paediatricians for hospital-based, multi-disciplinary, Child Protection Clinics. (Smith, & Hanson 1974, Helfer 1985). Multi-disciplinary interests resonated strongly in Australia. An initial low-key, informal event plan for first Interdisciplinary Conference on Child Neglect and Abuse in Sydney in 1980 was quickly replaced by an extensive, five-day program to mollify the enthusiasm among the professions. Encouraged by international research findings, a small number of leading paediatricians in Australia successfully persuaded their individual hospitals to open some form of multi-disciplinary Child Protection Clinic (Boss 1986, Yule 1999).

Advocacy for children in OOHC had been carried by the Medical Advisers Group through the British Agencies for Adoption and Fostering, but was not a part of the main paediatric
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agenda in England until the end of the 20th century (Mather & Batty 2000). In contrast, the responsibility of paediatricians to advocate for children was an established goal in North America well before child maltreatment entered the conversation (Oberg 2003). The persistent and multi-faceted advocacy of Kempe and his colleagues on behalf of maltreated children in the second half of the 20th century led to legal, cultural and attitude shifts in North America (Bross, & Mathews 2013) which spilled over to Australia.

Compared with North America and England, Australian society was much more reluctant to acknowledge sexual abuse of children (Lewis 1981). When recognition became unavoidable by the 1970s and 1980s, the nature of proper medical, legal and social supports was highly contested. Feminist advocates opposed child sexual abuse matters being the responsibility of pediatric hospital services, on the grounds that they did not have the right underpinning (feminist) philosophy, and were at risk of seeing children as legal objects. The tensions spread. Australian academic child protection literature was dominated by the sexual abuse issue through the 1980s and beyond (Scott, & Swain 2002). The medical goals for health assessment in cases of child sexual abuse were certainly more likely to be forensic, than to be about therapeutic interventions with parents, arguably setting this type of abuse apart as a 'special case' in medical care after child maltreatment.

North American research in the neurosciences shed new light on the biological impacts of early deprivation and child trauma (Shonkoff 2000, DeBellis 2001, 2005). This new scientific material was embraced in Australia, leading to an enthusiasm for ‘trauma-informed’ interventions, particularly around promoting adult-child attachment. As the previous chapter demonstrated, however, this did not translate into Australian research around the effectiveness of interventions. There has been a consistent lack of treatment research in Australia (Tarren-Sweeney 2010), in part attributed to financing and governance issues (Ronan, Canoy, & Burke 2009), a scarcity of medical staff with the specialized skills for treatment (Packer 2008), the need for cross-portfolio cooperation and financing of research (Segal, & Dalziel 2011) and poor study compliance among parents or caregivers (Oates 1989, Oates, & Bross 1995). Failure to draw the link between maltreatment, and research on health inequalities in children and young people became evident in Australia early in the 21st century (Nicholson, Carroll, Brodie, Waters, & Vimpani 2003, Segal, & Dalziel 2011).
Aside from the influence of research, other elements of North American responses to child abuse and neglect had impacts in Australia. Mandatory reporting legislation and the roles of health professionals in child advocacy proved to be of great interest.

Most North America states introduced mandatory reporting legislation in the 1970s, in response to the new medical explanations around the causes and effects of maltreatment (Sealander 2003). Mandatory reporting of suspicion of maltreatment entered the Australian conversation and became a matter of some controversy (Whatmore, Petty, & Southby 1969, Cashmore 2002, Takis 2008), but was adopted progressively by Australian jurisdictions between 1977 and 2007, in relation to cases involving risk of significant harm (Matthews, & Kenny 2008). Mandatory reporting had two key impacts in Australia. Firstly, as was witnessed in North America (Schene 1998), it led to an unpredicted and progressive explosion in the numbers of children removed from the care of parents suspected of abuse or neglect (Mendes 2001, AIHW 2010). Secondly, it was an added source of complexity and tension at the interface between child protection and medical professionals (Underwood, Clare, Gillieatt, Clare, & Paley 1999, Holland 1999, Webster, & Temple-Smith 2010). One of these tensions found common ground in the value placed, in both medicine and social work, on the privacy of the family unit. Both disciplines have preferred state intervention after child maltreatment as an action of last resort. A therapeutic relationship with parents, in contemporary terms labeled a partnership with parents, has been at the heart of interventions. This has not been without criticism, primarily that individualised interventions ignore the negative impacts of broader social issues such as material poverty (Lindsey 2004, Parton 2005) or that every suspected case should be reported. Although mandatory reporting remains controversial in North America there seems little suggestion of its removal in either country (Takis 2008, Worley, & Melton 2013).

In summary, while the theoretical goals of health assessment in OOHC outlined in the introductory chapter seem logical and straightforward, in practice societal goal setting has been complicated and disordered. Rehabilitation of parents, to ensure responsible parenting, has received priority over child safety or wellbeing, and this remains the case in the 21st century (Courtney 2009). Contemporary Australian child protection objectives have been about protecting children at risk of harm. The first service intervention, after identifying a child at risk, is to provide support services to strengthen the capacity of the family to care safely for their child. Notwithstanding that some children may need to be removed to a place of safety,
until protective concerns are resolved, family reunification as soon as possible is a stated objective (SCRGSP 2012). The secondary status of children’s needs, and the uncertainty of children’s entitlements to services in their own right, seem persistent.

The intersection with equity issues is the third site where wicked problems may be found. Health professionals face the challenge of responding to the aspirations of the UNCRC in relation to children’s rights to the highest attainable standard of health and access to reparative health care.

HEALTH PROFESSIONALS’ PERSPECTIVES ON HEALTH INEQUITIEs

Rittel and Webber identified the intersection between problem definition, goal setting and equity as the third important site where wicked problems may be found (as previously shown in Figure 2). Equity is both a goal in health care, and a key dimension of the quality of care (Bowling 2011). However it is not the only goal of health service systems. Health services must also treat disease, meet healthcare needs and maximise health outcomes, while trying to achieve equitable health status within the community. Holm (1998) argued there is no natural way of achieving balance between these complex, composite goals. Equity cannot be guaranteed.

Societal choices about priorities and rationing of valuable health resources inevitably involve health professionals, and are unavoidably conflict ridden and messy. Physicians face competing demands in their stewardship of finite health resources. Fidelity to the needs of individual patients may call for actions at odds with the demands of distributive fairness within the population (Sabin 1998). The overarching medical ethic of justice, beneficence, and non-malfeasance supports the personal, as well as the societal concern that health professionals have with equity issues (AAP 2005, Reading, Bissell, Goldhagen, Harwin, Masson, Saynihan, Parton, Pais, Thoburn, & Webb 2009).

Health professionals are exposed to health inequities in their clinical practice. Paediatricians in particular, have a professional interest and sense of responsibility in advocacy for children. Advocacy has a particular meaning in paediatric medicine, incorporating both the individual child needs, and the rights of the paediatric population; “…a process that seeks to champion the rights of all children and to make every child’s needs known and met” (Tompkins, Brooks, & Tompkins 1998, as cited in Oberg 2003 p.408). This aspect of a health
professional's work can be a stressor, with some reporting a lack of adequate understanding of the effects of maltreatment and lack of advocacy skills training to equip them for these challenges (AMA 2005, Raman, Woolfenden, Williams & Zwi 2007, Zalkin, & Hodes 2011).

The problem of health inequalities is particularly complex. Researchers with an interest in measuring and monitoring child health are also involved in identifying disparities in health status (Llewellyn, & Leonard 2010). Genetic and biological determinants of health status rest within the make-up of an individual. These are impacted by past and present behaviours, nurturance and health care experiences, and interactions with wider environmental factors including income, education, employment, political climate, social connectedness etc. Addressing differences in health status involves addressing the unequal distribution of health determinants (Graham & Kelly 2004). It is not always clear, however, which determinants contribute to, or cause, observed health disparities. In a challenge to the widely held view that poverty is a critical health determinant, Segal, Doidge, & Amos (2011) postulated that in the observed gradient of health according to socio-economic status, child neglect or abuse may have an equally central role in explaining these health disparities. Lack of national data about family functioning linked with child health data in Australia, has hampered understanding about this interaction on health disparities (Goldfield, & Oberklaid 2005).

The UNCRC (1989) accords children with the right to an equal opportunity to achieve the highest attainable standard of health. This right is not the right to be healthy. It involves children experiencing living and nurturing conditions known to be positive determinants of health, being protected from non-consensual medical treatment or experimentation, and having equal opportunities to achieve the best, individual health status possible (Hodgkin, & Newell 2007). There are four tests in examining enactment of this right; (i) service availability, (ii) service acceptability, (iii) service accessibility and (iv) service quality (Tobin 2006). The critical issue in relation to equity is that rights under the UNCRC are indivisible. In ratifying the UNCRC, countries, including Australia, made a commitment to enact health rights, including the right to rehabilitation after child maltreatment. Health care and rehabilitation services became a particular obligation, to be fulfilled for each and every child in OOHC. Accountability involved taking active measures, to respect and protect children's right to health (Tobin 2006). In response, a common focus in policy documents in the child protection sector has been about children’s access to health care. Aday & Andersen (1981) draw a distinction, which policy documents have failed to do, between potential access and realised access, where realised
access refers to those additional aspects of convenience, affordability, quality and congruence with the characteristics and needs of the specific population. These are the factors that shape whether people are successful in being able to access a service that meets their needs.

A rights-based approach has influenced the development of a Charter of Children and Young People’s Rights in Health Services in Australia (Children’s Hospitals Australasia and Association for the Wellbeing of Children in Healthcare 2010) which recognizes the right to the highest attainable standard of health care. Relevant elements include safe and expert care, continuity of care which is well-managed and physical settings of care designed for the comfort, safety and control of children. Australia’s Standards for the care of children in health services (Hill, Pawsey, Holt, & Goldfeld 2011) are complementary to the Charter and recognise that staff involved in the care of children and adolescents should have special training to meet the diversity of their needs. While the charter and the standards are not enforceable, they extend expectations beyond access alone and are available to serve as a self-assessment guide for health services concerned with continuous quality improvement.

The UNCRC (2005, 2012) criticised Australia’s implementation of the child rights to health in OOHC, and required the government to increase equitable health outcomes, and to assure rehabilitation in order to maximise children’s opportunities for recovery from maltreatment. While the Australian government has claimed its’ objective is “fair and equitable access to services, on the basis of relative need and available resources”, at the time of this research no national indicators were available to measure equity or access to Child Protection or OOHC services or Health services for children in OOHC (Steering Committee for the Review of Government Service Provision (SCRGSP 2012 p. 15.19). Furthermore, while "maximising children’s life chances by ensuring children in care have their educational, health and wellbeing needs met" was a stated objective (SCRGSP 2012 p.15.53), the sole national measure was the change over time in the learning outcomes of children on guardianship or custody orders, against national reading and numeracy benchmarks. Health outcomes have not been measured.

This soft approach to health priority is deeply embedded in history. Entitlement to health care was unrelated to medical need in England until the Metropolitan Poor Law Amendment Act of 1867 (Lane 2001). It was not until the late 19th century that poor relief and
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Health care were regarded as a positive duty of the state, where individuals had a right to fair, if not equal treatment (Grell, Cunningham, & Jutte 2002).

While the 1959 United Nations Declaration of the Rights of the Child included the right to opportunities “to develop....in a healthy and normal manner...”14 the subsequent conversations were more about rights and needs for safety and family restoration, than about health. These ideas resonated in Australia, as the Foundation Professor of Psychiatric Medicine at Monash University Prof Wallace Ironside attested:

The community responsibility for young children can be simply defined as ensuring that each and every child inherits his birthright of nurture by devoted parents in a stable family setting (Australian Frontier 1969).

Care in a nurturing family environment, and adequate attention to child health, have sometimes been seen as synonymous (Murphy 1996, Blythe, Halcomb, Wilkes, & Jackson 2013). Gilligan emphasised the importance of the nurturing environment in this way:

...the task of professional systems and services for children in care may be said to be to help release the inner strengths, resilience and healing powers of the child in care, and of the caring...(informal support) systems which surround the child (Gilligan 2009 p. 516).

In contrast, health professionals have argued that nurturing parenting alone is insufficient to meet the health needs of maltreated children (Kempe, & Kempe 1975, Rees 2011). The UNCRC acknowledges that rehabilitative health care is required.

Children in OOHC in Australia have historically been viewed as objects of charity (Penglase 2007) and as productive adults in training (Mason, & Gibson 2004), not holders of a right to equitable health outcomes. Following the 1989 UNCRC, Moira Rayner urged change in the way child rights were conceptualised in Australia, arguing that governments must put aside

14 The Declaration of the Rights of the Child (United Nations General Assembly Resolution 1386 (XIV) 1959 called upon parents, individuals, organisations local authorities and national governments to recognise and strive to observe by legislative and other measures a series of principles. These included Principle 2 - The child shall enjoy special protection, and shall be give opportunities and facilities by law, and by other means, to enable his to develop physically, mentally, morally, spiritually and socially in a healthy and normal manner and in conditions of freedom and dignity. In the enactment of laws for this purpose, the best interests of the child shall be the paramount consideration.
philosophical and policy differences and "recognise that (maltreated) children are more than responsibilities, needs or forensic or economic units" (Rayner 1994, p.iii). The UNCRC fosters tension and complexity. On the one hand, in the absence of effective sanctions, states parties may be slow to honor obligations to a child after maltreatment (Archard 2008, Bennett, Hart, & Suevo-Cianci 2009). On the other hand, the child and their advocates are not bound to passively rely on 'noblesse oblige'. Rather the UNCRC provides that a child may make active claims against the state for health care and rehabilitation services. Scientific medical evidence can be used to support such claims (Reading et al., 2009).

One inhibiting factor in enacting UNCRC Article 39 in relation to physical and psychological rehabilitation for children has been the slow progress towards understanding the nature and effectiveness of treatment and rehabilitation options after child maltreatment (Oates 1989, Kaplan, Pelcovitz, & Labruna 1999, Nicholson et al., 2004, AMA 2004, Tarren-Sweeney 2010). Professional bodies (AMA 2005, RANZCP 2008) have called for specialised training, specialised centres and more research for evaluation, diagnoses and management of problems associated with child abuse.

Child health disparities are a multi-layered problem, permeating the lived experience of children, the everyday experiences of health professionals and the ongoing challenges of social planning policy. From a health professional viewpoint, some fundamental shifts will be needed in health care structures and practices in Australia to enable equity to be better addressed from the consulting room (Nicholson et al., 2005, Zwi, & Henry 2005, Baume, Legge, Freeman, Lawless, Labonte, & Jolley 2013).

PROBLEM SUMMARY

This chapter has described the wickedness of the problem situation surrounding health assessment in OOHC in Australia. In the broader context where policy problems required definition, goals required agreement, and the moral imperative of inequity struggled for attention, a labyrinth of complex issues and contested ideas was evident.

In public policy making, a problem needs to be given definition, boundaries and structure before appropriate policies can be drafted. In discussing this need, Althaus, Bridgman and Davis (2007) introduce the ideas of Simon (1973) about ill-structured problems. Simon was also grappling with the 'wicked' problem type. Although less convinced of a clear and
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impassable line between structured and ill-structured problems than were Rittel and Webber, Simon’s contribution was to point out that much of task of problem solving is taken up with structuring problems, i.e. breaking them down into smaller components for study and solution. He also pointed out that while ill-structured problems can seem difficult, or even impossible, their scope can be progressively narrowed by explaining previously unexplained phenomena, within the problem situation.

CONCLUSION

The previous chapter established a lack of Australian research about policies and systems of health assessment in OOHC. My aim in this chapter was to explore the positioning of health assessment within the broader and problematic challenge of social planning for children who come into the care of the state. I found that this planning challenge has "wicked" and complex characteristics.

Of particular relevance for this study were the ideas of health professionals about the nature of the problems and their solutions. Health professional ideas about the purpose of health assessment have not neatly aligned with those of public policy or child welfare practice. Doctors in Australia had a legacy of concern for children in OOHC which was evident from the time of colonization which periodically put them at odds with governments. Doctors concerns were fuelled by benevolence, clinical interest, scientific knowledge, desires for societal improvement or personal career advancement. The work of doctors with children on the public common did not lend itself to mechanistic or instrumental explanations.

In contrast to the contemporary concerns of doctors, pressures to enact children’s rights to health and rehabilitation after maltreatment or neglect had elicited soft responses from governments. Appreciation of child maltreatment and neglect as important determinants of health was still developing in Australian public policy.

The next chapter describes the methodology chosen to explain the previously unexplained phenomena of how health professionals were attempting to enact the recommendations of their own professions within the prevailing social policy context in Australia.
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CHAPTER 4
THE SYSTEMIC INQUIRY APPROACH

OVERVIEW

Centralist, managerialist approaches such as surveys about policy compliance or case audits have characterised earlier research efforts to understand health assessment implementation in OOHC. Such approaches stem from a rationalist, linear and reductionist world view which starts with a policy decision or a guideline and examines the extent to which it is implemented over time (Geyer 2012).

In contrast, I argued in Chapter 3 for the complexity, indeed wickedness of the problematic situation of health assessment in OOHC. The complexity paradigm acknowledges that the links between policy and practice in complex systems of human activity are non-linear and highly interactive, that power is diffuse and participants are self-organising (Ozer, & Seker 2013). My research interest has focused on what new knowledge about health systems and policies for OOHC can be gained from the experiences and ideas of health professionals who are working to provide health assessment in OOHC. Rather than a top-down approach, I have preferred to take a bottom-up approach, useful when studying policy implementation or change in situations where there are weak regulatory structures and many actors with reasonable autonomy (Sabatier 1986). In the search for answers about the difficulties in implementing health assessment in OOHC, I set out to learn from the contemporary experiences, activities and decision making of health professionals immersed in such activities.

In my work in 2008 on a small pilot program for OOHC health assessment in general practice and in the course of my Master’s research I caught a glimpse of some of the unexpected challenges in the field. Preliminary analysis, reported in the earlier chapters, threw further light on the depth of complexity. As I was grappling with how best to further my research aims in this confusion of complexity, a PhD supervisory panel member, Professor Cathy Humphreys, suggested I may find Peter Checkland’s work on Soft Systems Methodology (SSM) of interest. SSM was developed as an approach to learning about problematic situations where it is important to seek clarity about the problems themselves (Checkland 1999, Holwell 2000). Where situations are messy and complex, SSM involves a methodical approach to observation and reflection (Hindle, Checkland, & Worthington 1995). Furthermore SSM takes a
systemic approach to examining complex problem situations and complex social realities, guiding both research design and analysis of findings (Checkland, & Scholes 2007). Reading Checkland’s articles and books was a watershed experience and led me on a trail further into the theoretical foundations of systems theory and complexity science. The glove seemed a perfect fit. SSM offered a way forward in developing a research approach consistent with the aim of identifying factors affecting health professionals working inside this complex, wicked situation.

In their exploration of ineffective implementation of recommended health guidelines, Susan Michie and colleagues from the University College, London identified professional roles and identity along with social influences including professional norms and professional leadership as being among twelve key domains of interest. Personal boundaries and goal setting were also included. These findings gave further impetus to my choice of an inquiry approach which could tap into individual experiences. Central questions from a constructionist perspective are how worldviews, beliefs and values influence personal actions and interactions. This perspective is useful in studying human planning systems (Patton 2002) and is congruent within SSM.

My research approach rests on theoretical perspectives of complexity, systemic thinking and constructivism. In this chapter I explain the chosen methodology and research design and my experiences in their implementation. The inevitable challenges, in particular the unexpectedly high burden associated with multi-site ethical and research governance review are discussed along with the small triumphs. I address the strengths and limitations of the approach and provide a self-assessment as to the rigour of the research design.

**SYSTEMIC APPROACH**

At the heart of systemic theories has been an understanding of a system as “a set of elements, standing in inter-relationship with themselves and within their environment” (Von Bertalanffy 1972 p. 417) or “a whole which functions as a whole by virtue of the interdependence of its parts” (Buckley 1968 p. xvii). My research was not concerned with mechanical or organismic systems but with the third type described by Ackoff (1994): the social systems found in societies, communities and organisations.
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Essential concepts in systemic thinking have influenced me in this study. Firstly the concept that health and social care organisations are complex, adaptive, social systems where people are actors involved in purposeful activities, where people self-organise, where interactions and interdependencies are non-linear, and where hierarchies of related systems co-exist. Important in this concept is the idea that human values influence choices and decisions in framing and responding to problematic situations (Churchman 1982). Secondly I have been drawn to the systemic concept of wholeness i.e. that the emergent properties of systems (i.e. the whole of what the system does), are a product of interdependencies and interactions and are distinct from any set of component parts. (Ackoff 1994, Anderson, Crabtree, Steele, & McDaniel 2005).


Systemic inquiry has been described as a heroic adventure.

If the intellect is to engage in the heroic adventure of securing improvement in the human condition, it cannot rely on ‘approaches’ like politics or morality, which attempt to tackle problems head-on, within a narrow scope. ...the key to success in the hero’s attempt seems to be comprehensiveness. Never allow the temptation to ‘be clear’, to ‘use reliable data’ or to ‘come up to the standards of excellence’ divert you from the relevant, even though the relevant may be elusive. (Churchman 1979 P. 145).

In my study of a wicked problem it was this notion of comprehensive inquiry in the search for the elusive factors of relevance that had a strong appeal.
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SOFT SYSTEMS METHODOLOGY (SSM)

Developed and refined over 40 years of operations research at University of Lancaster (Checkland 1981, Checkland, & Scholes 2007). SSM is a structured approach to the study of complex, problematic situations. The methodology is not evaluative (Ison 2008, Anderson, Crabtree, Steele, & McDaniel 2005, Winklhofer 2002, Mingers, & Taylor 1992). It is commonly used for action research (Davies 1989, Checkland 1999) although that was not the intent in this study. It also has value in exploratory study, taking a staged approach to characterising and examining problematic situations in systemic terms (Rose, & Haynes 1999, Checkland, & Winter 2006, Davies 1988). Researchers have found SSM to be suitable for questions where there are evident discrepancies between ideas and actions (Anderson, Crabtree, Steele, & McDaniel 2005), a need to negotiate explanations (Davies 1989) and to understand issues more deeply (Anderson, et al., 2005, Flood 2010). All of these characteristics could be found in the problematic situation of health assessment in OOHC. The interpretive stance, the privileging of the subjective views or weltanschauung15 of participants, and the holistic analysis of problematic situations are strengths of SSM (Holwell 2000). Systemic inquiry suited the nature of the problematic situation and research themes as it respects and captures multi-disciplinary perspectives while simultaneously dealing with complexity (Vickers 1959, Churchman 1982, Mingers, & Taylor 1992, Checkland 1999, Braithwaite et al., 2002, Holwell 2000, Durant-Law 2005, Van de Water, Schinkel, & Rozier 2007, Mingers, & White 2010).

Checkland’s interest was in finding a way, through operational research, to methodically observe what was happening in problematic situations with a view to finding sensible ways to bring about improvement. SSM achieves this by treating purposeful activities that take place in social planning as if they are component parts of systems16. It studies the values, ideas and actions of people involved in such processes and the characteristics and change processes

15 The term Weltanschauung is a German word often translated as worldview. Use of this term has been associated with the work of Wilhelm Dilthey (1833-1911) who sought a term for the human sciences where knowledge is a product of constructed meaning based on interpretation and where interpretation takes place within larger, historically and culturally bound understandings of the world.

16 Checkland defined a system as “the notion of a set of elements mutually related such that the set constitutes a whole, having properties as an entity (Checkland & Scholes 2007 p. 4). Checkland developed a way of representing purposeful action as a system, regarding a logically linked set of activities as constituting a whole system with its emergent property being its purposefulness (Checkland & Poulter 2010).
found along the intersections of various systemic elements. In SSM, a system is understood as a mental construct rather than an ontological entity.

In the development of SSM, Checkland drew heavily from Sir Geoffrey Vickers’ work on public policy making (Checkland & Scholes 2007). Vickers (1995) challenged previous thinking about the utility of seeking technical or rational solutions to complex political, social and moral problems. He introduced the notion of appreciative systems to explain the vital contribution of human judgment on the part of those planning, deciding and acting in response to public policy problems. His theory moved away from expectations that humans are, or can be made to work in the manner of efficient machines following logical processes. Rather, he recognised that at every level of human activity people develop personal and collective goals or norms, evaluate and interpret what they see, hear and experience, and choose how to respond.

Individuals work and live within their own setting, which is bounded by past and new observations, experiences and learning in differing contexts. In a policy environment where many people are working together, their combined interactions form what Vickers terms an 'appreciative field' (Vickers 1995 p. 83). In Vickers’ theory, individuals have unique "readinesses" to appreciate the world round them (Vickers 1995, p. 84). He regarded readinesses as something precious, without which humans would be inert or unresponsive. He argued for their artfulness. Furthermore, readinesses were seen as fluid, unfinished and irreversible. Once a change in appreciation occurs, it cannot be undone to re-capture a former appreciation, notwithstanding that it can continue to alter. A vital part of interaction is how people appreciate and accommodate the views and actions of other humans as they go about their work. I have taken from Vickers theory and rested this PhD study partly on the idea that the appreciative fields of health professionals involved in OOHC health assessment would vary from those of lawyers, politicians, foster parents, child protection managers. Furthermore, these appreciative fields may form part of organisational shadow systems which co-exist alongside official hierarchy, mission, policies and management practices (Shaw 1997). Learning more about the appreciative fields of health professionals could contribute new insights which would then be available for others to hear, observe and adapt to, both at an inter-disciplinary and organisational level.

While SSM has its critics I took the view that using SSM to capture some of the complexity of human interactions in systems for health assessment in OOHC would be an
advance on the dominant research approaches previously used in the field. Such approaches largely consisted of clinical studies, statistical comparisons, policy compliance audits, project or program evaluations or qualitative studies from single disciplines. In appraising the strengths and weaknesses of SSM for this study, I was mindful of the conclusions drawn by significant commentators on the methodology. Three cautions were relevant. Firstly, the results of a U.K. survey of 137 people who had some experience with SSM warned that the use of SSM can be time-consuming and requires experienced practitioners to grapple with its particular ways of thinking and novel terminology (Mingers, & Taylor 1992). I was re-assured by the findings of Ledington & Donaldson (1997) who repeated the UK survey in Australia and found that even those researchers and managers who had used some but not all of the elements of SSM, and who had less exposure to academic training in its use, found it a valuable methodology, particularly for sense-making. While SSM is often used for action-research where participants are involved in developing and sharing their own situational analyses and potentially in conceptual modelling in group settings, its designers argue that as long as five constitutive rules are followed SSM can also be appropriate in situations where participants are not involved in every analytical step, especially where the purpose is sense-making. The constitutive rules include faithfulness to SSM’s epistemology, a focus on bringing about improvement in a problematic situation, the use of SSM devices to interrogate the real world, demonstration by the researcher as to how SSM was applied in a particular situation and reflection on its use (Checkland, & Scholes 20007).

A second caution arose from a comprehensive review of 250 items of literature about SSM (Holwell 2000) which concluded that the secondary literature contains many misunderstandings about the methodology. For that reason I relied heavily on recent textbooks by the developers of SSM (Checkland, & Poulter 2010, Checkland, & Scholes 2007) to gain an understanding of the key concepts and their application.

In reviewing the contribution of systems thinking over the previous decade Mingers and White (2010) raised a third caution that although SSM is the most widely used application of systems thinking it is not well understood that SSM is a different but complementary methodology for use in phased approaches for learning about complex situations. To make further sense of this I considered other approaches used in the field and questioned how a study using SSM might make a contribution. In doing so I characterized other studies into five
broad approaches, drawing from my review of Australian and overseas literature outlined in Chapter 2. These approaches were as follows:

(i) Site-specific clinical studies which have observed higher rates of chronic and complex health conditions in small samples of maltreated children than in the broader population;

(ii) Population studies which have identified higher incidence of reported chronic and complex health conditions in larger OOHC populations.

Both of these types of studies have been used to support medical college recommendations and public policies about attention to assessment of health needs in individual children and competencies required for health professionals to address the complexity of such cases.

(iii) Audits of health assessment policy compliance, including reports by Ombudsmen, Auditors-General and Royal Commissions;

(iv) Qualitative studies and surveys which have examined the consequences for children and carers of poor compliance with policies.

These types of studies have highlighted where there are failures to implement policies but have been limited in being able to explain the reasons for poor compliance.

(v) Evaluative studies which have sought to judge the effectiveness of interventions. Examples include evaluations of the implementation of a clinical pathway or the development and delivery of carer education and support about child health in OOHC.

Evaluative studies of this type have been site-specific and have sought to measure change. This study was different from but complementary to these types of studies in that it sought to delve more deeply into underlying complexities. It was exploratory rather than evaluative and it used world views of health professionals about the problematic situation as its subject. Mingers and White (2010) argue that this approach is where SSM makes its primary contribution. Others have agreed that SSM is “a methodology par excellence for forming a consensus on the nature of the problem situation…and what the constraints are for possible solutions” (Van der Water, Schinkel, & Rozier 2007, p. 278).
In summary then, I took a systemic approach to a research question in the field of health services policy and systems research. Adopting Checkland’s methodology, my study involved both contextual and conceptual analysis. Conceptually, I treated health assessment in OOHC as a purposeful activity system, with several embedded sub-systems, all worthy of methodical observation. The next section introduces the processes involved in this dual analysis.

**SSM IN ACTION: CONTEXTUAL ANALYSIS**

Contextual analysis of the problematic situation overlapped all other research steps. Analysis was circular and ongoing, examining the historical, social and political influences at play. Every form of data collection, from the first reading of the research literature to the last interview in the field and the informal feedback from public presentations of study findings contributed material for this analysis. Methodologically, in SSM the analytical process is systematic in that particular themes must be addressed. These relate to the roles, values and norms of people involved in the situation being studied, the ways in which power is exercised, the systemic monitoring and control processes and criteria health professionals use for judging efficacy, efficiency and effectiveness. Using SSM, I was able to explore systemic barriers and enablers by examining who has an interest in the problematic situation and would be affected positively or negatively by change, who has capacity for making change, what worldviews make ideas about change meaningful for participants, who has authority to address the problems or demand change and who/what has authority or power to constrain change or problem resolution.

**SSM IN ACTION: CONCEPTUAL AND EXPLANATORY MODELS**

The development of intellectual models of purposeful activity systems is a useful methodological step to inform the shape of inquiry in the real world (Checkland & Poulter 2010). I developed a series of five intellectual models of task-focused activity systems, drawing from what I understood to be the declared worldviews of health professionals as expressed in medical policies, medical research and health services research. Each of the models began from a declared purpose to take some kind of transformative action, following the formula described by Checkland & Scholes (2007) which uses the mnemonic CATWOE. Within the modelling process people involved are termed actors and are distinguished from people outside the system who may be affected by the transformation either negatively or positively. Environmental factors are considered, as are the ways in which power is exercised.
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by people (who are labelled as the owners of the change or transformation that the activity system produces, in that they can either allow or prevent the activities from taking place).

The five models related to the following steps of care which, taken together, would theoretically describe a systemic approach to health needs assessment and health care provision in OOHC:

I. Collecting, storing and sharing child health histories;
II. Initial health assessment;
III. Comprehensive health assessment;
IV. Child health care management planning;
V. Ongoing monitoring and review of child health needs

These models and their underlying analytical frameworks are summarized in Appendix C and the results of their use in this thesis are discussed in Chapter 8.

SSM IN ACTION: CASE-STUDY DESIGN

Earlier researchers have used case study approaches within SSM to study a phenomena in-depth (Clarke & Wilcockson 2001, Anderson, Crabtree, Steele & McDaniel 2005, Anaf, Drummond & Sheppard 2007). As I wished to observe but not manipulate behaviours a case approach was methodologically appropriate for this study (Birley & Moreland 1998, Yin 2009). Taking an instrumental approach, I designed a multi-case, embedded case study (Stake 2006), strengthening the study by embedding a number of diverse data collection sites to increase opportunities to learn about the influences of complexity and contexts at play (Gibbs, Kealy, Willis, Green, Welch, &Daly 2007).

In order to bound cases I developed the framework described in Appendix B, p 322, guided by Miles & Huberman (1994). The case phenomena were processes and activities relating to health assessment of children and young people aged 0-18 years in home-based OOHC in Australia, as experienced by health professionals. The primary units of analysis were states where state-wide policies specifically required that the health needs of children in
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OOHC be identified. Four states and one territory of potential interest were identified from a search of grey literature. However the territory was excluded as a significant and extensive public inquiry into child abuse and child welfare in that jurisdiction was underway at the time this study commenced. My aim was to conduct studies in two states in the expectation of some variation in contexts at the state level. From the grey literature I identified that each case may potentially offer several embedded units of analysis of the following types:

i. Services which specifically offer health assessment for children and young people in OOHC such as OOHC clinics in tertiary settings, specialized child protection psychological and behavioural counselling services or multi-disciplinary assessment services in community health settings;

ii. State or local consultative, advisory or management delegates, committees or groups with oversight of implementation of policies relating to the health needs of children in out-of-home care.

Criterion sampling (Miles, & Huberman 1994) was used to identify specific organisations or bodies as units of analysis. The criteria were that individuals or organisations should have direct experience of providing or overseeing health assessment in OOHC. While I sought variety in the sample, cases and units were intended to be theoretically generalizable rather than representative. A detailed study protocol was developed and adapted as necessary for each unit of analysis. A sample protocol is at Appendix B pp. B3-B13. The four eligible states were ranked according to the size of their OOHC population and approached in turn until two had been engaged in the study.

CASE LIMITATIONS ASSOCIATED WITH MULTI-CENTRE ETHICAL REVIEWS

A significant hurdle in implementing the case study approach was the unexpected burden of ethical and research governance review by state government departments and local area health services. The study design was approved as a low/negligible ethical risk human research study by the University of Melbourne Human Research Ethics Committee in 2011. Within the first two states selected for recruitment all organisations with a known involvement in health assessment were considered eligible. In Australia, each organisation or institution is responsible for their own research governance. Funding requirements of the National Health & Medical Research Council about compliance with ethical standards have shaped the way in which governance is exercised since the mid-1980s (Israel, & Hay 2006).
Although a national Harmonisation of Multi-centre Ethical Review (HoMER) initiative designed to bring consistency and efficiency to review in studies involving multiple sites was in place, evidence uncovered in a subsequent literature review suggested that, researchers should not assume it has been implemented (Driscoll, Currey, Worrall-Carter, & Stewart 2008, Hunter 2008, Mallick, & O’Callaghan 2009, Guillemin, Gillan, Rosenthal, & Bolitho 2010, Ravina, Deuel, Siderowf, & Dorsey 2010, Boul, Fitzpatrick, Maddern, & Fitridge 2011, Chalmers 2011, Vajkic, Meagher, Hicks, Faedo, Ward, & Pearson 2012).

Although I was aware of the HoMER initiative through the grey literature, I had not researched evaluations of its implementation and was unprepared for the lack of mutual recognition of the University HREC decision and for extensive procedures in government departments which required additional, specific research governance site approvals. Among the eligible organisations I identified 5 which required an application to their own HREC for ethical approval. Only one of the 5 recognised the University HREC approval and abbreviated their application process. Another required approval through a strategic review process before a HREC application could be lodged.

Research governance approvals were complicated by the fact that a trunk organisation such as a state health department had many branch organisations in the form of independently governed local area health services. Each of these independently governed organisations required separate approval from separate review bodies. Before recruitment could begin, five HREC applications and 26 written site approval applications had to be developed, lodged and processed. These review processes consumed 12 months of unrelenting administrative work. The average time taken for ethics approvals was 69 days from the date of application, with a range from 51 to 90 days. The average time for site specific authorisations was 82 days with a range from 18 to 175 days. The processes and delays could not have been predicted from the guidelines and standards issued by HRECs. The results proved financially costly and resulted in significant delays in recruitment to the study.

I estimated that more than 150 people participated in ethical and research governance review for this study. Aside from the impact on the time taken for the study, the nature of the administrative processes involved with site authorisations threatened the anonymity of potential study participants and risked exposing them to undue pressure and distress. These
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threats required skilful management and constant maintenance of an objective approach to the review processes, despite the frustrations.

I felt so challenged by the complications of multi-centre ethical and research governance review on a 3-year, low-risk PhD study that I presented my experiences at the Australian Postgraduate Education conference in Adelaide in 2012 and subsequently published a descriptive account (Appendix D, pp. 387) which proved to be cathartic.

CASE STUDY RECRUITMENT

With the triumph of ethical and research governance approvals finally in place, I approached 22 organisations across the two states to participate in the study. Recruitment involved:

1) a written invitation to an organisation to participate (Appendix B, pp.337);
2) the provision of plain language statements for organisations (Appendix B, pp. 339);
3) written materials to participate for organisations to disseminate to their staff, including:
   i. invitation for individuals to participate (Appendix B, p. 341);
   ii. plain language statements for individuals (Appendix B, p.342);
   iii. individual consent forms (Appendix B, p.344).

Ten organisations agreed to participate and subsequently invited interested staff to contact me directly to discuss and arrange their individual involvement in the study. Among organisations which did not take up the invitation, some advised of the reasons for their decision which included:

a. Lack of interest in the research focus;

b. A directive from a more senior authority not to take part;

c. A concern that participation may deter staff participation in a separate, planned evaluation expected to take place in a later time-frame;

d. A self-perception of insufficient involvement in OOHC health assessment experiences to make a useful contribution.
In several instances the organisation’s reasons for not participating were not disclosed. In fact, despite being required by their own organisational policies to advise the researcher of the outcome of formal applications for site specific authorisations, seven organisations failed to provide any response, notwithstanding three follow-up contacts. One organisation disseminated details of the study but no individuals came forward to take part. That organisation was then discounted. Individuals were recruited from each of the other organisations which had agreed to participate. Details of organisational type and location have been withheld to protect the anonymity of individual participants.

From the nine organisations in the study, 47 individual participants were recruited, working from 12 separate sites, spread across rural, regional and metropolitan areas. The participants comprised 41 women and 6 men, likely reflecting both workforce composition and women being relatively more drawn to work with disadvantaged children. The disciplinary backgrounds of participants, collected on the individual consent forms, included paediatrics, social work, policy and administration, nursing, psychology, psychiatry, medical science, occupational therapy, speech therapy and psychiatry. I found in the course of the study that participants were more likely than not to be informally and/or formally networked with other potential participants through membership of special interest groups, disciplinary networks and organisational networks. In order to minimise the risk of any reader believing they could guess the identity of any individual participant, details of participants were aggregated across cases. After aggregation the number of individuals per discipline ranged from 1 to 13. Consequently a breakdown of disciplines has been withheld to further minimise risk of identity being guessed. Table 14 provides an aggregated summary of the disciplinary background of participants.

<table>
<thead>
<tr>
<th>Disciplinary Background of Participants</th>
<th>Number of Study Participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Specialist medical</td>
<td>15</td>
</tr>
<tr>
<td>Allied health disciplines</td>
<td>17</td>
</tr>
<tr>
<td>Social work</td>
<td>9</td>
</tr>
<tr>
<td>Policy and administration</td>
<td>6</td>
</tr>
<tr>
<td>TOTAL</td>
<td>47</td>
</tr>
</tbody>
</table>

Table 14 Number of study participants in each disciplinary category
SSM IN ACTION: DATA COLLECTION

Several methods were used for case-specific data collection including a grey literature search, direct observation during site visits, data collection using standard forms, document analysis and semi-structured interviews. Taken together these produced a wealth of rich material. With the exception of literature review, each approach is described in detail below.

SITE VISITS

In order to develop an appreciation of the settings of care and geographical contexts in the study I travelled to each site in each case which involved six inter-state and five regional flights totalling 6937 flight km. In addition, I drove more than 1100 km to travel between rural and metropolitan centres. I consolidated visits to one state over a two-week period in February-March 2012 and to the second state over a three-week period in June 2012. In some sites I was able to conduct interviews in the consulting rooms or clinics where child assessment took place. In other sites, interviews took place in meeting or interview rooms in administrative or other clinical areas and I could only gain an impression of the general facilities from my observations of a hospital or community health centre as I walked through corridors.

STANDARD DATA COLLECTION

As part of the research design, I developed a series of standard data collection sheets, following the recommendations of Stake (2006), for my own use as a prompt to collect consistent core data related to the five steps of care from each site. The types of data involved are listed in Appendix B, p. 345. They incorporated basic information such as elements of child health history that came with referrals for health assessment, the dimensions of assessments and health care plans and what types of systems monitoring data were collected at each site. I completed data sheets during and after site visits as a means of tracking what I had found from viewing documents and from interviews. The design of the data fields was based on my idealised systemic models for each of the five steps of care being studied. In reality, I found data from real systems could sometimes be incomplete, non-existent or not known to some informants. Interviewees also had a free choice as to what information they shared and may have withheld information. Accepting these limitations, the tools nevertheless provided an important aide memoire for my field visits.
HEALTH ASSESSMENT IN OUT-OF-HOME CARE

**DOCUMENT ANALYSIS**

I invited participants to share blank copies of any standard forms they used such as referral forms, health assessment report formats, health care plan formats or printed materials for carers about the health assessment process. Prior to site visits I reviewed grey literature related to each site in a search for documents such as annual reports, information for carers, information for child welfare agencies about health assessment processes, referral or clinical pathways, evaluation reports or other data.

**INDIVIDUAL INTERVIEWS**

Individual, semi-structured interviews were conducted with each of the 47 participants in a location of the participant’s choice and in private spaces which protected anonymity. These spaces included interview rooms, consulting rooms, training rooms or staff offices in public health settings and government or other organisational offices. One interview involved two colleagues seen jointly, at their request. My best efforts to insist on individual interviews in earlier discussions with them were resisted. Although scheduled separately, when I arrived for the first interview they were seated together in the room and re-stated their preference to be interviewed jointly. On reflection, this proved to be one of the most stimulating and interesting interviews in the series, provoking a higher level of engagement than the participants themselves had expected. Overall, interviews were scheduled for 60 minutes. In reality, while the majority were of this length, interviews ranged in length from 30 to 80 minutes. Those which exceeded the allotted time did so at the instigation of the participants who wished to keep talking. Two interviews were curtailed to 30 minutes because of unexpected clinical demands on participants. Of the 47 interviews, seven were conducted by teleconference at the request of interviewees or as a result of an unexpected change in the research schedule\(^\text{17}\). 46 participants gave consent for audio-recording of interviews. I took extensive notes during each interview, also with the consent of participants.

Through each stage of data collection, once I entered the field I found a pool of participants who were highly engaged, offering rich insights into their work and open to

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\(^{17}\) The site visit schedule for the second case in June 2012 was unexpectedly interrupted when my husband underwent unplanned coronary surgery. Three interviews were re-scheduled as a result and held by teleconference in July 2012.
HEALTH ASSESSMENT IN OUT-OF-HOME CARE

sharing their own learning. Among the methods of data collection, site visits and interviews were unsurprisingly the most fruitful.

SSM IN ACTION: DATA ANALYSIS

Data analysis was an iterative process. All data was de-identified by removal of personal names and places and was assigned a numerical code. I replayed all recordings and transcribed a sample. All remaining recordings were assigned codes and then transcribed by a commercial transcription service for academic research. I de-identified the contents of each transcript. I read each one twice and reviewed my written notes from interviews. Using an N-Vivo 9 software program I thematically coded each part of each interview, building and adjusting a framework of coding categories during the process. Copies of all transcripts and the coding framework were provided to the principal PhD supervisor who selected a sample for review and discussion. Thematic memos were developed which drew together summaries of interview material. Analysis involved ongoing sorting and categorising material, until I was satisfied that seeming contradictions and exceptions were accommodated. Case materials including data sheets, thematic memos, material from grey literature and from documents provided by participants formed a rich data collection and remain the subject of ongoing analysis.

Consistent with the theoretical base of SSM, analysis has been from a constructivist perspective. SSM incorporates some key types of systemic analysis (Ben-Ari, & Enosh 2011). It requires a constantly shifting focus between figure and ground and setting aside pre-existing expectations. Attention is drawn to explanations which can be contrasting or contradictory. Occasionally epiphanies occur. One small epiphany occurred, for example, when I heard people in diverse settings describe their service being operationally “forgotten about” in the context of major operational decisions by other, more powerful parts of their own organisation. It seemed not only were the children at risk of being marginalised, but also those who served them. The experience of a whole system of activity being forgotten could be expected to be of broader significance in the interactions and interdependencies among systems of care.

Theoretically, SSM rests on the premise that there is unlikely to be one best solution to problematic situations in social planning. Rather there will be many possible solutions, each valued differently by various stakeholders (Checkland, & Scholes 2007). Checkland summarised
the thinking processes used in SSM as involving both logic when in the mode of model building and slower, reflective thought in trying to make sense of the problematic situation. He urged the researcher to allow not just individuals but the whole situation “speak to you” while consciously holding back from reaching quick conclusions. (Checkland, & Poulter 2010 p. 195). In my analytical work I have tried to heed Checkland’s advice.

RIGOUR IN RESEARCH DESIGN AND IMPLEMENTATION

I adopted four frameworks for building rigour in my approach to this study. The overarching framework was provided by SSM. The second was an ethical framework. The third related to hierarchies of evidence for assessing qualitative research. Lastly, I have especially valued peer-review of the findings, given that my analysis is subjective.

Checkland cared about rigour. While he drew from the sociology of knowledge theories, in SSM he endeavoured to address issues of theoretical generalizability by introducing some of the rigour associated with thinking in the natural sciences into an applied social sciences approach (Checkland 2007). Just as cases are bounded in case study methods, analysis is bounded in SSM. The declaration of which weltanshuung is privileged is an example of how SSM applies a systematic approach to the study of complex situations where knowledge is contested and is situated among many worldviews (Checkland, & Poulter 2010). I have endeavoured to satisfy Checkland’s constitutive requirements for claiming to use SSM (Checkland, & Scholes 2007). In procedural terms these include intellectual treatment of social systems as existing in the real world as a conscious choice of the researcher rather than as a fact. Contextual analyses and the development of purposeful activity systems or holons are central as a device for comparative inquiry to identify systemic changes which may be desirable and feasible.

The second guiding framework for rigour was associated with ethics in human research. In an alternative research design I may have been able to avoid the frustration of external ethical and research governance review by leaving out the step of organisational consent for individuals to participate. Participants could perhaps have been recruited within ethical guidelines by more direct means through medical and other health disciplinary associations. My judgement was that the responsibility of state governments as the corporate parent for children in OOHC, together with their roles as employers of health professionals and policy advisors involved in OOHC health assessment, placed an obligation on me to recruit employees
HEALTH ASSESSMENT IN OUT-OF-HOME CARE

with the full consent of organisations. I believe that this cumbersome step did add rigour to
the study. At the same time, in publishing an account of my experiences of the red-tape
involved I satisfied myself that I was not blindly acquiescing in a flawed multi-centre ethical
review system.

Thirdly, I have been mindful of hierarchies of evidence for judging research (Daly, Willis,
Small, Green, Welch, Kealy, & Hughes 2007) and contend that this PhD study provides the
highest level of evidence-for-practice in qualitative health research. Multiple cases were
included to capture diversity of experience. Analytic procedures were bounded,
comprehensive and clear and sat within a well-established methodology. The results provide
clear indications for policy and practice change. I believe that theoretical generalizability has
been enhanced through the use of social theory in the construction and conduct of the study
(Willis, Daly, Kealy, Small, Koutroulis, Green, Gibbs, & Thomas 2007) and through triangulation
in contextual analysis by the inclusion of data which draws from different disciplines, various
geographical locations, and different types of data sources (Kitto, Chesters, & Grbich 2008).

At every step I have taken opportunities to disseminate my findings for peer review.
From the development of an advisory group to have input into the symposium program and
publication of a summary report through to conference papers, journal publications, seminars
and submissions to public inquiries I have been concerned to own this research and hold it up
to the light for scrutiny. In this way, my “subjective prejudices, rather than being viewed as a
distortion of reality and thereby a threat to be guarded against, become the background from
which all further understanding springs forth” (Angen 2000 p. 390).

LIMITATIONS ASSOCIATED WITH SSM

While undoubtedly SSM becomes intuitive to the researcher over time, enabling the
experienced researcher to display a “lightfootedness” and a “deft charm” in its use (Checkland,
& Scholes 2007, p.302), I was a novice, using SSM for the first time, and my approach was
more studious than intuitive as I focussed on satisfying Checkland’s constitutive rules. I
gradually built my knowledge through extensive reading, professional development activities,
peer discussions and practice.

Systems-thinking involves a set of concepts and a jargon of its own which have not
always been unified or well-integrated (Ackoff 1971, Checkland, & Scholes 2007, Adams et al.,
HEALTH ASSESSMENT IN OUT-OF-HOME CARE

2014). Where possible I have used plain language descriptions in addition to SSM terms in this thesis for the ease of readers not familiar with SSM.

Researchers using SSM can experience complexity syndrome, characterised by an information overload which accompanies the fact that there is no obvious cut-off point to inquiry or analysis (Davies 1988). I became more aware of this lack of a stopping point as the study progressed and was to some extent reliant on my principal supervisor to provide feedback as to appropriate boundaries which needed to be drawn for the purposes of the PhD.

LIMITATIONS WITHIN CASE-STUDY APPROACH

The two key limitations of the case studies related to recruitment and to my inability to directly observe health assessment processes in action. On the one hand, health professionals were easier to recruit into this study than participants in policy and administration roles. As a consequence, there is a stronger voice of health professionals in the findings. An alternative study from the worldview of policy advisors would undoubtedly reveal further matters for appreciation. Similarly, studies involving child protection case managers or carers may have provided quite different perspectives. At the same time, I was not able to recruit health professionals or policy advisors who were opposed to current systems for health assessment in OOHC or held negative views about this study. As the field of child protection and OOHC in highly politicised, there will undoubtedly be negative or outlier cases which may gain a voice in response to the research findings but whose views are not captured here.

Secondly, resource and ethical constraints prohibited direct observation of cases of health assessment in OOHC. While such observation would have provided rich data about the phenomena being studied, I was satisfied that the inclusion of insider accounts of the phenomena were of significant value and that by conducting field visits I was able to move as close as it was possible for an outsider to the phenomena.

CONCLUSION

This chapter has described how an appropriate methodology and research design were used with integrity in this study. Notwithstanding that implementation was in some ways limited by factors outside my control, a wealth of rich data was obtained and is available for
ongoing analysis. The next chapter closely compares my idealised models of the five steps of care involved in OOHC health assessment with what I uncovered in the field.

DISSEMINATION

I published a peer-reviewed article about the challenges of obtaining ethical and multi-site organizational approvals for this study.


This was preceded by a peer-reviewed conference presentation.


Attendance at the Postgraduate Research Conference was supported by financial assistance from the Department of General Practice, University of Melbourne.
OVERVIEW

The early chapters reported my first steps of systemic enquiry, introducing theoretical frameworks for thinking about child health needs, the approaches to health needs assessment in OOHC recommended by medical professional organisations and the knowledge gap in Australian research about translation of these recommendations into practice. I used a broad canvas to weave an impression of the social, policy and professional contexts and complexities that made up the larger, problematic situation in Australia.

In the previous chapter I explained my use of a systemic enquiry approach (SSM) to intellectually structure this problematic situation in order to develop theories about its nature. I hypothesized that a deeper appreciation of the nature of systemic connections was a way to tackle the wickedness (Althaus et al., 2007). The previous chapter also described the instrumental rather than representative nature of case selection to learn about the phenomena of health assessment in OOHC. The long-term goal rested on the hope of imagining alternative ways of social planning for health assessment in OOHC that might manage the problematic situation somewhat better.

My study findings are presented over four chapters. This chapter introduces the two study cases, provides a contextual analysis, summarises the recruitment outcomes and presents coding frameworks which were developed in the analysis of data from the study cases. Chapter 6 discusses in my findings about how health professionals in this study defined health in OOHC, a key question underpinning health assessment. Chapter 7 explores in depth the range of ideas participants put forward about the purpose of health assessment in OOHC. Health definitions and questions of purpose are foundation concepts for systemic thinking. In Chapter 8 I then explore the five steps of care associated with health assessment in OOHC.

The purpose of this chapter is to weave the background story to my discoveries in the field.
HEALTH ASSESSMENT IN OUT-OF-HOME CARE

INTRODUCTION

The two study cases in this research were situated in New South Wales (NSW) and Queensland (QLD), the first and third most heavily populated Australian states. Figure 3 summarises the recruitment outcomes in these cases.

**Introduction**

The two study cases in this research were situated in New South Wales (NSW) and Queensland (QLD), the first and third most heavily populated Australian states. Figure 3 summarises the recruitment outcomes in these cases.

**Figure 3** Summary of Case-Study Recruitment Outcomes

<table>
<thead>
<tr>
<th>organisations approached</th>
<th>Case One = 9</th>
<th>Case Two = 13</th>
</tr>
</thead>
<tbody>
<tr>
<td>organisations which declined or failed to respond to invitation</td>
<td>Case One = 5</td>
<td>Case Two = 8</td>
</tr>
<tr>
<td>organisations recruited</td>
<td>Case One = 4</td>
<td>Case Two = 5</td>
</tr>
<tr>
<td>number of geographical sites where individual participants recruited</td>
<td>Case One = 2 metropolitan + 3 rural/regional</td>
<td>Case Two = 3 metropolitan + 4 rural/regional</td>
</tr>
<tr>
<td>number of individuals recruited from participating organisations</td>
<td>Case One = 14</td>
<td>Case Two = 33</td>
</tr>
<tr>
<td>total number of individual participants</td>
<td>= 47</td>
<td></td>
</tr>
</tbody>
</table>

Taking the two cases together, I visited a total of 9 separate organisations. As some organisations operated from more than one geographical location, data was gathered from 12 separate health service sites. Case materials including interview transcripts, data sheets, thematic memos, material from grey literature and from documents provided by participants formed a rich data collection.

Before I undertook site visits, I explored the study cases ‘on paper’ to begin my analysis. The contextual descriptions below set the scene. I was interested in the regulatory and policy environments in state jurisdictions to the extent that they impinged on health assessment in
HEALTH ASSESSMENT IN OUT-OF-HOME CARE

OOHC. I expected that demographic factors, geography and the nature and distribution of the health workforce may also influence health service configuration and delivery at the state level. My aim here was to consider diversity and breadth across contexts, rather than to compare one site or one case with another. I therefore provide an overview of the individual case contexts in this chapter in order to illustrate their diversity.

NEW SOUTH WALES CASE STUDY CONTEXT

STATE POLICIES CONCERNING HEALTH ASSESSMENT IN OOHC

An object of the NSW Children and Young Person’s Care and Protection Act 1998 (2012) was that all institutions, services and facilities providing for the care and protection of children would foster children’s health and development. The Act also imposed an obligation on state departments such as the Health Department to provide services to children in OOHC if requested by the Director-General of the state government department responsible for child protection.

Although there was a legislative obligation to foster child health, a Special Commission of Inquiry into Child Protection (Wood 2008) in NSW was highly critical of case planning in Child Protection where many children did not have an allocated case manager, information exchange between the Child Protection and Health departments was poor and there was little focus on child health and wellbeing. Wood recommended that the health status of children in OOHC should be monitored and data collected to support resource allocation and identify areas of good practice.

In response to the Inquiry recommendations, the NSW government developed an inter-departmental strategy titled “NSW Keep them Safe: A shared approach to child wellbeing 2009-2014” (New South Wales Department of Premier and Cabinet 2009). As a part of that strategy, funding of $12 million was allocated over a 4 year period to implement new approaches to health assessment in OOHC, including the creation of OOHC Health Coordinator positions in local health service areas.

While comprehensive health assessments were recommended by the Inquiry and intended under the new inter-departmental strategy, they were not required in the pre-existing NSW Standards for Statutory OOHC. First developed in 2003 by the Office of the
HEALTH ASSESSMENT IN OUT-OF-HOME CARE

Children’s Guardian in NSW and revised in 2010, those standards set out mandatory requirements which any designated agency providing OOHC must meet in order to be accredited. The standards encompassed broad provisions that children should be cared for in placements which met their social, emotional and behavioural needs and that any health and developmental needs would be addressed (Office of the Children’s Guardian 2010). However the standards were not prescriptive about health needs assessment at the time of the research for this thesis.

EXPENDITURE ON OOHC

Against the background of the Inquiry findings (Wood 2008) and a steadily rising rate of children in OOHC between 2008 and 2012, the NSW state government increased recurrent expenditure on OOHC by approximately 41%, as shown in Table 15. As in other Australian states, the government OOHC system relied heavily on voluntary carers. Over half of the carer households in NSW had multiple children placed with them for OOHC at 30 June 2012 (AIHW 2013). While NSW was moving towards sub-contracting OOHC to non-government organisations, at the time of the study the NSW Department of Community Services was directly responsible for most OOHC service provision. No data was available about expenditure on health services to children in OOHC.

Table 15  Total national recurrent expenditure on OOHC compared with state recurrent expenditure on OOHC in New South Wales and Queensland in AUD$ 000s, between the years 2006-07 and 2011-12.

<table>
<thead>
<tr>
<th>JURISDICTION</th>
<th>2007-08</th>
<th>2008-09</th>
<th>2009-10</th>
<th>2010-11</th>
<th>2011-2012</th>
</tr>
</thead>
<tbody>
<tr>
<td>NSW</td>
<td>530,160</td>
<td>601,141</td>
<td>691,292</td>
<td>711,952</td>
<td>746,007</td>
</tr>
<tr>
<td>QLD</td>
<td>332,594</td>
<td>336,213</td>
<td>359,611</td>
<td>375,464</td>
<td>396,070</td>
</tr>
<tr>
<td>AUSTRALIA</td>
<td>1,435,595</td>
<td>1,589,399</td>
<td>1,778,678</td>
<td>1,883,242</td>
<td>1,952,450</td>
</tr>
</tbody>
</table>

NUMBER OF CHILDREN ENTITLED TO HEALTH ASSESSMENT IN OOHC

The rate of children placed in OOHC in NSW increased between 2008 and 2013 from 8.4 to 10.5 and was consistently higher than the national average, as illustrated in Table 16. Theoretically, if all children who entered OOHC in Australia in 2011-2012 had received comprehensive health needs assessment, then 12,240 would have benefited; including 3407 in NSW. If periodic health assessment had included every child in OOHC living in OOHC at 30 June
HEALTH ASSESSMENT IN OUT-OF-HOME CARE

2012 then 17,192 in NSW would have benefited. The numbers of children who actually received health assessments in OOHC was unknown.

Table 16  Number per 1000 children aged 0-17 years of children in OOHC in New South Wales and Queensland at 30 June each year in the period 2008 to 2012 (AIHW 2013).

<table>
<thead>
<tr>
<th>JURISDICTION</th>
<th>2008</th>
<th>2009</th>
<th>2010</th>
<th>2011</th>
<th>2012</th>
</tr>
</thead>
<tbody>
<tr>
<td>NSW</td>
<td>8.4</td>
<td>9.4</td>
<td>9.9</td>
<td>10.2</td>
<td>10.5</td>
</tr>
<tr>
<td>QLD</td>
<td>6.4</td>
<td>6.7</td>
<td>6.8</td>
<td>7.0</td>
<td>7.4</td>
</tr>
<tr>
<td>AUSTRALIA</td>
<td>6.3</td>
<td>6.7</td>
<td>7.0</td>
<td>7.3</td>
<td>7.7</td>
</tr>
</tbody>
</table>

The gaps in knowledge about outcomes in OOHC were appreciated by the NSW government who funded a prospective study titled *Pathways of Care: A longitudinal study of children and young people in out-of-home care* which commenced in February 2011, through the NSW Department of Family & Community Services.

HEALTH SYSTEMS RELEVANT TO OOHC

A Memorandum of Understanding between the NSW Department of Family & Community Services and NSW Health (2011) signified agreement on principles for joint work to make all reasonable efforts to facilitate access to health services for children and young people in statutory OOHC (and for whom the Minister for Family & Community Services had parental responsibility), including health screening, assessment, health management plans, intervention and review. Implementation at the local level would be subject to the local health district’s service capacity and existing resources. It was intended that a *Model Pathway for Comprehensive Health and Developmental Assessments* for all children and young people entering OOHC would be implemented using a staged approach with target groups identified jointly by the two departments. Importantly, the MOU anticipated that NSW Health would take the lead role in the development, implementation and review of child Health Management Plans. The Model Pathway anticipated that GPs in private practice would have an important role at the front line of health assessment and would be the point of triage and

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referral to comprehensive, state-funded specialist paediatric health services. Health workforce issues consequently formed part of the context in the study cases.

NSW experienced GP workforce shortages although these were more pronounced in rural and remote areas than in metropolitan areas. Many areas within Australia, including in the two study cases, are rural and remote, as illustrated in Figure 4. People living in provincial, rural and remote locations can face significant barriers in terms of local health service availability and travel distances to receive health care.\(^\text{19}\)

Specialist paediatric services were widely dispersed. NSW Health was configured into fifteen Local Health Networks, each with its own governance arrangements. The Sydney Children's Hospital Network was one of three additional specialist, state-wide Health Networks. Within the 228 public hospitals in the state, only 46 had specialist paediatric units. Five regional Child Health Networks coordinated public paediatric services at a more local level. Three specialist Child Protection Units operated in teaching hospitals in the capital city and one provincial city. NSW Health provided a regional network of Child Protection Counselling Services (formerly known as Physical Abuse and Neglect of Children (PANOC) services) which provided medium to long-term interventions for limited numbers of families where children had experienced abuse or neglect. These services which were only available to children on referral from the NSW Department of Family & Community Services, also provided secondary consultation to other health professionals (Department of Premier and Cabinet 2008). A network of 280 Community Health Centres provided specialist multi-disciplinary child and family health services. 46 Sexual Assault services delivered services to children and young people who had been victims of sexual assault. Specialised health programs were provided for children and young people who exhibited sexualised or sexually abusive behaviours. Child and Adolescent Mental Health Services provided clinical services as well as consultation and liaison with other agencies. Some Aboriginal Health Services provided systematic health assessment for Indigenous children in OOHC (Cashmore, Scott & Calvert 2008, Raman, Reynolds, & Khan 2011).
Subsequent to the field work for this study, the NSW Ministry of Health (2013) published very comprehensive *Health Assessment of Children and Young People in Out-of-Home Care (Clinical Guidelines)*. While these guidelines comprehensively describe processes for each step of care discussed in this study, the guidelines were still being developed at the time of the study and were not available in a composite or authorised document to health professionals who participated in the study.

Figure 4  Accessibility/Remoteness Index of Australia 2011 a

* Reproduced with permission of the author. Citation provided as APMRC (2013). Accessibility/Remoteness Index of Australia (ARIA) 2011. Adelaide, South Australia: Australian Population and Migration Research Centre (APMRC), University of Adelaide.*
CARER ISSUES IN CHILD HEALTH ASSESSMENT IN OOHC

The complexity of children’s physical, emotional and behavioural difficulties has been a contributing hurdle in foster carer retention (McHugh & Valentine 2011). Australian jurisdictions have faced persistent difficulties in recruiting and maintaining an adequate number of carers (Tilbury & Mazerolle 2008). Marked jurisdictional differences in legislation, funding, policies, procedures and service provision in OOHC included differences in the quantum and rules relating to carer allowances.

Carers were offered a tax-free Carer Allowance to compensate for the costs incurred in care of the child. In NSW fortnightly allowances for carers differed according to the age of the child and the complexity of the child’s needs. The minimum fortnightly carer allowance was approximately $440 in 2012, while the maximum rate was $1302 in NSW (Department of Family & Community Services 2012).

Differing rules and practices for claiming carer reimbursement for child medical expenses in OOHC have been an issue, with carers reporting inadequate remuneration and extensive delays in receiving approvals or payments (Wood 2008). Notwithstanding legislative obligations in NSW to provide carers with information (including copies of medical reports) as would be necessary for them to care for the health of a child in OOHC, evidence suggested this obligation was not always fulfilled. Lack of information about child medical histories, and problems in obtaining Medicare cards have been particular concerns for carers in Australia, along with dependence of state-funded health services with very long waiting lists. (McHugh & Valentine 2011).

GEOGRAPHY AND DEMOGRAPHY

New South Wales sits along the east coast of Australia covering a land mass of 800,628 km² it is more than three time larger than the U.K.20. In 2011 approximately 32% of Australia’s 22.6 million people lived in NSW, with the population significantly concentrated (63%) in the capital city, Sydney.

CONTEXUAL SNAPSHOT FOR THE NEW SOUTH WALES CASE STUDY

A contextual snapshot summarizing the declared purposes of activities and monitoring and control of the system in the New South Wales case is given in Box 5.1 on the following page.
BOX 5.1: SNAPSHOT OF THE CONTEXT OF STATE POLICY ON HEALTH ASSESSMENT IN OOHC IN THE NSW CASE STUDY

**POLICY:** The now NSW Department of Family & Community Services (DFCS) had worked collaboratively with NSW Ministry of Health (NSW Health) since 2008 to develop and implement a *Model Pathway for the Comprehensive Health and Developmental Assessments for all children and young people entering OOHC (OOHC Model Health Pathway)* initiative to facilitate initial health screening and comprehensive health assessment for children, initially targeting those who were expected to remain in OOHC for longer than 90 days. This was seen as a means of improving health outcomes (NSW Department of Premier, & Cabinet 2011). Children already in care aged 0-5 years were a second target group for assessment.

A state-wide OOHC Clinical Coordinator and nine regional OOHC Health Coordinator positions were created and assigned the task of coordinating implementation of the initiative at the local level. The initiative envisaged that initial health screening would be provided by GPs, who would triage the need for comprehensive assessment. For children aged 0-5 years, the parent-held NSW Personal Health Record, (commonly known as the Blue Book) would provide a tool for recording information about health assessments and treatments during OOHC placement which could be shared (APHPC 2011).

**LEADERSHIP:** The *OOHC Model Health Pathway* was an initiative designed to facilitate access to health services for the OOHC population. The initiative was a component of a broader inter-departmental child protection improvement strategy; *NSW Keep them Safe: A Shared Approach to Child Wellbeing 2009-2014*.

A memorandum of understanding was made in 2011 between DFC and NSW Health which described the respective implementation responsibilities of each department.

NSW Health was the lead agency for the OOHC Health Pathway.

Oversight of the initiative was managed by a NSW Health Keep the Safe Implementation Unit, NSW Health Planning Advisory Group and OOCH Research Advisory Group. Paediatricians from the sub-specialty of community child health and child protection were among members on both Advisory Groups.

**PERFORMANCE MONITORING:**

The NSW Children’s Guardian monitored compliance with legislation, statutory provisions and NSW OOHC standards by OOHC provider organisations. In 2008-2010 a statistically significant sample of OOHC case files was audited in relation to the extent of records held about child immunisation, authorised consent for psychotropic medications, assessments of psychological and psychiatric wellbeing, health assessments at entry to care and annual health reviews (NSW Office of Communities 2011).

The NSW government has provided public annual reports as to progress against the Keep them Safe strategy, including the OOHC Health Pathway. The 2010-11 recorded 600 children being referred for OOHC health assessment. However, the 2011-2012 report was confined to implementation processes, and did not address outcomes for children in OOHC.

State-wide evaluation of the OOHC Health Pathway is expected to be completed in 2014. The government engaged the Australian Institute of Family Studies, the Social Policy Research Centre at University of New South Wales and a private consulting firm, Urbis Pty Ltd in the design of the overall evaluation of the Keep them Safe strategy (Department of Premier and Cabinet 2012).

**FINANCING:** A specific, lapsing budget of $12 million was allocated over a four year funding cycle from 2009-2013 (NSW Health 2009) for implementation of health assessment in OOHC.
HEALTH ASSESSMENT IN OUT-OF-HOME CARE

QUEENSLAND CASE STUDY

STATE POLICIES CONCERNING HEALTH ASSESSMENT IN OOHC

The Queensland Child Protection Act 1999 Schedule 1 recognised that the state had responsibilities for a child in the custody or under the guardianship of the Chief Executive and established the child’s right: “to have access to dental, medical and therapeutic services necessary to meet the child’s needs”. Under s.122 of the same Act, the Chief Executive must take reasonable steps to ensure the child was cared for in such a way that “the child will receive dental, medical and therapeutic services necessary to meet his or her needs” and “if the child has a disability, the child will receive care and help appropriate to the child’s special needs...”.

The Queensland Department of Communities, Child Safety & Disabilities prescribed minimum service standards for organisations contracted to provide OOHC services, including non-government organisations. The standards required that organisations must:

a. address emotional, developmental, cultural and safety needs of children;

b. facilitate access to services by children and their families;

c. deliver services in a planned and targeted way that respond to the needs of the client group.

The Department of Communities, Child Safety and Disability Services, Foster and Kinship Carer Handbook (2012) stated that carers were required to meet standards of care under s.122 i.e. the carer was required to ensure the child receives necessary health care.

Notwithstanding this devolution of responsibility to voluntary carers, an inquiry by the Crime and Misconduct Commission in Queensland (2004) found case planning in OOHC to be inadequate, and health care less than optimal. The Queensland Department of Communities, Child Safety and Disabilities had responsibility for administering child protection legislation and regulations. The department’s policy and procedures for children in OOHC relied on GPs to monitor child health and record any findings in a Child Health Passport (a carer-held child health record) at each doctor visit.

It was not anticipated that specialist paediatricians would routinely be involved in comprehensive health assessment in OOHC in Queensland unless a GP referred them in the
normal course of practice for a specific concern. If referred, it was expected that children in OOHC would generally be referred to paediatricians working in the state-funded Health Services to avoid the additional costs associated with private health care.

EXPENDITURE ON OOHC

The Queensland government increased their recurrent expenditure on OOHC by 19% between 2008 and 2012. As shown in Table 15, the increase was considerably lower than the Australian average of 36% or the NSW increase of 41%. As in NSW there was a heavy reliance on voluntary carers and over half of the carer households had multiple children placed with them for OOHC at 30 June 2012 (AIHW 2013). The Queensland government sub-contracted a range of non-government child and family welfare organisations, including Aboriginal Community Controlled Health Organisations, to recruit and support carers for OOHC. No data was available about expenditure on health services to children in OOHC in Queensland.

NUMBER OF CHILDREN ENTITLED TO HEALTH ASSESSMENT IN OOHC

Consistent with the national trend over the previous 5 years, the rate of children in OOHC in Queensland had grown as demonstrated in Table 16 from 6.4 to 7.4, slightly lower than the national rate. Theoretically, if all children who entered OOHC in Queensland in 2011-2012 had received comprehensive health needs assessment, then 2671 would have benefited. If periodic health assessment had included every child in OOHC living in OOHC at 30 June 2012 then 7999 children would been assessed. As in NSW, the numbers of children who actually received health assessments in Queensland were unknown.

HEALTH SYSTEMS RELEVANT TO OOHC

The fact that Queensland experienced significant GP workforce shortages in rural and remote areas could be expected to impact on the ease with which children in OOHC could access GP services and may have impinged on GP willingness to complete any paperwork additional to their own clinical notes.

State government health services in Queensland, as reconfigured in 2012, came under the governance of seventeen district-level hospital and health services, each with a statutory Health and Hospital Board. Tertiary children’s hospitals were located in the capital city, Brisbane. Providing public specialist health care services across the state has been challenging
HEALTH ASSESSMENT IN OUT-OF-HOME CARE

(Thompson, Armfield, Slater, Foster, & Smith 2013). The majority of rural hospitals and some regional hospitals lacked paediatricians or paediatric sub-specialists. Only 18 of the 197 public hospitals in the state had specialist paediatric units (SCRGSP 2009). Outreach services and teleconferencing were used to connect paediatricians in provincial centres with children in remote locations. While tele-paediatric services were provided from Brisbane, many children needed to travel long distances, up to 3000km, to the capital for treatment (Smith, Armfield, White, Williams, Koh, Hurley, Maclean, McCrossin, Van der Westhuyen, & Coulthard 2010). Tertiary and provincial hospitals had Child Protection Units which provided secondary and tertiary child assessment and offered education to health staff.

Queensland Health’s regional network of up to 14 EVOLVE Therapeutic Services and the Department of Communities EVOLVE Behaviour Support Services provided intensive therapeutic mental and behavior support for the 20% of children in OOHC with the most severe and complex psychological and behavioural problems. However there was a significant lack of similar services for children in need in OOHC who fell outside of the eligibility criteria for either these or the usual child and youth mental health services provided by the state (Carmody 2013a).

Outreach services, additional travel costs and the higher costs associated with child protection cases were among the funding challenges for paediatric services. The Queensland government began a major initiative in 2010 to amalgamate paediatrics under a single, state-wide, Queensland Children’s Hospital and Health Service21. The overall picture was of dispersed health providers with a myriad of governance structures and diffuse responsibility for specialist paediatric medical care at a regional level.

CARER ISSUES IN CHILD HEALTH ASSESSMENT IN OOHC

Approved carers were eligible for a Queensland government, tax free Caring Allowance to meet day-to-day costs, including medical costs for children in their care. From this allowance, carers were expected to pay for:

HEALTH ASSESSMENT IN OUT-OF-HOME CARE

a. Everyday visits to general practitioners;

b. One-off visits to medical specialists;

c. Medical prescriptions for everyday illnesses;

d. Non-prescribed pharmaceuticals.

According to the Foster and Kinship Carer Handbook (2012 p. 23) the Department of Communities, Child Safety Services may meet other medical costs such as “…major or ongoing medical or dental costs...that cannot be provided through the public system or claimed through Commonwealth government benefits (e.g. physiotherapy, dental...orthodontic costs ...in some circumstances” if they were part of an approved care plan or placement agreement.

In Queensland the fortnightly allowances for carers differed according to the age of the child and the complexity of the child’s needs. Geographical location also determined allowances in Queensland. In 2012, the minimum fortnightly carer allowance of approximately $440 was similar to that of NSW while the maximum rate of $1172 (Department of Community, Child Safety and Disability Services 2012) was $130 less than in NSW.

GEOGRAPHY AND DEMOGRAPHY

Sitting on the north east of the continent and covering 1.72 million km², Queensland is approximately seven times larger than the U.K. In 2011, approximately 20% of Australia’s 22.6 million people lived in Queensland. Queensland. Less than half of Queenslanders (45%) lived in the capital city, Brisbane.

CONTEXTUAL SNAPSHOT FOR THE QUEENSLAND CASE STUDY

A contextual snapshot of the systemic communication and control context in the Queensland case is given in Box 5.2 on the following page.
HEALTH ASSESSMENT IN OUT-OF-HOME CARE

BOX 5.2: SNAPSHOT OF THE CONTEXT OF STATE POLICY ON HEALTH ASSESSMENT IN OOHC IN THE QUEENSLAND CASE STUDY

POLICY: In 2006 the Queensland Department of Communities -Child Safety Services (DCCSS) instituted the Child Health Passport initiative which focussed on the importance of each child in OOHC having a personal health record.

The initiative intended that each child who remained in OOHC for more than 30 days should have their health needs assessed, preferably by a General Practitioner, who would develop a record and health plan for the child, using the Child Health Passport as the preferred tool (QCCYCG 2010).

The DCCSS advised carers through their Foster and Kinship Carer Handbook that each eligible child would be issued with a Child Health Passport (DCCSS 2012). The department would obtain a Medicare card for the child and provide details to the carer. A Child Information Form would be provided by the department, giving the carer basic, but important information to pass on to health providers. Carers were advised that GPs, Indigenous Health Services, the Royal Flying Doctor Service, paediatricians in public hospital paediatric clinics or paediatricians working with child health nurses could complete an initial health assessment when a child entered OOHC. No written information was provided about who should arrange the assessment with the GP. However, it was implied that this fell to the carer, as the carer was required to pay any fees incurred.

The initiative envisaged that information about the child’s family medical history would be collected and recorded opportunistically by the child protection case manager over the time the child remained in care (DHA 2011)

LEADERSHIP:-DCCSS has responsibility for the Child Health Passport initiative.

The question of whether the initiative was intended to be implemented in partnership with Queensland Health, or merely with advice from Queensland Health, became a contested issue in 2010, after a statutory audit of children’s files revealed difficulties in implementation. Queensland Health insisted that while it had collaborated on the design of the initiative it had not entered into a partnership arrangement with the DCCSS to implement the initiative, and that DCCSS had always been the responsible agency This was disputed by DCCSS, which claimed Queensland Health had failed to implement the initiative (QCCYP CP 2010).

PERFORMANCE MONITORING:-The Queensland Commissioner for Children and Young People and Child Guardian had responsibility for auditing the implementation of the Child Health Passports initiative.

DCCSS reported that 94.2% of children in OOHC had a Child Health Passport completed or commenced at 30 June 2012. The term ‘commenced’ was not defined (DCCSS 2013). Queensland Health has not collected any state-wide data in relation to children in the child protection system, including those in OOHC.

FINANCING:-

DCCSS do not report a specific budget al., location or expenditure for the Child Health Passport initiative. In 2012-2013 Queensland Health funding for child protection activities, largely related to staff involvement in processes for assessing suspected cases of child abuse and neglect within a general child health budget. No specific budget allocation was identified for the Child Health Passport initiative (Carmody 2013b).
CONTEXTUAL SIMILARITIES AND DIFFERENCES IN CASES

The first aim of this chapter was to briefly analyse the contextual similarities and differences in the study cases. Both had some common contextual elements. The platforms for state policies had identical origins in the findings of commissions of inquiry in the previous decade about a paucity of state government attention to the health needs of children in OOHC. Each state experienced a continuing increase in the rate of children entering OOHC.

Each state had a complex configuration of publicly provided paediatric services with diffuse governance arrangements ranging from state Health Departments to local area Health Services. State policies in both cases relied on GPs in private practice being at the front line of health care for children in OOHC. The emerging picture of health care delivery possibilities in the study cases was untidy. State government policies tasked health professionals from different specialities to assess children in OOHC. The types of available paediatric services were not evenly distributed across the states. A heavy reliance on public medical services and Medicare bulk-billing did not appear to take account of the private nature of the majority of general practices or the need for private paediatric services in areas where no state-funded service was available.

Another common thread was the lack of measures in either state about health service efficiency effectiveness, equity or access for children in OOHC in Australia. Nor was there any data on health outcomes. Varied explanations were offered for this. Indicators had not yet been developed, data was incomplete or not comparable between jurisdictions or data had not been collected (SCRGSP 2013).

Along with commonalities there were diversities between the two study cases. In 2012 each operated under a different policy concerning health assessment in OOHC, particularly in terms of the expectations about comprehensive health assessment by specialist paediatricians. Leadership and resourcing varied within each state, with contested ideas about the respective responsibility of different government departments surfacing in Queensland. These contrasted with written inter-departmental agreements in New South Wales through which the NSW Ministry for Health received specific funding for OOHC health coordination and undertook well-articulated responsibilities.
Among these facts and figures were clues to the climate in which health professionals were working on health assessment in OOHC. In this climate the lines of accountability were unclear. The very people who could stop or start health assessment activities had significant concerns about costs, either to themselves (in the case of carers) or to their government department or organisation (in the case of Child Protection authorities).

CASE-STUDY DATA COLLECTED

In chapter 4 I introduced the research approach in the study cases and outlined the various forms of data collected. Data took the form of document reviews from the grey literature which largely informed the contextual analysis above. I travelled to each of 12 sites across the two cases. During site visits I experienced the challenges of travel distances, observed buildings and facilities and interviewed 47 health professionals and policy advisors. The process for preparing interview data for analysis was explained in Chapter 4. I developed coding lists with themes arising from interview data in two broad categories:

i. Participants experiences of five steps of care involved in health assessment (Table 17);

ii. Systemic issues involved in health assessment in OOHC (Table 18).

Theme development was iterative, producing some unexpected angles which will be uncovered in the following three chapters which report on the study results in depth. As explained in Chapter 4 and shown in Appendix B p. 345, I also used standardized data shells as aides memoire to explore available data from each site about such things as the dimensions of child health included in an initial health assessment.
Table 17: Coding categories arising from analysis of interview transcripts related to participants’ experiences of 5 steps of care involved in Health Assessment in Out-of-Home Care in Australia 2012.

<table>
<thead>
<tr>
<th>Category</th>
<th>Sub-Categories</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child Health Histories</td>
<td>Problems of incomplete history</td>
</tr>
<tr>
<td></td>
<td>Use of history for triage</td>
</tr>
<tr>
<td></td>
<td>History collection methods</td>
</tr>
<tr>
<td></td>
<td>Confidentiality of histories</td>
</tr>
<tr>
<td></td>
<td>Quality of histories</td>
</tr>
<tr>
<td></td>
<td>Timeliness of history collection</td>
</tr>
<tr>
<td></td>
<td>Parent-held records</td>
</tr>
<tr>
<td></td>
<td>Risks re history recording</td>
</tr>
<tr>
<td>Initial Health Assessment</td>
<td>Referral processes</td>
</tr>
<tr>
<td></td>
<td>Who conducts initial assessments</td>
</tr>
<tr>
<td></td>
<td>Content of assessment</td>
</tr>
<tr>
<td></td>
<td>Recording assessment findings</td>
</tr>
<tr>
<td></td>
<td>Sharing of findings</td>
</tr>
<tr>
<td>Comprehensive Health Assessment</td>
<td>Intake processes</td>
</tr>
<tr>
<td></td>
<td>Receiving the history</td>
</tr>
<tr>
<td></td>
<td>Who attends</td>
</tr>
<tr>
<td></td>
<td>Assessment of adolescents</td>
</tr>
<tr>
<td></td>
<td>Content of assessment</td>
</tr>
<tr>
<td></td>
<td>Recording of assessment</td>
</tr>
<tr>
<td></td>
<td>Time taken to complete assessment</td>
</tr>
<tr>
<td></td>
<td>Physical facilities</td>
</tr>
<tr>
<td>Health care plans</td>
<td>Process for plan</td>
</tr>
<tr>
<td></td>
<td>Content/format of plans</td>
</tr>
<tr>
<td></td>
<td>Recording of plan</td>
</tr>
<tr>
<td></td>
<td>Who receives plan</td>
</tr>
<tr>
<td></td>
<td>Who is responsible for implementation</td>
</tr>
<tr>
<td>Health reviews</td>
<td>Process for reviews</td>
</tr>
</tbody>
</table>
Table 18: Coding categories arising from analysis of interview transcripts related to participants’ experiences of systemic issues involved in Health Assessment in Out-of-Home Care in Australia 2012.

<table>
<thead>
<tr>
<th>Category</th>
<th>Sub-Categories</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Service Issues</td>
<td>Child health needs</td>
</tr>
<tr>
<td></td>
<td>Continuity of care</td>
</tr>
<tr>
<td></td>
<td>Referral processes</td>
</tr>
<tr>
<td></td>
<td>Physical location barriers</td>
</tr>
<tr>
<td></td>
<td>Physical location enablers</td>
</tr>
<tr>
<td></td>
<td>Triage for treatment</td>
</tr>
<tr>
<td></td>
<td>Waiting lists</td>
</tr>
<tr>
<td></td>
<td>Treatment</td>
</tr>
<tr>
<td>Jurisdiction</td>
<td>Corporate parent role</td>
</tr>
<tr>
<td></td>
<td>Carers / health provider relationships</td>
</tr>
<tr>
<td></td>
<td>Consent for child</td>
</tr>
<tr>
<td></td>
<td>Who oversees health plan</td>
</tr>
<tr>
<td>Organisational</td>
<td>Leadership</td>
</tr>
<tr>
<td></td>
<td>Inter-agency issues with child protection</td>
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<td></td>
<td>Issues with general practice</td>
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<tr>
<td></td>
<td>Strategic planning</td>
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<tr>
<td></td>
<td>Budget enablers</td>
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<tr>
<td></td>
<td>Budget barriers</td>
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<tr>
<td></td>
<td>Evaluation of OOHC health assessment services</td>
</tr>
<tr>
<td></td>
<td>Forensic services interface</td>
</tr>
<tr>
<td>Purpose of assessment</td>
<td>Basic</td>
</tr>
<tr>
<td></td>
<td>Close the gap</td>
</tr>
<tr>
<td></td>
<td>No further harm</td>
</tr>
<tr>
<td></td>
<td>Reparative</td>
</tr>
<tr>
<td>Verbal images of children in OOHC</td>
<td>-</td>
</tr>
<tr>
<td>Rights</td>
<td>Parents</td>
</tr>
<tr>
<td></td>
<td>Carers</td>
</tr>
<tr>
<td></td>
<td>Child</td>
</tr>
<tr>
<td>Staffing of health assessment</td>
<td>Position design and responsibilities</td>
</tr>
<tr>
<td></td>
<td>Personal motivation</td>
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<td></td>
<td>Recruitment</td>
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<td></td>
<td>Training</td>
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<tr>
<td></td>
<td>Vicarious Trauma</td>
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<tr>
<td></td>
<td>Workloads</td>
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<tr>
<td>Research ideas</td>
<td>-</td>
</tr>
<tr>
<td>Quality improvement ideas</td>
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</tbody>
</table>

**CONCLUSION**

In this first of four chapters presenting the research results my aim was firstly introduce the study cases and to give a flavor of the environments in which health professionals were working. In neither case had state governments claimed to have a robust systems in place for health assessment in OOHC. There were contrasts in geography, in workforce pressures, in the provision or absence of state funding for targeted health initiatives for OOHC and in levels of agreement between child protection authorities and public health services about their
respective roles. Importantly the study cases sat in contrast as only one state had a policy that children in OOHC should receive comprehensive health assessment.

In both cases GPs were at the front line of health assessment and there was significant delegation to carers of responsibility to bring children for health assessment. Notwithstanding differences in state policies, paediatricians in both states led initiatives to provide comprehensive health assessment for children in OOHC. These similarities and contrasts enriched the breadth of experiences captured in the study.

One of the surprising findings in this research was a breadth of ideas I encountered about how health is defined for children in OOHC. This emerged as such a central and contested concept that I have chosen to devote the following chapter to delve into these results in some depth.
CHAPTER 6
AUSTRALIAN CASE STUDIES IN HEALTH ASSESSMENT IN OOHC:
THREADS OF MEANING IN DEFINING HEALTH

OVERVIEW

“In this complex integration of disciplined science, creative artistry and personal reflexivity, we mould interviews, observations, documents and field notes into findings” (Patton 2002 p. 432)

This is the second of four chapters presenting results of the PhD study. The previous chapter introduced the contexts of the two study cases and the broad themes arising from case study data. In this chapter I continue my detailed exploration of health assessment in OOHC by discussing how health in OOHC was defined by Australian health professionals and policy advisors with direct experience of the assessment process. In the first chapter of this thesis I contrasted lay understandings about human health against the variety of frameworks and theoretical models which have guided the thinking of health professionals in clinical practice and health research. Wide diversity in how health has been defined and measured in OOHC led me to specifically examine health definitions as a pivotal question in my systemic inquiry approach. For both health professionals and those working in the child protection field, an appreciation of how health was defined would be an important component of defining the problematic situation and deciding whether and how to take action. Put simply, I was interested in what people believed they were assessing.
Chapter 8 in this thesis examines the recommendations of Australian and international medical colleges about health assessment in OOHC in detail and sheds light on implicit operational definitions of health. In framing my research questions about health however, I searched firstly for broader, summative definitions of child health within policy statements by these bodies. I found them missing. Without specifically defining health, the policies focused on the special health care needs (AAP 2005) or increased physical, mental and social health needs of children in OOHC (RACP 2006, RANZCP 2009), including chronic medical conditions, mental health disorders and developmental delays (CPS 2008). Not surprising then, Australia’s National Clinical Assessment Framework for children and young people in OOHC (APHPC 2011) did not attempt to define health. Rather, it began with a discussion of health need and referred to health domains to be assessed, namely physical, developmental, psychosocial and mental health.

I also searched for definitions of health in the policy and procedural documents from the study cases. In the NSW case the NSW Children’s Guardian guidance on meeting health standards for OOHC used the WHO definition of health as “a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity (Office of the Child Guardian 2010 p.2). Elsewhere, documents did not define health but referred to “high and unmet health needs...poor physical health, developmental delays and compromised mental health...and a lower rate of immunisation uptake compared to their peers” (DFCS 2011, p.2). Health was not defined in documentation about the Child Health Passport approach for OOHC in the Queensland case. In the absence of procedural definitions I was particularly interested in how health professionals and policy advisors defined health for the cohort of children in OOHC.

I asked participants how they defined health, in their own mind, when they thought of children in OOHC. A small number of participants were taken aback by the question, as can be observed in their initial comments.

*I haven’t thought about it (121715:2).*
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I've never really been asked that before (121927:16).

I am just thinking. I don't think I have ever put that into words before (12233:15).

Oh my God; what is health? (12235:29).

That is a very good question (12251:15).

That's a tough one (12279: 3).

I don't know how to answer that question (12271:19).

Several other interviewees hesitated thoughtfully before they answered. The only prompt given, in cases where the pause was protracted, was to ask how they might define health for children in OOHC when explaining their definition to a health sciences student.

Overall, responses to this foundation question fell into two broad threads. Health as “a state of being” was the first thread. The second was quite different. In that thread, health was defined in terms of access to health services, where health was thought of much more in terms of systemic health determinants, rather than as a state of being of the child. Both of these threads had several strands which I identify below.

FIRST THREAD OF MEANING: HEALTH AS A STATE OF BEING

It was exceptional for study participants to define health in terms of the desirable state of being for children in OOHC.

...good physical health, good mental health, good emotional health and stability. That would be the ideal. If everything was working on those different parts, then that would be a healthy child who was happy - because they have to be happy in the end (121715: 2).

There are multiple dimensions to health and well being. We are talking about physical and emotional health, about freedom from behavioural problems and developmental issues. This is a very vulnerable population. There are very few kids who
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don’t have problems in one or more of those areas. So we are not just talking about physical health - that’s an important part of it but the most challenging areas are the emotional, behavioural, and cognitive issues (122311:16).

...an ability to be in their body and to be comfortable to rest there (12215:4).

An alternative definition was about capability.

...that you can go about your daily business, and enjoy your daily business, without being constrained by limitations of your physical or emotional body (12247:38).

All other strands within the thread of meaning about health as a state of being related to child health status. They seemed to be of a practical, case-based origin, and were overwhelmingly focussed on health deficits. The origins of many of these strands could be seen in the frameworks discussed in the first chapter of this thesis. In my analysis I labelled these strands of ideas from participants as follows: (i) health is complex and different, (ii) health is bio-psychological, (iii) health is developmental, (vi) health is trauma-related, (v) health is over the life-course, and (vi) health is ecologically based. Each strand is illustrated in some detail below.

**HEALTH IS COMPLEX AND DIFFERENT**

The complex nature of health status and health needs in OOHC were central in several definitions.

...the issue...is the complexity of the children...It’s not a matter of just being able to send them off with their health referrals and do a big health plan...They just keep coming back because there’s so much to be done for them; medically and emotionally there’s just lots and lots of issues (12229:6).

I feel like I’m overwhelmed by chronic and complex cases. ...it would probably be half my caseload...maybe a little more...there’s definitely many, many children that have a very high level of medical and emotional needs...I think of the ones that don’t immediately appear to be chronic and complex; there may be a whole lot of hidden stuff we haven’t really found yet... We see with some of these children ...they may have had their
emotional wellbeing assessment and all was good. Then six months later all these issues start to emerge (12229:31).

What we get on the referral often does not predict the complexity we see in the clinical room (12233:17).

Our involvement with these children is long; and so it should be. There's never a straightforward case...they are much more complex (12225:14).

There's been a multidisciplinary recognition that children in OOHC are especially complex, and you have to have an understanding of a lot of things...to be able to manage their situation well (122113: 4).

...some kids are resilient no matter what's thrown at them and some aren't - they can both have the same traumatic experience but deal with it in very different ways (12245:28).

An alternative but related strand centred on difference: health status and health needs being other than normal. Health was seen as damaged in some way.

...in this population there's lots of kids that have neuro-developmental differences, including executive functioning problems... self control problems, differences of affect and regulation... Some of them have significant developmental disorders, like autism spectrum disorders, that make them a lot more vulnerable to harm (121711: 3)

...these children are not your normal, run of the mill kids the majority of the time (12231:12)

...they generally have more health needs than children not in OOHC, and they're the ones that need all the services, but getting them is often not the case (12241:17).

What's normal for them is so different to the general population (121927: 16)

... a weird and unique area....it's not really all that complex. It's just different to the way we are used to thinking about things (12213:17)
...they are so disadvantaged and delayed in so many health areas. That’s …another big eye opener (12253:4)

...I think it is a default starting position; the child was damaged in a relationship (12213:9).

**HEALTH IS BIO-PSYCHOLOGICAL**

Within this strand participants commonly listed the key health domains they felt were critical to defining child health.

*For me it is all encompassing; it is mental health, dental health, behaviour management, physical health...But...behaviour is seen as not a health issue, especially with the under 12s. A health practitioner will say no - it's not a health issue, it is behaviour (12275:27).*

*For me it's holistic. So it's looking at their physical, their social, emotional wellbeing...I think we are very quick to focus on ...what we can see as physically obvious. But ...certainly some of the biggest challenges are ...the social and emotional stuff that gets in the way... of their development because they are so focussed on being stuck in that survival mode (12221:39).*

*Health to me is about the entire aspects of the physical, social and emotional wellbeing. That's what health is... some people don't put as much emphasis on the social and emotional functioning as I do (12243:25).*

*I think there's still very much a tendency to think of health as just in purely their physical terms (121719:19).*

Alternatively, definitions were more descriptive of patterns of health difficulties, apparently based on case experiences.

*I would talk about the research that shows that a lot of health needs are not obvious in these children and I would talk about the social and emotional aspects of that... it depends on the age group; certainly in the younger kids there is a lot of developmental vulnerability you need to watch out for... in the older children its behavioural...
issues...obesity is a big problem as is lack of immunisation, there are dental problems...speech problems (12217:6).

...there’s been more emphasis in the past on the psychological impact and what’s not been properly considered...is the physical ramifications of their health needs...children that may have some chronic, underlying health issues that all the therapy in the world will not...rectify...It has allowed us to see children more holistically (12257:18).

...neglect is obvious in poor dentition, poor skin condition, malnourishment, developmental delay, autistic features... disorganised behaviour, unusual behaviour, hoarding food, gorging food, soiling (121715:2).

...there are a lot of speech deficits with these kids. There's a lot of encopresis problems, either soiling or wetting, or bed wetting (I think I am keeping our encopresis nurse employed)...you get children who are quite obese or very thin...the dental care is pretty poor...kids are having extractions (12231:16).

A lot of children in foster care don't have emotional language. They feel distressed ...they often don't have the capacity to explain. They just feel yucky and they can't tell you because their speech is often delayed (122111:10).

Instead of just behaviour modification they may now also see a paediatrician who identifies in fact they've got some...growing issue that's causing them significant pain...or there's a dental issue that's causing them pain, or they can't hear properly and that's the reason they are playing up in class (12257:18).

...aggression, sleeplessness; or they do sleep but they toss and turn or they cry out or that sort of thing. It's mainly the aggression (12231:9)

By far the most common would be behavioural concerns and attachment concerns...what the carers say is the child being defiant, has temper tantrums...stealing food or constantly eating....behaviour problems at school...not following household rules and damaging property (12223:9).
HEALTH ASSESSMENT IN OUT-OF-HOME CARE

HEALTH IS DEVELOPMENTAL

Some definitions made an association between current health status and past or future child development.

...we get little people coming in at 12 months... who should be within the range of starting to develop their walking. We'll often see that they've been put in one spot. They are left in a cot... or in a stroller or high chair...they haven't had the environment...to develop the muscles and skills they need to sit.... they can't transition to crawling...they are so far behind because they didn't get that fundamental time... or they've been put in a baby walker too soon and you see them walking on their tippy toes...they don't tend to develop the strength and coordination...even though there is nothing physically wrong with them, it's the neglect that has led to the physical impairment (12253:23).

...they might be eight or nine but they're still behaving like a four year old... a lot of the time the difficulties are so entrenched. Some of these children throw furniture and kick and scream. They need major support (12239:21).

...in the under-fives developmental delays, predominantly speech and language, would be our top thing. Behaviour difficulties. Then we've got our adolescent and middle years; the acting out, ADHD, pervasive developmental disorders, all those children showing...the impact of neglect and abuse (12213:14).

...it's not a privilege (for the child) to have a friend, it's an absolute right. It's not a privilege to be able to read and write. It's an absolute right. Some of these children aren't meeting that potential because of interruptions to their health (12239:15)

HEALTH IS TRAUMA-RELATED

Ideas about past trauma in children’s lives and its impact on their health status shaped some responses.

I've started to really understand the very specific issues for children in terms of what the impact of the abuse is for them, in terms of their learning, in terms of their speech in particular. I had no idea how much abuse affects children being able to speak (12259:10).
HEALTH ASSESSMENT IN OUT-OF-HOME CARE

...of course we should screen for physical health issues... but one of the big things is the impact of developmental trauma on specific parts of the brain... conceptual thinking, abstract reasoning....so often kids who have lived with trauma flare up and will be agitated and angry and kicking and when they are in that state they are not able to use ... reasoning and trying to do that when they are distressed doesn’t help....they can feel quite a level of discomfort or distress and worry but ... are not able to convey that. Then they are seen as being difficult or mucking up or misbehaving (12111:10).

Placement in OOHC was seen as a trauma which in itself which might affect child health as it was seen in OOHC.

...the trauma that those children or young people have experienced as a result of coming into care. Having that recognised, that it’s impacting on their health (12271:20).

...what I didn’t understand was... when those (placement) changes happen are significant, depending on the child’s age. There are significant ages in terms of attachment where if there is a change during that time it’s going to have a greater impact (12259:14).

The need for accuracy in defining health in OOHC was a feature of some responses. These participants reflected a concern about the risk of misdiagnoses if health was not defined using knowledge of the health impacts of traumatic experiences.

...direct health issues as a result of abuse... misdiagnosis in terms of the behavioural disorders being diagnosed with things such as ADHD but it’s actually the result of trauma... some things may be over-diagnosed rather than in the context of trauma (12227:3).

...we know they (the children) are very vigilant, they are kind of screening for danger, they don’t understand there’s been strong feelings. Their nervous systems aren’t regulated the way they should be... they are not able to just sit in their bodies and tolerate things... and understand who they are.... I don’t know how well recognised that is anywhere in the health system (12215:5).
HEALTH ASSESSMENT IN OUT-OF-HOME CARE

...the kids who’ve been...abused and neglected, their attachment relationship, their ability to trust, their ability to believe that this world is in some way a safe place wherein their needs will be met has been compromised (12213:23).

(The children) are so focussed on being stuck in that survival mode, and often not knowing what is happening. Not feeling in control...it’s just about their security needs...so to me, it’s about getting that on the agenda for these kids (12221:39).

...I quite prefer the behavioural description rather than whacking diagnostic labels on kids (12213:8).

HEALTH IS OVER THE LIFE COURSE

In one participant’s definition I found evidence of a life-course perspective: an appreciation of the long-term context.

...it needs to be focused more on overall wellbeing, rather than probably what we would see as traditional health, and there needs to be that understanding of the long-term consequences. Just because everything’s okay now, doesn’t mean it’s always going to be okay, and so someone needs to be vigilant over time” (121925:15).

HEALTH IS ECLOGICALLY-BASED

Participants whose ideas fell along the ecological strand defined the health of a child in OOHC as enmeshed within a wider context and affected by several determinants.

I have a very...ecological view to what is health and that’s kind of like the holistic. You don’t just have the systems, the biological systems, but you have the mental health, you have the families as well. ..you have the biological family, the caring family, the foster family. Then above that you have the networks they run in...each of these has an impact on the child’s wellbeing..at the level of staying healthy, in terms of physically healthy, but also staying socially and emotionally healthy as well... (12235:29).

I look at wellbeing in a range of domains. I think about how they are sustained at school. That their immediate social environment is OK...their home placement...their physical health, which includes sleeping and eating, and then other basic functions. I know
Heath assessment in out-of-home care (education) is not part of health’s jurisdiction but it is definitely part of the kid’s health (122113:19).

We have to understand the journeys and the place in which a child may be looked after by a carer; a formal carer, kinship carer or in many cases formal foster carer. The broad base of needs: health, educational and social. An understanding of the critical requirements that cohort needs. It isn’t good enough today I think... to look at all those elements in isolation. You really need to see the child’s needs in concert with all those factors. They have a co-relationship (121721:11).

Health... is probably really broad; a broad definition of health, their health & well-being.... their physical, developmental, educational, mental health. And probably...more of a global function and how they ...have been fitting into as in terms of family context. And now they are in a very different situation. ...it’s really difficult for children to exist outside of a family. They are very, very interlinked, but here we’ve got a situation where that hasn’t been optimal. And now we’re going to a situation that’s not usually ideal either. So that’s a particular kind of need around that (121923:5).

Health is about capacity to have all those other needs met....all those attachment and wellbeing needs, so that the child...can go to school, ...be able to settle...have regulation (122111:12).

As I wove the strands of meaning together, an enriched picture emerged of how health professionals observed and then defined health, based on the many manifestations they see in children they assess. This thread which focused on health as a state-of-being included elements from some of the more common theoretical frameworks used for defining health.

Other participants followed a quite different thread of ideas defining health in OOHC which seemed to be centred on health as a service, not as something within and of the child.
SECOND THREAD OF MEANING: HEALTH AS ACCESS TO HEALTH CARE

An alternative way of thinking about health was to define it in terms of access to health care services. Simply put, health in OOHC was defined as:

*Make sure they get basic health care* (121927:16).

...just getting access to services... because many of them get moved around so much, they just... seem to get forgotten about, and things don’t happen (12241:8).

...making sure their basic needs have been addressed... making sure that things we take for granted have been done. That they’ve had their scheduled health checks... their immunisations. Things like that we sort of think are just given that they happen. Things like just not getting dental checks, not getting immunisations. That seems to be a lot of their biggest issues. Not so much that they have a condition or an illness as such... it’s just making sure normal everyday things are happening. (12253:22)

The added dimension of this was an underlying concern about greater health risks.

...it’s recognising that... health outcomes are not as equal to (those of) children that don’t come into care. So it’s about making sure that children in care are actually having their health needs met. Like the expectation would be that all other children in functioning families would (12271:20).

Four separate strands were apparent in the responses centred on health service access, namely (i) past access to health services, (ii) future access to health services, (iii) early access to health services and (iv) health neglect. These are explained more fully below.

HEALTH AS REDRESS OF PAST LACK OF ACCESS TO HEALTH SERVICES

For some participants, thinking about health in OOHC was about redressing past failure to access health services for a child.

*Children were meant to be always receiving health services before our service .... but we do know that a lot of them missed out* (12223:24).
HEALTH ASSESSMENT IN OUT-OF-HOME CARE

...less than 10 percent of these children have been accessing these services...that surprised me...there is a general lack of awareness about how these children can access (these services) or how significant it was they can access services (12227:4).

HEALTH AS ENSURING FUTURE ACCESS TO HEALTH SERVICES

A second expressed concern related to the problem of access to needed health services in the face of resource rationing.

...these kids are pretty much stuffed up by their background and we can see they are suffering. But what are we going to do with the resources that we have? ...so many of them have speech delays, so many of them need OT. Here we have a 12-month wait for OT....I've got kids needing ENT surgery...and they're just being shoved almost to the bottom of the public hospital waiting lists (12229:28).

HEALTH AS EARLY ACCESS TO HEALTH SERVICES

Ideas about defining health could be found blended with ideas about the purpose of health assessment in OOHC and with ideas about greater health risks for children entering care. Here, the flavour of the definition related to the need for early intervention.

I think that really it's ensuring that we have a system for early identification and early intervention of their health needs once they enter care... it's about addressing that early, rather than letting that go. For some kids they weren't getting seen for some time, or certain things weren't being picked up early enough, which then, for them developmentally and physically and things down the track, made their lives a lot more difficult. So what I see now is that we are getting kids seen earlier and then their problems are being addressed earlier and that's only going to benefit them into the future. I've seen some great things. I've seen kids with heart murmurs identified really early. I've seen babies seen by dental really early when their teeth aren't even through their gums yet but we've still been able to identify what some of the issues are for them. So... I think health is really about the early identification and recognising that these kids are different to the general cohort - general population, in terms of their trauma and their experiences and that sort of thing (12277:20).
HEALTH ASSESSMENT IN OUT-OF-HOME CARE

HEALTH AS REDRESSING HEALTH NEGLECT

Concern about neglected health needs was a separate theme in definitions around access to health care. Here, complexity emerged about lack of detection, or inattention to child health needs in OOHC.

...consistently we get kids who have issues that in other circumstances would already have been picked up and been managed... So I don't think health necessarily means an absence of disease or an absence of health issues but that same level of engagement and response from the health service... we saw two children on one day who had obvious undiagnosed either autism or some other major developmental issue...and these were kids who were 4 years old (and had been in OOHC for some time)...(our) service has many children of that age who have already had, if not a diagnosis, then that question asked, and they're receiving services and assessment. Yet these kids had had nothing (12233:15).

...health issues that haven't been picked up...or have been missed (12227:3).

...what we've seen in the past is that these children are pretty much forgotten. They're labelled. They're put on the bench, so to speak (12257:19).

CONCLUSION

My aim in this chapter was to explore how health professionals and policy advisors defined health in OOHC as part of their own sense-making in the problematic situation of working to assess children's health needs in OOHC. I found a significant dichotomy between ideas about health as a state-of-being and of health as a health service. The strands in the first thread of ideas encompassed the impact of trauma. They observed child health in OOHC as being about difference, complexity and the effects of maltreatment across the developmental pathway and life-course. There was a stronger sense of health being defined in part through the determinative experiences of social and family disadvantage. At the same time, these ideas recognized that health may also be defined for individual children by their own degrees of resilience or their biological inheritance.

On the other hand, those who defined health in OOHC as being about health service access may or may not have appreciated difference, complexity or the determinative effects of
trauma or maltreatment to the same degree. Some appeared to believe that the health of children in OOHC was not so different to that of other children except in terms of risk of missed diagnoses or missed treatment. Others however clearly did define health not only in terms of difference, complexity and higher degrees of health need but also in terms of the impact of inequality of opportunity for health needs to be addressed.

I argue that these findings are important for two reasons. Firstly, while individual’s definitions were acceptable and defensible, when taken separately they lacked sufficient congruence to support robust systems for health assessment. They indicated many different personal starting points for the work of individuals and lacked consistent, coherent direction and boundaries. There did not seem to be a sufficiently common language around defining health in OOHC. Strong monitoring and control functions in a system for health assessment would rest firstly on an agreed definition of the concept of health.

Secondly, I was interested in what I did not hear in response to my question about how health is defined in OOHC. Among participant definitions, appreciation of the spectrum of maltreatment and of differential health impacts depending on types of maltreatment were poorly articulated. Similarly, factors underpinning child resilience were poorly articulated. There may have been several reasons for poor articulation. My question often seemed unexpected which meant participants were clearly speaking off the cuff. Some health professionals told me they were relatively new to the field of child maltreatment and they were continuing to learn about health impacts. Some responses were bounded within the scope of a health discipline. I found this was associated with ideas which had more depth but less breadth. As will be reported in Chapter 8, most health professionals in this study lacked information about the past maltreatment or child protection histories of children they were assessing. I expect this would have hampered their case-based appreciation of the interplay between the maltreatment spectrum and child health.

In the next chapter I explore a second foundation question. What is the purpose of assessing health in OOHC? Ideas about “what is health” and the purposes of health assessment were closely inter-twined.
HEALTH ASSESSMENT IN OUT-OF-HOME CARE

DISSEMINATION

This analysis was the subject of the following peer-reviewed presentation:

CHAPTER 7
AUSTRALIAN CASE STUDIES HEALTH ASSESSMENT IN OOHC:
FINDING PURPOSE IN CHILD HEALTH ASSESSMENT

OVERVIEW

The theoretical purposes of health needs assessment and how the intent of health assessment in OOHC has been shaped at different points in history were both discussed in earlier chapters. At a population level, systematic health needs assessment can aid decision making about the efficient use of health service resources to improve the health of a population. Theoretically it can:

a. provide epidemiological data to inform the design of effective health service delivery for particular populations, such as children in OOHC;

b. better enable evidence-informed policy and improved service system design;

c. inform inter-agency collaboration, research or funding priorities (Wright et al., 1998).

Historically, the purposes of health assessment in OOHC have included saving lives, controlling infectious diseases and protecting the health of the future workforce. Theory, experience and medical advances have combined to influence the current thinking of medical professional bodies about the contemporary theoretical purposes in OOHC which have been described by Leventhal (2000) as follows:

i. immediate health screening to check for signs of abuse, health problems that need urgent treatment or serious mental health problems;

ii. comprehensive health evaluations to review immunisation status, growth, vision, hearing and development;

iii. ongoing health supervision to provide periodic review of growth and development, to manage chronic conditions and to carry out preventive health activities.

Government or public policy, however, emerges less from theory and more from the world of politics, being ultimately designed to achieve political objectives. Purpose in public
policy may not necessarily be as clear, logical or well-articulated as academic theory or professional standards (Althaus et al., 2007).

This chapter reviews the current stated purposes of health assessment in OOHC within three levels of policy in Australia; medical professional policy, Commonwealth government policy and policy in state jurisdictions. The development of policies by medical professional bodies has been outlined in previous chapters. Australia’s first Commonwealth government policy, as expressed in new national standards (FaHCSIA 2011) and a new clinical framework (APHPC 2011), was also discussed earlier. State government policies and the purposes of health assessment in OOHC in the study cases are introduced in this chapter, along with an overview of their monitoring systems.

Monitoring processes and systems are indicative of the strength of public purpose and act as “the handrail of policy” (UNICEF 2007). Monitoring indicates a concern about policy outcomes. In order to consider the strength of purpose in government policies I compared the monitoring system and feedback measures used to track policy implementation.

Among those charged with implementing policy, personal values, norms and morality, as well as professional knowledge, beliefs and judgement shape how policy purposes are understood and implemented (Vickers 1995, Michie et al., 2005). In order to explore such influences, the purposes declared within the three levels of professional, Commonwealth and state policies are contrasted with ideas expressed by health professionals in this study.

PURPOSE IN MEDICAL COLLEGE AND GOVERNMENT POLICIES

I reviewed and compared two policies developed by medical colleges (RACP 2006, RANZCP 2009) and two national public policies (DHA 2011, DSS) against state government policies in the two case studies. I then developed a composite list of stated purposes and objectives within these policies, which are listed below and in a comparative summary in Table 19.

a. Preliminary health assessment by a health professional;

b. Comprehensive and collaborative assessment by health professionals;
HEALTH ASSESSMENT IN OUT-OF-HOME CARE

c. Individual profiling for each child of risk and protective factors within a
developmental framework by a health professional;
d. Individual health management plans for each child;
e. Systematic, ongoing monitoring of child health with health professionals;
f. Continuity of health information sharing;
g. Access to health care services based on clinical need;
h. Provision of health care services based on clinical need;
i. Identified health coordinator for each child;
j. Continuity of health care provision;
k. Accurate data recording;
l. Best quality health care provision;
m. Evaluation of treatment effectiveness;
n. Research and evaluation;
o. Optimal child health
HEALTH ASSESSMENT IN OUT-OF-HOME CARE

Table 19: Aggregated elements of professional and national public policies in Australia about health assessment in Out-Of-Home Care, contrasted with elements reflected in state government policies in Australian case studies.

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Each objective was underpinned by theories of cause and effect, resource implications, ideas about boundaries of responsibility and limitations on knowledge about 'what works'. Notwithstanding the general congruence of these objectives, they were not equally shared.
among organisations. Nor were individual objectives accorded the same priority among organisations, as will be shown in the following overview.

PURPOSE IN MEDICAL COLLEGE POLICIES

The RACP (2006) and RANZCP (2009) influenced public policy in Australia through promotion of their policies about health assessment in OOHC. The RACP flagged the place of health assessment within the broader purpose of addressing child health issues in OOHC.

The frequent multiplicity of problems mandates a comprehensive and collaborative assessment and treatment approach. Ongoing health care should incorporate systematic monitoring with improved continuity of care and information sharing between involved parties, and attention to preventative health care, health education and health promotion. The effectiveness of therapeutic interventions requires ongoing evaluation and is contingent on accurate data collection and ongoing research (RACP 2008 p. 24).

The RANZCP position was that children in OOHC warranted special attention and priority access to multi-disciplinary mental health care, competent to meet their complex care needs RANZCP 2009). The College recommended that:

a. every child entering OOHC have a multi-modal mental health assessment as part of the admission to care process and that children already in care have the same assessment;

b. a profile based on a developmental framework of psychopathology that identifies the risk and protective factors that contribute to resilience, be documented for every child as part of a comprehensive assessment.

OUTCOME MONITORING OF MEDICAL COLLEGE POLICIES

Medical colleges may use two measures of policy outcomes. Firstly the extent to which their recommendations are enacted in government policy and secondly, the evidence from research and evaluation about policy implementation. The development of the first National Clinical Assessment Framework for children and young people in OOHC (APHPC 2011) represented a significant step forward to enacting medical policy about health assessment in OOHC. However there is currently insufficient research of evaluation data available to make judgements about the breadth of implementation.
HEALTH ASSESSMENT IN OUT-OF-HOME CARE

PURPOSE IN COMMONWEALTH GOVERNMENT POLICIES

National OOHC standards recognised the diversity in how health was addressed in state and territory OOHC standards, and established a national standard, that children should “have their physical, developmental, psychosocial and mental health needs assessed and attended to in a timely way and receive specialised services so chances for optimum health are maximised.” (FaHCSIA 2011, p.10) The purpose of developing the national standards was to “drive improvement in the quality of care so that children in OOHC could have the same opportunities as other children in Australia to reach their potential in life” (FaHCSIA 2011 p.6).

The National Clinical Assessment Framework for Children and Young People in OOOHC provided "a structure for the necessary health assessments and pathways to clinical services that will contribute to the best quality care for children and young people" (APHCP 2011).

OUTCOME MONITORING OF COMMONWEALTH POLICY IN AUSTRALIA

As indicated in Chapter 3, although it was intended that states would be required to report on the implementation of health standards within the National OOHC Standards from 2014 (up to 24 months later than implementation of other standards), no reporting measure had been agreed upon. No national indicators or data about child health and wellbeing in OOHC were available up to 2011-2012 (SCRGSP 2013). Although reports from the SCRGSP (2013) and the Australian Institute of Health and Welfare (2013) have flagged the development of national data descriptors and data collection to strengthen systems for addressing health in OOHC, discussions have been ongoing for more than seven years (AIHW 2006) with uncertain progress.

PURPOSE IN NEW SOUTH WALES GOVERNMENT POLICY

In NSW, a memorandum of understanding between the state departments responsible for child protection services and health services established a joint objective to “facilitate access to health care, based on clinical need, in order to promote best health outcomes in OOHC”. In that memorandum, the departments specifically endorsed the goal of “comprehensive health and development screening, assessment, intervention and review” for all children and young people in statutory OOHC (NSW DFCS, &NSW Health 2011). NSW Health developed an agreed clinical pathway for that purpose. NSW OOHC accreditation standards
HEALTH ASSESSMENT IN OUT-OF-HOME CARE

require that children and young people have their health and developmental needs assessed and addressed (Office of the Children’s Guardian 2010).

OUTCOME MONITORING OF NSW POLICY

Judicial and government reviews, along with audits by statutory bodies, have addressed the extent to which policy objectives have been achieved in relation to health in OOHC in both study cases.

Despite the recommendations of the 2008 NSW government inquiry into child protection that the government should collect data on the health status of children in OOHC to “identify the most effective allocation of resources and those areas of service that...require maintenance or remediation” (Wood 2008 p. 1029) little progress in data provision was apparent by 2012. In response to the Wood recommendations, the NSW Children’s Guardian sought to develop a baseline measure. The Guardian’s audit of a statistically valid sample of 3482 OOHC case files conducted in 2008-2010 found the percentage of files:

- which contained evidence of current immunisation history ranged from 55% to 80% of files for 0-8 year olds and 27% to 60% of files for children aged 9 years and over;
- which contained documented consent from an authorised person for the use of psychotropic medication for a child ranged from 24% to 57%;
- where a report on the psychological or psychiatric wellbeing of the child was available in inform case planning ranged from 41% to 66%;
- that included evidence of the child receiving a health assessment within 60 days of entry to OOHC ranged from 16% and 29%;
- that included evidence of the child having an annual health review ranged from 15% to 62%.

At the time of the audit, there was no standard requirement for children in OOHC to receive systematic health assessments or have health plans in place (NSW Child Guardian 2010b). The audit results formed a baseline from which ongoing practice improvement could be measured. A follow-up audit was planned for completion by 2014 (NSW Children’s Guardian 2010a).

In an alternative accountability mechanism, the NSW Department of Premier and Cabinet reported to parliament annually on the implementation of the state-wide Keep Them Safe strategy, including the implementation of the clinical pathway for OOHC health
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assessment. Although the 2010-2011 report indicated 600 children in OOHC had been referred for health assessments, the subsequent 2011-2012 report was confined to describing processes and did not contain any performance data.

PURPOSE IN QUEENSLAND GOVERNMENT POLICY

The Queensland Department of Communities, Child Safety and Disability Services (DCCSDS) stated their objective was to “promote the health, wellbeing and dental needs of children in OOHC by ensuring they have the necessary health and dental assessments and services they require” (DCCSDS 2011 p.11a). Unlike the medical profession policies and those of the Commonwealth and NSW, comprehensive, specialist health assessment in OOHC was not part of public policy in QLD (Queensland Commission of Inquiry into Child Protection 2013). Rather, health checks by GPs or other primary health care providers were considered adequate.

The provision of a format and process for creating and managing a standardised, carer-held child health record (Child Health Passport) was considered as the state’s key strategy for achieving its purpose re child health in OOHC.

“This comprehensive record of the child’s medical history will aid diagnosis, ensure they receive appropriate health care and treatment throughout their time in out-of-home care and improve their health and wellbeing” (Department of Communities 2010).

No OOHC accreditation standards were in place in Queensland. However under contract arrangements, non-government organisations receiving state government funding for providing OOHC were expected to ensure that the physical, social, cultural, health and educational needs of children in OOHC were met (DCCSDS 2011b).

OUTCOME MONITORING OF QUEENSLAND POLICY

The Queensland child protection system had been criticised in 2004 for failure to address the non-urgent health needs of children in OOHC or to hold adequate child health records. Case planning, including health planning, was judged to be inadequate, with some children having no case manager for long periods of time. The standard of record keeping in case files was described as ‘alarming’ (Crime and Misconduct Commission 2004).
In June 2013 the Queensland Child Guardian reported that, according to the Department of Communities (Child Safety Services) the process of creating a Child Health Passport had been commenced for 94.2% of children in OOHC. The term "commenced" was not defined. There had been no previous data available to the Guardian from the Department about the implementation of the Child Health Passport initiative (Queensland Child Guardian 2013). In a state-wide survey, the Commission for Children and Young People (QCCYPCG) had, however, found significant levels of dissatisfaction among responding carers in relation to poor implementation of the Child Health Passport initiative. The failure to provide carers with health and other essential information about children placed with them was at the heart of the reported dissatisfaction (QCCYPCG 2012). An earlier audit of individual children's OOHC files conducted by the same Commission (QCCYPCG 2010) showed:

a. Child Health Passport records were complete for only 16% of cases audited;

b. In at least 40% of audited cases the child's health had not been assessed by a health professional;

c. A health care plan was recorded in only 22% of those cases where a health assessment had taken place.

The Commission deemed these results indicated the Department of Communities (Child Safety Services) had not complied with the government's policy.

PURPOSE FROM PARTICIPANTS' PERSPECTIVES

I found that health professionals involved in the everyday work of health assessment of children in OOHC held diverse views about the purpose of these activities. While in some instances these personal viewpoints may be consistent with those of any current government policy, they were equally likely to be independent of current government thinking. As discussed earlier, health professionals’ responses to public policy initiatives depended on their own appreciation of the social problem, based on their own values, observations and experiences. Their everyday workplace sometimes seemed quite distant from the policy room, as the following participant observed.

"When it (OOHC health assessment) was initially rolled out it was a bit cumbersome. It was really unclear...how it would work for us up here we didn’t know. It was discussed
way above my head...To meet the requirements that were set at the beginning of the rollout we really had to start doing something here, despite the fact that we didn't have clear direction. So we decided to do our own thing ...” (12111: 1).

This observation provided a lived example of Vickers’ appreciative systems theory in action. A detailed analysis of interviews with health professionals sought to uncover the essential element of judgment about purpose that might be at play in appreciative systems about health assessment. Interviews revealed some distinct threads of thinking about the purpose of health assessment in OOHC. Each thread had several strands. Rather than being separate, each thread appeared connected when viewed across the study sample. However sitting beneath these ideas about the purpose of health assessment were some more fundamental ideas about the core work of being a health professional.

PROFESSIONAL NORMS AND VALUES UNDERPINNING HEALTH PROFESSIONALS’ PERSPECTIVES ABOUT PURPOSE

Four fundamental ideas are worthy of note before unravelling threads of meaning about purpose. These centred on more overarching professional norms or values and included (I) individualised care for each child, (II) the doctor/parent relationship, (III) professional responsibility and (IV) the health professional’s role in population health.

PROFESSIONAL NORM: INDIVIDUALISED CARE

Firstly, a particularly individualised, patient-centred approach accompanies clinical practice. A health professional’s primary purpose, regardless of external demands, was reported as looking after the health of the individual child.

You need to look after every child, but one child at a time. And that’s really what it’s about here because every child is so different and every family is so different. It is really hard, sometimes you can’t advocate for them all...it’s not possible to do it all. You can only do your best within the realms of what you’ve got. We’re only individual people, individual units, you can’t just take on...the greater burden (121923:11).

OHC screening is for the children. The 90 minutes they spend in the health visit, and then the comprehensive report that follows, is there for the children. Nothing is written in
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display this report that the children can’t read when they are 18. This is about them, to reflect on, and it forms part of their history when they become a young adult (12239:19).

This individualised approach may cut across public policy ideas about the overall purpose of health assessment for the cohort of children in OOHC.

It is about being really clear that the child is our focus and that we will advocate for their needs... whatever that might mean. For me, it's about maintaining a very child-focused perspective (121717:15).

PROFESSIONAL NORM: RELATIONSHIP WITH PARENTS

Secondly, health professionals are accustomed to participative clinical consultations involving a child's parents, who know their own child’s history, state the purpose of the medical visit, and decide about any intervention planned for the child. The absence of the child's own parent posed a problem.

Who is the parent? That's the whole problem with (child protection) and OOHC. The foster carer is not given parenting responsibility. They're given care of the child for their everyday needs but they’re not treated like a parent. The case workers are not the parent (12255:10).

I am sure you have heard this a million times...we still get the kids who arrive with a...support officer who has never met the kid before...What do they want us to do? Wave a magic wand over them? (121925:21-22).

PROFESSIONAL NORM: PROFESSIONAL RESPONSIBILITY

Thirdly, people grappled with significant unanswered questions about how child protection professionals and health professionals were to successfully work together in practice. In these instances, which agency's purpose was being served was sometimes an unresolved issue. At an organisational level ambiguity was evident about which was the lead agency with final responsibility for the child's health care.

Allied health services are very stretched... there are a number of children on the waiting list but that might be six or eight months...My recommendation back to child
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protection would be that they need private allied health. They don't like that much....there's some very interesting boundaries around whose role is it (12243:24).

...if it meets the health plan and it actually says it ...the case manager at (child protection) has to follow through with it. If it's on the health plan it then becomes their responsibility. Maybe that's why they (child protection) are not returning our calls...Sometimes there's a gap between what is the policy...and what's the practice (12251:29).

"(Child protection's) lack of understanding as to what our (health) role should be - that has been a real challenge" (12257:22).

PROFESSIONAL NORM: POPULATION HEALTH ROLE

Lastly, many people interviewed in the study had no information about how many eligible children had been assessed or required assessment in the locality. Most participants reported hearing anecdotally that child protection authorities had failed to refer children who were entitled to assessment. At the same time, some were very concerned about a backlog of children waiting to be assessed and were struggling to manage their workload. In the absence of any OOHC population data or feedback, many people interviewed appeared at a loss in thinking about any population health-related purpose of assessing the cohort of children in OOHC.

The first question was how many kids are entering care...in the state and also in our area. That was not the easiest of questions to answer, or find answers to. Another challenge was who would let us know about kids who were entering care...? (12217:1)

These fundamental ideas hint at variable levels of conviction about purpose, which seemed to rest in part on the strength of conviction about a health professional's own role, as opposed to the roles of others. On the one hand, a person might argue for an arm’s length purpose:

These kids don’t belong to us, they belong to the State (12231:12).

On the other hand, a different person may extend the boundaries of their perceived role responsibility.
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...following up and just being the (health) case manager for these kids is another role we will try... to be overarching and take on board these kids (121715:7).

Such views appeared to be more internalised than external; more connected to personal knowledge and values than to state policy. The most striking examples involved participants who described how they pushed the policy boundaries to meet personal purposes in the quality and level of service they offered.

Q. How is your (OOHC health assessment) work funded?

A. It’s not.

Q. How do you manage to keep it going?

A. Motivation and commitment... it’s just something that was felt important and we just did it. Nobody stopped me... (12157:17).

I wanted to see what outcomes we could achieve for kids if we, in the initial phases, provided the best practice model - a really comprehensive model...and I was hoping we would be able to attract more funding to the program, be able to demonstrate the benefits of it (12221:22).

THREADS OF MEANING ABOUT THE PURPOSE OF HEALTH ASSESSMENT

Three threads of meaning about the purposes of health assessment in OOHC emerged from the interviews. Individual threads held several strands. Analysis suggested these three threads represent ideas within a hierarchy of complexity. Similarly, they represent ideas about purpose along a timeline for the child, ranging from immediate to longer-term.

The threads each described related but distinct purposes as follows:

I. Identify immediate need and do no further harm to the child

II. Provide a safety net

III. Ensure reparative care
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Individual study participants were much more likely to present ideas which mainly followed one of these threads, consistent with their individual ideas about the main purpose of assessment.

**THREAD (I) IDENTIFY IMMEDIATE NEED AND DO FURTHER HARM**

The lens in the first thread seemed focussed on a purpose of checking children's immediate needs while not further harming children who have already been abused or neglected. There was sense of assessment as an intrusion on the child. While responses of this type recognised that health needs must be attended to, concerns were expressed about the risk of bureaucratic procedures involved in doing so systematically for all children which could lead to children being over-assessed.

*...if you remove children from their families and place them in alternate care, you have an obligation to give them, or to make sure that their fundamental needs are met...to do no further harm by having them in care (12261:1).*

*...we didn't want to vicariously traumatise children by over-assessing them (122511:8).*

The main priorities were understood as making sure children were physically safe and applying a first-aid approach to address immediate needs.

*When people are in crisis (entering OOHC) you are looking after the outside systems. You are making sure they are safe. You don't spend time for counselling, it's not the time for it. It's kind of first aid and feeling safe... (12215:7).*

Another aspect of this thread was the idea of opportunistic assessment

*It really is worth taking the time when they do present to do all that you can. Check all that may or may not have been done, and do all you can right there and then, because the next time they present could be a long time away (121927:17).*

At this end of the spectrum, participants tended to focus on the purpose of health assessment as providing advice to child protection authorities about the child's current health needs and what child protection should be doing in response.

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The core business...is to look at their current health needs and let the department know what they need done (12213:13).

Assessment was seen as an end in itself. It was separate from larger tasks of negotiating health treatments or rehabilitation. A written assessment report, the writing of a referral, or entry on health service waiting lists were the end purposes

We are trying to identify what the carers and case managers are seeing as the potential health and development problems. For us, that's planning how we get all those assessments in (12179:2).

People described little tracking of what was happening for individual children once these steps had been taken. An associated risk was in the repeated assessment of children without it leading to the provision of health services.

People are not sure what to do so they request another assessment, particularly psychological assessments and the kids get done over and over again. Lots of assessments but no health care ...The system is still struggling with tracking information and therefore tracking children...to ensure they get the assessment and treatment they need (12113:6).

We don't seem to have a journey of care which we often do in health...a patient journey. I think if you looked at a child or young person's journey around foster care, we still don't have a vision...it is not being done (122111:14).

While publicly funded health services were giving priority to health assessment, only one service gave priority to children in OOHC when it came to treatment. Assessment was seen as a less complex intervention for governments to provide.

Assessment is so popular because...you can just watch and observe and comment. You can almost stay outside of it...If you are doing interventions and they involve relationships and connection and linkages...it becomes more complex and challenging (122111:16).
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THREAD (II) PROVIDING A SAFETY NET

In the second thread, the purpose extended to identifying health need, and putting in place a safety net for children who may have missed out on basic care like immunisations or GP visits, by ensuring their access to primary care services. The thread was evident in both case studies, but particularly in sites where the most common procedure was to have children attend a local GP who should institute basic care and identify the need for any further assessments or treatments. Opening a door to health services was seen a key purpose.

...to improve the health outcomes of this group of children...helping them access and link in with primary health service providers - so that they have the same potential or possibility as those of their peers in the general community... there is a general lack of awareness about how significant it is if they can access services (12227:3).

You have got to make sure they get basic health care (12113:14).

...historically, clinically, we haven’t been meeting their needs. So ensuring there’s minimal, well hopefully no children, falling through any gaps (12251:15).

One participant made a distinction as to the quality of access to services.

It’s about the importance of timely, adequate and meaningful access to health, as appropriate to the individual child (12225:3).

Developing a baseline child health record and health status report was seen as a form of catch-up care for the child about whom little health history could be found.

These kids don’t have a lot of health information. We wanted... an accurate snapshot at that point in time (122511:9).

From such patchy histories...part of what we are doing to maintain their health is actually getting a good health record for them (12245:44).

There was an alertness to, and expectation of, the need to redress past health neglect.
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The main purpose is to detect areas of the child's health maintenance...that may have been overlooked or neglected...There is that high risk that health needs will have been overlooked...these children...have a higher risk for a range of health problems; that's a double whammy... (12213:2).

Participants observed a contrast between policy intent and the extent to which policy purposes had been realised.

The purpose should be to provide a safety net for children whose medical...needs haven’t been met. Obviously that's the stated goal of the program but it's not really what we are seeing happening on the ground (12229:29).

There was implicit recognition of the opportunity for assessment to support early intervention for health difficulties.

It is ensuring that we have a system for early identification and early intervention ...addressing that early rather than letting that go (12277:20).

Early identification of disabilities and those sorts of things, so referrals can be made appropriately for them to harder to access services (12272: 19).

Further complexity became evident where the purpose extended to reparative care.

THREAD (III) REPARATIVE CARE

Within this thread, health professionals demonstrated an expectation that multi-disciplinary approaches were needed for health assessment and to meet children’s needs. The purpose of health assessment was more closely aligned to a vital step in rehabilitation from the effects of abuse or neglect. With the focus on rehabilitation came ideas about achieving positive health outcomes, not just in the immediate future but through the life course. Reparative care was seen as extending professional care to include support for carers and provide continuity of health care in the longer term.

At the cusp between the safety net approach and reparative care were ideas about a purpose being to formulate diagnoses, to develop a comprehensive picture of all dimensions of the child’s health and development, going beyond immediate need.
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Our purpose is to try and understand the child's presentation in the context of what we know about their past life...we are aiming to come to some sort of formulation of opinion that centres around what the issues are for this child that reflect specific factors within their biology and to what extent those factors might have been influenced by their life experience (121711:2).

Diagnoses could be seen either as the end point of the assessment process or as the starting point, or baseline, in the expectation that children may have chronic or complex health needs in the future. Reparative care was seen as involving specialised assessments, from multi-disciplinary teams with the knowledge and experience to identify hidden or complex health risks and conditions, particularly resulting from trauma.

It's around the specialist knowledge of our paediatricians and how willing they are to work with the (child protection) department. How committed they are to child protection, as opposed to being generic doctors... (121717:10).

These children are so disadvantaged that they really need a specialised, dedicated service that know what they are doing and can do the best by them. It takes a long time...to get an understanding in this area (121923:4).

Recognition that children who enter care have significantly often more issues...and that their issues are very complex and often need extra specialist input...it's very much more of an informed approach to managing and coping with these children (12335:27).

The importance of multi-disciplinary assessment was stressed.

There is no one health professional who can do that all that (comprehensive health assessment) for you any more than there is one builder who can single-handedly build a whole house. You will want a plumber, an electrician, a tiler, a bricklayer (12247:26).

The multi-disciplinary approach is absolutely crucial. If they streamlined a service to nursing or a medical officer it is too narrow in its focus. We lose the context of multiple medical agencies involved. Also our exposure to the external, multiple professional frameworks involved (121721:7).
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Explicit references were made to the purpose of rehabilitation from the trauma of maltreatment.

*It’s about healing…it's certainly about recognising there has been damage done. There’s been trauma…I just encounter too often the view that ‘oh they are safe now, so we’ve done our job’. …But that’s far from it* (12221:45).

*…to help these children regain some of their optimal health that has suffered because of the trauma they have been through* (12179:7).

*We need to have those specialised health practitioners involved who are familiar with the effects of trauma and neglect on children* (12275:6).

Health professionals with this reparative purpose placed a strong emphasis on positive health outcomes.

*It’s not only identifying what the need is…it is how you bring them to that potential. That is what you are striving for all the time* (12179:2).

*The long term goal is that we see significant improvements in health outcomes for these children….ultimately, that we lower the burden of health need* (12257:26).

*…for children to receive health assessments and have health needs identified which provides opportunities to have those needs met….children actually getting health services means ultimately it will improve their health outcomes* (12271:18).

The longer term purpose of achieving positive outcomes across several different domains of health was recognised.

*We try to get to that nice model of health. The easy bit is addressing the physical concerns….We also then obviously start monitoring their emotional and their behavioural health which is important for their own health and wellbeing and their own happiness in the home and school situations. I guess follow on would be the stability in their placement. That’s when it gets really hard* (121715:6).
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The purpose is to do what can be done to ensure the optimal physical, developmental, emotional wellbeing of a vulnerable group of children...you need to be able to respond...it’s not good enough just identifying needs and not being able to support it. You need to be able to follow through (12247:30).

A sense of purpose could embrace a longer term, and even inter-generational perspective.

To see these kids not start with (a safe home environment), the implications are so great for them personally but also for the children they raise in the future. I am hoping these things make a difference to that child’s path and there is an opportunity too to stop that cycle...I have worked with many adults with a history of abuse and seen the impact of that on their work and their families and their marriages and their parenting (12259:15).

If you are going to make a difference to one child, then you are going to have an exponential effect on their children and their children’s children and so on. So if you can make a difference for one person, it’s worth it (12157:21).

There was also an economic imperative for reparative care.

If we assist the children in OOHC now then we can save millions in unemployment and housing issues, mental health, in the future....If we put the funding in now we have better outcomes in the future (12275:26).

...I still don’t think there is an understanding that if we do well, we prevent those children turning up in our drug and alcohol services or juvenile justice settings or mental health services when they are adults (122111:17).

Health professionals who saw reparative care as the purpose of health assessment were concerned to provide continuity of health care. In some cases this related to their experience of children at risk of being lost in the child protection system.

I often know more about that child’s family than the carers or child protection do because I see all the other siblings...So that can be kind of helpful because you know the
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family, especially when the foster carer and child protection don’t know the background (12255:9).

I always keep my tabs on what is actually happening. History and experience have taught me not to rely on others to carry through (122311:11).

The review process is absolutely integral. It’s much more important than we ever anticipated. We are picking up kids who have moved, kids have been restored back to the parents, the parents have got no support around a certain issue or weren’t aware that this is what’s been flagged...it is the recognition of complexity...the ongoing, holistic continuity of care that is child-focused (122511:27).

Allied to this was awareness of the greater knowledge that some health professionals can hold about a child when they practice in the same location for a long period of time.

We have our ongoing children who we see (12179:6).

...at least I can do that constant thing for them, and at least they know me, and at least I can now tell this new foster family this is where we are up to, these are the issues... (12213:23).

Continuity of care could involve helping to navigate the health system.

These are supposed to be one-off assessments but my experience of them is it doesn’t work that way. You have often got to see those kids again...particularly if it’s something that has to be done by a paediatrician or a child psychiatrist. We haven’t got any child psychiatrists where I am (122311:11).

I have to do follow up because there are not the services available to do it, or the children are not being picked up by other services. It is often more about re-linking them back in because...these children are so prone to changing placements. The only continuity they have, often, is myself (12235:2).

At the worst case level there were times when I realised I knew more about the child and where they have been and what treatments they have had....than anybody else
because it was on my file and I'd been keeping records. But they had had such inconsistency or interruptions to record keeping elsewhere that nobody knew the story (12113:7).

Paediatric services incorporated clinical case management, often characterised as child advocacy, within their mission and their practice.

We are also doing a lot of advocacy....recognising the gap in support for both the carer and the child we can make recommendations for kids to attend services...and lobby and get things happening (121715:6).

There is a real ownership for me of what's happening for each and every child in making sure they have what they need (12259:10).

There are things we can do to make their lives easier for them...getting appointments a little bit quicker...doing the running around and chasing things up, making sure consents are signed properly...having someone that is sort of in-between carers and child protection and the health system...to help advocate for these children (12223:4).

Supporting carers was understood to be a component of the rehabilitative purpose.

Carers come to us so alarmed...because what they see is not in context. They are seeing behaviours that come out of nowhere and they don't know why and it frightens them. Then they become frightened for the child as well. It's a terrible thing to see...because carers feel helpless. Psycho-education, I think it is absolutely necessary (12235:26)

Health professionals can support the needs of carers in providing good, high standards of care (121721:13).

It has allowed an opportunity for carers to see children more holistically. They are able to feel supported in terms of ...knowing something is not quite right but being unable to identify it....to see the child as a whole person rather than that specific behaviour... (12257:19).
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The ultimate benefit of supporting carers was understood as protecting the continuity and effectiveness of care arrangements for the child.

A carer who is well supported and well-resourced will provide a reparative environment for the child (12213:22).

Looking out for placement breakdown is part of what we do as well. You just get that sense that this placement is not going to last and within weeks you hear of a change of placement (12239:22).

No matter where health professionals’ ideas about health assessment in OOHC fell on the spectrum from complex to simple, from long-term to immediate, it was clear that as a group they appreciated assessment as desirable for children and a significant and interesting clinical challenge. A link between appreciation and personal values or judgement about what response was required also emerged. There was evidence of some health professionals taking on personal responsibility in excess of any demands of policy, and sometimes even by means of side-stepping policy. In order to understand this a little more clearly, participants were asked what motivated them to continue working in OOHC health assessment. Some people described a moral imperative.

If you can’t even take care of the most decrepit kids in society…..we are something that keeps a bit of standards going for these kids… (12113:12).

They mentioned the quality of compassion.

I have a passion for helping people see these children in a constructive and compassionate light. That’s what keeps me here (12213: 23).

Others spoke of their clinical interest in the complexity and variety of cases they saw. Those with more experience of the cohort and greater medical knowledge about child abuse and neglect as health determinants were more focused on reparative care as the end purpose of assessment.

There was a strong resonance between the purposes of health assessment set out in professional policies and the ideas of individual health professionals about purpose. Themes
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included continuity of care, regular review, multi-disciplinary assessment, tracking of health service receipt and advocacy for children’s health needs

While individual ideas were consistent with ideas about purpose within government policies, some participants expressed concern that government purpose seemed hollow when they could not achieve treatment or further assessment services once a child’s needs had been recognised, despite clearly documenting the clinical need. One participant judged public policy to be a minimalist approach:

…it isn’t so much that government doesn’t acknowledge it as an issue…it’s a bit of a response of, we’ve fixed it - because we have a policy and we have a process. So we’ve done it... (121925:6).

DISCUSSION

The theoretical purpose of developing epidemiological data for population health planning in OOHC was not reflected in Commonwealth or state policies. Nor did it feature strongly in individuals’ reported ideas about the purpose of health assessment in OOHC. Senior staff members in two different sites had each made it their personal mission to collect and analyse aggregated OOHC health assessment data at the local level. They were able to describe how they had used this to broker additional, or different, specialist paediatric and allied health services to meet the needs of their local cohort of children. In another site where a senior medical professional had an interest in research they lamented that aggregated clinical data was not collected and retrospective mining of data from case files would be necessary if there was ever the financing available to undertake any research. At the local site level many study participants described weak or non-existent monitoring and feedback loops in emerging systems for health assessment in OOHC. In contrast, some exceptional sites had invested time, financial resources and considerable judgement in designing and implementing local databases to collect and manage child and health assessment data. It is possible that such data was more widely available within organisations but not accessible to, or known by some staff. However as participants reporting a lack of data came from several hierarchical levels and organisations such reports did not appear to be isolated. Lack of data had been consistently observed in reports from public monitoring bodies. This absence of effective monitoring and feedback loops suggested a significant flaw in systems design.
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In the absence of data, it is not surprising that assessment was not generally reported as a means to support judgments about the efficacy or efficiency of health services to children in OOHC. It was common for health practitioners to comment that they could only rely on experience with their own cases to make judgements about realised access to services for the OOHC population. While government policies referred to ensuring access to health services and treatments based on clinical need, little evidence was found that anything other than individual, local triage was being purposefully pursued.

Chapter 4 introduced the theoretical foundations (Vickers 1959, Checkland, & Scholes 2007) for concern with human purpose in systems research. Purpose flows from appreciation, on which social planning system designs are premised. Purpose is at the heart of human activity in social systems. Purpose is critical to the design of any system. Objectives for actions within a system and the direction of ongoing change towards imagined system outcomes are aligned with ideas about the purpose to be achieved. The choice of information for system monitoring flows from purpose. The results in both case studies at the time of this research indicated monitoring had been at low levels, resulting in weak evidence as to objectives being realised. This called in to question the real strength of stated purposes.

In public policy, clarity and strength of purpose can influence health service provision, resourcing, service design, and investment in monitoring and evaluation. As described in earlier chapters, introducing systematic as opposed to opportunistic health assessment in OOHC involves systems change. Analysis of public policies, operational documents and reports from those with experience of these changed systems revealed a continuum of purpose from immediate changes to health care access to longer term change to child health trajectories through the provision of reparative health care. I have described this continuum in detail, centred around three points which I characterised as (i) Identifying immediate need, (ii) as providing a safety net and (iii) as reparative care. Seen through the mirror of comparison with model systems, it emerged that incongruent purposes have contributed to incomplete systems development.

People grappling with an imperative to identify immediate needs were also concerned to be not further harming children through invasive assessment processes. I observed considerable ambiguity here about whose clients the children were and disagreements about processes of care which could take several months to resolve. I was struck by the sense or
absence of ideas about where responsibility lay for the health of children in OOHC. In one sense here, the children of the state risked being left stateless.

Participants reporting ideas about the purpose of providing a safety net focused on immediate needs and identifying areas of health neglect. This purpose was described purely as assessment, separated from issues and challenges of ongoing treatment.

At the cusp between the focus on immediate needs for basic care and ideas about provision of reparative care were understandings about a purpose of assessment being to formulate diagnoses, to develop a comprehensive picture of all dimensions of the child’s health and development, going beyond immediate need. This was understood as requiring specialised assessments, from multi-disciplinary teams with the knowledge and experience to identify hidden or complex health risks and conditions, particularly conditions related to past traumas. The purpose of reparative care encompassed advocacy, support for carer, planned and managed treatment and continuity of health care.

In my analysis, a variety of personal principles emerged which seemed to guide individuals when they thought about the purpose of health assessment in OOHC. These included working to ensure legal compliance, to ensure safety for children, or enabling access to basic health care. Only those who expressed ideas about reparative care articulated the principle of each and every child having appropriate, timely access to health care which meets their individual needs in order to optimise their physical, developmental and emotional health and wellbeing.

It is impossible to see how systemic health assessment could develop in OOHC without the active engagement of health professionals. Theoretically, the purpose of health assessment would be a critical factor in engagement. According to Vickers’ (1995) theory, whether or not health professionals would play critical roles in health assessment activities would significantly rest on their personal beliefs, judgments and intentions. Only a small minority of primary health and specialist providers rely on salaried hours in state and territory funded services as their sole employment. Australian doctors in their private practices retain professional autonomy in how they practice medicine. At the area of local health services, fidelity with state policies, especially policies which lack any penalty for non-compliance, needs to be gained by persuasion and incentive. Individually and collectively, health professionals in
the cases studied had the power to make health assessment activities start or stop, according to their own intentions. In their relationships with governments they had the power to lead, to challenge, to comply, to ignore or to defy public policy about health assessment in OOHC. It was the holding of this power that made the findings about what they understood to be the purpose of assessment particularly significant.

Considered against the framework for enacting children’s right to the highest attainable standard of health discussed in Chapter 3, study participants universally spoke of their work in ways which reflected a valuing of child rights. They described sustained and creative efforts to make health assessment readily available for OOHC and to provide services in accessible locations. Health professionals showed a mindfulness about appropriate physical facilities to offer calm and welcoming spaces for children, even when this was in the context of lamenting restricted access to suitable spaces. Frequent frustration was expressed at the long waiting times for further assessment and treatment which were a significant barrier to overall service availability. High levels of positive concern were expressed about the quality of health care and the acceptability of assessment methods. Efforts to minimise distress or discomfort for children and to build relations with carers through phone contact, home visits or rural outreach services were evident. It was rare for informants in the study to overtly discuss enacting child rights under the UNCRC as a purpose of their work. Comments about rights tended to be about rights to privacy, adolescents’ rights to give their own consent or children’s rights to have universal health services they may have missed out on, like immunisation.

CONCLUSION

In this chapter, comparison of the policies of medical colleges with those of the Commonwealth government and two state jurisdictions captured a snapshot of Australia in the midst of a purposeful transition in thinking about health assessment in OOHC.

This PhD was not an evaluation study. Nevertheless some conclusions were drawn about the strength and clarity of government purposes for health assessment in OOHC. The extent to which these were consistent with enacting child rights to the highest attainable standard of health and recovery from the effects of maltreatment was of particular interest.

While Commonwealth and NSW policies described elements of quality care and specialised services striving for optimal child health and positive health outcomes, in reality,
the lack of systemic feedback as to whether these purposes were being achieved weakened
the evidence of real intent. At the time of this study, lack of data meant it was not possible to
judge whether national or NSW policies of comprehensive assessment were producing
different outcomes to the Queensland policy, which aimed to promote child health and
wellbeing through referral to primary health care services.

As discussed in Chapter 2, the Commonwealth government had revised its Medicare
policy to effectively extend universal health insurance coverage to systematic health
assessment for OOHC. On the one hand, this represented an unambiguous sign of purposeful
intent from the then Department of Health and Ageing. It clarified that specialised,
comprehensive health care could be made available to the OOHC cohort with financial
assistance from the Commonwealth. On the other hand, the lack of an effective
implementation strategy to promote or support the changed policy indicated an “at arms-
length” approach by that department.

Incongruent ideas about purpose undoubtedly contribute to the problem of resolving
national data descriptors for health need and health care in OOHC. Purpose and monitoring
measures are twin elements in robust systems. Ideas about purpose influence what
governments expect of health providers, what resourcing they allocate, what guidelines are
developed and what measures are adopted for monitoring and evaluation. As Australia moves
to implement new national standards I believe much could be gained from stronger and more
congruent vision about the purpose of comprehensive health assessment, both for individual
children and the OOHC population.

DISSEMINATION
This analysis was the subject of the following peer-reviewed conference presentation:

Webster, S.M., & Temple-Smith, M.J. (2012) Addressing the health needs of looked-after
children in Australia: Divergent visions and their effect on principles and processes of
intervention. 12th International Conference, European Scientific Association on
Residential and Foster Care for Children and Adolescents, September 4-7, 2012,
Edinburgh, Scotland.
CHAPTER 8

AUSTRALIAN CASE STUDIES OF COMPREHENSIVE HEALTH ASSESSMENT IN OOHC: STEPS OF CARE

OVERVIEW

This is the fourth chapter presenting research findings from two case studies of health assessment in OOHC in Australia. The background context of each case was outlined in Chapter 5. The previous two chapters explored critical underlying themes in comprehensive health assessment in OOHC: (a) how health is defined and (b) the purposes of assessment. This chapter illustrates most clearly the back and forth analytic process within Checkland’s soft systems methodology. In this chapter I compare findings from field visits against my abstract framework of five steps of care associated with health assessment in OOHC.

For the purposes of the study, I imagined health assessment in OOHC as comprising the following five steps of care, each of which could be thought of in abstract terms as a discrete system:

I. Collecting, storing and sharing child health histories;

II. Initial health assessment;

III. Comprehensive health assessment;

IV. Child health care management planning;

V. Ongoing monitoring and review of child health.

Using this abstract framework, I undertook a process of analysis which is illustrated in Appendix C which contains all of the analytical summaries relevant to this chapter.

Firstly, I synthesised the medical recommendations from Australian, U.K., U.S. and Canadian medical colleges pertinent to each step of care. These have been my reference points for modelling abstract systems from a health professional’s point of view.
HEALTH ASSESSMENT IN OUT-OF-HOME CARE

Drawing from these synthesised recommendations, I considered what I knew of the difficulties with each step of care and drew a simple picture to summarise key ideas for myself. Checkland refers to these as rich pictures. My series of rich picture are shown in Appendix C.

I then developed analyses (based on Checkland’s CATWOE framework) of how potential improvement in each individual step of care may be conceived in systemic terms. These analyses imagined idealised systems, held only in my own mind, but based on what I understood to be the weltanshauung of health professionals based on the recommendations from medical colleges.

Fourthly I drew a simple system diagram of my abstract, idealised system for each step of care (or in SSM terms, a Purposeful Activity System holon22), also based on what I believed to be the weltanshauung of health professionals. These system diagrams illustrating the activities within a system and how they relate to each other are also in Appendix C.

For each step in turn, I compare these abstract ideas against a brief outline of each case’s particular child health assessment processes for that step, as I found them described in organisational documents and procedural guides in the study cases. This is followed by a more detailed exploration of health professional’s descriptions of their own experiences of each step of care.

My comparison between each model and what I learned about every-day practice unfolds below, shedding light on interesting and important systemic issues.

22In Soft Systems Methodology holons are an intellectual device used to represent abstract ideas, from a particular world viewpoint, about a set of activities believed to be connected to achieving a declared, social, human purpose. Holons developed in SSM are commonly referred to as Purposeful Activity System models (PAS), usually represented in hand-drawn diagrams (Checkland & Poulter 2006). They are not to be confused with diagrams which try to accurately illustrate sets of activities in the natural or mechanistic worlds. A holon is a researcher or analyst’s tool for learning. The nature and use of holons is described by Checkland & Scholes 2007.
STEP ONE: COLLECTING, STORING AND SHARING CHILD HEALTH HISTORIES

SYSTEMIC RECOMMENDATIONS FROM MEDICAL COLLEGES AND ASSOCIATED PUBLIC POLICIES

Step one focused on consolidation of all relevant health information and establishment of a comprehensive health record for each child, in a form which would ensure easy access for health professionals conducting an assessment. Medical college guidelines recommended a wide range of aspects of the health history which are important, as summarised in Appendix C, p.351. These included perinatal and family medical histories, information about past and current health care providers, hospitalisations, chronic health conditions, surgery, medications, allergies, immunisations and developmental, psychosocial, nutritional, educational, behavioural and mental health histories. Recommendations envisaged that child protection authorities would obtain parental consent for the release of past medical records. In step one, recommendations also envisaged that child protection authorities would obtain consents for assessment and treatment for the child.

The American Academy of Paediatricians recommended that the child’s health history should be stored in the child’s medical home. Similarly, the English statutory guidance (Department of Children, Schools and Families (DCSF) 2009) recommended the centrality of the primary medical provider in declaring that one of the key guiding principles was “the lead health record for a child in OOHC should be the GP-held record” (DCSF 2009, p. 46).
BOX 8.1: CONCEPTUAL MODEL FOR COLLECTING, STORING AND SHARING CHILD HEALTH HISTORIES

My model system for child health histories, described in Appendix C p. 354 incorporated steps to collect and verify information, manage privacy, consent and security of health information, and share information between the child protection and health sectors. A preliminary activity at this step of care is to determine the minimum child health history data that should be collected.

In SSM terms, the owners in this model system are the child protection sector who provide the ‘trigger’ for the whole assessment process by referring a child to a health provider with a request for an assessment, accompanied by at least basic health information, and the child’s parents who hold health history information. Either or both can prevent a history from being available to health professionals conducting an assessment, either by failing to collect information or withholding consent for the sharing of information.

STATE POLICIES AND PROCEDURES

In both study cases, state health departments produced pro-forma child health records variously titled a Child Health Passport (for 0-18 year olds) or Personal Health Record (for 0-4 year olds), known as the Red Book or My First Health Record, known as the Blue Book (0-4 year olds). I also sighted a separate Pregnancy Health Record booklet in the Queensland case. These child health records were designed as parent-held records which began at birth and built a cumulative record tailored to each age and stage of child development. Both types of record included spaces where health professionals could make hand-written notes after any medical visit.

State policies and procedures for child protection case managers in both study cases required the collection of standardised health information for children entering OOHC, as summarised in Table 20. In Queensland, minimal, essential health history information was to be provided to the child’s OOHC carer. (The Child Safety Officers Manual in Queensland distinguished essential from non-essential health history information. Non-essential information, including illnesses and hospitalisations, developmental progress, perinatal history and the child’s family health history were to be gathered opportunistically by a Child Safety
Officer over the first year of a child being in care) In NSW the information was to be provided to the health professional conducting the health assessment.

Table 20: Health-related information which child protection case managers were required to provide when referring a child in Out-of-Home Care for health assessment in Queensland or New South Wales in 2012.

<table>
<thead>
<tr>
<th>QUEENSLAND</th>
<th>NEW SOUTH WALES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child protection case managers were required to provide the following child health information (as data in a standardised Child Information Form Part A) to carers at the time of placement</td>
<td>Child protection case managers were responsible for providing the following health information as part of the referral process for health assessment.</td>
</tr>
<tr>
<td>Disabilities</td>
<td>Known health issues of child’s mother, father and siblings.</td>
</tr>
<tr>
<td>Medicare enrolment details</td>
<td>Sense of identity</td>
</tr>
<tr>
<td>Allergies</td>
<td>Interests and recreation</td>
</tr>
<tr>
<td>Medical conditions</td>
<td>Child’s general level of health</td>
</tr>
<tr>
<td>History of substance abuse</td>
<td>Diagnosed medical conditions</td>
</tr>
<tr>
<td>Daily routine</td>
<td>Names of medical practitioners who have treated made diagnoses.</td>
</tr>
<tr>
<td>For children aged 0-2 this also included</td>
<td>Current treating GP, dentist and paediatrician</td>
</tr>
<tr>
<td>Breast fed or formula fed</td>
<td>Operations or hospital admissions</td>
</tr>
<tr>
<td>Eating solids</td>
<td>Checklist of physical, developmental and psychosocial mental health issues which the child may have a suspected history of</td>
</tr>
<tr>
<td>Postnatal history</td>
<td>Medication details</td>
</tr>
<tr>
<td>Birth discharge details</td>
<td>Day to day assistance required to meet health needs</td>
</tr>
<tr>
<td></td>
<td>Dietary requirements</td>
</tr>
<tr>
<td></td>
<td>Mobility aids required</td>
</tr>
<tr>
<td></td>
<td>Emotional and behavioural functioning</td>
</tr>
<tr>
<td></td>
<td>Risk taking behaviour</td>
</tr>
<tr>
<td></td>
<td>Daily living skills</td>
</tr>
<tr>
<td></td>
<td>Current support services working with child</td>
</tr>
<tr>
<td></td>
<td>The procedure also asked for</td>
</tr>
<tr>
<td></td>
<td>Medicare Card number</td>
</tr>
<tr>
<td></td>
<td>State health personal child health record book (Blue Book)</td>
</tr>
<tr>
<td></td>
<td>Immunisation History Record</td>
</tr>
<tr>
<td></td>
<td>Health Care Card number</td>
</tr>
<tr>
<td></td>
<td>Place of birth (which hospital)</td>
</tr>
</tbody>
</table>

The DCCSDS Child Safety Officers Manual instructed that a separate Health Care File be registered in the departmental records management system and cross-referenced to the child’s file.

A carer-held file called the Child Health Passport was also to be created and given to the carer at the time of placement, with the Child Health Information Form Part A and the child’s Medicare card.

Reference:
QUEENSLAND Department of Communities, Child Safety & Disability Services.
Child Safety Practice Manual

NEW SOUTH WALES Department of Family & Community Services
OOHC Health Referral Form v. 4 November 2011.
HEALTH ASSESSMENT IN OUT-OF-HOME CARE

In contrast with medical recommendations, processes in both study cases envisaged that either the carer and/or the child protection authority would be the holder of the child’s health history while the child was in OOHC. Neither system anticipated a ‘medical home’ for the child, except through a tacit assumption that some children may serendipitously have some continuity of GP.

FIELD OBSERVATIONS OF DOCUMENTATION

In both cases I witnessed instances of pro-active measures being taken by health services to gather health information from a range of sources. Firstly I witnessed a variety of forms used by health professionals to collect information. In NSW there was a comprehensive NSW Family & Community Services OOHC Health Referral Form (a 9 page form with 147 fields to be completed, 28 of which were mandatory). In the Queensland case, forms were developed locally for a single site and were variously described as Pre-Assessment forms, Referral forms or Child Questionnaires. These could be generic or could be tailored for different age groups of children.

In a second pro-active approach, particular staff members were delegated the task of collecting child health history information. Child Protection Liaison Officers were employed in some health services sites in the Queensland case study. These Officers had responsibility for searching for child health records from multiple sources and building a consolidated, contemporary record for children where there was a concern or notification of child abuse or neglect. This could aid health history availability if children subsequently entered OOHC. In the NSW case, OOHC Health Coordinators employed in health services usually found the task of closing gaps in health histories fell to them, along with their other coordinating functions for health assessments.

A less-used strategy was for a health professional to conduct a telephone interview with the child’s parent to gather a comprehensive history. Interviews of this type were reported as taking up to 30 minutes and involved the use of a standard written questionnaire as a prompt. The most comprehensive questionnaire I sighted covered 74 items of family and child health history. Agreement was sought in each child’s case from child protection staff as to the

23 The document sighted was the “OOHC Health Referral Form v4, November 2011”, produced by the NSW Government Department of Family & Community Services
HEALTH ASSESSMENT IN OUT-OF-HOME CARE

acceptability and safety of making such a contact. In practice child protection staff deemed parent interview a suitable approach with approximately 50% of parents. Health professionals found that this approach provided valuable information and parents engaged willingly once it was made clear that the interviewer was from Health, rather than from child protection.

I designed a standard data shell as a prompt to explore the information fields that health professionals intended to collect in each study site. I asked study participants during interviews to indicate those items they intended to collect and to estimate the frequency with which this was achieved. I also asked them to estimate whether they thought the information they received on each item was reliable. The frequency ratings were (a) usually, (b) sometimes, or (c) almost never. Analysis revealed some patterns of discrepancy between the information sought and that received. In the Queensland case study, participants reported that the Child Health Passport was not in common use. In forms designed at the local level, the information sought tended to be less comprehensive. For example, they tended not to seek information about medications, allergies, blood group or dental problems. Despite local efforts, it was commonly reported that Health Services almost never received information about the parent or sibling health history or perinatal history. Nor was information usually provided about other health services where the child may have been seen in the past, including hospital admissions, mental health, forensic or community health services, dental or school nursing services. For younger children details of a maternal and child health service were only sometimes available.

In the NSW case where the standardised referral form was in use, health professionals identified where information may be usually provided but where details were insufficient. These information gaps fell into three categories. Firstly the child’s family circumstances including the history of past trauma, details of parent access and the father’s health history. Secondly, details of past health care use including GPs and private paediatricians. Thirdly, details of current and past medications were almost never provided.

I observed an anomaly between the accepted approaches to data collection for health services when compared with those in specialist child protection counselling services. These counselling services shared a common goal with health services in assessing the needs of the child in OOHC and supporting carers to meet those needs. However, while health services reported receiving poor information about maltreatment, the intake process for the counselling service collected detailed information about the types of maltreatment the child
HEALTH ASSESSMENT IN OUT-OF-HOME CARE

may have experienced and the extent to which each type had been substantiated. In addition, a detailed family psycho-social history was sought including information about a wide range of parent difficulties which may have affected the child. Specific details about the most recent maltreatment reports, investigations and outcomes, including information which may suggest ongoing risk were also collected.

In both study cases and across most sites, interviews revealed that the level of child health history detail on any written form usually fell short of what could be obtained if the health service followed up by making telephone inquiries of the referring case manager. As one participant described the system, they receive a written referral and then “rely on a phone call to flesh out the details” (12213:7). Consequently, concerns were expressed about the reliability of some information as within this approach it could be difficult to distinguish what was hearsay.

FIELD OBSERVATIONS THROUGH INTERVIEWS

In interviews at each site visited, I framed my enquiry around each activity in my conceptual model, as it was conducted at that site. Set out below are key themes which emerged in relation to each activity in the model system for child health histories.

DETERMINING MINIMUM DATA REQUIREMENTS

Health professionals observed that even given the procedures set out in state policies for Child Protection case managers, in practice little regard was sometimes held for the health history.

...for me it’s the detail. The number we get that are three or four words, or three or four lines...They never consider the history. I don’t think I have ever seen (a referral) where anyone has done any kind of file review...that’s not even seen as important (121717:8).

In contrast, health professionals stressed the importance of the child and family health history and in particular its relevance to any formulation about a child’s present health and development and risks to future health.
HEALTH ASSESSMENT IN OUT-OF-HOME CARE

We aim to... understand the child’s presentation in the context of what we know about their past ...we want that information and I think if you don’t get it, you are compromised... (121711:2).

...it is all the more subtle things we find that they have difficulties with...those more subtle things are not picked up unless you get a comprehensive history (12217:4).

Examples were given of the potential for serious harm to a child when the health history was missing or overlooked.

There was child...who had a serious cardiac condition... it was quite clearly written in his health record...that every time he has a dental procedure...he was meant to have antibiotic treatment.. He had some dental extractions of a really infected tooth. They didn’t take his health records with them....he could have had a very serious cardiac infection which can kill you...that kind of oversight is not really good enough (121715:8).

Study participants spoke of efforts they had made at the local level to establish and agree on the exact nature and extent of minimum data re child medical history information that health professionals required. Some spoke of frustration that referral information in forms designed in Child Protection services did not contain important types of health information that health professionals needed. Many common items in a child’s health history which a health professional would normally have recorded for their own patients, or would rely on a parent to provide, were reported as only sometimes, or almost never available for children in OOHC. These included information about the father’s health history, the mother’s health, the child’s blood group, allergies, medications, treatments, dental history, past illnesses, past diagnoses, infectious diseases, and any forensic examinations.

They have a child health record folder that is supposed to come with them...It never happens (12111:1).

The Medicare number is impossible to ever get (121713:3).

Participants also commented on the lack of information they received about the child’s placement history in OOHC or other child protection interventions.
HEALTH ASSESSMENT IN OUT-OF-HOME CARE

They don’t think the child protection history is relevant because we are doing a paediatric assessment. Maybe they don’t quite understand what it is we are doing (121715:5).

We lack our child protection authority gathering all that data and presenting it in a clear and coherent way...that says these are the 10 agencies that have been involved, these are the 12 assessment reports, this is a summary of what they say and essentially these are the key services. (122111:4).

In response to the frustration resulting from information gaps, some health services had introduced their own referral or pre-assessment forms. Completion of these forms, which contained the minimum data needed, was then made a requirement before the health service would accept a referral from child protection.

Our forms have been done in conjunction with the paediatricians...we know the information they need to know is on our form...there is an extra form which Child Protection have...that is a bit of a struggle. Some people are quite happy to send back both...one centre only want to do one form. We would be happier with ours (12179:4).

I think nurses here have done a really good job of doing that pro-forma questionnaire just to get some extra information. I have done clinics...where we’d often have zero information (121715:4).

It is better now that we’ve got the form...They are filled in poorly but they are better than what it was. They are certainly much better than our (Child Protection standard form). They were never filled in (121713:2).

COLLECTING MEDICAL INFORMATION

While the policy in other sites was to require provision of the state-based parent-held child health record book, actual rates of provision of such books was reported as frustratingly low.

...the biological parents aren’t always willing to give it up (12135:2).
HEALTH ASSESSMENT IN OUT-OF-HOME CARE

In some instances the health service made concerted efforts to encourage biological parents to attend the child’s health assessment.

…it’s a way of me being able to get the information that I need to better understand this child. That is essential if I'm going to be able to make a difference (121711:4).

As was described earlier, some health services employed a dedicated staff member with clinical qualifications and experience to gather health records for children from multiple locations and sources in the public and private health systems. These records would then be collated, and in some circumstances summarised, prior to a health assessment. In some positions this task was the key responsibility. In other instances, the task was one of a multitude of health care coordination tasks undertaken for child protection and/or OOHC. The complexity of the task was oft repeated.

The downside in our area is we actually have eight health charts per person. ...we have got hospitals records...community health...mental health.....their GP...and then if they were seen at a tertiary hospital that would be another chart... My job was to get all of those charts together and build a picture (12135:20).

Improvements in health history collection were reported in sites where there had been continuity of health staff involved with referral and screening processes and where appropriate forms, designed by health services, had been in use for some time.

VERIFYING INFORMATION AND RECORDING INFORMATION ACCURATELY

Given the challenges of collecting any information about child and family histories, it was not surprising that little comment was offered about data verification and accurate recording, except to note problems with the legibility of hand-written case notes and difficulties understanding unfamiliar medical terms. Even where dedicated staff time was allocated to health record retrieval, dependence on Child Protection information could still influence data integrity.

We don’t have a system that goes across the state...I am really relying on a caseworker to say...this child was placed in another town in 2010. If i don’t know that, then I am not going to know what was done up there (12211:11).
STORING INFORMATION SECURELY AND SUSTAINABLY

The difficulties in the task of mining data from existing state public Health Service records included not being able to electronically upload and store information efficiently because of inadequate information management system capacity.

...we are not allowed to upload records...because there is not enough room (12211:10).

Responses to this problem varied. One interviewee made photocopies of every relevant report, which they then passed on to the health professional undertaking the assessment. At another site, no material was copied or retained but a summary was made. A third alternative was the holding of “private” files on each child which were not part of the organisation’s record keeping system but provided the person trying to coordinate care with a record for each child for whom they were responsible. Lastly, some health services had developed an OOHC code which attached to electronic health records and could assist in searching records systems for different types of health services a child may have received. Several services were hoping to move to electronic records at some time in the future.

PROTECTING INFORMATION PRIVACY

Privacy was an issue in accessing existing records and in sharing information with other providers. Layers of privacy protection on health records even within a single public health organisation, could make record access complex.

There is a general confidentiality which means that anyone can access the information. Then there’s a partial confidentiality ...you can see that there’s a record for the service, but you can’t necessarily see what’s in it unless you have access to the organisation unit. Then there’s full confidentiality... you don’t even know that they have accessed a service...an example is sexual assault services (12257:24).

Particular sensitivities were reported around sharing health information relating to adolescents.

They may not want Child Protection to know what they are doing sexually, or about their sexual orientation...I don’t believe, unless it is a significant risk to the adolescent, that I should be breaching their confidentiality (12157:10).
Participants believed that both Child Protection authorities and health providers were sensitive to privacy protection, not only for the child but also for their parents.

**SHARING INFORMATION EFFECTIVELY**

Consent, gatekeeping and role delineation also seemed to play a part in shaping boundaries around child health information sharing. Consent was influenced firstly by legal arrangements.

*What legal order the child is under...whose guardianship...that really impacts on consent (12111:6).*

Consent for the sharing of health information could be granted to a specific person, rather than an organisation which could pose a barrier as there was no provision for delegation of consent.

*A lot of the time...they (the health professional who has seen the child in the past) say you need parent consent...we then have to explain that in OOHC the consent is with Child Welfare, and then they want something written from Child Welfare...the case worker will sign consent for our ...coordinator to get information...it hasn't helped me because it is her name, not mine (12253:27).*

Gatekeeping by Child Protection authorities and non-government organisations as to what child health information could be passed on to carers was a recurrent issue.

*This has been an area of...debate...we have come up with an agreement...we send a copy of the health report initially to the Child Protection department, and then they have 72 hours...to let me know if they don’t want it shared with the carer (12225:6).*

*NGOs don’t want us to have direct liaison with their carers...they don’t like us or the Child Protection authorities to contact carers directly...they ask us to go through them for all liaison...which can be tricky....the message...gets lost in translation...(12223:5).*

Timeliness of information provision could also be an issue.
HEALTH ASSESSMENT IN OUT-OF-HOME CARE

It would be very interesting to do an audit ... and see how many children going into care actually get a child health history provided in the timeframe that it is supposed to occur. I don’t have a lot of confidence that it is occurring, but I don’t have any evidence (121925:4).

UPDATING INFORMATION CONTINUOUSLY

Not surprisingly, continuity of case manager and of child placement were reported as having a significant influence on whether child health information was kept up to date.

“Changing the child protection case worker frequently... the child health records are not travelling with the children (12113:20).

SYSTEMIC ANALYSIS OF STEP ONE

Overall, health professionals in both study cases judged the availability of child health histories in OOHC as highly problematic. Information needed for clinical decision making was difficult to obtain. In one study case, state policy required the use of a standardised, carer-held child health history intended to be passed on whenever the child moved placement. The experiences reported by participants confirmed the findings of state-wide audits and surveys that the carer-held record was not in common use. While a variety of processes were being trialled to improve history collection, consent requirements, incompatibility between records management systems and insufficient IT infrastructure made storage and transfer of histories cumbersome, even within a single health organisation. The experiences recounted by staff members with specific responsibility for compiling health records impressed on me how complex and skilled this activity is.

In response to inadequate health history information, health professionals attempted to implement their own systemic controls which comprised either taking over the task of data collection from Child Protection by going directly to the child’s parents, or designing data collection questions which they then embedded in referral forms. As will be discussed further on, the use of screening tools completed prior to the child attending an appointment was also an attempt to fill in gaps in what was known about the child’s health history. To exercise leverage over Child Protection, some Health Services refused to accept referrals when their minimum data about child health histories was not provided.
HEALTH ASSESSMENT IN OUT-OF-HOME CARE

My model system predicted that Child Protection authorities played a pivotal role as ‘owners’ of the child health record system (i.e. those who could either make child health histories available or prevent them from being available) and this was born out by my observations. However I had underestimated the extent to which Health Services also own this system in that there are separate facilitators and barriers within Health Services that impinge on the availability of histories. Firstly, the co-existence of separate, unlinked records for the same child across several arms of a single Health Service or multiple health services makes for complexity. The absence of links and layers of confidentiality provisions may prevent access to some or all records from a particular arm of service, even to an OOHC Health Coordinator working within the broader organisation. The situation may be mimicked between health services in a local health district. Secondly, Health Service infrastructure issues such as lack of electronic records storage capacity or lack of databases with sufficient power and accessibility to store and share multiple records left some health professionals keeping “private” records, or managing clumsy paper-based systems to improve their individual efficiency and effectiveness, perhaps at the same time masking the systemic limitations.

The integrity of child health history content was something that concerned health professionals in systems which had both written and oral collection processes.

In both study cases, the aim was that once compiled, a current child health history would be held and maintained within a child protection authority case files. Neither case study clearly articulated a system, either in policy documents or in everyday practice which would retain and maintain an integrated health record for each child in OOHC within a state-funded health system or medical home. Some health professionals did describe this as an aspiration.
STEP TWO – INITIAL HEALTH ASSESSMENT

SYSTEMIC RECOMMENDATIONS FROM MEDICAL COLLEGES AND ASSOCIATED PUBLIC POLICIES

Medical recommendations envisaged an initial step in the health care process in OOHC where every child should receive an early assessment of their health needs. This type of assessment was variously termed health screening (AMA 2010), a Medical Screen (AAP 2005), a Statutory Health Assessment (DCSF 2009), an Initial Health Assessment (CPS 2008) or a Preliminary Health Check (APHPC 2011). A list of components of initial assessment from these medical recommendations (Appendix C, p. 355) informed my conceptual model. The notion of a preliminary assessment was less related to the magnitude of the task and more to the timing of assessment in relation to when children entered OOHC. Taking the medical recommendations together, the task was in fact comprehensive, involving reviewing and consolidating the child’s health records, screening for urgent problems and health risks, a preliminary assessment across all domains of health and a physical examination covering growth, infections, injuries and chronic conditions. Emphasis was also placed on addressing any health issues of concern from the child’s perspective. It was then expected that the doctor assessing the child would formulate diagnoses, provide treatment, order any further assessments or make referrals for specialist treatment. The final product would be a completed health record for the child and a report from the doctor to Child Protection services with recommendations for ongoing health care management.

BOX 8.2 CONCEPTUAL MODEL FOR INITIAL HEALTH ASSESSMENT

My systemic analysis and conceptual model for Step Two are described in Appendix C, pp. 357-358). Within this model, the first step is to identify an appropriate health professional to undertake the assessment, then facilitate the attendance of the child, accompanied by responsible adults who can provide a detailed history and consent. The child would be physically examined and the findings, together with opinions based on the history would enable the health professional to make decisions about treatments, further assessment or ongoing monitoring which may be needed. Given that the child’s parents would often not be present and that Child Protection authorities would usually have custody or guardianship authority for the child, a written report in relation to clinical decisions made would be provided to the responsible child Protection authority and the current carer.
HEALTH ASSESSMENT IN OUT-OF-HOME CARE

STATE POLICIES AND PROCEDURES

Key policy documents stating state policies for initial health assessment are listed in Table 21. State policy in both case studies was that initial health assessments at entry to OOHC would most often be completed by a GP, preferably the child’s usual GP. If a GP was not available, for example in remote locations, then another health professional such as a nurse or Indigenous Health Worker may perform the assessment. Different terminology used to describe this step included Primary Health Check, Primary Health Screen or, a Health Appraisal, Health Assessment or Child Health Passport check. A dental assessment would often also be organised.

Table 21: Procedural documents where Initial Health Assessment in Out-of-Home Care processes were described in the New South Wales and Queensland case studies in 2012.

<table>
<thead>
<tr>
<th>State jurisdiction</th>
<th>Procedure</th>
<th>Procedure Documentation Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>New South Wales</td>
<td>Primary Health Check</td>
<td>Model Pathway for the Comprehensive Health and Developmental Assessments for all children and young people entering OOHC</td>
</tr>
</tbody>
</table>

In the Queensland case, the carer was expected to organise an appointment with a GP and retain the record of the appraisal or assessment in the Child Health Passport.

In the NSW case, Community Services Interagency Pathways Coordinators were employed in Child Protection Service regions to facilitate the referral of children for OOHC health assessment. Regional OOHC Health Coordinators employed in area health services had responsibility for facilitating and co-ordinating these initial health assessments cooperatively with carers.

FIELD OBSERVATIONS OF DOCUMENTATION

I observed three types of documentation around this step of care. Firstly, both state government and local area Health Services produced information brochures, flyers or booklets to explain OOHC health assessment aims and processes as well as eligibility to carers and/or health professionals. However these were not available or used universally in the sites visited.
HEALTH ASSESSMENT IN OUT-OF-HOME CARE

A generic guide previously provided to GPs in Queensland (Queensland Department of Communities, Child Safety Services 2010) explained that Child Safety Services required that a health and dental assessment be completed when children have stayed in OOHC for 30 days or more. The guide listed what a GP “needs to do” (p. 4) when a carer requested a health assessment which was to “assess the child’s health markers across all areas, including the child’s general physical health, including visual and hearing screenings and an appraisal of...developmental milestones”(p.4). Although this document was superseded when the National Clinical Assessment Framework for OOHC was published in 2011, participants were generally unaware of this change or the implications for general practice, especially in terms of financing through Medicare.

In a second type of documentation in the New South Wales case, some OOHC Health Coordinators used a standardized letter to advise a GP about the processes of health assessment and ask them to assess a particular child. These letters were either sent directly to GPs or given to carers who made GP appointments and accompanied the child. A letter of this type also requested that the GP provide a referral to a paediatrician for a comprehensive health assessment and complete a form giving a summary of findings and recommendations which was to be returned to the OOHC Health Coordinator. These summaries of findings were a third form of documentation.

I developed a data collection form as a prompt to explore which potential dimensions of child health were included in initial health assessments, drawing from suggested items in medical college recommendations. In the Queensland case study very little information was available as to initial health assessment as there were no GP participants in the study. Some health services conducting comprehensive health assessments in both study cases did not require a GP referral or report of any kind. In the NSW case, health professionals reported on what they expected or received from GPs completing initial assessments.

The combined results suggested four dimensions always or usually included were a physical examination, a vision check, an immunization status check and a review of child behaviour. The carer’s concerns, needs for support and own health were also commonly included. Much less common were checks for child allergies, a medication review, a review of the child’s physical activity or consideration of a child’s strengths and interests. Domains which were not usually mentioned were growth, signs of recent or old injuries, physical examination
of the child’s body surfaces, HIV or STI testing, learning or educational progress, integration with the foster family, the child’s sense of identity, or their current sense of safety. The extent to which these may have been included within physical examinations was not mentioned.

FIELD OBSERVATIONS THROUGH INTERVIEWS

My observation of the activities within the system which were the responsibility of child protection staff was mainly limited to third party reports by health professionals about their experiences of the outcomes of these activities.

IDENTIFYING AN APPROPRIATE HEALTH PROFESSIONAL

In both study cases there was a preference for children to have an assessment with their usual family GP. However, participants reported that in many cases there either was no usual GP or their details were unknown.

*Maybe four out of 10 referrals ... will specify the previous GP... most of the kids have got a history of going to the casualty department at their local hospital (12275:11).*

Problems with engaging GPs in health assessment were widely reported in both study cases.

*In some Area Health Services we still have hardly any GPs engaged at all which I think is quite disappointing (12271:9).*

*I think there is still a long way to go with educating GPs in general about children in OOHC. There is that stigma, that fear of legal ramifications if they write a report (12275:8).*

*I have found there are GPs who absolutely refuse to do those health checks, or do them and then refuse to provide me with the paperwork or refuse to make a referral to the paediatrician (12229:10).*

The complexity of cases, the time needed for assessment and the perceived skills of GPs were offered as possible explanations as to why GPs were difficult to engage.

*I don’t think GPs have the time or training to really understand (121711:6).*
HEALTH ASSESSMENT IN OUT-OF-HOME CARE

A GP might be really interested, but they wouldn’t have an hour time slot, or even 45 minutes (121715:10).

There have been occasions when that hasn’t been in the best interests of the child because I wouldn’t say the GP had had a good interest in child health (12221:23).

In other instances there were difficulties accessing GP services because of limited service availability in rural and remote areas, or because GPs had ‘closed’ their practice to new patients.

We have a lot of rural carers. Often for them access to GP clinics is limited. Sometimes those places only open two half-days per week and you have got to take what you can get (12221:23).

At the local level, the response to problems with GP engagement varied. Participants reported mixed success in gaining assistance from local GP organisations.

We were fortunate that the Divisions of General Practice came on board quickly because we had two really great champions for the cause. So they were able to do a lot of the leg work to get the Divisions involved (12275:6).

There was one Division who were really proactive and really wanted to be involved but...they had little power...All they could do was distribute information and invite us to some training nights. But then we would be told we needed to foot the bill to feed the GPs...we just went “oh, too hard” (12211:32).

Where they could, OOHC Health Coordinators tended to develop working relationships with individual local GPs, one GP at a time.

Some GPs are great because they have been doing this for a little while and they think it is a fantastic program, and then other GPs don’t like it whatsoever...But the majority have been really positive. Some GPs, if they haven’t ever received a referral before, aren’t quite sure what to do and what’s needed. I just go through it with them (12223:8).
Paediatricians expressed views about their preferred models of working with GPs.

What I think needs to be explored is a model where we have a group of GPs in an area who put their hand up and say “I am really interested in being involved with kids in care”. They become a resource and get supported by paediatricians who do child protection (121925:5).

Given the frustrations of engagement with GPs, a small number of sites had developed primary health OOHC assessment initiatives led by allied health professionals.

We tried to get GPs involved to see kids initially, then refer to us if there were concerns. But we have had issues engaging with the GPs so we ended up using our Child and Family Health Nurses (12217:2).

People were struggling to get to their GP and then provide the information back to us ...(the nurse-led approach) was a way of getting through a backlog of kids...not needing to rely on a number of other services to ultimately do our work (12243:11).

In other instances, health professionals in public Health Services had found GP engagement just too difficult.

We decided that although GPs ought to be an important part of this...in practice it will be very difficult for them to be so. That is in part because of the discontinuities when children move...Whether GPs ...would have the resources to do the necessary chasing up....In effect we write the GPs out of the management system (122113:22).

Some public paediatric services waived the requirement for a GP referral.

We have seen having to get a GP referral as yet another barrier...I think it is disrespectful for someone to take this kid to a GP just so they can write a referral letter (121711:6).

Alternatively, even where GPs were available, the initial health assessment with a GP could be viewed as a second-best option.
HEALTH ASSESSMENT IN OUT-OF-HOME CARE

In rural or regional areas...kids would often end up seeing a GP instead of a paediatrician, just because of access. I know one case worker I have spoken to said it is much better here (with a paediatrician) where you have got the time...and a bit more expertise and a bit more background training in trauma and even just general child development (121715:10).

Some participants expected that most children entering OOHC would require a comprehensive health assessment anyway and put most of their focus and energy on that next step.

I don’t put as much emphasis on the initial health screen as I do on the paediatric assessment (12221:24).

ENSURING CHILD ATTENDS WITH RESPONSIBLE ADULT/S

Carer reluctance could be a determining factor in whether a child was taken to for an initial health assessment, with some carers reportedly preferring an opportunistic approach.

Often the carers will say “we will just make an appointment when (the child) is sick” (12223:6).

There are instances where our little clients see a GP and what is addressed is the issue of the day. A runny nose or a sore toe. But it’s not really a primary health screen...the carers do that opportunistically when there’s an issue they feel they can discuss with the GP (12231:7).

If an adult informant with a good knowledge of the child was not present at the health assessment, health professionals felt hampered.

I’m sure you have heard this a million times. We still get the kids who arrive with a Child Protection staff member who has never met the kid before...We go, what do you want us to do? Wave a magic wand over them?” (121925:21).
HEALTH ASSESSMENT IN OUT-OF-HOME CARE

PROVIDING APPROPRIATE CONSENTS AND HEALTH HISTORY

Participants in one study case reported that regulatory changes to procedures for privacy protection had smoothed the path of information exchange between health and child welfare.

There is a new policy...to say we need to be sharing information. That has worked really well...It means that people aren’t actually having to apply for information. If it is in the best interests of the child’s wellbeing then we should be able to exchange it quite freely (12211:24).

However, the provision of child health histories was still problematic, as discussed earlier. Without a history, the scope of an initial health assessment would be limited.

PHYSICAL EXAMINATION, SCREENING AND REVIEW OF HISTORY

Wide variations were reported in the breadth of issues included in the initial assessments. The most thorough process I observed involved a systematic approach, supported by an age-adjusted pro-forma which prompted the health professional to address the following dimensions:

i. Medical and social history

ii. Known or suspected allergies

iii. Overall health status

iv. Health issues identified by carer

v. Current medications

vi. Immunisation status

vii. Growth

viii. Vision
HEALTH ASSESSMENT IN OUT-OF-HOME CARE

ix. Hearing

x. Oral health

xi. Diet and eating habits

xii. Speech and language development

xiii. Physical activity

xiv. Toileting

xv. Behaviour and Mood

In another example, where initial health assessments were nurse-led, a multidisciplinary working group including professionals from seven disciplines developed agreement on the domains to be covered.

We decided that the Child and Family Nurses would use the (state child health record)...and then would do the Ages and Stages Questionnaire and Ages and Stages Social and Emotional Questionnaire on that visit. The idea was that if there were just issues in one domain, that child would be referred to a specific service. If there were issues in two or more domains, we would send them to our comprehensive paediatric psychosocial clinics (12211:15).

MAKING CLINICAL DECISIONS

Medical guidelines for initial health assessment include clinical decision making based on review of pre-natal risk factors and birth history, identification of any detrimental effects on the child’s development, assessment of any acute or chronic conditions requiring treatment and evaluation of the need for blood tests. Where initial health assessment was nurse-led, a doctor may not necessarily become involved. If a GP referral was not required by the local Health Service then some nurses had the option of referring directly to a paediatrician for comprehensive assessment. In some cases nurses reported that they made clinical judgments about the child’s health status.
HEALTH ASSESSMENT IN OUT-OF-HOME CARE

In some areas we have been able to have screening clinics with nurses... The carer ... comes to that health check with... the Ages and Stages questionnaires and the nurse looks at those and does a check. Then, from a combination of those things makes a decision about whether paediatrician review is necessary. They are checking eyes, looking at ... hearing... weight... diet. So it’s a basic check (12259:2).

SHARING WRITTEN RECORDS OF INITIAL HEALTH ASSESSMENT

In sites using a systematic approach, it was expected that findings would be reported around each aspect of health examined, including where development and health were satisfactory. At the other end of the spectrum, only a report on current health issues which required further assessment or referral for treatment was expected. The ways in which records were compiled and shared from initial health assessments caused frustration for many interviewees. Sometimes GPs were reluctant to pass on their findings.

GPs are really reluctant to give information if you ring them (12221:15).

Even if they did, these findings were not then necessarily provided to paediatricians

I don’t know that I usually see the results of the initial health check. That doesn’t come to me... I think that’s an issue I need to address because you would expect to be able to review the findings of your colleagues on vision, hearing, teeth and so on” (122311:8).

SYSTEMIC ANALYSIS OF STEP TWO

Initial health assessment was embedded in medical and government policies and described in my model for Step Two. I frequently observed that no data were available to health professionals in the study sites to indicate the efficiency, efficacy or effectiveness of this step. Paediatric services in some sites had developed positive working relationships with GPs and had implemented a systematic approach where GPs provided assessments and triaged referral to specialist paediatric services. At the other end of the spectrum, participants expressed dissatisfaction with the extent of information provided by child welfare at the time of referral, carer reluctance to seek more than opportunistic health care, obstacles to GP engagement which resulted in devolution of clinical decision making, and barriers to sharing child health records.
The critical point of control rested with Child Protection staff who triggered referral for assessment. The priority given to the initial health assessment varied, partly influenced by whether or not a key purpose was to gain a GP referral for a comprehensive paediatric assessment so that the cost of the paediatric service could be billed to Medicare. Where this was not imperative then efforts were not always be made to ensure initial assessments. Alternatively where a GP referral for comprehensive assessment was required, health professionals reported their frustration with the difficulties of engaging GPs.
HEALTH ASSESSMENT IN OUT-OF-HOME CARE

STEP THREE – COMPREHENSIVE HEALTH ASSESSMENT

SYSTEMIC RECOMMENDATIONS FROM MEDICAL COLLEGES AND ASSOCIATED PUBLIC POLICIES

Medical standards and guidelines envisaged that every child in OOHC should receive a comprehensive assessment of their health needs (AAP 2005, RACP 2006). Some guidelines used different terminology such as Comprehensive Health and Development Assessment (APHPC 2011) or, as in the case of the RANZCP (2009), called for Multi-modal mental health assessment or Comprehensive Mental Health Assessment as an additional component.

Recommended time frames within which health assessment should be completed after entry to OOHC varied, between 30 days (AAP 2005, RACP 2006) and 90 days (APHPC 2011). All medical guidelines envisaged that comprehensive assessment should be directed and overseen by a lead clinician, ideally a paediatrician, and involve a multi-disciplinary team according to specific needs of child (APHPC 2011).

BOX 8.3 CONCEPTUAL MODEL FOR COMPREHENSIVE HEALTH ASSESSMENT

Working from the medical guidelines, I developed a composite list of the activities involved in comprehensive assessment (Appendix C, p. 359) which were incorporated into my conceptual model. Additional tasks which fall to child welfare authorities were also included. The model includes triage of referrals, review of medical histories, screening and examination of children, the formulation of diagnoses and the development and dissemination of the results of the assessment. The first task is for child welfare authorities to identify the local availability of health providers undertaking comprehensive assessments and to make referrals and appointment, along with providing the necessary child information and ensuring that the child, their carer and their case manager attend. The systemic analysis and conceptual model are shown in Appendix C, pp.361.

STATE POLICIES AND PROCEDURES

Comprehensive health assessments were not envisaged in Child Protection policy in Queensland at the time of this study. Nevertheless, they were available in some tertiary paediatric services, at the discretion of local service managers. In NSW the OOHC Clinical
HEALTH ASSESSMENT IN OUT-OF-HOME CARE

Pathway assumed that the majority of children newly entering OOHC and expected to remain in OOHC for a period of 90 days or longer would be comprehensively assessed by a paediatrician, unless a case was made otherwise, such as if the child was already under the clinical supervision of a paediatrician. In a second wave of targeted assessment activity, several sites in the NSW case study had also been conducting comprehensive health assessments for children already in OOHC who were aged 0-5 years.

FIELD OBSERVATIONS OF DOCUMENTATION

As discussed earlier, some but not all sites in both study cases had developed brochures or booklets to explain the comprehensive health assessment process in OOHC to carers. I also became aware that in the NSW case a resource designed specifically for children had been made available although this was not sighted. A simple brochure for young people in the Queensland case explained the purpose of the Child Health Passport (DCCSSD 2012).

Several types of documentation supported health professionals conducting comprehensive health assessment. Firstly, I observed instances in the Queensland case where a Child Health Passport was developed for each child by the Health Service undertaking assessment. The Passport provided a template for domains covered within the assessment, as appropriate to the age of the child. Consistent with state government policy, the completed Passport document was intended to be kept by the carer. In other sites, where no specific OOHC health assessment documentation had been developed, health professionals followed their usual clinical practice and worked with existing clinical record keeping and letter writing protocols.

In the NSW case the extent of documentation was also variable along a spectrum from generic to tailored practice. The points along the spectrum included: (i) usual clinical practice with no modified documentation, (ii) written triage guidelines for acceptance for comprehensive assessment, (iii) a paediatrician’s informal, personal checklist of which domains they usually cover, (iv) a documented, local clinical pathway covering each domain of assessment in detail, including local multi-disciplinary health service providers who could participate, (iv) a guide to standardized written assessment reports for OOHC.

Variability in documentation from one site to another appeared to me to be somewhat idiosyncratic in that it tended to reflect the personal style and approach of local leaders or the
ongoing efforts of individual team members to improve the quality of assessment processes over time. The uptake of materials developed at the state-level appeared discretionary.

FIELD OBSERVATIONS THROUGH INTERVIEWS

Comprehensive health assessments were most commonly carried out in publicly funded health services. In both study cases assessments may have involved a paediatrician alone, or a multi-disciplinary team. The majority of participants spoke of children being brought in to public health facilities such as hospitals or community health centres for assessment. Some paediatricians travelled to regional areas to provide an outreach clinic in order to reduce travelling for the carer and child. In such cases, consulting rooms in a public health facility were ‘borrowed’ for the purpose. At the local level, dedicated approaches to health assessment for OOHC varied in their longevity and sophistication. Personal leadership was the explanation most offered to explain such variations.

There has been a very strong and proactive health district. They have got a lot of very high profile professionals. They have done a lot of research that has assisted them in the past...maybe they have had the financial backing of being at that teaching, tertiary hospital (12275:9).

It is partly personality driven...we have a very excellent OOHC coordinator who is good at facilitating...a very proactive person...she has probably put back into the system way more than she has cost us (122113:24).

Budget limitations could result in less sophisticated approaches.

Children entering OOHC...get channelled into the conventional paediatric clinics...our clinics work on the basis that if you are a new patient you get an hour and that is it...There is no funding for any nursing or other allied health expertise...so they don’t get developmental or mental health assessments...We identify what the shortcomings are as best we can (12247:4).

Not only were budgets limited in some instances, but health professionals were aware that diverting clinicians from existing case-loads left no-one to pick up those patients.
We are robbing Peter to pay Paul (12233:13).

I observed state-wide and local procedural rules designed to limit the numbers of children eligible for comprehensive assessment. Limits differed, but could be based on the length of time a child was expected to remain in care, the age of the child, the type of legal child protection order in place or threshold scores on standardised screening tools. These rules were largely in response to capacity restraints.

One of the major challenges for health was...how to roll out this system with existing resources...they were not provided with additional funding for actual health services, only for funding OOHC coordinator and health case manager positions...they just couldn’t manage the influx...without recurrent funding I think you would have to close the books. It would not be sustainable (12277:14).

In some sites, the additional budget resources provided for OOHC Health Coordinators were seen as a positive enabler, especially where this led to identification of children in OOHC who were already in the health system or improved workforce planning to meet the particular needs of children in OOHC e.g. additional speech and language services. Additional funding also assisted in building the capacity of clinicians through additional training and resources.

IDENTIFYING A HEALTH PROFESSIONAL TO UNDERTAKE COMPREHENSIVE ASSESSMENT

The following quote provided a glimpse of the winding path between a Child Protection case manager and a paediatrician who could provide a comprehensive assessment.

A caseworker fills out a lengthy referral form. Their manager is supposed to look through it and sign it then send it on to the regional Interagency Coordinator in the Child Protection department. They find out which Health department OOHC health coordinator covers the area where the child resides and send the referral to that coordinator (12211:3).

In most sites the regional boundaries for child welfare departments and health services differed and participants reported some initial confusion in aligning responsibilities. As will be discussed further on, a triage system in the Health Department would then take place which could identify whether a child would receive a comprehensive assessment and which health professionals might be involved.
HEALTH ASSESSMENT IN OUT-OF-HOME CARE

At the simpler end of the spectrum, a paediatric clinic in a public hospital would accept referrals to their OOHC clinic directly from child welfare professionals. In some (but not all) sites no GP referral was required. The process for identifying a health professional to complete a comprehensive assessment was handled either by the health professional or administrative staff member who managed intake for the clinic.

Where comprehensive assessment was not part of state or local policy, identification of an appropriate health professional could be further complicated.

In our district...we didn’t have the support of the paediatricians for the official model, so we actually did a bit of a snapshot of a group of children and as a Child Health Nurse I did nurse assessments (12135:7)

Similarly, if there was no local paediatrician available then comprehensive health assessment was less likely.

We haven’t got that many paediatricians up here. It is just too hard getting the children in to be seen. So, unless they have an identified issue...they just get reviewed either every six or twelve months (12241:4).

MAKING AN APPOINTMENT

The arrangement of health service appointments for comprehensive health assessments had its own complexities. Comprehensive health assessments involved scheduled appointment times of 60-90 minutes with a paediatrician. Appointments were variously the responsibility of a child protection case manager, carer, health service provider or OOHC Health Coordinator.

The Department of Child Protection takes ownership of the clients, so they ring and tell them of the appointment...they also let our Outpatients Admin Officer know who will be coming so we can pull the appropriate charts or make a new chart (12157:3).

As the OOHC Health Coordinator, I always...book the paediatrician appointment before I have even met the carer because we have such a long wait...usually at least three months for a paediatrician appointment (12229:9).
HEALTH ASSESSMENT IN OUT-OF-HOME CARE

Paediatricians spoke of the overwhelming demand for health assessments affecting the availability of appointments.

We got 18 referrals last week but only had two spaces to see kids. So they can wait several months for an assessment...we have re-allocated resources because we recognized this is an important area but we actually don’t have any further resources to re-allocate, because we still need to provide that acute health service...I don’t think it is a sustainable system if we look at the full expectations (12233:18).

PROVIDING A REFERRAL, CONSENT AND MEDICAL HISTORY

Child Protection authorities were the sole point of referral for most children into comprehensive health assessment

We only take referrals from Child Protection...they contact the Intake Officer and then send a request form (12179:1).

In this unit we take referrals from the Child Protection Department...they would refer children they have a particular medical concern with (121923:2).

ENSURING ATTENDANCE OF CHILD, CARER AND CASE MANAGER

Significant concerns were evident about the efficiency costs to health services if children and carers did not attend booked appointments for health assessment. Health professionals took active steps to contact carers and case managers to confirm appointments and provided reminders. In terms of accountability, they relied on Child Protection Case Managers to ensure children attended.

I find it really helpful when the case worker comes....at least we can guarantee we are not...just sitting twiddling our thumbs (121715:13).

In the absence of the biological parents, health professionals preferred to have both the carer and the Child Protection Case Manager attend, although this was difficult to achieve.

Occasionally somebody from Child Protection would come, but that would be about one in twenty (122311:9).
HEALTH ASSESSMENT IN OUT-OF-HOME CARE

The presence of the Case Manager was valued for two reasons: first as an informant about the child’s health and social care history, and because it provided an opportunity for direct communication about how health care needs might be met.

It definitely makes a difference if the Case Manager is there because they are the one who can make decisions. Otherwise you are suggesting things to the foster carer that they then have to ask Child Protection for...it carries a lot of weight if you can say (directly to the Case Manager) ‘I am suggesting this; what can you organise or what can you provide?’ (12255:13).

Thirdly, there was a sense of caution about assessing a child accompanied only by their carer.

...foster carers may....have their own biases about the children that can inadvertently influence medical treatment decisions (121711:7).

All services had the experience of carers bringing multiple children to an assessment appointment, often unexpectedly.

Sometimes a carer might be minding three other children and they bring them all in. Then we are minding them (12179:5).

Whenever the opportunity arose, health professionals’ preference was to have a child’s parents present at a health assessment.

There is a bit of negotiation sometimes. I can be a bit mean and point out that it is in their best interest to come...and prove to the department (that you are a good Mum). So there’s a little bit of hard talking (121713:7).

I see it is absolutely ideal and optimal. The barrier is that obviously the parents feel very judged and often they may see coming up to the hospital as yet another time when someone says they are an inadequate parent. So I personally go out of my way to find whatever opportunity I can to give parents a pat on the back...because they often don’t get enough of that (121711:4).
Although having parents in attendance was preferred, it was not always an easy experience.

*Sometimes foster carers and parents attend...that can be a bit tricky (12111:6).*

*You will have a cast of thousands in there sometimes, the caseworker, the parent, the foster parent. I will take it in turns to see them individually, getting everyone’s viewpoint if time permits (121715:7).*

**TRIAGE**

Where health professionals were working in smaller facilities with less staff, triage may be left to an administrative staff member. However, in sites where multi-disciplinary teams could allow more time for OOHC assessment processes, health professionals preferred to meet together to review referrals and make triage decisions jointly.

*Clinical triage happens with the paediatrician, the clinical nurse specialist and the developmental psychologist. They intake every referral and they make a decision on whether to accept it for comprehensive assessment or not (12233:3).*

Alternative a child health nurse may triage all referrals

*I have found it best if one person pulls it all together. It goes to the Clinical Nurse (12179:3).*

Some sites in both study cases required completion of a standardised screening tool as part of the referral process. The results were then used to triage the urgency with which a health assessment was scheduled and to determine the professional disciplines of the health professionals who would complete the assessment.

**ADDRESSING DIFFERENT DOMAINS OF HEALTH IN COMPREHENSIVE HEALTH ASSESSMENTS**

I used a standard data collection form *Dimensions of Health Assessed in CHA* as an aide memoire for my inquiries about which domains of child health were assessed. Most dimensions from my composite list of medical college recommendations for comprehensive health assessment were always or usually covered, with the exception of three items which
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were only sometimes or rarely included. These were (i) examination of all body surfaces, (ii) genital and anal examinations and (iii) HIV and STI testing when indicated by clinical findings.

Across the study sites, the range of health disciples involved at some time in health assessment included (a) general practice, (b) paediatrics, (c) child health nurses in hospital, community health and school settings, (d) maternal and child health nurses, (e) psychologists (f) psychiatrists (g) medical social workers, (h) Aboriginal Health Workers, (i) dentists, (j) speech pathologists (k) audiologists (l) optometrists and (m) occupational therapists (n) physiotherapists and (o) paediatric registrars. Participants indicated in each site that a paediatrician was usually involved, and in some cases a Senior Paediatric Registrar. Other disciplines were either usually or sometimes involved. The composition of an assessment team may have affected which dimensions of health were assessed.

Against this background, the following themes arose in relation to specific activities conducted by health professionals.

REVIEWING THE MEDICAL HISTORY

In addition to reading the available medical history, I observed that reviewing the child’s history with the adult accompanying the child was a universal practice.

You still ask all the questions you would ask of any parent. The birth history, newborn history, behavioural development, milestones, immunisations, family history, allergies...development, how they are going at school, any medical problems...if they have a disability have they got the equipment they need, mobility aids, medications (12255:13).

Participants reported that medication review was not always included or recorded in the assessment task. Some possible explanations for this were that allied health professionals may record medications already prescribed but may not consider this a review as no clinical judgments were involved. Asking about medications may be so routine for doctors that they distinguish between making a note of any current medications in a child health history and making decisions about ongoing medication management.

The vast majority don’t have medications...the common ones are asthma medication which we would always talk about. Occasionally we have kids on psychotropic medication.... We see stimulant medications a bit more commonly... I suggest they go back
to the child psychiatrist who started them on it...if the child is on medications...if you are going to be changing them they will need ongoing review (12217:5).

The approach to making any changes to a child’s medication varied according to whether there was any intent for that doctor to see the child for review and the likelihood of continuity of medical care from another health provider who could be expected to monitor the child

CONDUCTING A PHYSICAL EXAMINATION

The format for physical examinations and assessments was usually led by the paediatrician. I noted variation between sites and from one doctor to another as to which dimensions were usually covered. Firstly, the content of assessments appeared to be influenced by the composition of the assessment team. In this study, comprehensive assessments were usually completed by paediatricians working in a public health facility who most often reported being supported at least by a nurse. Examination tasks would then be shared. In some sites, children were first assessed by a paediatric registrar, who then discussed the child with a paediatric consultant. In other sites the paediatric consultant took a very proactive role.

The paediatricians here...talk to the schools, do visits, do a lot of hands on work. I think the service the children get here is high quality. The foster parents are not dealing with a registrar (12111:3).

Some paediatricians could routinely call on a social worker or psychologist to be involved in health assessments. Geographical location was relevant to the availability of health professionals.

The intensity of multi-disciplinary involvement varies...I do my (outreach) clinics by myself. I don’t have a psychologist or social worker or speech pathologist ...with me (122311:7).

Budget and workforce availability also restricted the size of the assessment team.

"...the Rolls Royce assessment is two hours of multiple allied health (professionals) doing assessments we just haven’t achieved that (121711:11).
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The nature of physical examinations depended on the clinician. Some doctors examined all body surfaces, as recommended in the AAP guidelines. Others would only examine a child undressed if they had a particular reason to.

*We only examine babies undressed up to 12 months old. We would not undress an older child unless there was some concern that maybe they had bruising or something like that...We would not do it routinely (12179:6).*

Examination of all body surfaces...that only happens sometimes, depending on the age of child...not routinely (12225:9).

If a child was under-immunised, practice varied as to whether immunisations were given as part of the assessment.

*We talked about opportunistic immunisation and I was willing to do that. But what we found out early on was...at every consultation...those children will say ‘are you going to hurt me?’ So we have made sure we don’t...we have actively made a decision not to that because it is traumatic enough, and there is so much to worry about that we have been very careful to say anything we do here won’t hurt you and that’s been really important (12247:10).*

Health professionals in both cases placed considerable importance on the suitability of the physical settings for comprehensive health assessment. Where these were designed for the purpose, they were greatly appreciated, as it was felt the setting enabled better assessment.

*We have a large, refurbished family interview room...with lounges...a coffee table...cushions...children's play tables and chairs...age appropriate toys set up for developmental assessment (12239:12).*

In some cases, publicly employed health professionals used their own discretion about where they conducted health assessments.
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Well, I seek out my own (facilities)...I try to keep the carer’s location in mind so they don’t have to drive a zillion miles...I have my own hands-on equipment...I know what (facilities) are in the area I am going to work in and I take what I need with me 12231:13).

The particular needs of children for a tailored health service environment after abuse or neglect was described as follows:

The children, very often, are not able to regulate (themselves)...so they need an environment that says safety...it needs to be somewhere they don’t feel tense to come back to...simple in the layout...low key, soft, able to keep everything down to a minimum. It’s safe, quiet and predictable (12215:18).

There are separate examination and interview rooms...we are very aware that children can pick up on things and not to upset them by talking about things that might hurt them in front of them. So if that is the case we will somehow arrange to speak away from the child (12217:4).

ADMINISTERING SCREENING

I observed considerable variation in the use of screening tools as part of comprehensive assessment. Tools may include standardised instruments or alternative aids and prompts developed locally.

It probably varies from doctor to doctor. I might use a Denver Developmental Assessment. We also have some cheat sheets developed here over the years...we used to teach registrars...Just very basic...because really we are doing a very basic developmental assessment (121927:10).

Lack of training and lack of time were among the reasons put forward for not using standardised tools.

I wasn’t trained in developmental paediatrics so that is one of the gaps...I have looked at the training for them and taking a whole week out of the practice...I don’t think it is worth it...At the end of the day I am not going to have time to apply them...The SDQ we gave up on a long time ago because I didn’t even get the time to go on the internet to score it...it just wasn’t really practical (12113:27).
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Where the use of standardised tools was routine practice, they seemed highly valued.

*Assessment and treatment I think are intimately linked. We are trialling some assessment tools, in particular...the Assessment Checklist for Children (ACC). I quite like administering it and would use it to talk to carers...as a point of finding information (12213:9).*

*The ACC is very helpful. I am constantly surprised at the number of things it records that carers and parents don’t think to tell you when you ask...like sexualised behaviours or children saying they want to kill themselves, or children hurting themselves...for some reason it seems to be easier to report on one of those and they do (12215:15).*

The Strengths and Difficulties questionnaire (Goodman 1997), Ages and Stages (Squires, Bricker, & Potter 1997) and Child Behaviour Checklist (Achenbach, & Ruffle 2000)) were the most frequently reported tools used. Efficiencies were achieved by having carers and case managers provide completed questionnaires prior to the assessment. These were then scored by a nurse or other allied health professional to save time for the paediatrician. Where multi-disciplinary assessment teams incorporated a psychologist, it was more likely that secondary level screening tools would also be used to screen for adaptive skills, learning difficulties or other specific concerns.

**REFERRING FOR ADDITIONAL SCREENING OR ASSESSMENT**

Where difficulties or developmental delays were identified in a comprehensive assessment children were referred for further, specialist assessment. Speech and language assessment, audiology, optometry, psychology and psychiatry were more often mentioned. Genetic testing may occasionally be ordered to aid diagnoses. Tracking of any further assessments ordered and the outcomes of these for the cohort of children in OOHC however was less common. Where tracking occurred, data was available on the number of referrals per child and the types of services to which the child had been referred.

**FORMULATING DIAGNOSES**

The link between the availability of the child’s medical history and the doctors’ ability to form diagnostic opinions was often repeated. Commenting on what it is like to examine a child without knowing sufficient of their history was described by a paediatrician as follows:
It is like you are providing a veterinary service (122311:9)

**PRESCRIBING TREATMENT OR OTHER INTERVENTIONS**

An important issue for health professionals in deciding on treatment was the question of how it would be paid for.

You might want to try a medication...and you have got to get approval from Child Protection...Medication that is not on the Pharmaceutical Benefits Scheme...those kids often miss out (12255:2).

A lot of the time carers say “we need help right now so we will pay for it anyway”...sometimes the Child Protection Department relies on carers being very compassionate and doing things for the needs of the children (12223:12).

There is an expectation that the Health Department needs to pay for specialist services or orthodontic work that we don’t provide. So there are some very interesting boundaries around whose role it is (12243:25).

Financing concerns were a symptom of overall concern about the provision of treatment.

I don’t think the problem is assessments but...no or limited supports after that (122111:4),

**PROVIDING ADVICE TO OTHER PARTIES, INCLUDING THE PRIMARY CARER**

Consistent with the recommendations from medical professional organisations, it was common for participants to consider advice or support to the carer as part of the child health assessment task.

One of my jobs...is that spontaneous education that will help the carer...they are asking for that...They are beside themselves...We are offering some re-assurance...that frankness...you know, Mum was Hepatitis C positive so at 18 months let’s have that checked...that can be very reassuring to our carers...looking out for placement breakdown is part of what we do as well (12239:20)
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RECORDING AND DISSEMINATING ASSESSMENT FINDINGS

My observation was that all health professionals were willing to share a record of their health assessment findings but there was no consistent format used across a state or even across most sites. Paediatricians demonstrated a strong preference for adhering to their usual practice of professional letter writing. They varied as to whether such letters had standard headings and whether they would report nil findings in any particular domain. Diagnostic opinion formed a core element of reports.

*Paediatricians just do their own assessment. They tailor it to the child. Each one would look different. Their letter reflects what they find (12111:8).*

“But we always get information from multiple sources and I certainly write reports that represent more of a formulation of diagnosis rather than just a categorical diagnosis - the DSM-IV - because I think it’s important to capture not only categorical diagnosis but dimensions and more of a psycho-social formulation that’s probably more commonly used in mental health to properly represent the complexities and factors that are at play in these children” (121711:5).

As discussed earlier in relation to child health histories, there were widespread sensitivities around what information would be passed on to carers, with health professionals very aware that Child Protection authorities may withhold information from carers. One way of overcoming concerns about information sharing was for health professionals to provide hand-written and verbal summaries to a carer at the end of the assessment.

*We give the carer and the referrer a little handwritten summary...a brief summary report and the data (the appointments, phone numbers and things to follow up with) so they have got it. We type up the proper report afterwards (12215:10).*

*They formulate some recommendations and they would talk to the carer about what those are likely to be (12233:6).*

Among the health professionals, the transfer of comprehensive health assessment reports was not always seamless even within the health sector itself. One OOHC Health Coordinator commented that on occasion their only method of obtaining a copy of a paediatrician’s report was via Child Protection.
SYSTEMIC ANALYSIS OF STEP 3

All elements of my model system for the step of comprehensive health assessment in OOHC could be found within the study cases to a greater or lesser degree. A common factor was the leadership of paediatricians and their universal involvement in assessment processes. Once a referral had been received the key means of monitoring and control lay within Health Services. How these were exercised is discussed later in this chapter. At the site level there was considerable local variation in triage processes, the composition of the multi-disciplinary team involved in assessment, the extent to which standardised screening tools were used and the format of assessment reports.
STEP FOUR – HEALTH MANAGEMENT PLAN

SYSTEMIC RECOMMENDATIONS FROM MEDICAL COLLEGES AND ASSOCIATED PUBLIC POLICIES

Medical recommendations identified the key functions of individual child health planning for OOHC as coordination, planning for continuity of health care providers, establishing lines of clinical governance, recording health-related activities and assigning responsibility for them, consolidating child health records and planning for carer support. These are summarised in Appendix C, p. 363.

The usual terminology for the written planning record was a Health Plan (DCSF 2010), Health Management Plan (RACP 2006, APHPC 2011) or Treatment Plan (RANZCP 2009). Clinical governance has been a particular concern of the medical professions, with expectations that a paediatrician or other medical practitioner will lead health planning. Where nurses or other allied health staff were involved in planning, some guidelines specified that this should only be under the supervision of a medical practitioner (DCSF 2010, APHPC 2011).

BOX 8.4: CONCEPTUAL MODEL FOR HEALTH MANAGEMENT PLANNING

In my conceptual model, described in Appendix C, p. 366, the planning system comprises of a Child Health Management Plan developed by health professionals and the designation of a named person as the health care coordinator. The coordinator would have responsibility to track the implementation of the plan, to address any implementation barriers and to continually update the child health record. The coordinator would also ensure that the plan was reviewed within the time frame recommended by the lead health professional.

STATE POLICIES AND PROCEDURES

Health management plans were theoretically part of the process of care in each study case. I identified at least three different processes through which a plan might be developed. Firstly, where use of a state government child health record was anticipated (i.e. a Child Health Passport for children in OOHC aged 0-18 years or Personal Health Record for child aged 0-4 years), a GP or other medical officer could make hand-written notes within that record which may constitute a health plan. For example, in the Child Health Passport there was provision to
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record significant findings from health assessment, proposed treatment plans and who had responsibility for these, recommended follow-up, a nominated time frame for this and a list of actions to be taken.

In both study cases, activities relating to implementing health plans appeared to be largely left to child protection case managers or carers who were not participants in this study. In the NSW case where OOHC Health Coordinator positions existed, a newly emerging or future role may include implementation of health plans but initiatives in most sites had not yet reached that stage of development. As with other steps of care, tasks involved in developing and recording a health plan, passing it on to others and clarifying who would implement the plan were complex and variable between sites.

FIELD OBSERVATIONS OF DOCUMENTATION

Health plans in the Child Health Passport consist of a handwritten note by a doctor. These were not however in common use. The more usual form was a paediatrician’s letter giving the findings and recommendations following a comprehensive health assessment.

In the NSW case not only paediatrician’s letters but also locally designed proformas were sometimes used. These were variously named Care Plans, or Health Management Plans. They did not follow a consistent format except in their inclusion of health issues to be followed up, actions which needed to be taken, the naming of who would be responsible and the time frame for actions. In this respect proforma plans seemed more prescriptive than paediatrician’s letters.

FIELD OBSERVATIONS THROUGH INTERVIEWS

In participant interviews I explored experiences of the key activities in health management planning as follows.

DEVELOPING AND RECORDING A HEALTH MANAGEMENT PLAN

Use of standardised formats for health management plans appeared idiosyncratic.

*The forms are a guide for some people. The paediatricians don’t use them...they just do their own assessment. They tailor it to the child. Each one would look different. Their letter reflects what they find* (12111:8).
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We write a letter back to the GP, covering all the points ...in a general medical examination. There is a pro-forma Child Protection...like you to fill out...each time. There is a fair bit of paperwork actually (12255:14).

As reported earlier, the Child Health Passport was not commonly seen or used at the time of this study.

Alternatively, where an OOHC Health Coordinator was available within the local health district, the coordinator may commence developing a written Health Management Plan early in the health assessment process. Commencing with details of the Primary Health Screen such a plan would note any and all subsequent health assessments or treatment planned for a child in OOHC and would build incrementally.

In a third alternative, the health plan was taken to be the written report, often in the form of a letter, completed by a paediatrician or multi-disciplinary paediatric team as a result of a comprehensive health assessment. In the study case where it was expected that the state Health Department would take the lead in developing Health Management Plans, significant confusion and debate was reported over whether a paediatrician’s letter constituted such a plan.

We use a standard health assessment report...we brokered acceptance of the report as a health plan (12237:1).

One site exemplified how they had endeavoured to blend usual practice for paediatricians with new processes for Health Management Plans. A pro-forma had been designed for written letter style health assessment reports which incorporated a section headed OOHC Health Management Plan which had fixed sub-headings. They had also developed a set of well-described local clinical pathways including referral criteria for allied health referrals, immunisations, audiometry and vision testing to improve consistency of planning among clinicians.

Similarly, in the other study case, a paediatrician demonstrated how their usual letter included a management plan section.
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This is how I do my diagnostic letters all the time… I start with trying to identify their specific strengths, attributes and abilities… then the next section is on difficulties… then diagnosis is the next part; that relates to DSM-IV diagnosis… Then the next bit is the management plan (121711:12).

Different approaches were taken to clinical governance in different sites. On the one hand, health planning was to be completed by a medical practitioner.

The coordinator initially was writing up health management plans but was then told to cease doing that, because she did not have the medical capacity to understand what was required (12275:22).

On the other hand, as discussed earlier, in some sites decisions could be made by nurses as to health management plans and whether a comprehensive health assessment was even warranted.

DISSEMINATING THE HEALTH MANAGEMENT PLAN

I was not able to observe whether GPs wrote health management plans in the study cases as they were not among the study participants. Where paediatricians wrote plans, these most often consisted of medical letters which they sent to other parties. Some disquiet was expressed about how well the plans were appreciated.

I do write a medical letter, but I try to use lay terms… I often think they (Child Protection Case Managers) have missed things that have been serious because… they haven’t read the letter (121715:8).

Paediatricians in all settings described following their usual practice of medical letter writing.

I usually get a referring note from a GP so we can charge for the visit through Medicare. So I write to the GP and a copy goes to the OOHHC Coordinator. They forward it on to Child Protection (122311:10).

For the most part, OOHHC Health Coordinators were the people more likely to make some distinction between a Health Management Plan and a paediatrician’s medical report of
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the outcome of a comprehensive health assessment. A plan might have a paediatric report attached to a pro-forma titled a Health Management Plan which held details of further assessment appointments, contact details for other health providers, etc.

The form of a Health Management Plan could also be shaped by who it would be disseminated to. Some types of information were not included, based on an understanding that people other than health professionals would be reading the plan.

We don’t give all that to the Child Protection Department. It is health information...what we do give them is, as we would any parent, a copy of every report that is done. We don’t give them the birth medical questionnaire...all of the background medical history material...that is not our role...we explain to parents very clearly that we don’t provide this information to Child Protection (12221:29).

We have made a decision in the team that we don’t send those letters to the carer, because they potentially have quite a bit of information in them that they may not have previously had access to...We say that if the case worker believes it is reasonable then they can send it to the carer (12233:7).

I observed a range of practices in disseminating a copy of the Health Management Plan to the carer.

Usually you send a copy to the case worker ...but not to the foster parents. You are not supposed to (12255:14).

The written report goes to the case worker, the carer and any other professionals involved in the child’s care (12217:5).

DESIGNATING A RESPONSIBLE HEALTH CARE COORDINATOR FOR EACH CHILD

It was apparent from health professionals that there were nuances around the question of responsibility for health care coordination in OOHC. On the one hand some participants reported a sense of having a watching brief and being willing to hold Child Protection authorities accountable, even where formal case management rested with Child Protection.
I would like to hope that because there is somebody overarching...providing case management...that the children are receiving better healthcare service and addressing their needs. I think this role (of OOHC Health Coordinator) makes community services have more responsibility...because we are making very clear recommendations around what needs to happen (12243:15).

In other cases participants drew a very clear line around responsibility.

The responsibility...sits with...Child Protection, to develop a medical plan around the child, and it is not clear to me really how often that happens (121925:4).

I do a report back to the Child Protection Department and I don’t need to see the child again. It is not my job to chase what the department are doing (121711: 14).

Others reported that they would clearly exercise authority in health matters and were clear that the health service was the lead agency.

(Our role) is to be over the top...people come in and I say “here is what you need to do”...We make some ...determinations around the needs...and say “go and do”. Then if it doesn’t happen, we then go back to Community Services and say “it is your job to...” (12243:23).

I think our will should prevail. Because if it was a normal parent of a child in OOHC...and they didn’t follow through and the child was being harmed we would be expected to make an application to Child Protection. ...Whereas if Child Protection don’t do it, then who can you notify? They are abrogating their responsibility. I think it should be their responsibility to follow through...or stop bringing them back to us. (12255:10).

I developed a sense of an implicit and largely unresolved distinction between the potential range of people who should have responsibility to undertake discrete activities within a health management plan and ideas about overarching responsibility to ensure that plans were enacted.
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SYSTEMIC ANALYSIS OF STEP FOUR

The key activities in this step were to develop, record and disseminate a health plan with clearly designated responsibility in relation to how the plan would be enacted. In this study I was not able to observe the extent to which health services could track that children received treatments or further assessments recommended in health plans or assure that children had any aids or appliances they required. What was often repeated was anxiety that when funding for OOHC Health Coordinator positions lapsed after 2013, many of the steps of care may become unsustainable, including tracking of health management plans and reviews. Without planned tracking of outcomes, systemic monitoring and control were visibly lacking in both study cases. It became apparent that ownership of the health management planning system rested at its end point with the Child Protection case manager or carer, except in cases where individual paediatricians or OOHC Health Coordinators took personal responsibility for follow through.
STEP FIVE – HEALTH REVIEW AND MONITORING

SYSTEMIC RECOMMENDATIONS FROM MEDICAL COLLEGES AND ASSOCIATED PUBLIC POLICIES

Health review was envisaged in the medical profession recommendations as a periodic check of the child’s health status and review of the outcomes of any treatment or assessment interventions described in the child’s health plan. This step was also referred to as ongoing monitoring and assessment (APHPC 2011). Medical guidelines varied as to the frequency of periodic checks. The most rigorous guidelines recommended a review 30 days after a comprehensive health assessment, monthly review for infants to 6 months of age, and bi-annual review for all children aged 2-18 years (AAP 2005). Additional assessments at critical times, including change of OOHC placement or return to home, were also recommended. The summary at Appendix C, p. 367 compares the AAP recommendations with recommendations from other colleges which are less explicit.

BOX 8.5 CONCEPTUAL MODEL FOR HEALTH MONITORING AND REVIEW

My conceptual model envisaged that Child Protection would ensure a child returned to the health professional who conducted previous assessments at the time recommended in the health plan. As with other assessments, Child Protection would provide medical history and consent documentation and ensure the child, carer and case manager attended the review. The health professional would review the past and recent health status and the outcome of any assessments and treatments provided. The child would be physically examined and a revised health plan, including any preventive health activities would be developed and disseminated to all parties. These activities are incorporated in the conceptual analysis and model shown in Appendix C pp. 369-370.

Those with power to control this system (Owners in SSM terms) were child protection staff who would have responsibility to track when health reviews were scheduled, make appointments and accompany the child. Health services would also be in a position of power (i.e. Owners) as they would need to make time available for review appointments. Both children and their carers would be beneficiaries.
STATE POLICIES AND PROCEDURES

In the Queensland case it was anticipated that a child’s health plan as set out in their Child Health Passport would be incorporated into their overall OOHC case plan and reviewed at least on an annual basis.

In the NSW case, discussions in the field about the developing OOHC Health Screening and Assessment Pathway model envisaged that children could remain subject to the Pathway for the duration of their stay in OOHC. This meant in theory that no child would be discharged from monitoring by a Health Service while in OOHC. This position was not however accepted at all sites. Some sites had very clear guidelines restricting their own roles in reviews and monitoring and referred children to GPs to take on this role. Other sites felt overwhelmed by the workload of a never-ending number of children being admitted to the Pathway. These issues were the subject of active debate at the time of this study.

FIELD OBSERVATIONS

In the field I observed limited systemic attention to reviews. In the Queensland case reviews were not envisaged except as part of routine care ordered by a doctor and negotiated directly with a carer on an individual basis. Individual health professionals in both study cases recognized the importance of reviews but were limited in their capacity to provide them.

Initially...we were offering review clinics to see whether recommendations were followed through. We found that to be ...unsustainable...not having enough staff to do it (12157:2).

From the health service’s perspective, they are really struggling under their current resources to manage the...huge caseloads...Health Case Managers across the area are managing up to 60 or 70 kids each...managing all their appointment, liaising with carers, producing reports, making sure no one slips through the cracks then doing a review for them...as the kids are increasing, their workloads are only getting larger...I think it is really going to require that they review their service model (12277:10).

Despite health reviews being part of state policy in the NSW case, local Health Services made local decisions as to whether they would provide this. One service clearly stated in its
procedural guide that it would not offer follow-up, ongoing care or annual reviews to children who were provided with a comprehensive OOHC assessment. In other sites reviews were anticipated, but efforts up to the time of this study had been squarely focused on initial and comprehensive health assessments. Anxiety was often expressed about Health Service capacity to manage scheduled reviews.

I am not sure we have got a sustainable system yet. We have already got kids waiting for comprehensive assessment. I have no idea how we will manage reviewing kids (12233:13).

The kids aged 0-5 years are reviewed every six months and then from 5 years up are reviewed annually. So that’s a huge burden for health staff...a huge demand...I think it’s really going to require that they review their service model ...if they don’t get additional resources....I don’t track the reviews from the Community Services end...Health is required to do that....some of them are just desktop reviews, so they may just pull out the last health management plan, identify that there are not follow-up assessments required and contact the carer and the child just to make sure everything is tracking along okay. For other kids they may go back and see a practitioner (12277:11).

In some services, staff were debating whether a child should ever be discharged from health monitoring while they were in OOHC.

One of the things we are looking at is the processes...if we are not allowed to discharge then do we run two spreadsheets? One for active clients and one for inactive...we have a list of active clients that we actually need to be doing things for...psychologically it feels more manageable (12221:38).

Paediatricians told of their concerns about routine monitoring being difficult to rely on and making their own plans of management for children they were concerned about.

Following up and just being the case manager for these kids is another role... we will try mostly to be overarching and take on board these kids (121715:7)
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History and experience has taught me not to rely on others to carry through...I take responsibility for just checking that all the assessments that we recommended...actually happen (122311:11)

SYSTEMIC ANALYSIS OF STEP FIVE

Ongoing monitoring and review appeared to be the least developed step in the cycle of care. Clearly there were cases where paediatricians sought to offer continuity of care but this was more often a personal than a systemic decision. The most frequent phrase I heard in all discussions of all steps of care was “assess and refer”. It was much less common to hear a health professional discuss continuity in how they systematically assessed, treated and monitored children, except in small rural areas where they may be the only possible option for treatment. Sometimes continuity of care occurred almost by accident.

There were times...when I realised that I knew more about the child than anyone else did. I had more continuity and information...than anyone else because it was in my file and I had been keeping records. But there had been such inconsistency or interruptions to record keeping that nobody else knew the story...I would like to think that for most children there is somebody else who had a better database on them than the doctor (122113:9).
SYSTEMIC SYNTHESIS ACROSS FIVE STEPS OF CARE

Methodically exploring the five imagined steps of care which together capture the essential activities for meeting the health care needs of children in OOHC allowed me to weave threads together across the larger canvas of the problematic situation of health assessment. Firstly it was apparent that health professionals owned the problematic situation equally with child protection staff and are able to exercise some but not complete power at every step of care except initial referral by child protection. Along with the child protection managers, they bent and shaped systemic boundaries and activities at the local level, sometimes acting independently of state policy. They could stop activities by refusing to become engaged as both GPs, and to a lesser extent paediatricians demonstrated. Alternatively, they could lead and champion activities. Doctors were the only actors who could exercise clinical governance over how things happen both at formal and informal levels.

Staff who spanned the inter-sectoral boundaries in liaison and coordination roles contributed enormously to relational coordination which was integral to every step. Each step involved mutually dependent activities from each sector.

Some of the variations in approach to health assessment were attributable to the variability of purpose among health professionals which was reported separately in Chapter 7. The extent to which the purpose of reparative care was a driver or indeed was understood between the sectors seemed influential. I found evidence that health professionals did not yet enjoy a common appreciation of the nature or value of their health assessment activities.

Within the health sector, highly motivated staff were struggling to do more with less by building new, managed-care style approaches within a system largely designed for opportunistic health care. With time-limited funding for liaison and coordination functions in one case but rarely with additional clinical workforce resources for assessment or treatment in either study case, health professionals were “robbing Peter to pay Paul” by moving children in OOHC to the head of the public health queue as much as they were able. Health professionals interpreted delays in referring children, the paucity of child health history information, and difficulties in engaging child protection case managers in health assessment processes as showing a lack of understanding about what health professionals need in order to do their job well. Indeed, even a poor appreciation of what that job was.
In both study cases participants reported being disheartened by their failures in engaging general practice in initial health assessments or other steps of care. Participants in this study, for the most part seemed somewhat at a loss to explain why engagement was so difficult. I found a low level of appreciation of the factors affecting GP willingness and readiness which I had identified in an earlier study.

Within the health sector OOHC health assessment was reported as having variable status, dependent on the historical experience of specialist child protection medical services, the presence or absence and relative power of clinical champions, the extent of senior management support and the level of engagement which could be achieved with GPs and paediatricians in both public and private practice. One sign of this variable status was what physical facilities were made available for OOHC health assessment activities. Some sites were well served with modified, purpose designed assessment and interview rooms and appropriate waiting room facilities. In other sites, paediatricians at times spoke of their service being administratively “forgotten” or marginalized. This could manifest in managers failing to accommodate a service in new building plans, health service records systems leaving no capacity to take on additional patient records for OOHC assessment processes, or no clinical staffing being provided to cover leave for holidays, sick days or study days.

Notwithstanding issues of internal status, I witnessed evidence of significant creativity and mindfulness across a variety of sites about the needs of children and their carers. Health professionals created innovative outreach approaches including telephone interviewing of parents, home visiting to OOHC families and outreach clinics. They formed stable multi-disciplinary teams who built enhanced assessment approaches by working together to solve problems and improve quality. They created materials locally to explain assessment to children and detailed information packs for carers. A distinguishing feature among health professionals in each site was the oft expressed desire and intent to treat each child individually and a strong aversion to any sense of ‘ticking boxes’. One paediatrician summed up this philosophy as treating “all of the children, but one child at a time” (121923:11).

I also witnessed widespread variation in ideas about where responsibility was assigned for making health care decisions and coordinating health care for children in OOHC. Assignment was variously to carers, child protection case managers, paediatricians or OOHC
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health coordinators. Decisions around this question appeared to be autonomous among many health professionals, notwithstanding official state policies.

An essential feature of systemic thinking is to examine systemic monitoring and controls. As the following discussion illustrates, I found systemic feedback loops were inconsistent.

SYSTEMIC MONITORING AND CONTROL

It was not my intent in this study to evaluate how states implemented health assessment in OOHC, but rather to explore the human experiences of health professionals in the midst of such activities. I was interested however to ask them about how they or their organisations monitored their own work. From these responses, I learned something about how they were able (or unable) to judge their efficiency, efficacy and effectiveness which are domains of interest in SSM analysis.

In SSM terms efficiency measures can broadly be any measure of output relative to the amount of resources used. Efficiency was rarely mentioned by participants in any global way. However participants did have some sense of what was probably inefficient.

Each local health district is doing a different thing with technology and databases and record keeping. It’s ridiculous…Financial data would be really interesting because there must be so many models out there that could have a huge difference in costs…depending on the new Medicare funding for more complex appointments…the children are supposed to get a referral from a GP but if they don’t …then we don’t bill them…we are actually doing a lot of this (12245:49).

On the other hand, sometimes careful data monitoring led them to identify children in OOHC who were existing patients. This changed the picture around efficiency as not every child referred then represented a new or additional patient.

What really shocked me was the paediatric clinic…doing mapping of the clinic showed that at any one time a third to a half of their clinics are actually for children in OOHC. They just weren’t aware (122511:4).
Furthermore, where data was collected and analysed, efficiencies were sought through targeted service planning to improve the match between services and child health needs.

The data has made us look at...what are we seeing in...terms of oral health? Which age group are we working predominantly with? ...It is about actually meeting the needs of that group...it is OT and speech that are very big for these little ones, so it is about putting capacity into those services...these are the resources we need to be working towards getting, because these are the needs of the kids...we have a lot of four and five year olds transitioning to school so I have been working with the Department of Education....about making sure their learning support team meetings flag these kids...we have got a lot of teenage mums in OOHC...community services wanted to trial having the same case worker for a child and the baby...they are saying how can we negotiate this with health? So there are big picture, sustainable things happening. We know where these kids live...we look at how far they have to travel to get a service...do we need to put in some funding to do an outreach clinic?(122511:25)

Views were mixed as to efficacy i.e. did health assessment approaches work? Many people said they could not judge efficacy.

We don’t have a way of tracking what happens to children after they have finished with us. Our statistics cover who we see and the number of times we see them. There is a case closure code for the reason it was closed (12215:12).

I just don’t know how many children in OOHC have been referred to us. I couldn’t answer that question. I don’t know if there are benefits for the children in the health assessment process. I have never seen the children. I just deal with the paperwork (12241:7).

I don’t think we have reached agreement on what data we want to collect...in terms of what do we need to know...there is a lot of work to be done there ....so we have got a better handle on...their health status....It would be great to create data about the cohort but...there is just no standardised data that is collected...In terms of being able to maintain investment in this area, we ...do need to have a profile of the health status (122311:4).
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Where services were collecting and analysing local data, they felt more (or sometimes less) confident about efficacy.

*We have got this massive, big, huge database. We are recording every time the child sneezes, just about...I am able to...look at the data and break it down separately, for the districts or the whole organisation....I am keeping track of placement changes (12221:28).*

*Out of all the cases that have been assessed, we have only got about 24% with health management plans back...although our coordinator thinks that data is totally out...that they have completed a lot more...I am wondering whether it is a matter of what I am calling a health management plan is different to what child protection are calling a plan...we have always had an issue with this...that is still in discussion between the two agencies (12275:19).*

Others felt they were not able to achieve the results they wanted to as they lacked capacity, not only to deliver timely services but also to evaluate their own activities.

*Our clinic operates a half day a week...we can see two children...the appointment alone is 90 minutes and then you have got all the information gathering, report writing...We get more referrals than we can service...We have at least 40 on the waiting list. Two weeks ago we got 18 referrals in a week (12233:13).*

*It will be interesting to go back and review some of the outcomes...we have not had an opportunity to really do that...We haven’t got a plan for how we will review it. We have got an idea.... We have just been trying to keep ahead...we have a different model...we took the services out to the children...as a clinic model it is a sustainable model...from a financial perspective it is certainly not sustainable in this current financial environment. It would take additional funding....our capacity to evaluate is limited...what we are learning is more anecdotal...refining and feeding back around that (12257:14).*

*We have not systematically kept a note ...about how many children have had middle ear disease or how many have had other things...You would have to go back to the letters and look at them...We have just been asked to provide a service, not to ...manage the service...I am assuming others would be very mindful that we need to evaluate this and to*
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count...I certainly hope somebody is planning to do something with it... It would be so wasteful if we didn’t (12247:43).

I see that data from the individual ASQ and SDQ but unfortunately no one puts it together to provide any kind of population profile for OOHC. ...the information is there. So someone could look at it...we always try to collect data...at the moment there is no plan to evaluate it but we would definitely be doing it at some stage (12217:2).

Local efficacy measures became more refined over time. One common example was altering the day on which the timing began in terms of how long it took to complete a health assessment. While medical college recommendations refer to time from child entering OOHC, health services were finding they had no control over the time taken for child protection to refer children after entry to care. So they counted day one as the day they received a referral (which may sometimes be several months after the child enters OOHC).

Often it will take possibly 30 to 40 days from the time a child enters OOHC for us to get the referrals for health assessment, so we weren’t meeting any of the time requirements...we started to document how long the referral takes to get to us and then try to meet the 30 day indicator as of that day (12253:26).

Another example involved targeted research.

We are doing a research project looking at the referrals we generate from the comprehensive assessments. Looking at the quality of them...interviewing carers and caseworkers to see what they have found useful...looking at the recommendations we made and which were actioned and which ones were not...checking if people read our reports, or understand them (12217:6).

In a further example, a local service had developed a data set that extended well beyond the state level requirements

The state department is really only interested in are we meeting the timeframes? ...They want to know the percentage of children referred who get a primary health screen and who is the provider? How many progress to a comprehensive assessment and who is the provider? How many have a health management plan within three weeks of their
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comprehensive assessment? That is their benchmark. Other measures are at our own direction. How many are returned to their birth parents, are adopted or living with kin? How many over 14 do not consent to health assessment? People from culturally and linguistically diverse backgrounds. Age groups and disabilities. Which service types each child was referred to? I can extract any information about specific health needs (12221:50).

In terms of effectiveness participants were not always able to judge whether long-term aims were being met.

*I have no sense of what percentage of children in OOHC we see...I would not even like to...guess. ...Our standard data sets do not distinguish children in OOHC....someone would have to go through the files and look at their status (122113:19).

*We don’t have any hard data or any kind of evidence that...health outcomes are being directly improved....the initiative has been ...running for about two years...we haven’t even looked at or discussed health outcomes....everybody is saying this can only help...we haven’t any hard evidence (12271:20).

Where local services had invested in evaluation, they had more confidence in their effectiveness

*I did the evaluation. I sent out surveys to all of our kids. What the surveys showed was just beautiful...really good feedback for us (12221:19)

*We have had some positive feedback from carers...they are getting (the child) in to see a specialist...that hasn’t happened before really for them...More health people are understanding the needs of children in OOHC. It has raised awareness...the Health Department has really embraced ...the service delivery aspect for children in OOHC...and made significant effort to ...deliver on...providing access to screening, services and health plans. It is such a huge step forward (12271:27).
CONCLUSIONS

The aim of this chapter was to compare my idealised systemic models of steps of care involved in health assessment and health monitoring with data I collected in the field about how such steps of care are enacted. In doing so I was able to explore the lived experiences of health professionals and policy advisors in a systematic way.

Overall, my idealised models resonated with the features of systems I saw in operation, notwithstanding that systems in some sites lacked sophistication. A further conceptual model could have been developed solely for triage activities as a system. I had not been alert to the variety or significance of triage activities when I designed this study.

In the field I identified some key systemic features which warrant further accommodation of views among those working in OOHC health assessment. Firstly, if the centrality of the child health record at every step of care was better understood then more creative solutions may have been developed to the problem of paucity of information, the lack of information continuity and the barriers to sharing child health information with carers and between professionals. Secondly, if the health burden associated with child maltreatment and the goal of reparative care was more strongly shared then barriers to treatment which include waiting lists of up to 12 months in some cases would have been addressed. Thirdly if the link between systematically assessing the health needs of individual children in OOHC and the opportunity to build a coherent picture of the health status and health needs and treatment of this cohort of children in Australia was better appreciated then data management systems which were fit for purpose would have been put in place. Fourthly, if the additional and more chronic health needs of children who have experienced maltreatment were better appreciated, then greater attention may have been given to creating additional service options beyond linking children to usual, opportunistic health care.

Lastly, I bore witness to the great complexity of health assessment in OOHC. The four steps of care from Initial Health Assessment onwards in the continuum each involved sophisticated and multi-layered clinical decision-making by health professionals and generally assumed, both in theory and in practice, that these activities would be led by a GP or paediatrician. Health assessment and monitoring were also made complex by the interdependence between the child protection and health sectors. I concluded that gains
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which have been made through employing staff whose work constantly spans these sectors on behalf of individual children are at risk if not recurrently funded. All sites I visited reported such staff were working beyond capacity and demands on them were continuing to grow. Service enhancement and future security of resources were seen as vital for expansion to cope with the complexity and the increasing numbers of children being referred.

DISSEMINATION

These findings were included in an invited presentation which was digitally recorded and can be viewed at http://www.gp.unimelb.edu.au/about/people/student_susanwebster.php


Findings were also summarised in a poster presentation as follows:

Webster, SM., Temple-Smith, MJ. When impassioned pleading for improved health service access is not enough: exploring factors that aid or inhibit Australian health professionals in managing the health of children in out-of-home care. Poster presentation; XIXth International Congress on Child Abuse and Neglect, September 9-12, 2012, Istanbul, Turkey.
CHAPTER 9
FACTORS AFFECTING HEALTH PROFESSIONALS ENGAGED IN
HEALTH ASSESSMENT IN OOHC IN AUSTRALIA

“...all the many threads of the thesis are woven into a golden cloth” (Thomas 2005 p.87)

This thesis has examined health assessment for children and young people living in home-based OOHC in Australia. It reports the results of the first multi-centre health policy and systems study to explore the contemporary experiences of health professionals with direct involvement in a continuum of health assessment and monitoring processes for the OOHC cohort. The continuum spanned five steps from gathering of a child’s health history to ongoing monitoring and review of health and development. My aim in this study was to better understand the complexities of health assessment in OOHC by identifying systemic and policy factors which inhibit or enable the work of health professionals from their own perspectives.

If the thesis can be imagined as Thomas’s golden cloth, then the key strands in the weft of the cloth came from diverse skeins. The strongest strands were firstly the appreciation among medical professionals of child maltreatment as an important determinant of health. This appreciation stood in contrast to the relative silence on child maltreatment in Australian policy discussion about health determinants. A second and reinforcing strand was the congruence between recommendations by Australasian medical colleges about health assessment in OOHC and the recommendations of similar bodies in the U.K., U.S. and Canada. All shared a strong concern about the determinative nature of abuse or neglect over the life-course development and health of children. Health professionals involved in health assessment in OOHC were attempting to enact these recommendations in a complex social environment where the broader issues around child maltreatment, child health, health need and health measurement were unstructured and ill-defined.

Consistent with historical precedents, I found social and political goal setting was complex and disordered in relation to health needs in OOHC. It was an ongoing source of angst
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in public administrations with successive public inquiries and audits castigating governments for their shortcomings as health-promoting, corporate parents. In fact, inquiry reports and research agreed that health had been largely ignored as an outcome worthy of public accountability in OOHC. In research and in practice, the issue of child health struggled for attention in the labyrinth of contested, wicked problems in the field of child protection.

One of the vital but thinner strands was the nature and extent of health need in the OOHC population. A paucity of Australian research and of record keeping or health monitoring in OOHC had left governments without a key handrail of policy: that of data. Available research, although relatively scant compared to the US, supported the view that children in care were more likely than average to experience significant levels of complex health concerns and added strength to the calls by the RACP (2006) and the RANZCP (2009) for systematic, individualised needs assessment. These calls emerged from a developing understanding about a higher prevalence of physical, neurological, developmental, psychological and behavioural difficulties compared to the average child in Australia (Nathanson, & Tzioumi 2007). Lack of routine health checks, underimmunisation, poor oral health and undiagnosed or untreated conditions were also more likely.

Concerned for both the short and longer term impacts of child maltreatment on health and development, health professionals pushed for a resurgence of emphasis on child health in OOHC as a health issue, not just a social problem. Australian researchers urged investment in further clinical specialization and training in recognition of the complex psychopathology observed in children after abuse or neglect. Scant research investment in Australia relative to that for other child health problems and inadequate health service capacity to meet existing clinical needs were at the heart of advocacy for further research and service expansion. This study identified an apparent absence of a unifying thread in Australian research about health in OOHC which appeared a symptom of the larger issue of competing paradigms.

Unlike England there were still both inter-disciplinary and inter-sectoral ambivalence in Australia as to the proper governance of health matters. The debate encompassed ideas about whether ‘good enough’ parenting by voluntary carers along with opportunistic health care as it was available in the broader community were sufficient to meet needs, or whether more specialized care and health management plans monitored by health professionals were required. One of the signals of this ambivalence was the soft approach taken by the Australian government in the face of external criticism of inadequate enactment of the children’s rights
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to reparative health care after child maltreatment. No Australian state could claim to have a robust and sustainable system for meeting health needs in OOHC. What was not well understood was why.

In my exploration of the history of the medical profession in health care of children on the public common which unfolded in Chapter 3, I found that doctors have not been the foot soldiers of governments or public policy. Rather, doctors have been instrumental as leaders, opponents and rebels. Their professional interests have been shaped by benevolence, clinical curiosity, scientific endeavor, career development, clinical research, population health ideas and concerns for social good and equity. Doctors have taken upon themselves not only the role of healer but of child advocate. At the same time there have always been medical colleagues who have averted their gaze from the whole issue of child maltreatment. Historically, doctors who have championed the cases of maltreated children have unwittingly attracted both admiration and vehement criticism, most often seeking neither as they focused on the child.

These ideas contributed two further threads for the weft of the cloth. Firstly it would be naïve of governments to take a mechanistic or instrumental view of the role of doctors and other health professionals in policies about health assessment in OOHC. Professional purposes, judgement and will are individual matters, more influenced by peers, training and clinical experience than by public policy. Secondly, not only do doctors have a unique role to play in clinical governance but their knowledge and skills, their professional roles and identity and their beliefs about the consequences of their work are important influences in bringing about quality improvement in health care. Messages from research and the recommendations of medical colleges in Australia, U.S. and U.K. were clear that health professionals believed individualized, systematic health assessment was warranted in OOHC, notwithstanding the cost. Views were strongly put about the need for service expansion in health systems to meet the particular needs of children in OOHC. Calls for enhanced training to build specialized clinical competencies and further research around assessment methods and evidence-based interventions had increasing support. Furthermore, doctors had sufficient power and professional autonomy to stop, start, block, enhance or lead initiatives to improve health assessment in OOHC.
From a public policy viewpoint I identified three clear gaps in knowledge in Australia which required further research. Firstly, the broad extent and exact nature of children’s health needs in OOHC were not known. Research from single-site studies with relatively small samples of children suggested significant need. However the quantum of need for the OOHC population could only be guessed. Secondly, in terms of children’s rights to the highest attainable standard of health and to appropriate health care for rehabilitation from maltreatment, Australia lacked data to assess the availability, accessibility, acceptability or quality of health services to enact those rights. As a consequence it was not surprising that appropriate health service configuration was as yet unknown. Thirdly, the reasons why governments in different jurisdictions had failed to gain traction in addressing health in OOHC were not well understood. Given the unique position of doctors and other health professionals there seemed to be a considerable gap in knowledge about what enabled or inhibited their work in this field.

Hence the purpose of this research was to bring the perspectives of health professionals to the public administration table. Peter Checkland argued that action to improve a problematic situation is always best thought about in terms of managing relationships. (Checkland & Scholes 2007). My hope was that a greater appreciation of the needs and values of health professionals in the problematic situation of health in OOHC could contribute to better managing inter-agency relationships in the field of health care for children who have been maltreated. In order to explore experiences in the social word, I used an embedded case-study approach (Stake 2006) to collect data from 9 organisations (incorporating 12 geographical sites) across two states of Australia with large OOHC populations. Case study data comprised (a) observations from site visits, (b) my analysis of recordings from 47 semi-structured interviews I undertook with health professionals and policy advisors spanning 10 disciplines, and (c) my analysis of policy and procedural documents from state jurisdictions and local sites.

This thesis contributes some new insights about health assessment in OOHC. Two emergent conceptual themes related to how health is defined and the extent to which ideas about the purpose of health assessment are congruent and cohesive. I have argued for greater attention to these core concepts and further discussion and debate towards more coherent consensus statements for the guidance of the field.
A systemic analysis of the steps of care involved in health assessment demonstrated that disparate ideas about purpose, coupled with environmental constraints contributed to virtual cycles of “assess and refer” rather than continuums of care with reparative treatment and continuity of health provider as the cornerstones. Diffusion of effort and lack of clarity in inter-sectoral coordination can be inherent risks where human activities are at cross purposes. I found a synergy between conceptual models of steps of care associated with health assessment and the steps which health professionals both value and strive to implement in everyday practice. The results provide a compelling illustration of systemic complexity and interconnectedness. Across all steps of care the study results show that much hinges on the efficacy and effectiveness of the first step of collecting and sharing child health histories. In this first step health professionals found themselves in a dependent relationship with staff from the child protection sector whose roles included gate-keeper, referrer, family liaison officer, child case manager and corporate parent. This dependence exemplified a recurring theme in the everyday experiences of health professionals: the contrast between usual processes of patient care and the greater complexity of health assessment steps in OOHC.

Health service configuration must better recognize the multi-faceted and long term nature of recovery from maltreatment and the nature, purpose and timing of therapeutic services (Rees 2011). In this study health professionals in general, and paediatricians in particular, lamented that continuity of health care was not usually built-in for children in OOHC and that waiting several months for the next usual appointment for comprehensive assessment or a therapeutic service was not therapeutic after maltreatment. While a strong case was argued in medical college recommendations for children in OOHC to have health care continuity or a medical home, I found little evidence of intent to implement this in the Australian case studies. A medical home would be a place of medical case coordination. Rather, I found a default position where medical case coordination was as likely to be delegated to a child protection case manager or carer without medical training as it was to a health professional.

Consistent with findings about poor continuity of health care were new insights from this study about the variable appreciation in state policies and procedures of the sophistication and complexity of the clinical tasks and clinical judgements involved in health assessment in OOHC. This was reflected in several ways. Firstly, policy intent in the case studies was diverse. In one case the state government had no expectation of comprehensive, multi-disciplinary
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health assessment as a routine approach. In stark contrast, specific investment in the other case was producing a thoughtful, emergent state-wide clinical health pathway for comprehensive assessment within publicly funded health services. In both cases most study participants were unfamiliar with the National Clinical Assessment Framework for OOHC (albeit that the framework had only been published a few months prior to the study commencing).

Secondly, the study shed further light on the critical importance of the child’s medical history to health professionals and the apparent lack of appreciation of this in public administration systems and child protection agencies. When children entered OOHC, details of their medical history and family medical history are often missing, along with an intuitive parental appreciation of the child’s health and wellbeing which is a cornerstone of a usual paediatric consultation. A detailed examination of information fields, methods of obtaining histories, storage processes and barriers to information sharing has woven important threads into the cloth of this thesis. The questionable success of carer-held child health records reported in the US (Leslie et al., 2003) and the U.K. (Mooney et al., 2009) was confirmed in this study where I observed infrequent use of Child Health Passports. A tangle of other issues included disparate ideas about essential versus non-essential health information, a plethora of controls over information exchange (often associated with privacy protections) and parallel written vs oral processes for information sharing. Concerns about inadequate capacity to support comprehensive health records management for OOHC within existing IT-based client records systems were widely reported. From an inter-sectoral perspective, a fundamental tension exists around child health records. Child protection processes are premised on an expectation of parental responsibility, including responsibility for health care coordination being returned to parents as soon as practicable, at which time a child’s file is closed. In contrast, from a health professionals’ perspective, the health history file for a child who has experienced maltreatment is never, and should never, be closed (Krugman 2012).
A third factor indicative of lack of appreciation of the health professionals’ task was a policy expectation that initial health assessments could easily be completed as part of usual care in general practice. Not surprisingly these expectations were frequently disappointed at the local level. The case studies revealed significant issues in engaging GPs in implementation of assessment processes. This resonated strongly with results from an earlier study in Victoria (Webster, & Temple Smith 2010). While staff in some sites developed effective integration with individual local GPs, those in other sites were so frustrated by their lack of success that they bypassed GPs and developed alternate processes such as nurse-led clinics. The clinical governance issues associated with alternate processes which lack medical practitioner involvement will undoubtedly surface over time, as they did in the U.K. (Mooney et al., 2009).

Inadequate measurement and data emerged as areas of significant systemic weakness in the Australian case studies. Diversity was evident in dimensions of child health assessed and of screening tools. Site-specific policies, the usual practices of different health disciplines, and the clinical discretion of individual health professionals all contributed to variability. Furthermore, only isolated examples emerged of investment in mapping health status and health needs of local cohorts of children in OOHC. Although I identified a lack of data about realized access to health services for children in OOHC, I heard repeated concerns about barriers to access to treatment after health needs assessment. Issues reported as inhibiting access were consistent with those found in the U.S. (Premji et al., 2005). Prohibitive out-of-pocket costs for health services, transience in OOHC placements, gaps in local health service availability and long waiting lists for publicly funded services, ambiguity of responsibility for health coordination and difficulties in inter-agency exchange of child health information were widely cited. The reliance on child protection case managers to coordinate provision of recommended health services could also inhibit access which was consistent with earlier findings about the centrality of the case management role (Tarren-Sweeney 2010a).

I argue that a key strength of this study was the strong emergent voices of health professionals, unique in current Australian research in OOHC. Through site visits and individual interviews I was able to enter the everyday world of health assessment in OOHC and hear directly the stories through which health professionals were making sense of their work. This privileging of world views was enabled by the use of soft systems methodology.
A second strength was the multi-case approach and purposive sampling which resulted in the collection of rich participant insights, not only into factors that help or hinder health professionals but into what they value, the costs of compromise and their ingenuity in problem solving. Themes emerged which transcended a variety of sites and jurisdictions and which resonated across disciplines, thus enhancing the generalisibility of the study findings in Australian home-based OOHC contexts.

Thirdly, systematic comparison of everyday practice against theoretical models added rigour to the inquiry. I found a strong synergy between my conceptualized steps of care and those I witnessed in action across various sites, notwithstanding that the steps occurred with variable degrees of sophistication. There is scope to further conceptualise triage in systemic terms which I had failed to anticipate in the design of this study. I also believe there is scope to use these conceptual models for further studies to inform development of data collation and general systemic monitoring approaches.

There are several limits as to what can be generalized from the findings of this study. Firstly, specific health assessment initiatives for Indigenous or refugee children, those with health conditions which would entitle them to specific disability services or children in residential OOHC were outside the scope of study. Such initiatives may present alternative or additional issues for health professionals. Secondly, health professionals working in adolescent-specific health services were not identified by participating organisations and hence were not among the study participants. There are likely to be unique experiences in these settings which are not reported in this thesis. Thirdly, although there were important prescribed health assessment roles for GPs in state policies, efforts to recruit GPs to this study were not successful and their voices were therefore unheard. Fourthly, health professionals who lacked experience of health assessment in OOHC or who were opposed to such an approach were not included in the purposive sampling for this study. Alternate views as to the desirability or practicality of health assessment were therefore less likely to be captured. Notwithstanding these limitations, the study has added new insights and an enhanced depth of understanding about what health professionals in Australia need in order to make the most effective contribution to health assessment in OOHC.

A central question arising from this study is whether systemic approaches which aim to deliver a continuum of appropriate and reparative health care for maltreated children can best
be delivered with minimal adaptation of existing health service configurations. It could be argued that, challenging though they are to implement, policies to award children in OOHC priority access to health care, to employ OOHC Health Coordinators and to develop clinical pathways are essential but minimal adaptations. Strong feedback arose from the study that without recurrent funding even these minimal adaptations are at risk of being unsustainable. A desire to provide health care in close geographical proximity to the child had strong support from participants in this study. At the same time, experienced health professionals argued for specialization in clinical competencies and further development of multi-disciplinary teams, along with ongoing training and research to better meet the complex and chronic health needs found in OOHC. These specialized paediatric functions are more commonly centred in tertiary hospital settings in major cities and provincial centres. I observed some efforts to provide outreach clinics from such centres so that health professionals rather than children were doing the travelling, with mixed results reported. Outreach approaches certainly warrant further study.

If improved access to local generic health services falls short of meeting the goal of reparation of potentially long-term health consequences of maltreatment, can Australia afford to hold on to the local service focus? Policies based on local service delivery were also strongly based on a lead role for GPs in initial health assessment and ongoing health case management. The results of this study taken together with my earlier study (Webster, & Temple-Smith 2010) indicated that in the three largest Australian states state government engagement of GPs in improved health assessment and continuity of care for children in OOHC was problematic. While the National Clinical Assessment Framework has clarified a financing base through Medicare subsidies for GP involvement in health assessment in OOHC, the lack of a national implementation strategy for the Framework through Medicare Locals or the Royal Australian College of General Practitioners has left state governments unsupported in their efforts at GP engagement.

Another central question for governments is whether the contemporary philosophy that good enough parenting by a substitute parent who coordinates opportunistic health care through the gateway of a local GP is really adequate to meet the greater prevalence of chronic and complex health problems found among children in OOHC. The results of this study suggest that what is required to identify and address these complex needs are in fact sophisticated, tailored systemic approaches spanning both the child protection and health sectors and
HEALTH ASSESSMENT IN OUT-OF-HOME CARE

creating sustainable pathways beyond usual health care in the community. Health professionals in this study reported being acutely aware of some unique needs of both children and carers which require more than usual care. The additional length of paediatric consultation time required is just one simple example. Health services with the capacity to provide timely, evidence-based interventions and treatments for children in OOHC and to evaluate their efficacy is another. Development and provision of health services that move beyond usual care for maltreated children depend on clinical leadership, political and policy support, an adequate research base, financial creativity and vision. In some sites I visited these were the features that stood out. Service re-configuration to meet the longer term health needs of children in OOHC will require sophisticated and complex health policy and systems problem solving by Commonwealth and state governments. Certainly this is not something that can rightly be expected of child protection authorities which have different capabilities. Currently however there is an enormous reliance on child protection agencies to collect child health histories, initiate referrals for health services and accompany children to medical appointments. Health professionals in this study observed first hand the great challenges for child protection agencies in completing even these tasks.

Checkland’s methodology is useful in assisting identification of those who can exercise power to bring about change. It is also useful to focus on how the efficiency, efficacy and effectiveness of alternative systemic approaches might best be measured from particular world viewpoints. In summing up the results of this study I propose that health professionals have unique clinical and leadership powers to bring about change and vital perspectives which need to be better appreciated within public administration in Australia. Health professionals in Australia currently lack adequate data to draw conclusions about current systemic approaches to health assessment in OOHC or even to properly establish the nature and extent of health needs in OOHC populations, both met and unmet. Questions of efficiency, efficacy and effectiveness currently appear unanswerable but are worthy of deliberate and robust thought and debate among health professionals. So too is the fundamental conceptual question of a congruent health definition for children who have been maltreated that can clearly guide health assessment processes and support a shared understanding in the health and child protection fields about the purpose of health assessment.
Several arguments have been put for health professionals working towards more conceptual coherence. Firstly, emerging medical science is contributing new understandings about child health vulnerability (Keenan 2013). Secondly, while clinicians are confronted with child rights concerns in everyday practice, coherent ideas about how best to respond can help clinical practice and assist health professionals to manage the vicarious trauma of challenging cases (Waterston 2005, Raman, Wolfenden, Williams, & Zwi 2007). Thirdly, there are ongoing debates in the child protection field about which paradigms are the most useful. Coherent medical voices are needed to reinforce that child health and wellbeing are the pre-eminent goal in child protection (Bennett et al., 2009).

The UNCRC principles are consistent with medical ethics (AAP 2010, Reading et al., 2009) and children’s rights to reparative health care after maltreatment have underpinned this study. I argue that in bringing health professionals views about service design policies and practices to the fore, the study contributes to the formation of the “coherent vision within which rights-based practice will flourish” as Connolly and Ward (2007 p. 175) so strongly advocate.

If this thesis was a golden cloth I would offer it to medical leaders in Australia to reinforce their advocacy banner on behalf of children in OOHC. One doctor in this study discussed with me the experience of occasionally feeling overwhelmed by the vicarious trauma of caring for maltreated children and shared with me a guiding philosophy of “treating all of the children, but one child at a time”. I subsequently heard this repeated in many different forms. The role of health policy and systems research is to bring to the fore the voices of health professionals whose energies are consumed with the provision of individualized, personalized and skilled care. Many voices contributed to this thesis. To these health professionals and the policy advisors who work with them I express my thanks.

A succinct summary of what I have found about the key factors that inhibit and enable the work of health professionals in assessing and monitoring the health of children in out-of-home care in Australia is given at the conclusion of this chapter in Box 9.1.
1. In policy and practice, current definitions of the concept of health for children in OOHC show neither sufficient appreciation of the interplay between the impacts of different types of maltreatment on child health, nor sufficient congruence to support robust systems for health assessment. Put simply, we have not reached sufficient agreement on what to assess.

2. Incongruent ideas about the primary purpose of health assessment in OOHC fall along a continuum, from improving short-term access to universal health services, to longer-term change in child health trajectories through the provision of reparative health care. This incongruence has contributed to sub-optimal health policy and systems development.

3. At the intersection of child protection and child health policy and planning in Australia a broad deficit is evident in the extent to which child abuse and neglect are appreciated as significant determinants of health through the life-course. The work of health professionals is hampered when public policy fails to adequately characterize the impacts on children of child abuse and neglect as health-related as well as social problems.

4. Clinical decision making required for child health assessment and health monitoring in OOHC is sophisticated and complex. Health professionals recognize this as an area of clinical specialization and value doctor-led, multidisciplinary approaches. Health professionals resist initiatives, policies or procedures which fail to sufficiently appreciate or acknowledge the level and nature of clinical judgement involved.

5. The persistent lack of child health histories in OOHC represents a significant clinical barrier for health professionals. Australian policies have yet to effectively appreciate or redress the fact that children in OOHC are adversely affected by a chronic lack of continuity of child health histories and child health care providers.

6. Policies and initiatives which take an instrumental or managerial approach to engagement of health professionals can underestimate the value health professionals place on clinical acumen, independent decision making and professional roles, norms and values. Health policies and systems are enhanced where health professionals play an active part in design, monitoring and problem solving to ensure that services are offered in ways which are consistent with professional values.
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7. Health assessment and health monitoring in OOHC can be understood in systemic terms as involving (a) the collection and management of child health histories, (b) initial health assessments, (c) triage of the need for comprehensive health assessment, (d) comprehensive assessment, (e) the development and implementation of child health management plans and (f) ongoing monitoring and review of health status and health needs. Each of these steps of care involves a complex set of inter-connected and mutually dependent activities which are carried out across both the child protection and health sectors. A lack of appreciation of the complexity and inter-connectedness of these steps of care and their associated activities, either in policy or in child protection or health service operations, can significantly impede the work of health professionals.

8. State and Commonwealth government policies enhance or impede the extent to which publicly funded health services are configured to provide comprehensive health assessment and ongoing monitoring for children in OOHC. Policies with the explicit purpose of comprehensive assessment of health need and targeted human and financial resource allocation to enact policy can enhance the work of health professionals. This thesis argues that without recurrent expenditure on health systems configured to offer more than usual, opportunistic health care in the community, systematic health assessment in OOHC may not be sustainable.

9. The results of this study support advocacy by other Australian researchers for service enhancement to meet the treatment and other therapeutic health care needs of children in OOHC. Health service configurations which leave children in OOHC on long-term waiting lists for important treatment inhibit the engagement of health professionals in health needs assessment activities.

10. Health service planning and responsiveness to the needs of children in OOHC is inhibited or enhanced by the extent to which individual health assessment leads to population health data capture and analysis at the local level. Except in isolated sites, the results of this study indicate lack of data significantly inhibits the development of appropriate health policies and systems for OOHC in Australia.

11. The ‘appreciative field’ of health professionals forms part of the shadow systems that co-exist alongside official hierarchies, policies and management practices. Learning more about how health professionals experience the challenges of health assessment in OOHC provides insights which can enable others to better hear, observe and adapt to working together.
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APPENDIX A

NATIONAL SYMPOSIUM:

AIMS,

PROGRAM

&

REPORT

Prepared by Susan M. Webster as an Appendix to a Thesis submitted in total fulfilment of the requirements of the degree of Doctor of Philosophy, University of Melbourne May 16, 2014.
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HEALTH, HOPE & RESILIENCE
Fostering better health for Australian children and young people in out-of-home care

PROGRAM

Presented by the General Practice and Primary Health Care Academic Centre,
Melbourne Medical School, University of Melbourne

In collaboration with General Practice Victoria and the Office of the Child Safety Commissioner, Victoria
BACKGROUND

New draft national standards for out-of-home care, released in July 2010 by the Commonwealth Minister for Families, Housing, Communities & Indigenous Affairs, mark a turning point in Australian approaches to achieving better health outcomes for children and young people for whom governments have statutory responsibilities. The draft standards propose comprehensive health assessments for all children and young people entering out-of-home care and address ongoing health service provision and health record management.

Diverse approaches are currently used across Australia to resource and deliver health assessments in out-of-home care, including:

- Child Health Passports;
- comprehensive, multi-disciplinary entry to-care assessment systems, involving general practitioners;
- out-of-home care health coordinators in area health services and Aboriginal community controlled health settings;
- assessment in hospital-based Child Protection Units or Child Advocacy Centres;
- formal agreements between child welfare and state health departments;
- specific provision in state health budgets.

It is timely to discuss how such systems are working and how well placed we are to meet new Australian standards.

SYMPOSIUM AIMS

1. To enable sharing of the best available evidence from Australian research and everyday practice about how we manage health needs in out-of-home care, including systems for comprehensive health needs assessment, models for improving continuity of health service and methods of managing child health records
2. To identify factors likely to affect the achievement of national standards for child health assessment and management
3. To identify where increased advocacy is needed to improve access to ongoing health services for children and young people in out-of-home care
4. To discuss minimum requirements for change in health and child protection sectors to meet proposed new standards in relation to child health

COLLABORATING ORGANISATIONS

The Symposium is presented by the General Practice & Primary Health Care Academic Centre, Melbourne Medical School, University of Melbourne, in collaboration with the Office of the Child Safety Commissioner, Victoria and General Practice Victoria. The University appreciates the generous financial support of these organisations and the active participation of their staff in the design and planning of the Symposium.

Health, Hope & Resilience National Symposium: 18 & 19 October 2010
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<tr>
<th>Time</th>
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<tr>
<td>9:15 to 9:45</td>
<td>Welcome: Prof Jane Gunn, Dr Lena Sanci &amp; Prof Glenn Bowes, University of Melbourne</td>
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<td>Opening address: Bernie Geary, AM Victorian Child Safety Commissioner</td>
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<td>9:45 to 10:25</td>
<td>Keynote address: Assessing the health and wellbeing needs of children entering out-of-home care – necessary and sufficient? Prof Graham Vimpani AM, Professor of Community Child Health, University of Newcastle</td>
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<td>10:25 to 10:45</td>
<td>Discussion: Key issues for implementation of Australian standards for better health in out-of-home care</td>
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<td>10:45 to 11:10</td>
<td>MORNING TEA provided</td>
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<td>11.10 to 11.30</td>
<td>Cultural wellbeing and its impact on health</td>
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<td>Ms Yolanda Glenn, Victorian Aboriginal Child Care Agency</td>
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<td>11.30 to 11.50</td>
<td>Health assessment and health care issues in refugee and immigrant children</td>
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<td>Dr Kirsten Walsh, Western Region Health Centre, Royal Children’s Hospital &amp; Dr Georgia Paxton, Murdoch Children’s Research Institute, University of Melbourne, Royal Melbourne Hospital</td>
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<td>11.50 to 12.10</td>
<td>Pigs might fly: challenges of implementing the national standards for out-of-home care in a rural area</td>
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<td>Ms Louise Blanchard, Ms Patricia Preston &amp; Ms Martina Rich, Taree Child Protection Counselling Service NSW</td>
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<td>12.10 to 12.30</td>
<td>Universal mental health assessment for infants when they enter out-of-home care: It’s time</td>
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<td>Dr Nicole Milburn, Take Two Program Berry Street Victoria</td>
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<td>12.30 to 12.50</td>
<td>Health outcomes for young people transitioning from out-of-home care in rural Victoria</td>
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<td>Assoc Prof Philip Mendes, Monash University</td>
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<td>12.50 to 1.50</td>
<td>LUNCH provided</td>
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<td>1.50 to 2.10</td>
<td>Why doctors and child protection workers infuriate each other- the war on the telephone</td>
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<td>Dr Clare Rozniok, General Practitioner and Ms Raelene McKenzie, Take Two Program Berry Street Victoria</td>
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<td>2.10 to 2.30</td>
<td>Discussion: Minimum requirements for Child Health Records in out-of-home care</td>
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<td>2.30 to 2.50</td>
<td>Promoting the physical, emotional and spiritual development of children and young people in out-of-home care in Victoria</td>
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<td>Geoff Jende, Victorian Department of Human Services</td>
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<td>2.50 to 3.10</td>
<td>Initial health assessments for children entering out-of-home care: the benefits of parental involvement</td>
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<td>Ms Julie Prentice &amp; Mr Marcus Coates, Take Two Program, Berry Street Victoria</td>
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<td>3.10 to 3.40</td>
<td>AFTERNOON TEA provided</td>
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<td>3.40 to 4.00</td>
<td>General practice: role and experience as key providers of comprehensive health assessment for children and young people in out-of-home care</td>
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<td>Ms Sonya Trenellen &amp; Dr Hubert van Doorn, General Practice Victoria</td>
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<td>4.00 to 4.20</td>
<td>The Small Talk Project: developing a validated screening tool re hearing, speech and language needs</td>
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<td>Annette Jackson, Take Two Program, Berry Street Victoria &amp; LaTrobe University</td>
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<td>4.30 to 5.00</td>
<td>Keynote address: Ms Fran Thorne, Secretary, Victorian Department of Health</td>
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<td>5.00 to 5.15</td>
<td>Reflections on key research and policy issues: Prof Jane Gunn &amp; Dr Lena Sanci</td>
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<tr>
<td>9.15am</td>
<td>Welcome: Dr Lena Sanci</td>
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| 9.20 to 9.40| Health of Australian children in out-of-home care: health needs and recognition by carers  
Ms Melissa Kallner, Child Advocacy Service, Royal Children's Hospital, Brisbane Qld |
| 9.40 to 10.00| Key Findings from the Child Guardian about health needs and health care in child protection in Queensland  
Mr Barry Salmon, Commission for Children and Young People and Child Guardian Qld |
| 10.00 to 10.20| Good Intentions, Devils and Detail: Health Standards for Children under the Guardianship of the Minister, SA  
Diana Lawrence, Flinders Medical Centre, Lisa Henderson, Families SA & Sue Foster, Child Protection Program, Children, Youth & Women's Health Service |
| 10.20 to 10.45| Discussion: Who should have final responsibility for health needs assessment and health care planning for individual children and young people in out-of-home care: carers, child protection workers, health professionals or someone else? |
| 10.45 to 11.10| MORNING TEA provided                                                              |
| 11.10 to 11.30| Lessons from the Kaleidoscope OOHC Clinic: what have we learned from 200 child health assessments  
Dr Anne Piper & Ms Margaret Ryan, Kaleidoscope OOHC Clinic, John Hunter Children's Hospital, NSW |
| 11.30 to 11.50| A holistic approach to the early assessment of children in out-of-home care  
A Strachurska, Child Protection Unit, Children's Hospital at Westmead & Westmead Hospital, NSW |
| 11.50 to 12.10| Health outcomes for children and young people in out-of-home care in NSW  
Ms Kerryn Boland, NSW Children's Guardian |
| 12.10 to 12.30| Children in statutory out-of-home care in NSW: what do case files tell us about their health status?  
Prof Graham Vimpani & Ms Jenny Marshall, NSW Health |
| 12.30 to 1:15| LUNCH provided                                                                     |
| 1.15-2.30   | Keynote session: Applying the "Best Interests" Principle to decisions about child health in out-of-home care.  
Panel members:  
Dr Maree Crawford, Paediatrician and Snr Staff Specialist, Child Advocacy Service, Royal Children's Hospital, Brisbane  
Ms Annette Jackson, Asst Director, Take Two Program, Berry Street Victoria & Adjunct Assoc Prof, LaTrobe University  
Mr John Tobin, Snr Lecturer, Melbourne Law School  
Dr Hubert van Doorn, General Practitioner, East Brunswick, Victoria |
| 2.30 to 2.45| Key themes for research and policy: Dr Lena Sanci                                    |
| 2.45 to 3.15| Guest speaker:  
Ms Christina Asquini, Executive Director, Children, Youth & Families, Victorian Department of Human Services |
| 3.15 to 3.30| Closing address:  
Prof Glenn Bowes, Associate Dean, External Relations, Faculty of Medicine, Dentistry and Health Sciences, University of Melbourne |
NATIONAL SYMPOSIUM REPORT
HEALTH, HOPE & RESILIENCE:
Fostering better health for Australian children and young people living in out-of-home care

BACKGROUND
“Good enough care is not good enough for children and young people living in out-of-home care. They have a right to the highest quality health care Australia can provide” argued Dr Maree Crawford, Paediatrician and Senior Staff Specialist at the Child Advocacy Service, Royal Children’s Hospital, Brisbane, speaking at a national symposium held on 18 and 19 October 2010 at The University of Melbourne.

The idea for the symposium, which attracted more than 100 clinicians, policy makers, researchers and program managers from around Australia, was initiated by a PhD candidate in the General Practice and Primary Health Care Academic Centre, Ms Susan Webster.

Children and young people living in out-of-home care following abuse or neglect are among the most vulnerable in Australia and are known to experience a range of health and developmental problems.

New draft national standards for out-of-home care released in July 2010 by the Commonwealth Minister for Families, Housing, Communities & Indigenous Affairs, challenge the child protection sector to improve how health is managed for this vulnerable group. The draft standards are consistent with the policy of the Royal Australasian College of Physicians that complete health needs assessment, better health records, improved access to health services and ongoing monitoring are all needed to reduce the burden of complex and chronic conditions.

Mr Bernie Geary AM, the Child Safety Commissioner for Victoria who opened the symposium, called for the development of comprehensive health services tailored to the long-term needs of children and young people in out-of-home care and underpinned by better research and improved data collection.
SYMPOSIUM AIMS

More than 34,000 Australian children currently live in out-of-home care*. The child protection sector cannot address the health needs of this growing population without the expertise, resources and collaborative efforts of the health sector and in particular of our doctors. The aims of the national symposium were:

1. To enable sharing of the best available evidence from Australian research and everyday practice about how we manage health needs in out-of-home care, including systems for comprehensive health needs assessment, models for improving continuity of health service and methods of managing child health records.

2. To identify factors likely to affect the achievement of national standards for child health assessment and management.

3. To identify where increased advocacy is needed to improve access to ongoing health services for children and young people in out-of-home care.

4. To discuss minimum requirements for change in health and child protection sectors to meet proposed new standards in relation to child health.

* Out-of-home care is one of a range of services provided through state and territory governments to children in need of care and protection and provides alternative accommodation to children and young people aged 0-17 who are unable to live with their parents often after experiences of abuse or neglect. Accommodation includes foster care, placement with relatives or residential care.

PROGRAM

"Is it worth the effort and expense to improve health needs assessment and health service access for children and young people living in out-of-home care, especially as most kids in foster care seem healthy enough on a day to day basis and can just be taken to the doctor if they feel sick?" Prof Graham Vimpani AM, Head of the Discipline of Child Health at University of Newcastle and Clinical Chair of Kaleidoscope Children’s Health Network, Greater Newcastle delivered a persuasive response to this question in the keynote address, arguing not only for systematic assessment once children are in care, but also for more attention to these children’s health needs earlier in their life, from the time vulnerability related to abuse or neglect is determined.

In the second keynote session, a multi-disciplinary panel addressed the complex question of how the ‘best interests of the child’ principle should be applied to decisions about child health in out-of-home care.

Panel members:
• Dr Maree Crawford, Paediatrician and Senior Staff Specialist, Child Advocacy Service, Royal Children’s Hospital, Brisbane
• Ms Annette Jackson, Assistant Director, Berry Street Victoria Take Two Program
• Assoc Prof John Tobin, Melbourne Law School
• Dr Hubert Van Doorn, a general practitioner based in private practice in Victoria explored a range of perspectives, drawing on their professional experience and the wisdom of their respective disciplines.

A call for papers attracted wide interest in the symposium with 17 papers being selected for inclusion addressing four key themes:

1. Diversity of age, cultural background and geography among the out-of-home care population and consequent implications for health services design and access.
2. The variety of state-based models for providing systematic health needs assessment.
3. The shared challenges of assuring all eligible children receive such assessments.
4. The outcomes of Children’s Commissioners and Child Guardians monitoring and reporting on the performance of states and territories in meeting statutory responsibilities for the health and well-being of children in out-of-home care.
Much of the research we draw on comes from the US and UK. Short structured sessions embedded in the symposium program provided an opportunity for participants to reflect on and discuss the implications of overseas research findings in the Australian context. These sessions reviewed:

1. Elements shown in the US to have affected the quality of health care for children in out-of-home care such as coordination of care, data and information management systems and family participation.
2. The future minimum features required of child health record systems, for example paper-based records versus electronic records.
3. The testing question of who should have final responsibility for making health care planning decisions for children in out-of-home care, eg. parents, carers, child protection case managers, health professionals or independent advocates, which has been the subject of some significant policy reviews in other countries.

The National Clinical Assessment Framework, currently under development, will be an important future driver of increased cross-sectoral endeavour to address the recognised health disadvantages faced by young Australians in out-of-home care, according to Ms Fran Thorn, Secretary of the Victorian Department of Health, who described these children to the symposium as “our great challenge”.

WHAT DID WE FIND OUT?

There are strong imperatives to improve the way health is managed in out-of-home care in Australia. “Children and young people who have experienced abuse or neglect can’t afford bureaucratic or court delays to keep hampering the timely assessment of their individual health needs”. This was the argument made by clinicians who explained that available evidence about the high incidence of chronic and complex health difficulties and the need for early intervention to address the effects of trauma on the development of the growing child are compelling. Furthermore, from a clinical perspective presenters drew on evidence to support implementing health assessments much earlier in the child protection trajectory, eg. from the time of a first substantiated report of abuse or neglect.

Clinical challenges in assessing the health needs of these children are closely intertwined with both research and policy questions including:

- How child and family health histories can be more effectively collected, analysed, stored and shared among those involved in assuring the child’s health and well-being.
- How to establish the competencies and capacities required to collect and manage health records and to exercise final responsibility for making health care decisions about individual children.
- How processes to engage parents in child health assessment can be improved.
- How to resource high quality comprehensive health assessments which take more time than usual health care. (The average time varies significantly between current state-based systems ranging from a few hours up to one and a half days.)
- How to increase systematic screening using standardised assessment tools both to minimise the risk of health needs going unrecognised and to more effectively identify those children with the highest levels of need for further assessment, treatment and therapy.

Prof Vimpani cautioned that “One group of children at risk of being missed ... are kids with hidden emotional distress, sometimes referred to as ‘closed book’ children or children who are ‘too good to be true’; the quiet children who internalise their pain and distress. They have a relationship style that hides their needs from view. No one misses the disruptive child.”

Importantly, the dimensions of health which are routinely assessed are critical. Cultural health for example cannot be seen as an “add-on” according to Ms Yolanda Glenn from the Victorian Aboriginal Child Care Agency, but “as an overlay, the first and foremost aspect of a child’s health.” Dr Kirsty Walsh from the Royal Children’s Hospital Immigrant Health Clinic argued for careful additional assessment and screening of refugee and other immigrant children who are known to have a higher incidence of communicable diseases such as Hepatitis B and TB and often require catch-up immunisations. The inclusion of positive measures in health assessment and a focus which includes preventive care and health promotion, alongside identification of health problems was stressed by presenters.

Health professionals, carers and case managers involved with managing health for children in out-of-home care need ongoing training and support to understand the health impacts of trauma, avoid misdiagnosis of health problems, ensure reparative parenting and improve the quality of record keeping and health care planning.
WHERE CAN YOU FIND OUT MORE ABOUT THIS SYMPOSIUM AND RELATED ISSUES?

PROCEEDINGS:
The Symposium program, abstracts, audio recordings of keynote sessions and powerpoint presentations are available on-line. Abstracts include references to relevant published research by presenters.
www.gp.unimelb.edu.au/otieringHealthSymposium

PUBLICATIONS BY PRESENTERS NOT LISTED IN ABSTRACTS:

OTHER RELEVANT PUBLICATIONS:
Webster S, Temple-Smith M. Children and young people in out-of-home care: are GPs ready and willing to provide comprehensive health assessments for this vulnerable group? Australian Journal of Primary Health. 2010; 16:296-303

National Standards for Out-of-home care from 1 July 2011


Royal Australian & New Zealand College of Psychiatrists. The mental health care needs of children in out-of-home care.

www2.ohchr.org/english/law/crc.htm

IMPLICATIONS FOR POLICY AND PRACTICE

ASSURANCE OF CHILDREN’S RIGHTS UNDER THE 1989 UN CONVENTION ON THE RIGHTS OF THE CHILD IS A SIGNIFICANT POLICY AND PRACTICE CHALLENGE IN AUSTRALIA. ACROSS CULTURAL AND SOCIAL GROUPS, IT IS IMPORTANT TO CONSIDER THE VARIOUS FACTORS THAT INFLUENCE CHILD HEALTH AND WELLBEING.

WHILE NO SINGLE MODEL IS LIKELY TO SUIT ALL GEOGRAPHICAL LOCATIONS OR JURISDICTIONS, AUSTRALIA DOES NEED A SINGLE, JOINT POLICY DIRECTION WHEN IT COMES TO ADDRESSING THE HEALTH NEEDS OF MALTREATED CHILDREN AND YOUNG PEOPLE. THIS WOULD ENTAIL FIRSTLY DEVELOPING A SHARED LANGUAGE ABOUT DIMENSIONS OF HEALTH NEED AND PROCESSES OF HEALTH NEEDS ASSESSMENT AND CARE THAT IS WELL UNDERSTOOD IN BOTH THE HEALTH AND CHILD WELFARE SECTORS. THE NATIONAL CLINICAL ASSESSMENT FRAMEWORK WILL BE A FIRST STEP TOWARDS ACHIEVING THIS, BUT FURTHER DEVELOPMENTAL WORK WILL BE NEEDED TO IMPLEMENT SUCH A FRAMEWORK. SECONDLY WE MUST FACE THE CHALLENGE OF HOW TO SIGNIFICANTLY IMPROVE CONTINUITY OF HEALTH CARE. THIS NOT ONLY INVOLVES DEVELOPING ROBUST SYSTEMS FOR BUILDING AND MAINTAINING THE INTEGRITY AND PORTABILITY OF CHILD HEALTH RECORDS, BUT ALSO ENSURING THAT ONE OF THE SIGNIFICANT THERAPEUTIC RELATIONSHIPS AVAILABLE TO VULNERABLE YOUNG PEOPLE IS WITH THEIR OWN DOCTOR.

Dr Clare Rocznik urged the symposium to consider how we can ‘embed’ GPs and paediatricians with child protection teams to improve information sharing and understanding. The new role of Out-of-Home Care Health Coordinator recently introduced in NSW shows promise, not only in introducing further health sector expertise, but in recognising that additional resources are needed to support child protection professionals in their important and complex work.
APPENDIX B

CASE SELECTION,

CASE-STUDY RESEARCH PROTOCOL,

STUDY TOPIC /THEME LIST,

INVITATIONS TO PARTICIPATE,

PLAIN LANGUAGE STATEMENTS

(FOR ORGANISATIONS AND INDIVIDUALS)

CONSENT FORMS

& DATA COLLECTION SHELLS

Prepared by Susan M. Webster as an Appendix to a Thesis submitted in total fulfilment of the requirements of the degree of Doctor of Philosophy, University of Melbourne. May 16, 2014.
## BOUNDARY ELEMENTS FOR CASE SELECTION

<table>
<thead>
<tr>
<th>Boundary Elements</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Phenomena</strong></td>
<td>Processes for collection and recording of the child health history, health screening, comprehensive health assessment, health care planning and health needs monitoring for children and young people aged 0-18 years living in home-based OOHC, as experienced by health professionals and policy advisors</td>
</tr>
<tr>
<td><strong>Jurisdictional policy setting</strong></td>
<td>State-wide policies and procedures operate in the jurisdiction requiring routine health assessment in OOHC</td>
</tr>
<tr>
<td><strong>Organisational setting</strong></td>
<td>Any organisation employing staff with health professional or policy advisor roles and experience in health assessment in home-based OOHC care</td>
</tr>
<tr>
<td><strong>Excluded settings</strong></td>
<td>Health assessment activities taking place in residential OOHC care, in Indigenous health services or in specialised settings for children with permanent disability.</td>
</tr>
<tr>
<td><strong>Geographical setting</strong></td>
<td>The activities and processes relating to the phenomena, were operating within the geographical area of an individual Australian state</td>
</tr>
<tr>
<td><strong>Time setting</strong></td>
<td>Health assessment activities and processes in operation from June 2011 to June 2012</td>
</tr>
<tr>
<td><strong>Roles of eligible informants</strong></td>
<td>Health professionals and policy advisors from any discipline who had direct experience of health assessment activities and processes in home-based OOHC.</td>
</tr>
<tr>
<td><strong>Context affecting interpretation of findings</strong></td>
<td>Historical context, legislative context, policy context, professional best practice standards, local or regional organisational context.</td>
</tr>
</tbody>
</table>

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PHD CASE-STUDY RESEARCH PROTOCOL

STATE-BASED APPROACHES TO ADDRESSING THE HEALTH NEEDS OF CHILDREN AND YOUNG PEOPLE LIVING IN OUT-OF-HOME CARE IN AUSTRALIA.

COORDINATING INVESTIGATOR

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ADDITIONAL PHD SUPERVISORY PANEL MEMBERS

Prof Cathy Humphreys, Alfred Felton Chair in Child & Family Welfare, School of Social Work, Faculty of Medicine, Dentistry & Health Sciences, The University of Melbourne, 200 Berkeley St, CARLTON VIC 3053

Assoc Prof Lena Sanci, General Practice and Primary Health Care Academic Centre, Faculty of Medicine, Dentistry & Health Sciences, The University of Melbourne, 200 Berkeley St, CARLTON VIC. 3053

Dr Anne Smith, Medical Director, Victorian Paediatric Forensic Medical Service, Royal Children's Hospital, Flemington Rd, PARKVILLE VIC. 3052
SYNOPSIS

The purpose of this study is to explore the challenges in important work already underway in some Australian states, by examining how different steps of health needs assessment and care are undertaken to address the health care needs of children aged 0-17 living in home-based out-of-home care. Out-of-home care is provided through state government departments with responsibility for child protection when children cannot live with their parents. The majority of children enter such care because of significant child abuse or neglect.

Internationally it is well established that children who have experienced maltreatment are vulnerable to poor health outcomes (United Nations 1989). Medical guidelines show doctors agree that children living in out-of-home care need systematic screening and assessment, regular ongoing review, and access to therapy (AAP 2002, RACP 2006, RANZCP 2009). There has been no published academic Australian research about how health is systematically assessed and monitored at a state level for children in out-of-home care.

The key questions in this study are about how health care staff undertake five tasks for children in out-of-home care, and what helps or hinders staff in this work. The tasks are collecting child health histories, initial health screening, comprehensive health assessments, health care planning and ongoing health monitoring.

This is a qualitative study, using a case-study approach. Researchers will involve senior managers responsible for policy development and implementation, as well as medical staff from health service organisations which routinely undertake comprehensive health needs assessment for children in out-of-home care. These include community and hospital-based clinics for out-of-home care, primary care organisations, area health services, state coordination committees and child advocacy services. The study will involve on-site interviews with staff members, and review of key policy and procedure documents.

The study occurs at an important time, because of the implementation of the first national child welfare standards for out-of-home care from 1 July 2011. These new standards will throw a spotlight on the challenges of meeting children’s health needs.

The study meets the National Health & Medical Research Council’s criteria for low risk research. It involves interviews only with key informants who are professionals with specific knowledge or expertise about the issues being investigated. The only foreseeable risk is the inconvenience of taking time to participate.

The study was approved by The University of Melbourne Human Research Ethics Committee on 10 May 2011 as a Minimal Risk research project. (Approval ID 1135829)
RATIONALE / BACKGROUND

There has been little published health policy or health services research on this topic in Australia. Australian medical colleges have called for closer attention to comprehensive health assessment for children in out-of-home care (RACP 2006, RANZCP 2009). Different approaches are currently being implemented in five Australian states and territories.

More than 100 participants attended the two day 2010 Health, Hope & Resilience: Fostering better health for children and young people in out-of-home care in Australia National Symposium, convened by the researchers in October 2010. The high registration rate and the discussions at the Symposium reinforced that there is a stakeholder interest in research in this area, particularly research on factors that are enablers and barriers across the states. (Details of the Symposium are at www.gp.unimelb.edu.au/FosteringHealthSymposium)

LITERATURE REVIEW: A review of Australian research literature since 2006 for this study, and a previous national audit of child protection literature since 1995 (Bromfield, & Osborn 2007) highlighted a paucity of research in relation to the health needs of children in out-of-home care. Bromfield, & Arney (2008) have noted a lack of cross-jurisdictional research, the need to conduct research in different contextual settings, and policymaker and practitioner interest in systemic issues. There has been a lack of Australian research about the interface between health and child protection services and about health care professionals’ involvement with children and young people in out-of-home care.


A variety of systemic problems in addressing the high level of need have been noted, including:

- the exclusion of health care management from accountability measures in child protection (Tilbury 2006);
- variable recognition by statutory guardians of the duty of care owed to children in relation to health (Tarren-Sweeney 2010);
- difficulties in engaging carers in health assessment processes (Chambers, et al 2010);
- problems with the collection and retrieval of child health records (Nathanson, et al 2009, Crawford 2006);
- geographic and other barriers to health service access and lack of monitoring of child health needs (Smith 2008).

Australian researchers have argued that more systematic measurement of health needs for all children in care is needed and the most visible shortcoming is the lack of capacity to address health for each and every child, despite the high rate of clinically significant difficulties (Tarren-Sweeney 2010, Zhou, & Chilvers 2010, Milburn 2008, Crawford 2006).

JUSTIFICATION: This study will contribute new learning about how the health care needs of a very vulnerable cohort of children are addressed, and what enables or impedes services designed to assist them. The study findings will be of interest to paediatricians and other health professionals with a significant interest in child health, policy makers, child protection service managers and health service staff.
RESEARCH TEAM

This PhD study is supervised by:

- Assoc Prof Meredith Temple-Smith, (B Sc, Diploma Applied Child Psychology, MPH, DHSc), Director of Research Training, General Practice and Primary Health Care Academic Centre, University of Melbourne. (Principal Supervisor)
- Assoc Prof Lena Sanci, MBBS, PhD, FRACGP, Deputy Head, Department of General Practice, University of Melbourne.
- Prof Cathy Humphreys, Alfred Felton Chair of Child and Family Welfare, University of Melbourne.
- Dr Anne Smith, Medical Director, Victorian Forensic Paediatric Medical Service, Head of Forensic Paediatric Medicine, Royal Children’s Hospital, Melbourne.

Susan M. Webster, BA, MPH, has 35 years of experience in senior health and welfare positions in Commonwealth and Victorian government and community service organisations. She completed a Master of Primary Health Care Research in 2009 with a study of general practitioner willingness and readiness to undertake comprehensive health assessments for children in out-of-home care in Victoria (Webster, & Temple-Smith 2010).

AIM AND OBJECTIVES

AIM

The aim is to explore and explain how health care providers address the health care needs of children in out-of-home care at the state level in Australia, and the factors that act as enablers and barriers in this work.

OBJECTIVES

To examine how and why five tasks are carried out at the state level in relation to children and young people in home-based out-of-home care, and what factors act as enablers or barriers. The five tasks (referred to from this point as HSAPT) are:

a) collection and maintenance of child health histories;
b) provision of initial health screening;
c) provision of comprehensive health assessments;
d) development of individual health care plans;
e) monitoring of the provision of assessment and treatment.

RESEARCH PLAN & STUDY DESIGN

TYPE OF STUDY

This PhD study, being conducted in the General Practice and Primary Health Care Academic Centre at The University of Melbourne, is qualitative research relating to the field of effective health care.

The study findings will be published in the PhD thesis to be submitted in 2013. Study findings will be submitted as a paper presentation to the 2012 International Society for the Prevention of Abuse and Neglect (IPSCAN) Conference and for journal publication. The findings may also be submitted as a paper to Australian conferences in 2012-2013.
TIMING OF STUDY

The research study is being conducted from April 2010 until March 2013. Data collection in the case studies will commence from 5 September 2011 and continue until approximately April 2012.

STUDY DESIGN

The qualitative design incorporates two commonly used approaches:

- an embedded case study approach (Yin 2009), with purposive sampling and
- soft systems methodology (Checkland, & Scholes 2007).

The key data collection tools will be semi-structured interviews and review of organisational documents e.g. public reports and staff procedure guides.

EMBEDDED CASE STUDY APPROACH

The research uses an embedded case study design (Yin 2009). This method is useful for research questions which are primarily about how and why. The key study themes are about how five tasks are carried out at the state level in relation to children in out-of-home care, and why they are carried out in the way they are. The themes also include how and why different factors act as enablers or barriers to carrying out these tasks.

SAMPLING

Purposive sampling of Australian states and territories is based firstly on selection of states which have already adopted state-wide approaches to addressing child health needs through systematic, comprehensive health needs assessment by trained health professionals. Only four Australian states have such systems. The four states in the purposive sample have been ranked from highest to lowest, according to the number of children who were in out-of-home care on 30 June 2010 (AIHW 2010), as follows; NSW, QLD, WA, SA.

Each case (i.e. state) will be made up of several embedded units of analysis. Each unit of analysis is defined as an organisation within that state which is currently actively involved in systematic approaches to addressing health needs in out-of-home care. Units of analysis have been identified and purposively selected by the researchers, on the basis that there are senior people within the organisation with professional experience and knowledge of HSAPT who can act as key informants. A senior staff member is defined as one with policy, management, clinical or program responsibilities related to one or more of the five tasks (HSAPT). Participants will be adults with professional experience and qualifications. The number of key informants may vary across organisations, from one up to five in most organisations.

The type and number of organisations in each case with appropriate key informants is variable by state. As the scope of this study does not allow research in every organisation, a research plan for each state (this protocol is an example) will identify types of organisations in that state which have direct roles in health service provision or monitoring for home-based out-of-home care. Participation will be sought from one of each type of organisation. Participating organisations will be invited to identify any other organisation in their state which meets the purposive selection criteria (but is not currently known to the researcher) and which should be invited to participate. By including at least one organisation of each type in each case, we aim primarily to capture and describe the unique insights within each case (Stake 1995).

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1 While the Northern Territory has such a system, it has already been the subject of an extensive public inquiry, released in 2010. The vast majority of children in care in the Territory are Aboriginal or Torres Strait Islander. Strong cultural expertise is necessary to investigate systems for predominantly Aboriginal children. For these two reasons, the Territory is judged to be outside the scope of resources or expertise available for this study.
A minimum of two cases are sought to improve data source triangulation (Stake 1995). Central themes may also emerge that cut across variations between the world views of individuals and organisations, and across different contexts in different states.

**DATA COLLECTION**

All data collection will be undertaken on-site at the participating organisation, directly by the principal investigator, including document reviews and semi-structured, individual interviews. Appendix A sets out the study topics and themes which will guide the researcher.

**PARTICIPANT TASKS AND TIME INVOLVED**

Where an organisation is interested to take part in the study the investigator may be invited to attend a routine staff or team meeting for a brief 15 minute agenda item to explain the purpose and design of the study and answer questions. Organisations with an interest will be asked to pass invitations to participate to all appropriate staff members. (The plain language statement for individuals is at Appendix C.) Where organisations have several staff who may wish to participate, the investigator will negotiate where possible to remain on-site for between one and three days to maximise the flexibility of times available for staff participation.

Individuals interested in taking part in the study will be invited to make direct contact with the investigators. Consent will involve completing a brief, one page form (Appendix D).

Semi-structured, tape-recorded individual interviews with participants will take approximately 60 minutes and be conducted in a private space. People will be asked to reflect on the purpose, processes and challenges of their work with children in out-of-home care. They may be guided in the interview to sketch simple diagrams about their work eg. about referral and intake processes or comprehensive assessment processes. Interviewees will be asked to review a transcript of their interview and provide corrections or additions.

Retrieval of policy and procedure documents may take between five and thirty minutes for one staff member from the organisation. An inability to provide administrative assistance with document retrieval will not preclude an organisation from participating in the study.

**DATA ANALYSIS**

Several levels of data analysis will be involved. Data management will be guided by Miles & Huberman (1994) and Yin (2009). A field journal, contact summary forms, document summary forms and prepared data shells will be used. A preliminary list of such shells is at Appendix E.

Data of all types from each organisation will be coded and analysed, then collated to form a set of data about each state (case), which will then be integrated, synthesised, further coded and analysed. N-Vivo software will be used to record coding efficiently. Data analysis will also be guided by SSM (Checkland, & Scholes 2007). Diagrammatic models relating to the health assessment and planning tasks being studied will be developed by the investigator.

Triangulation of data sources, pattern matching and cross-case synthesis will also be used for overall analysis (Yin 2009).
MANAGEMENT OF ETHICAL RISKS

LOW RISK

The likely risk to participants is no more than the inconvenience to their time if they volunteer to participate in the study. The participants in this study will be senior policy makers, clinicians and experienced health professionals with existing knowledge and experience of health assessment and health care planning for children and young people living in out-of-home care.

The inclusion criteria is active involvement in, or a working knowledge of, comprehensive health needs assessment and/or health care planning activities for children and young people living in home-based out-of-home care in Queensland. As this study only seeks to uncover the current expert knowledge and understanding of people working at a professional level who are conducting the activities being explored, the risk to participants is minimal.

There is no foreseeable risk to non-participants.

RECRUITMENT

Participating organisations will be asked to provide information about the study to all managers and senior staff members who have knowledge and experience of any of the matters being studied and distribute information about the study to them (Appendices C, E and H). Individuals willing to participate will be asked through the Plain Language statement (Appendix C) to make direct contact with the investigators.

Organisation managers will be asked to provide staff with direct contact details for the investigators, and assure that staff are under no obligation to participate and will not be penalised in any way for not participating.

People being invited to participate in this study are key informants involved in purposeful activities, employed by organisations which have a role in implementing state policies. As no pre-existing relationship exists between investigators and participants, the study will require the assistance of organisation managers in identifying people in appropriate staff positions who should be invited to take part in the study. It is not considered that an employer/employee relationship in this study poses a risk from dependency or coercion, as key informants would themselves be senior, professional staff, capable of forming independent views about participation.

The integrity of the research will be protected by ensuring that potential participants are able to discuss the study directly with the investigators and every effort will be made through negotiation with participating organisations to ensure both that all appropriate staff are given an opportunity to participate, and there are no negative consequences associated with declining to participate. The study does not seek a representative sample of staff within any organisation, or across the state.

The total of participants from Queensland Health is expected to number between 5 and 15.

PARTICIPATION

Individual, semi-structured interviews of approximately 60 minutes will be used. The principal investigator may briefly attend a staff meeting for 15 minutes or less to introduce the study and answer questions if this is appropriate and convenient on a site-by-site basis. Participants will also be offered the opportunity to meet with the investigator to discuss a summary of the findings at the site. Interviews and any other contact with participants will be at times and of a duration that is carefully and individually negotiated with each participant.
to minimise the inconvenience to them. Where appropriate and practical, the principal investigator will be present on-site for one to three days to maximise the flexibility of arrangements.

**CONSENT**

Prior to confirming individual consent from participants on-site, a plain language statement will be discussed with each person and questions will be invited. Where it is feasible to do so at a staff or team meeting at the site being visited, the investigator will present the study design to staff prior to commencement of any individual interactive activities. Individual consent will be confirmed at the end of interviews and meetings to give participants the opportunity to withdraw once they have reflected on their own input.

**CONFIDENTIALITY**

Confidentiality will be safeguarded for all participants. Although the principal investigator will know the identity of participants, identifying information about organisations and individuals will be removed and replaced by codes. Only the investigators will be able to link the codes to the original identities. Information about participant identity will be stored securely in a password protected computer at the University of Melbourne.

In the PhD thesis and any other publication associated with this study, individuals will be referred to only by an interview number. Interview numbers will be assigned in such a way that they cannot be linked by a reader to a site or a staff position. The only biographical information recorded about individuals will be their organization and discipline. Only aggregated data about responses across all organizations in one state or across individuals from any discipline within the study will be reported in the thesis or any other publication. These measures will help to protect the privacy of individuals.

**DISSEMINATION OF FINDINGS TO PARTICIPANTS**

If they elect to do so, the participant's name will be added to a mailing list to receive a notice of any publication arising from the study. Participating organisations can elect to receive a copy of the PhD thesis.

**PARTICIPATING SITES**

Table 1 indicates the types of organisations in QLD currently involved in health assessment and health care planning for out-of-home care. These organisations will be approached in writing with an invitation to participate (Appendix F).

The Information for Participating Organisations (Appendix B) sets out details of participation, researcher agreement to organisational policies and procedures, research feedback mechanisms and so on.
Table 1

*Groups and organisations to be invited to participate in the Queensland case study in 2011.*

<table>
<thead>
<tr>
<th>Organisation Type or Function</th>
<th>Organisations Involved</th>
<th>Purposive selection &amp; Justification</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>QLD Government Policy</strong></td>
<td>1. Child Safety Directors Network</td>
<td>The Network leads the coordination, communication and strategic planning of the QLD child protection system.</td>
</tr>
<tr>
<td></td>
<td>2. Child Protection Partnerships Forum</td>
<td>Inter-departmental coordination functions</td>
</tr>
<tr>
<td></td>
<td>3. State-wide Child and Youth Clinical Network</td>
<td>Health service coordination, including child protection units</td>
</tr>
<tr>
<td></td>
<td>4. Department of Health, Child &amp; Youth Unit</td>
<td>Auspice for Child Protection Advisers Network (paediatricians)</td>
</tr>
<tr>
<td><strong>Health Coordination for out-of-home care</strong></td>
<td>Department of Communities</td>
<td>Publish the <em>Child Safety Practice Manual</em> which establishes procedures and practice guidelines for dealing with child protection matters.</td>
</tr>
<tr>
<td></td>
<td>1. Child Safety Programs Unit</td>
<td></td>
</tr>
<tr>
<td><strong>Health services providing direct health care services to children in out-of-home care</strong></td>
<td>1. Mater Children’s Hospital, Child Protection Unit</td>
<td>Tertiary services for children who have experienced abuse or neglect.</td>
</tr>
<tr>
<td></td>
<td>2. Child Protection Advisory Service Royal Children’s Hospital</td>
<td></td>
</tr>
<tr>
<td></td>
<td>3. Paediatric mental health services</td>
<td></td>
</tr>
<tr>
<td></td>
<td>4. Evolve Interagency Services</td>
<td>Evolve Behaviour Support Services / Evolve Therapeutic Services deliver direct services to children in out-of-home care</td>
</tr>
<tr>
<td><strong>General Practice</strong></td>
<td>General Practice Queensland</td>
<td>Represented on government policy bodies</td>
</tr>
<tr>
<td></td>
<td></td>
<td>General practitioners provide health assessment and care and complete Child Health Passports for children in out-of-home care</td>
</tr>
<tr>
<td><strong>Children’s Commissioners and Guardians</strong></td>
<td>QLD Commission for Children and Young People and Child Guardian</td>
<td>Audit and monitoring of health assessment, planning and health care records integrity for children in out-of-home care.</td>
</tr>
</tbody>
</table>
REFERENCES


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# Study Topic and Theme List for Researcher Use in Data Collection and Analysis Across Cases

**Project Title:** State-based approaches to addressing the health needs of children and young people living in out-of-home care in Australia

**Names of Investigators:** Assoc Prof Meredith Temple-Smith, Assoc Prof Lena Sanci, Prof Cathy Humphreys, Dr Anne Smith, Susan M. Webster

<table>
<thead>
<tr>
<th>Study Topics</th>
<th>Themes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Defining Child Health in Out-of-Home Care</strong></td>
<td>Individual’s working definitions of health in children and adolescents Organisational views of child health, including any officially documented definitions/ views /goals</td>
</tr>
<tr>
<td><strong>Child Health Histories of Children and Young People in Out-of-Home Care</strong></td>
<td>Processes for collecting child health histories for children and young people in out-of-home care Necessity for, and purposes of, collecting child health histories. Processes and issues relating to consent Access to and use of child health histories Quality improvement goals</td>
</tr>
<tr>
<td><strong>Health Assessment for Children and Young People in Out-of-Home Care</strong></td>
<td>Eligibility for health assessment Purpose/s of health assessment Processes for initiating health assessments Attendance of third parties Management of informed consent Assessment locations and facilities How are assessments financed? Health assessment processes: Dimensions of health assessed Standard tools used Time involved Funding of assessment processes Management of assessment records Kinds of aggregated data kept Benefits to the child of the assessment process Strengths and weaknesses of health assessment process Quality improvement goals</td>
</tr>
<tr>
<td><strong>Coordination and Monitoring of Child Health Plans for those in Out-of-Home Care</strong></td>
<td>Processes for meeting identified health needs Monitoring Data collection Roles of different parties in coordination and monitoring Strengths and weaknesses of coordination and monitoring processes Quality improvement goals</td>
</tr>
<tr>
<td><strong>Policy and/or Research Issues</strong></td>
<td>Policy and/or research issues at state and Commonwealth level Child and family welfare services Health services</td>
</tr>
</tbody>
</table>

1v1.1/7/11 The University of Melbourne HREC Approval 1135829 Dated 10 May 2011
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INVITATION TO AN ORGANISATION TO PARTICIPATE IN STUDY

Name / Address of organization in New South Wales

Dear

State-based approaches to addressing the health needs of children and young people living in out-of-home care in Australia

Your organisation is invited to participate in the above research study, which is being conducted by Assoc Prof Meredith Temple-Smith (supervisor) and Ms Susan Webster (PhD Candidate) of the General Practice and Primary Health Care Academic Centre at the University of Melbourne. The study will form part of Ms Webster’s doctoral thesis, and has been approved by this University’s Human Research Ethics Committee.

The aim of this study is to explore the challenges in addressing health needs in out-of-home at a state level in Australia.

The study occurs at an important time, with the implementation of new national standards for out-of-home care from 1 July 2011 that will throw a spotlight on the challenges of meeting children’s health needs. A review of Australian research literature since 2006 for this study, and a previous national audit of child protection literature since 1995 (Bromfield & Osborn 2007) highlighted a paucity of research in relation to how the health needs of children in out-of-home care are met. Bromfield & Arney (2008) have noted a lack of cross-jurisdictional research, the need to conduct research in different contextual settings, and policymaker and practitioner interest in systemic issues. There has been a lack of Australian research about the interface between health and child protection services and about health care professionals’ involvement with children and young people in out-of-home care.

This study will contribute new learning about how the health care needs of a very vulnerable cohort of children are addressed, and what enables or impedes services designed to assist them. Participants in the 2010 National Symposium Health, Hope & Resilience: Fostering Better Health for Children and Young People in out-of-home care in Australia, convened by the researchers, reinforced that there is a stakeholder interest in research in this area.

The study objectives are to explore and explain the barriers and enablers in how five tasks for children in out-of-home care are undertaken at a state level, namely:

- collection and maintenance of child health histories;
- provision of initial health screening;
- provision of comprehensive health assessments;
- development of individual health care plans;
- monitoring of the provision of assessment and treatment.

Should you agree to participate, your organisation would be asked to contribute to this in several ways.

Firstly we would ask you to discuss the study with all staff with knowledge and experience of any of the matters being studied, and invite them to take part. A copy of information which is available for distribution to individual staff members is enclosed. Individuals who are interested to take part should make direct contact with Ms Webster who will answer any questions they may have and discuss their involvement in the study.

Secondly we would ask you to enable Ms Webster to visit your organisation for between one and five days, at a time convenient to you, between 1 July 2011 and 30 March 2012 in order to:
explain the study to senior staff in your organisation;
peruse policy, procedure and administrative documents relevant to the topic of the study (but not records
relating to individual clients or patients, or which contain material which could include any private or confidential
information about an individual client or patient);
conduct semi-structured, individual interviews of approximately 60 minutes with policy, clinical and/or program
staff;
observe the physical facilities of your organisation which are used in relation to health care for children in out-of-
home care;
discuss research observations with your staff at the end of the visit.

The accompanying information sheet for participating organisations provides further information about the study. Your
participation in this study, and that of any individuals in your organisation, is completely voluntary. Should your
organisation, or any individuals, wish to withdraw at any stage, or to withdraw any unprocessed data you have supplied,
you would be free to do so without prejudice.

An application is being made in accordance with the Research Governance in NSW Public Health Organisations Guideline
(2011) for ethics approval for staff from NSW Health to participate in the study.

If your organisation would like to participate, please indicate that you have read and understood this information by
signing the attached form and returning it in the envelope provided. The researchers will then contact you to arrange a
mutually convenient time for you to discuss your organisation's participation further.

Should you require any further information, or have any concerns, please do not hesitate to contact either of the
researchers whose details are given below. Should you have any concerns about the conduct of the project, you are
welcome to contact the Executive Officer, Human Research Ethics, The University of Melbourne, on ph: 8344 2073, or fax:
9347 6739

Assoc Prof Meredith Temple-Smith (Supervisor)        Susan Webster (PhD Candidate)
Ph: (03) 8344 3371                                  Ph: (03) 9035 5834
Email: m.temple-smith@unimelb.edu.au                Email: s.webster@unimelb.edu.au
Fax: (03) 9347 6136                                Fax: (03) 9347 6136

General Practice and Primary Health Care Academic Centre,
The University of Melbourne,
200 Berkeley St, Carlton Victoria 3053 Australia T: 03 8344 7276  F: 03 9347 6136  W: www.gp.unimelb.edu.au

HREC Approval No.1135829.1  Dated 6 April
INFORMATION FOR PARTICIPATING ORGANISATIONS

STUDY TITLE: State-based approaches to addressing the health needs of children and young people living in out-of-home care in Australia

RESEARCHERS:
- Assoc Prof Meredith Temple-Smith, Principal Researcher & Supervisor
- Assoc Prof Lena Sanci, Co-Researcher
- Prof Cathy Humphreys, Co-Researcher
- Dr Anne Smith, Co-Researcher
- Susan Webster, PhD Candidate

1. THE STUDY
The study will form part of Ms Webster’s doctoral thesis, and has been approved by the University of Melbourne Human Research Ethics Committee.

2. TERM
Participation in the study will take place during the 2011 - 2012 financial year. It is anticipated that duration of participation will be between 1 and 5 days, depending on the size of the organisation.

3. OBLIGATIONS
The University will have the primary responsibility for the conduct of the research study. The participating organisation agrees to ensure the provision of all necessary assistance reasonably required for the conduct of the study, including enabling the PhD candidate to conduct on-site research activities at the organisation’s premises for a period not exceeding five days.

4. CONDUCT OF THE RESEARCH
The University will:
   a) supervise the PhD candidate;
   b) take all reasonable steps to ensure the candidate carries out the study in a competent and diligent manner;
   c) provide the candidate with the necessary equipment and training to undertake fieldwork within the organisation;
   d) ensure that no research activities commence in the organisation without appropriate ethics approvals for human research as required by the organisation;
   e) ensure that the study is carried out in accordance with the Australian Code for the Responsible Conduct of Research

Where the organisation agrees to grant the PhD candidate access to its site, the University will ensure that the candidate complies with the organisation's policies and procedures, and all reasonable requirements in connection with that access.

The participating organisation may raise any concerns about the conduct of the research initially with the Principal Supervisor, Assoc Prof Temple-Smith. If concerns are not able to be resolved, the participating organisation should notify the Executive Officer, Human Research Office, University of Melbourne, Carlton, Victoria 3010. Phone: 9344 2073 or fax: (03) 8347 6739.
5. RESEARCH DATA
The data collected for this study will be kept securely in the General Practice and Primary Health Care Academic Centre for a minimum of five years from the date of publication, before being destroyed.

6. INTELLECTUAL PROPERTY
The University will not seek a claim, ownership or interest in any intellectual property of the participating organisation.

The organisation may grant the PhD candidate access to its intellectual property for the purposes of the study.

The PhD candidate will obtain written agreement from the senior staff member of the participating organisation prior to the copying or retention of any item of intellectual property provided by the organisation for the purposes of the study.

The PhD candidate will own any intellectual property generated by the research study.

7. CONFIDENTIALITY
The PhD candidate will keep any confidential information obtained during the study confidential, unless strictly required otherwise by law.

The candidate will not use any confidential information obtained during research activities in the organisation in any way other than for the study.

8. PUBLICATION
Once the thesis arising from this research has been completed, a brief summary of the findings will be made available to participating organisations.

The participating organisation acknowledges the University’s obligation under its statutes to deposit a copy of the completed thesis in the University library.

Findings from the study may be used by the candidate for academic purposes including presentation at academic conferences and publication in academic journals.

8. INSURANCE
The University is responsible for maintaining appropriate insurances for the PhD candidate.
INVITATION TO TAKE PART IN A RESEARCH STUDY

We have invited your organisation to participate in a research study being conducted as part of a PhD in the General Practice and Primary Health Care Academic Centre at the University of Melbourne.

**STUDY TITLE:** State-based approaches to addressing the health needs of children and young people living in out-of-home care in Australia

**NAMES OF INVESTIGATORS:** Associate Professor Meredith Temple-Smith, (Principal Researcher), Associate Professor Lena Sanci, Professor Cathy Humphreys, Dr Anne Smith, Susan M. Webster (PhD Candidate 2010-2013)

We would like to provide you with more information about the study, which examines how the health needs of children and young people in out-of-home care are addressed.

The purpose is to explore the challenges in this important area by examining how different steps of health needs assessment and care are undertaken. Knowledge and information generated from this study may help others to more fully understand some of the complex issues involved, from the perspectives of those working in health services.

We hope to connect with people in your organisation who have knowledge and experience in this area of work and will have unique understandings and stories relating to meeting the health needs of children in out-of-home care. During the course of this study, Susan Webster will be conducting interviews with people to gather their ideas. At the end of this study the publication of the PhD thesis will share the knowledge from this study with clinicians, researchers, policy makers and community members who have a special interest in this area.

To respect the privacy and rights of your organisation and its staff, your organisation has been provided with the attached information to pass on to staff. Our contact information is given below. If you are interested in taking part in this study please read the attached statement. If you have any questions regarding this study or would like additional information to assist you in reaching a decision about participation, please contact me.

We hope that the results of the study will be beneficial to your organisation and to the interests of children in care across Australia, as well as the broader research community.

---

**Susan Webster**  
**Meredith Temple-Smith**  
**PhD Candidate**  
**University of Melbourne**  
Email: s.webster@unimelb.edu.au  
smith@unimelb.edu.au  
Ph: 03 9035 5834  
Mobile: 041 357 1119

**Associate Professor**  
**Principal Researcher**  
**University of Melbourne**  
Email: m.temple-smith@unimelb.edu.au  
Ph: 03 8344 3371

HREC Approval No.1135829.1  Dated 6 April 2011
PLAIN LANGUAGE STATEMENT FOR
PEOPLE PARTICIPATING IN A RESEARCH
STUDY

RESEARCH STUDY TITLE:  State-based approaches to addressing the health needs of children and young people living in out-of-home care in Australia

NAMES OF INVESTIGATORS: Associate Professor Meredith Temple-Smith, Associate Professor Lena Sanci, Professor Cathy Humphreys, Dr Anne Smith, Susan M. Webster

INTRODUCTION
Your organisation has been invited to participate in the above study. The aim of the study is to explore the challenges in addressing health needs in out-of-home at a state level in Australia. The objectives are to explore and explain the barriers and enablers in how five tasks for children in out-of-home care are undertaken at a state level, namely:

- collection and maintenance of child health histories;
- provision of initial health screening;
- provision of comprehensive health assessments;
- development of individual health care plans;
- monitoring of the provision of health assessment and treatment.

The study has been approved by the University of Melbourne Human Research Ethics Committee.

WHAT WILL I BE ASKED TO DO?
Should you agree to participate, you will be asked to contribute in two ways. Firstly you may be asked to agree to the researcher briefly introducing the study and/or providing feedback about the findings at a staff or team meeting in your organisation. Such discussions would be for approximately 15 minutes duration. Secondly, you are invited to take part in an individual interview of approximately 60 minutes to assist the researcher to learn more about how any or all of the tasks listed are carried out. During the interview, you may be guided to sketch two or three simple diagrams relating to how the tasks being studied are done in your organisation. We do not expect this interview will cause you any distress or discomfort. With your permission, the interview would be tape-recorded so we can ensure we have an accurate record of what you say. When the tape has been transcribed, you would be provided with a copy of the transcript so you can verify the transcript is correct and/or request deletions.

HOW WILL MY CONFIDENTIALITY BE PROTECTED?
We intend to protect your anonymity and the confidentiality of your responses to the fullest possible extent. Your name, discipline and contact details will be kept in a password-protected computer file, separate from any data that you supply. This will only be able to be linked to your responses by the researchers, for example in order to know where we should send your interview transcript for checking. In the final report, you will be referred to by a pseudonym (e.g. interview 14). We will remove any personal information, including your discipline, which might allow someone to guess your identity. However you should note that as the number of people we will interview is small, it is possible that someone may still believe they can guess your identity. The data will be kept securely in the General Practice and Primary Health Care Academic Centre for at least five years from the date of any publication from the study, before being destroyed.
HOW WILL I RECEIVE FEEDBACK?

At the end of the research visit to your organisation, you will receive a brief report about the researcher's observations for your comment. Once the thesis arising from this research is completed a brief summary of the findings will be available to you from the General Practice and Primary Health Care Academic Centre. You may ask to be added to a mailing list to receive notice of any academic conference presentations or academic publications about the study findings.

WILL PARTICIPATION PREJUDICE ME IN ANY WAY?

Please be advised that participation in this study is completely voluntary. Should you wish to withdraw at any stage, or to withdraw any unprocessed data you have supplied, you are free to do so without prejudice. You will not be asked to give any reason for your withdrawal. You will be asked to sign a consent form at the commencement of any interview and your consent will be checked again when the interview has been completed, in case you have changed your mind. The participation of your organisation is not dependent on your personal participation, and your decision about whether or not to participate will have no bearing on the relationship between your organisation and the researchers.

WHERE CAN I GET FURTHER INFORMATION?

Should you require any further information, or have any concerns, please do not hesitate to contact Meredith Temple-Smith or Susan Webster on the telephone numbers given below. Should you have any concerns about the conduct of the study, you are welcome to contact the Executive Officer, Human Research Ethics, University of Melbourne on phone: (03) 8344 2073 or fax: (03) 8347 6739.

HOW DO I AGREE TO PARTICIPATE?

If you would like to participate, please signify that you have read and understood this information by signing the attached form and returning it in the envelope provided. Alternatively you can email Susan Webster or fax your form using the contact details given below. The researchers will then contact you to arrange a mutually convenient time for an interview when they visit your organisation.

Assoc Prof Meredith Temple-Smith (Supervisor)  
Ph: (03) 8344 3371  
Email: m.temple-smith@unimelb.edu.au  
Fax: (03) 9347 6136

Susan Webster (PhD Candidate)  
Ph: (03) 9035 5834  
Email: s.webster@unimelb.edu.au  
Fax: (03) 9347 6136

General Practice and Primary Health Care Academic Centre,  
The University of Melbourne,  
200 Berkeley St, Carlton Victoria 3053 Australia  
T: 03 8344 7276  
F: 03 9347 6136  
W: www.gp.unimelb.edu.au

HREC Approval No.1135829.1  Dated 6 April 2011
CONSENT FORM FOR PERSONS PARTICIPATING IN A RESEARCH PROJECT

PROJECT TITLE: State-based approaches to addressing the health needs of children and young people living in out-of-home care in Australia

NAMES OF INVESTIGATORS: Assoc Prof Meredith Temple-Smith, Assoc Prof Lena Sanci, Prof Cathy Humphreys, Dr Anne Smith, Susan M. Webster

Name of participant:

Organisation:

Discipline:

1. I consent to participate in this project, the details of which have been explained to me, and I have been provided with a written plain language statement to keep.

2. I understand that after I sign and return this consent form it will be retained by the researcher.

3. I understand that my participation will involve an interview and I agree that the researcher may use the results as described in the plain language statement.

4. I acknowledge that:

   (a) possible effects of participating in the interview have been explained to my satisfaction;

   (b) I have been informed that I am free to withdraw from the project at any time without explanation or prejudice and to withdraw any unprocessed data I have provided;

   (c) the project is for the purpose of research;

   (d) I have been informed that the confidentiality of the information I provide will be safeguarded subject to any legal requirements;

   (e) I have been informed that with my consent the interview will be audio-taped and transcribed. I understand that audio-tapes and transcripts will be stored at University of Melbourne and not be destroyed for at least five years after the publication of any study results;

   (f) my name will be referred to by a pseudonym in any publications arising from the research;

   (g) I have been informed that a copy of the research findings will be forwarded to me, should I agree to this.

I consent to this interview being audio-taped □ yes □ no (please tick)

I wish to receive a copy of the summary report of findings □ yes □ no (please tick)

Participant Signature: Date: Email

HREC Approval No.1135829.1 Dated 6 April 2011
# DATA SHELLS FOR RESEARCHER USE IN DATA COLLECTION AND ANALYSIS ACROSS CASES.

<table>
<thead>
<tr>
<th>Study Topics</th>
<th>Data Shells</th>
</tr>
</thead>
<tbody>
<tr>
<td>Definitions of Child Health</td>
<td>1. Checklist of written and spoken definitions compared with theoretical elements</td>
</tr>
<tr>
<td>Child Health Histories</td>
<td>2. Titles of forms used to collect health histories</td>
</tr>
<tr>
<td></td>
<td>3. List of health history informants used, by type, and by form used</td>
</tr>
<tr>
<td></td>
<td>4. Checklist of health history data items collected routinely</td>
</tr>
<tr>
<td></td>
<td>5. Comments re level of confidence in accuracy of information obtained</td>
</tr>
<tr>
<td>Initial Health Screening</td>
<td>6. Checklist of dimensions of health screened compared with theoretical elements</td>
</tr>
<tr>
<td>Comprehensive Health Assessment</td>
<td>7. Checklist of dimensions of health screened compared with theoretical elements</td>
</tr>
<tr>
<td></td>
<td>8. List of disciplines involved in comprehensive assessment</td>
</tr>
<tr>
<td></td>
<td>9. List of standardised assessment tools used compared to list of those used in Australian research studies</td>
</tr>
<tr>
<td></td>
<td>10. Titles of forms used to record assessment findings</td>
</tr>
<tr>
<td>Health Care Planning</td>
<td>11. Checklist of dimensions in any standardised planning document</td>
</tr>
<tr>
<td></td>
<td>12. Sources of funding for further health assessment and treatment</td>
</tr>
<tr>
<td></td>
<td>13. Checklist of positions/roles/disciplines with responsibility for authorising individual health plans</td>
</tr>
<tr>
<td>Monitoring</td>
<td>14. Checklist of measures for which aggregated data is developed</td>
</tr>
<tr>
<td></td>
<td>15. Checklist of who accesses/ uses aggregated data and purpose</td>
</tr>
</tbody>
</table>
APPENDIX C

SYSTEMIC ANALYSES
&
CONCEPTUAL MODELS
FOR
FIVE STEPS OF CARE
ASSOCIATED WITH
HEALTH ASSESSMENT
IN
HOME-BASED OUT-OF-HOME CARE

Prepared by Susan M. Webster as an Appendix to a Thesis submitted in total fulfilment of the requirements of the degree of Doctor of Philosophy, University of Melbourne May 16, 2014.
INTRODUCTION

This research study used a form of systemic enquiry known as Soft Systems Methodology (SSM). A particular terminology associated with SSM is evident in this Appendix. A brief glossary of terms, as described in Checkland and Scholes (2007, pp. 288-289) is set out below.

GLOSSARY

CATWOE
Mnemonic for elements considered in formulating root definitions. The core is expressed in T (transformation of some entity into a changed form of entity) according to a declared Weltanschauung, W. C (customers): victims or beneficiaries of T. A (actors): those who carry out the activities. O (owner): the person or group who could abolish the system. E: (the environmental constraints which the system takes as given).

Conceptual Model
The structured set of activities necessary to realise the root definition and CATWOE, consisting of an operational sub-system based on the Es.

Problem Situation
A real-world situation in which there is a sense of unease, a feeling that things could be better than they are, or some perceived problem requiring attention.

Real World
The unfolding interacting flux of events and ideas experienced in everyday life.

Rich Picture
Pictorial, diagrammatic representations of the situation’s entities (structures), processes, relationships and issues.

Root Definition
Concise verbal definitions expressing the nature of purposeful activity systems regarded as relevant to exploring the problem situation.

The 5 Es
Criteria by which T would be judged:
Efficacy (does the means work?),
Efficiency (are minimum resources used?),
Effectiveness (does the T help the attainment of longer term goals related to O’s expectations?),
Ethicality (is T the moral thing to do?),
Elegance (is T aesthetically pleasing?).

Weltanschauung
A German word, often translated in English as “worldview”.

SOFT SYSTEMS METHODOLOGY

“SSM is a structured way of thinking which focuses on some real-world situation perceived as problematical. The aim is always to bring about what will be seen as improvements in the situation” (Checkland, & Scholes 2007 p. 286).

The methodology for enquiry is a staged approach to analysis, conceptual modelling, comparison with everyday reality from a declared world view and the formation of judgements about desirable and feasible changes which may result in improvement. This enquiry approach is expressed in the following diagram (Checkland & Scholes 2007, p. 292).

(Checkland, & Scholes 2007 p. 292). Figure 10.6. The common dynamics of operating the stages of SSM.
STEPS OF CARE

For the purposes of this study I conceived of five steps of care listed below which I associated with systematic (rather than opportunistic) health assessment for children and young people in OOHC.

1. Collecting, storing and sharing child health histories
2. Initial Health Assessment
3. Comprehensive Health Assessment
4. Child health care management planning
5. Ongoing monitoring and review of child health

As part of the research study I undertook several analytic processes which are demonstrated in the materials in this Appendix.

Firstly, I reviewed and compared public policies from Australia, U.K. and U.S. along with recommendations from medical professional colleges in Australia, U.K., U.S. and Canada about health assessment in OOHC and developed a composite picture of the recommended activities aligned with each step which I present in this Appendix as a series of World Views of Health Professionals.

Secondly, I drew a series of diagrams or Rich Pictures representing the entities, processes, relationships and issues in each step of care, appearing in this Appendix as RICH PICTURE1-5.

Thirdly, I analysed the core purpose and context of an imagined model system for each step of care, drawing from the enquiry approach of SSM. A summary analysis is provided for each step of care in tabled formats, headed STEP ANALYSIS.

Finally I developed a conceptual systemic model for each step of care which comprised a set of activities necessary to achieve the purpose of the system. These are illustrated in this appendix as a series of diagrams, each labelled Conceptual Model.

These five sets of documents are aligned. Four documents (Worldview, Rich Picture, Step Analysis and Conceptual Model) are collated together against each step of care for the ease of the reader and can be found in the following pages:

<table>
<thead>
<tr>
<th>Step</th>
<th>Page Reference</th>
</tr>
</thead>
<tbody>
<tr>
<td>STEP ONE</td>
<td>351-354</td>
</tr>
<tr>
<td>STEP TWO</td>
<td>355-358</td>
</tr>
<tr>
<td>STEP THREE</td>
<td>359-362</td>
</tr>
<tr>
<td>STEP FOUR</td>
<td>363-366</td>
</tr>
<tr>
<td>STEP FIVE</td>
<td>367-370</td>
</tr>
</tbody>
</table>
## WORLD VIEWS OF HEALTH PROFESSIONALS ABOUT STEP ONE

Elements of Child and Family Health History collection identified as important in the recommendations of medical professional colleges and associated public policies in Australia, U.K., U.S. and Canada.

<table>
<thead>
<tr>
<th>ELEMENTS OF CHILD AND FAMILY HEALTH HISTORY</th>
<th>REFERENCE</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Establish Child Health Record</strong>&lt;br&gt;Consolidate all relevant health information to establish a comprehensive health record, including that held by: Child protection re child and family / School nurse / Dental services /Community health /GP/ Hospitals (including A&amp;E) /Child-held, parent-held records /Australian Childhood Immunisation Register/Child &amp; Adolescent Mental Health Services&lt;br&gt;Timing and outcome of all assessments completed to date, outcome of specific assessments, test results, medication schedule, ongoing interventions</td>
<td>APHPC 2011 DCSF 2009</td>
</tr>
<tr>
<td><strong>Establish family medical history</strong>&lt;br&gt;A health history of the child and family must be documented to ensure easy access for medical professionals. The College encourages governments to develop and resource permanent and easily transferable health records on children in OOHC, which will be accessible to future health providers and available to parents and carers, by using electronic health records linked to Community Services files.</td>
<td>RACP 2006</td>
</tr>
<tr>
<td><strong>Sharing Child Health History Information</strong>&lt;br&gt;It is the responsibility of the child welfare worker to provide consents for medical charts and obtain thorough documentation of past medical history including medication and immunization records</td>
<td>CPS 2008</td>
</tr>
<tr>
<td><strong>Health information to be gathered at the time of entry to OOHC</strong>&lt;br&gt;• Site (named clinic or provider) of ongoing health care prior to OOHC&lt;br&gt;• Chronic medical, developmental or mental health conditions&lt;br&gt;• Hospitalisations (when, where, why)&lt;br&gt;• Surgery (when, where why)&lt;br&gt;• Medications (names/ indications/ doses)&lt;br&gt;• Allergies (e.g.food, medication, insect stings)&lt;br&gt;• Hospital of birth&lt;br&gt;Items to accompany child&lt;br&gt;• Eyeglasses / medication / medical equipment/ immunization record&lt;br&gt;Information on newborns discharged from hospital to OOHC&lt;br&gt;• Discharge summary/ follow-up appointments / state newborn screening form / immunization record / results of newborn hearing screening</td>
<td>AAP2005</td>
</tr>
<tr>
<td><strong>Information to be gathered before comprehensive health assessment</strong>&lt;br&gt;Complete perinatal history&lt;br&gt;• Mother’s age/ gravidity/ parity/ prenatal care/ illness or infections in pregnancy / medications during pregnancy /drugs, alcohol or tobacco use during pregnancy/ problems with labour/type of delivery/ gestational age / weight, length and head circumference at birth, Apgar scores, Urine toxicology, any neonatal problems&lt;br&gt;Family medical history with particular attention to asthma, TB, hepatitis, STIs, HIV, drug and alcohol use, genetic disorders, developmental and learning issues and psychiatric illness&lt;br&gt;Developmental history of child&lt;br&gt;Psychosocial history, including reasons for placement in OOH, history of previous placements and preventive services, history of child abuse \ or sexual abuse&lt;br&gt;Behavioural and mental health history of child, including diagnoses, use of psychotropic medications, therapy received, history of substance abuse&lt;br&gt;Nutritional history&lt;br&gt;School history</td>
<td>AAP 2005 NICE 2010</td>
</tr>
</tbody>
</table>

Parent consent for routine and emergency medical treatment and to the release of past medical records
RICH PICTURE OF THE PROBLEMATIC SITUATION FOR HEALTH PROFESSIONALS OF STEP ONE: OBTAINING A CHILD’S HEALTH HISTORY IN OUT-OF-HOME CARE, as drawn by Webster SM.
SSM ANALYSIS FOR STEP ONE
Analysis by Webster SM (using an analytical framework drawn from Checkland, & Scholes 2007) of the core purposes and context of an imagined systems for Child Health Histories in Out-of-Home Care, drawing on the worldview of health professionals as expressed in the recommendations of medical professional colleges and associated public policies in Australia, U.K., U.S., and Canada.

<table>
<thead>
<tr>
<th>PROBLEMATIC SITUATION</th>
<th>Children in OOHC lack medical histories</th>
</tr>
</thead>
<tbody>
<tr>
<td>MODEL</td>
<td>1. A system for health histories in OOHC</td>
</tr>
<tr>
<td>ROOT DEFINITION (Definition expresses core purpose of the purposeful activity)</td>
<td>A system which collects information relevant to each child’s medical history and creates a current, written, complete and verified medical history in order to support health assessment and health care planning</td>
</tr>
<tr>
<td>CUSTOMERS (Who benefits or is burdened during the transformation process)</td>
<td>Beneficiaries: health professionals (HP) / children / carers / parents / child protection case managers (CP) / other professionals. Burdened: CP / parents and other family members / community service organisations</td>
</tr>
<tr>
<td>ACTORS (Those who take part in the transformation process)</td>
<td>Parents and other family members / children and young people / CP / HP / government departments and community service organisations</td>
</tr>
<tr>
<td>TRANSFORMATION (The conversion of inputs to outputs; what to do, how to do it, why do it)</td>
<td>Medical information collected from various sources then consolidated into one current, written, comprehensive and verifiable medical history in a standard format, with component parts available to health care providers, child, carers, parents, guardians as required.</td>
</tr>
<tr>
<td>WELTANSCHAUUNG (The worldview which makes the transformation meaningful in this context)</td>
<td>An up-to-date and reliable child and family medical history is an essential requirement for all health professionals in order to provide effective health care.</td>
</tr>
<tr>
<td>OWNER (Those who could stop the transformation)</td>
<td>CP / young people / parents / HP / community service organisations</td>
</tr>
<tr>
<td>ENVIRONMENTAL CONSTRAINTS (Elements outside the system which it takes as given)</td>
<td>Depends on information sharing within privacy legislative constraints. Parents may be unable or unwilling to share child health information. Variable health literacy may affect interpersonal communication. Depends on policy intent re inter-sectoral communication. Depends on effective inter-disciplinary communication.</td>
</tr>
<tr>
<td>ACTIVITIES NECESSARY TO CARRY OUT TRANSFORMATION</td>
<td>1. Appreciate health professionals and carers needs for child health record 2. Establish and agree exact nature and extent of minimum data re child health history information required by health professionals 3. Collect health information 4. Verify information 5. Record information accurately 6. Store information securely and sustainably 7. Protect information privacy 8. Update information continuously</td>
</tr>
<tr>
<td>SYSTEMS PERFORMANCE MEASURES</td>
<td>Efficacy – 95% + of children have minimum health data recorded by CP. Efficiency – Complete record available to health professional as required Effectiveness – (a) High rate of verified health data on children (b) Data meets minimum requirements of health professionals. Ethical – Health history management compliant with Privacy Legislation Elegant—Health history forms part of life story for child in OOHC.</td>
</tr>
</tbody>
</table>
CONCEPTUAL MODEL FOR STEP ONE: A SYSTEM OF CHILD HEALTH HISTORIES IN OUT-OF-HOME CARE
WORLD VIEWS OF HEALTH PROFESSIONALS ABOUT STEP TWO

Elements of Initial Health Assessment identified as important in the recommendations of medical professional colleges and associated public policies in Australia, U.K., U.S. and Canada

<table>
<thead>
<tr>
<th>ELEMENTS OF INITIAL HEALTH ASSESSMENT</th>
<th>REFERENCE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Review Health History</td>
<td></td>
</tr>
<tr>
<td>Review health information from child welfare</td>
<td>AAP 2005, DCSF 2010</td>
</tr>
<tr>
<td>Establish sites of previous/ongoing health care, dental care, routine checks, chronic conditions, hospitalisations, surgery, medications, allergies, hospital of birth, medical equipment used, treatment and monitoring, preventive measures, screening, advice and guidance on promoting health</td>
<td></td>
</tr>
<tr>
<td>Ascertain outstanding appointments and places on waiting lists</td>
<td>DCSF 2009, CPS 2008</td>
</tr>
<tr>
<td>Review medical history including pre-natal risk factors of drug and/or alcohol exposure, family history of mental health disorder or cognitive or functional impairment of parent</td>
<td>DCSF 2009, AAP 2005</td>
</tr>
<tr>
<td>Consolidate health information to establish child health record</td>
<td>APHPC 2011</td>
</tr>
<tr>
<td>Screen for conditions requiring prompt medical attention e.g. illness, infection, pregnancy, chronic conditions needing medication</td>
<td>CPS 2008, AAP 2005, APHPC 2011</td>
</tr>
<tr>
<td>Screen for depression, suicide risk, violent behaviour</td>
<td></td>
</tr>
<tr>
<td>Screening and preliminary assessment across physical, developmental, psychological and mental health domains. Screening tools should be evidence-based, validated, age appropriate, normative and non-stigmatising, cost efficient, able to be used by appropriate clinician. Use of and choice of tools defers to clinical acumen of practitioner</td>
<td>CPS 2008</td>
</tr>
<tr>
<td>Review immunisation status</td>
<td></td>
</tr>
<tr>
<td>Physical Examination</td>
<td>AAP 2005, DCSF 2009</td>
</tr>
<tr>
<td>Physically examine child across all systems – growth, infection, injury, chronic conditions, infections</td>
<td></td>
</tr>
<tr>
<td>Identify signs of abuse or neglect</td>
<td></td>
</tr>
<tr>
<td>See and hear from child and talk about health worries</td>
<td></td>
</tr>
<tr>
<td>Establish current state of child’s health including physical/ emotional/ mental health</td>
<td>DCSF 2010, CPS 2008</td>
</tr>
<tr>
<td>Identify significant development delay or mental health disorder</td>
<td>NICE 2010</td>
</tr>
<tr>
<td>Identify needs of children who do not attract attention (internalizers)</td>
<td>DCSF 2009, DCSF 2010</td>
</tr>
<tr>
<td>Identify unrecognised health needs</td>
<td>AMA 2010, AAP 2005</td>
</tr>
<tr>
<td>Determine the effect of health and health history on child’s development</td>
<td></td>
</tr>
<tr>
<td>Identify factors that adversely impact on healthy child development</td>
<td>DCSF 2009</td>
</tr>
<tr>
<td>Identify chronic physical, developmental and mental health conditions that will require ongoing therapy</td>
<td></td>
</tr>
<tr>
<td>Evaluate need for blood tests e.g. for HIV, hepatitis B and C, STIs, ferritin, lead exposure</td>
<td>DCSF 2009</td>
</tr>
<tr>
<td>Assess health risk</td>
<td></td>
</tr>
<tr>
<td>Determine optimal health care for child in OOHC</td>
<td>AAP 2005</td>
</tr>
<tr>
<td>Provide Treatment</td>
<td></td>
</tr>
<tr>
<td>Determine the urgency for further assessments</td>
<td></td>
</tr>
<tr>
<td>Identify need for vision, hearing and dental screening</td>
<td></td>
</tr>
<tr>
<td>Provide guidance on appropriate composition of multi-disciplinary team required to complete comprehensive and developmental assessments</td>
<td></td>
</tr>
<tr>
<td>Referral</td>
<td>NICE 2010</td>
</tr>
<tr>
<td>Refer to specialised services</td>
<td></td>
</tr>
<tr>
<td>Complete child health record</td>
<td>APHPC 2011</td>
</tr>
<tr>
<td>Establish ongoing relationship between child, carer and primary health provider in order to establish continuity of care</td>
<td></td>
</tr>
<tr>
<td>Provide Assessment Report and Recommendations</td>
<td>DCSF 2010, DCSF 2009</td>
</tr>
<tr>
<td>Provide written report as a basis for monitoring child development in OOHC</td>
<td></td>
</tr>
<tr>
<td>Allow commencement of a Health Management Plan to manage any immediate health, dietary, emotional, sensory or behavioural concerns</td>
<td></td>
</tr>
</tbody>
</table>
RICH PICTURE OF PROBLEMATIC SITUATION FOR HEALTH PROFESSIONALS OF
STEP TWO: INITIAL HEALTH ASSESSMENT
FOR A CHILD IN OUT-OF-HOME CARE, as drawn by Webster SM.

[Diagram showing health care issues for a child in out-of-home care, including need for a safe place, health not urgent, Medicare number paperwork, moving placement, child protection, and lack of child records.]
SSM ANALYSIS FOR STEP TWO

Analysis by Webster SM (using an analytical framework drawn from Checkland, & Scholes 2007) of the core purpose and context of an imagined system for Initial Health Assessment in Out-of-Home Care, drawing on the worldview of health professionals as expressed in the policies of medical professional colleges in Australia, U.K., U.S. and Canada.

<table>
<thead>
<tr>
<th>PROBLEMATIC SITUATION</th>
<th>Child health needs usually unknown at time of entry to OOHC</th>
</tr>
</thead>
<tbody>
<tr>
<td>MODEL</td>
<td>2. A system for initial health assessment at entry to OOHC</td>
</tr>
<tr>
<td>ROOT DEFINITION (Definition expresses core purpose of the purposeful activity)</td>
<td>A system by which CPS ensures each child is examined by a medical doctor at the time of entering OOHC to identify any immediate health difficulties and arrange appropriate, comprehensive health needs assessments which CPS will ensure the child receives.</td>
</tr>
</tbody>
</table>
| CUSTOMERS (Who benefits or is burdened during the transformation process) | **Beneficiaries:** children / carers / parents / child protection staff (CP) / other professionals  
**Burdened:** CP / carers / parents and other family members / government departments and community service organisations / health professionals (HP) |
| ACTORS (Those who take part in the transformation process) | Parents and other family members / children and young people / CPS / HP  
/Government departments and community service organisations  |
| TRANSFORMATION (The conversion of inputs to outputs; what to do, how to do it, why do it) | Using the child’s medical history together with a physical examination, the HP identifies any physical and developmental health issues and recommends appropriate assessment and/or treatment plans in order to meet health needs. |
| WELTANSCHAUUNG (The world view which makes the transformation meaningful in this context) | A medical history and a physical examination are essential requirements for a health professional to determine a child’s health status and health care needs. |
| OWNER (Those who could stop the transformation) | CP / Young person / Carer / HP |
| ENVIRONMENTAL CONSTRAINTS (Elements outside the system which it takes as given) | Child in OOHC may not have usual GP to undertake health assessment.  
Depends on identification by CP of health professional to undertake assessment given health workforce shortages, waiting times and closed books in some GP practices.  
Depends on CP providing health history, consent for assessment and facilitating attendance of child and carer.  
Depends on carer willingness to meet time and financial costs to take child to assessment.  
Depends on carers juggling other competing care responsibilities.  
Depends on health professional readiness and willingness to provide initial health assessment. |
| ACTIVITIES NECESSARY TO CARRY OUT TRANSFORMATION | 1. Child protection agency identify appropriate health professional to conduct health assessment.  
2. Child protection agency refer child to health professional and provide health history information and consent for assessment.  
3. CP ensure child attends health assessment with carer and CP.  
4. Health professional reviews child health history  
5. Conduct appropriate screening tests  
6. Conduct physical examination of the child  
7. Formulate a diagnostic opinion  
8. Order treatment if required  
9. Schedule for additional assessment if required  
10. Refer to another health professional for assessment and/or treatment as required  
11. Update child health record  
12. Write assessment report and health care recommendations  
12. Disseminate report to carer, child protection agency and parent/s as appropriate |
| SYSTEMS PERFORMANCE MEASURES | Efficacy – 95% + of children have initial health assessment at time of entry to OOHC.  
Efficiency – (a) Minimal number of cancelled HP appointments. (b) Child, carer and CP attend most assessment appointments.  
Effectiveness – CP and carer know which child health needs are to be addressed and by whom.  
Ethical – Child rights to health promoting care situation are respected  
Elegant – Health assessment in child friendly environment does not cause undue stress or harm for child. |
CONCEPTUAL MODEL FOR STEP TWO: A SYSTEM FOR INITIAL HEALTH ASSESSMENT IN OUT-OF-HOME CARE, as drawn by Webster SM
### ELEMENTS OF COMPREHENSIVE HEALTH ASSESSMENT

<table>
<thead>
<tr>
<th>ELEMENTS OF COMPREHENSIVE HEALTH ASSESSMENT</th>
<th>REFERENCE</th>
</tr>
</thead>
</table>
| **Review Medical History**  
Review all aspects of history – perinatal, family, developmental, psychosocial, behavioural, nutritional, school and request records (AAP) | AAP 2005 |
| Identify health issues overlooked in the past and need to be addressed (DCSF2010) | DCSF 2010 |
| **Conduct Physical Examination**  
In-depth examination across physical, developmental and psychosocial domains  
Complete unclothed physical examination, including genital examination  
Close inspection for any signs of physical abuse, neglect or maltreatment | APHPC 2011  
CPS 2008  
AAP 2005  
AAP 2005 |
| **Administer Screening**  
Use standard screening tools for developmental surveillance e.g. Strengths & Difficulties Questionnaire (SDQ) or, Achenbach Child Behaviour Checklist (CBCL), Brigance, Ages & Stages as an adjunct to clinical assessment | RACP 2006  
DCSF 2010 |
| **Refer for Additional Screening or Assessment**  
Evaluate the need for referral for psycho-educational assessment  
Identify medical conditions requiring immediate attention  
Implement screening and preventive health measures, including dental follow-up | APHPC 2011  
CPS 2008  
AAP 2005  
AMA 2010  
CPS 2008 |
| **Formulate Diagnoses**  
Detect problems at pre-clinical stage and provide early intervention  
Early diagnosis and treatment to reduce morbidity and disability | RANZCP 2009  
AMA 2010  
RANZCP 2009 |
| **Prescribe Treatment**  
Identify further treatments or interventions required  
Determine optimal treatment for child  
Develop an individualized treatment plan  
Ensure timely access to professional help for children most in need to reduce burden of illness in OOHC | APHPC 2011  
RANZCP 2009  
AAP 2005  
AMA 2010  
RANZCP 2009 |
| **Provide advice to other parties concerned with health of child**  
Provide advice and support to carers.  
Provide information for schools, judges, child welfare and carers to help them better meet the child’s needs and contribute to child’s mental wellbeing. Ensure child’s primary caregiver is fully informed of the child’s developmental history and health symptoms and has appropriate education, training and support available to enhance their capacity to provide optimal care. | APHPC 2011  
RANZCP 2009 |
| **Record and share Assessment Findings**  
Identify medical conditions  
Clearly define the child’s health needs  
Establish and maintain thorough child health record to support consistent care  
Develop a child framework based on a developmental framework of psychopathology that identifies risks and protective factors that contribute to resilience | AAP 2005  
APHPC 2011  
CPS 2008  
RANZCP 2009 |
RICH PICTURE OF THE PROBLEMATIC SITUATION FOR HEALTH PROFESSIONALS OF STEP THREE: COMPREHENSIVE HEALTH ASSESSMENT IN OUT-OF-HOME CARE, as drawn by Webster SM.
SSM ANALYSIS FOR STEP THREE
Analysis by Webster SM (using an analytical framework drawn from [Checkland & Scholes 2007]) of the core purpose and context of an imagined system for Comprehensive Health Assessment in Out-of-Home Care, drawing on the worldview of health professionals as expressed in the recommendations of medical colleges and associated public policies in Australia, U.K., U.S. and Canada

<table>
<thead>
<tr>
<th>PROBLEMATIC SITUATION</th>
<th>Child abuse and neglect can be a determinant of poor life-course health outcomes. Many children in OOHC as a result of maltreatment do not receive systematic and comprehensive assessment to determine their health and development status and health care needs</th>
</tr>
</thead>
<tbody>
<tr>
<td>MODEL</td>
<td>3. A system for comprehensive health assessment in OOHC</td>
</tr>
<tr>
<td>ROOT DEFINITION (Definition expresses core purpose of the purposeful activity)</td>
<td>A system by which child protection services (CP) ensure each child receives routine, comprehensive multi-disciplinary assessment, led by a specialist medical practitioner, of the child’s physical, developmental, emotional and behavioural health needs.</td>
</tr>
<tr>
<td>CUSTOMERS (Who benefits or is burdened during the transformation process)</td>
<td>Beneficiaries: children / carers / parents / CPS / other professionals. Burdened: CP / carers/ parents and other family members / community service organisations / health professionals (HP).</td>
</tr>
<tr>
<td>ACTORS (Those who take part in the transformation process)</td>
<td>Parents and other family members / children and young people / CPS / HP / community service organisations</td>
</tr>
<tr>
<td>TRANSFORMATION (The conversion of inputs to outputs; what to do, how to do it, why do it)</td>
<td>Using the child’s medical history together with screening tools and physical and psychological examinations, the HP identifies health and development difficulties, risks and strengths, and recommends appropriate assessment and / or treatment plans in order to meet health and development needs.</td>
</tr>
<tr>
<td>WELTANSCHAUUNG (The world view which makes the transformation meaningful in this context)</td>
<td>A medical history, health screening results and multi-disciplinary examinations and assessments led by a paediatric medical specialist can improve understanding of a child’s health and development status, enable diagnosis of current conditions and identify risk factors for child health over the life course. This understanding informs the design of appropriate interventions to maximise opportunities for healthy development.</td>
</tr>
<tr>
<td>OWNER (Those who could stop the transformation)</td>
<td>CP, HP, community service organisations. Carers. Parents. Child or adolescent</td>
</tr>
<tr>
<td>ENVIRONMENTAL CONSTRAINTS (Elements outside the system which it takes as given)</td>
<td>Depends on local HP workforce availability. Depends on carers with competing commitments bringing children for assessment. Depends on CP appreciation of the value of comprehensive health assessment. Depends on CP provision of referrals, consents, child health histories and staff to ensure child attends assessments.</td>
</tr>
<tr>
<td>ACTIVITIES NECESSARY TO CARRY OUT TRANSFORMATION</td>
<td>1. CPS identifies specialist HP who already has care of child or new specialist HP to provide comprehensive health assessment for OOHC</td>
</tr>
<tr>
<td></td>
<td>2. CPS makes health assessment appointment with specialist HP and facilitates child, OOHC carer, parent and case manager to attend</td>
</tr>
<tr>
<td></td>
<td>3. CPS provides specialist HP with GP referral, written child medical history information, written guardian’s consent to medical assessment and routine preventive care e.g. immunisation</td>
</tr>
<tr>
<td></td>
<td>4. Specialist HP/ team triages referral</td>
</tr>
<tr>
<td></td>
<td>5. Specialist HP/ team reviews medical history, obtains input from child, carer and/or parent and examines child</td>
</tr>
<tr>
<td></td>
<td>6. Specialist HP/team determines and provides an appropriate range of comprehensive health assessments for each child</td>
</tr>
<tr>
<td></td>
<td>7. Specialist HP/team leader formulates diagnoses</td>
</tr>
<tr>
<td></td>
<td>8. Specialist HP/team leader updates child medical history and provides written records and health management plan to CPS, carer, parent and guardian and child.</td>
</tr>
<tr>
<td>SYSTEMS PERFORMANCE MEASURES</td>
<td>Efficacy – 95% + of children have comprehensive health assessment within 90 days of entry to OOHC. Efficiency – (a) Minimal number of cancelled HP appointments. (b) Child, carer and CP attend most assessment appointments. Effectiveness – (a) HP, CP and carer know which child health needs are to be addressed and by whom (b) HP contributes to data about health needs of OOHC cohort. Ethical – Child rights to health promoting care situation are respected. Elegant—Health assessment in child friendly environment does not cause undue stress or harm for child.</td>
</tr>
</tbody>
</table>
CONCEPTUAL MODEL FOR STEP THREE: A SYSTEM FOR COMPREHENSIVE HEALTH ASSESSMENT IN OUT-OF-HOME CARE

Child Protection Service

1. Identify health provider
2. Make appointment
3. Provide GP referral, consent, & medical history
4. Ensure attendance

Monitor

Control

Specialist health provider/s

5. Triage

6. Review child history

7. Screening
8. Physical examination

9. Formulate diagnoses

10. Update medical history

11. Write assessment report & Health management plan

12. Disseminate report to carer/case manager / parent
WORLD VIEWS OF HEALTH PROFESSIONALS ABOUT STEP FOUR:

Elements of Child Health Management Planning identified as important in the recommendations of medical professional colleges and associated public policies in Australia, U.K., U.S. and Canada.

<table>
<thead>
<tr>
<th>ELEMENTS OF CHILD HEALTH MANAGEMENT PLANNING</th>
<th>REFERENCE</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Coordinate and Plan Continuity of Care</strong></td>
<td></td>
</tr>
<tr>
<td>Plan how to organise and prioritise health interventions</td>
<td>RANZCP 2009</td>
</tr>
<tr>
<td>Provide continuity with previous plans and interventions</td>
<td>DCSF 2009</td>
</tr>
<tr>
<td>Identify appropriate multidisciplinary approaches</td>
<td>RANZCP 2009</td>
</tr>
<tr>
<td>Facilitate coordination and continuity of care</td>
<td></td>
</tr>
<tr>
<td>Describe how health care will be coordinated to support effective and efficient use of health care services</td>
<td>RANZCP 2009</td>
</tr>
<tr>
<td><strong>Clinical Governance</strong></td>
<td></td>
</tr>
<tr>
<td>Establish line of clinical authority to paediatrician or psychiatrist</td>
<td>RANZCP 2009</td>
</tr>
<tr>
<td>Specify who should undertake review assessments</td>
<td>DCSF 2009</td>
</tr>
<tr>
<td>Identify health care coordinator for each child</td>
<td>RANZCP 2009</td>
</tr>
<tr>
<td>GPs have central position in coordinating services and identifying needs for CYP</td>
<td>AMA 2010</td>
</tr>
<tr>
<td><strong>Record Planned Activities and Assign Responsibility</strong></td>
<td>DCSF 2009</td>
</tr>
<tr>
<td>Set out objectives, actions, timescales and responsibilities arising from health assessments, including routine checks, treatment and monitoring for identified health needs, preventive measures, screening, health promotion</td>
<td></td>
</tr>
<tr>
<td>Plan for treatment and assistance to be provided in a timely manner, aimed at reducing impairments and disabilities and minimizing suffering. Plan rehabilitation to ensure acceptable quality of life.</td>
<td>AMA 2010</td>
</tr>
<tr>
<td>Medical plan to reduce symptoms and facilitate functioning</td>
<td>RANZCP 2009</td>
</tr>
<tr>
<td>Describe management plan including:</td>
<td></td>
</tr>
<tr>
<td>a) Treatment plans developed to organise and prioritise interventions in major areas of life i.e. home, peers, school with emphasis on enhancing strengths.</td>
<td>RANZCP 2009</td>
</tr>
<tr>
<td>b) Therapeutic interventions planned, which may include medications, to address symptoms and facilitate functioning</td>
<td>RANZCP 2008</td>
</tr>
<tr>
<td>c) Monitoring of progress and outcomes of therapeutic interventions</td>
<td></td>
</tr>
<tr>
<td>d) Identify any complications associated with treatment and remedial action</td>
<td></td>
</tr>
<tr>
<td>e) Maintain strategies for control of chronic problems</td>
<td></td>
</tr>
<tr>
<td><strong>Consolidate Child Health History</strong></td>
<td></td>
</tr>
<tr>
<td>Record child’s state of health</td>
<td>DCSF 2009</td>
</tr>
<tr>
<td>Partner with child welfare to establish and maintain thorough health records to support consistent care and follow up</td>
<td>CPS 2008</td>
</tr>
<tr>
<td>Health plan will consist of comprehensive health record, + relevant referrals + schedule of future assessments or treatments. Health Management Plan should be incorporated in personal health record held by child/carer and supplemented at each health visit.</td>
<td>APHPC 2011</td>
</tr>
<tr>
<td>Lead health record should be GP held record, including health assessment and health plan</td>
<td>DCSF 2010</td>
</tr>
<tr>
<td><strong>Plan Carer Support</strong></td>
<td></td>
</tr>
<tr>
<td>Describe education and support activities for child’s social network</td>
<td>RANZCP 2008</td>
</tr>
<tr>
<td>Carer is fully informed of child’s developmental history and mental health symptoms and appropriate training and support is available to carer to enhance their capacity to participate in provision of optimal care</td>
<td>RANZCP 2008</td>
</tr>
</tbody>
</table>
RICH PICTURE OF THE PROBLEMATIC SITUATION FOR HEALTH PROFESSIONALS
OF STEP FOUR: CHILD HEALTH CARE PLANNING IN OUT-OF-HOME CARE, as drawn
by Webster SM.
SSM ANALYSIS STEP FOUR

**Analysis by Webster SM (using an analytical framework drawn from Checkland & Scholes 2007) of the core purpose and context of an imagined system for Child Health Management Planning in Out-of-Home Care, drawing on the worldview of health professionals as expressed in the recommendations of medical professional colleges and associated public policies in Australia, U.K., U.S. and Canada.**

<table>
<thead>
<tr>
<th>PROBLEMATIC SITUATION</th>
<th>Children in OOHC often lack continuity of carer, of case management and of geographical location which can result in lack of continuity in how their health care needs are managed.</th>
</tr>
</thead>
<tbody>
<tr>
<td>MODEL</td>
<td>4. A system for child health management planning</td>
</tr>
<tr>
<td>ROOT DEFINITION (Definition expresses core purpose of the purposeful activity)</td>
<td>A system by which child protection staff (CP) ensure each child receives the steps of care and/or treatments and reviews recommended by health professionals (HP)</td>
</tr>
</tbody>
</table>
| CUSTOMERS (Who benefits or is burdened during the transformation process) | **Beneficiaries:** children / carers / parents  
**Burdened:** CP / carers / parents and other family members / government departments and community service organisations / HPs |
| ACTORS (Those who take part in the transformation process) | HPs / children / CP / carers / Government departments and community service organisations |
| TRANSFORMATION (The conversion of inputs to outputs; what to do, how to do it, why do it) | Health professional responsible for assessing health needs develops an individual Child Health Management Plan which people caring for the child follow, according to their agreed responsibilities, to ensure the child receives the steps of care, treatments and reviews recommended by the HP |
| WELTANSCHAUUNG (The world view which makes the transformation meaningful in this context) | Clinical governance for the health of a child in OOHC most effectively rests with a qualified health professional. Following the recommendations in a Health Management Plan will maximise the opportunities for the child’s healthy development. |
| OWNER (Those who could stop the transformation) | CP / Government departments and community service organisations. HPs |
| ENVIRONMENTAL CONSTRAINTS (Elements outside the system which it takes as given) | Development and recording of Plans can require additional health professional time.  
Delegation of role of health care coordination role will require negotiation between parties in most cases.  
A threshold level of health literacy is required for effective health care coordination.  
Active case management in OOHC has been found to determine likelihood of implementation of Health Management Plans |
| ACTIVITIES NECESSARY TO CARRY OUT TRANSFORMATION | 1. Develop and record Health Management Plan  
2. Disseminate Health Management Plan  
3. Designate responsible Health Care Coordinator for each child  
4. Track that child receives treatments  
5. Ensure that child had aids and appliances  
6. Track that child and carer attend assessment or therapy appointments  
7. Address barriers to implementing plan  
8. Continually update child health record  
9. Ensure the Health Management Plan is periodically reviewed |
| MONITORING AND CONTROL | Efficacy – 95% of children in OOHC have a current Health Management Plan with implementation responsibilities assigned.  
Efficiency – Plans are written in formats which are easy to produce and easy to follow.  
Effectiveness – 95% of children (a) have their Health Care Plan periodically reviewed, at intervals indicated by the lead health professional (b) have up to date health records  
Ethicality – Child Health Management Plan represents a plan for reparative health care as required to minimise the health impacts of past maltreatment.  
Elegance – an age appropriate form of the Child Health Management Plan is available to the child in a format which is valued by the child. |
CONCEPTUAL MODEL FOR STEP FOUR: A SYSTEM FOR CHILD HEALTH CARE PLANNING IN OUT-OF-HOME CARE, as drawn by Webster SM
## Elements of Ongoing Health Monitoring and Review

<table>
<thead>
<tr>
<th>Frequency of Review</th>
<th>Reference</th>
</tr>
</thead>
</table>
| Follow-up frequency is a clinical decision for each child, dependant on age and individual case | AAP 2005  
| Timing may be aligned with recommendations for general population in jurisdiction. | APHPC 2011  
| Additional assessments should also occur after change of placement or transition from care. | APHPC 2011  
| Health plan review should take place at least every 6 months for 0-5 year olds and annually for children aged 5+. | DCSF 2010  
| Monitoring should take place monthly for infants aged 0-6 months, and then at the discretion of the physician until child aged 2 years. From age 2-17 years reviews should occur 6 monthly. | AAP 2005  
| First review should occur 30 days after Comprehensive Health Assessment | AAP 2005  
| Children who are currently or have previously been in OOHC should be monitored more frequently than the general paediatric population. | CPS 2008  

### Purpose of first review after Comprehensive Health Assessment

- To identify problems while the child has been in OOHC, assess goodness of fit between child and foster placement, update immunisation, provide health information and education to carers, review findings of developmental and mental health assessment, update, refine and reinforce treatment plan/health plan.

### Purpose of subsequent Reviews

- Foster healthy growth and development.
- Identify significant problems with health, schooling, behaviour, emotional health and development as they occur.
- Assess foster placement.
- Monitor for signs of abuse or neglect.
- Provide age-appropriate anticipatory advice.
- If any health concerns or problems arise for child it is essential that treatment and assistance are provided in a timely manner. Failure to do so may increase the likelihood of long term negative outcomes.
- Ongoing health care should incorporate systematic monitoring with improved continuity of care and information sharing between involved parties and attention to preventative health care, health education and health promotion.

### Clinical Governance

- GPs play a pivotal role in the early recognition of problems and identification of at risk children. General practice nurses also provide valuable support, particularly in screening activities.
- Every Child Health Management Plan should be reviewed by a paediatrician at least once every 2 years.

### Health Monitoring as part of OOHC Case Review

- The health assessment is not an isolated event but part of a continuous process with emphasis on ensuring actions in the health plan are being taken forward. Issues raised by the health review should be considered as part of the OOHC care planning and review process and any necessary actions included in the child's OOHC case plan.

### Monitoring the Health of the OOHC Cohort

- The role of health professionals conducting health assessments and reviews is to ensure the quality of assessments, ensure that sensitive health promotion is offered, provide an analysis of the range of health neglect and need for health care for local children in OOHC, ensure the implementation of health plans, contribute to the production of data on children in OOHC, review patterns of health care referrals and their outcomes and evaluate the extent to which children's views are informing the design of local health services for them.

### Reference

- AAP 2005
- APHPC 2011
- DCSF 2010
- AMA 2010
- RACP 2008
- CPS 2008
RICH PICTURE OF THE PROBLEMATIC SITUATION FOR HEALTH PROFESSIONALS
OF STEP FIVE: ONGOING HEALTH MONITORING & REVIEW
IN OUT-OF-HOME CARE, as drawn by Webster SM.
SSM ANALYSIS FOR STEP FIVE

Analysis by Webster SM (using an analytical framework drawn from Checkland & Scholes 2007) of the core purpose and context of an imagined system for Health Monitoring and Review in Out-of-Home Care, drawing on the worldview of health professionals as expressed in the recommendations of medical professional colleges and associated public policies in Australia, U.K., U.S. and Canada.

<table>
<thead>
<tr>
<th>PROBLEMATIC SITUATION</th>
<th>Child maltreatment is a determinant of poorer health outcomes in child health and development over the life-course. Different health issues can be expected to arise at different ages and stages of development.</th>
</tr>
</thead>
<tbody>
<tr>
<td>MODEL</td>
<td>5. A system for routine, systematic, ongoing monitoring and review of health of each child in OOHC</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>ROOT DEFINITION</th>
<th>A system by which child protection staff (CP) ensure the health of each child in OOHC is re-assessed by a health professional (HP) at regular intervals appropriate to their age and stage of development and at the time of sentinel events such as changes in OOHC placement.</th>
</tr>
</thead>
</table>
| CUSTOMERS (Who benefits or is burdened during the transformation process) | Beneficiaries: children / carers / parents / CP / other professionals  
Burdened: CP / carers / government departments and community service organisations/ HP |
| ACTORS (Those who take part in the transformation process) | CPS / carers / children and young people/HP / Government departments and community service organisations |
| TRANSFORMATION (The conversion of inputs to outputs; what to do, how to do it, why do it) | CPS engage HPs to re-assess the health of each child according to an agreed schedule for the child to ensure that treatment efficacy is reviewed, newly emerging health needs are addressed and health risk factors are identified for modification. |
| WELTANSCHAUUNG (The world view which makes the transformation meaningful in this context) | Preventive care, ongoing monitoring and timely health interventions for children at high risk of adverse health outcomes can improve health trajectories over time. |
| OWNER (Those who could stop the transformation) | Government departments / CP / community service organisations/ HP |
| ENVIRONMENTAL CONSTRAINTS (Elements outside the system which it takes as given) | Entails financial cost for CPS  
Depends on cooperation of child and carer  
Depends on CP systems to track children who change place of residence  
Depends on active CPS case management  
Depends on availability of appropriate health professional |
| ACTIVITIES NECESSARY TO CARRY OUT TRANSFORMATION | 1. Following agreed review schedule for each child in OOHC, CPS ensures HP reviews are scheduled, as far as possible with a HP who has conducted previous assessments.  
2. CP provides HP with child medical history, consents for assessment and preventive care e.g. immunisations, and with payment arrangements.  
3. CP ensures child, carer, parent, and case manager participate in the assessment.  
4. HP reviews child medical history, including findings of developmental and mental health assessment, reviews carer and other input and examines child, to identify any significant problems with health, schooling, behaviour, emotional health and development as they occur.  
5. Treatments or further assessments are provided or coordinated as indicated  
6. Provide health information and education to carers  
7. Update, refine and reinforce treatment/health management plan  
8. Update child medical history  
9. New Child Health Management is written and shared with all parties involved in the child’s care. |
| SYSTEMS PERFORMANCE MEASURES | Efficacy – The health plan is reviewed as per schedule  
Efficiency – Missed health appointments for reviews are < 5%  
Effectiveness –  
a) Health problems are detected and managed in timely way  
b) Carers feel adequately supported to manage child health needs  
c) Data from reviews contributes to understanding of health needs in OOHC cohort.  
Ethicality – Reviews supported child right to highest attainable standard of Health. The process is valued by the child. |
CONCEPTUAL MODEL FOR STEP FIVE: A SYSTEM FOR MONITORING AND REVIEW OF CHILD HEALTH IN OUT-OF-HOME CARE

1. ARRANGE FOR HEALTH PROFESSIONAL TO REVIEW CHILD HEALTH PLAN

2. ORGANISE HISTORY, CONSENTS & PAYMENT

3. ENSURE CHILD / CARER / CASE MANAGER ATTEND

4. REVIEW MEDICAL HISTORY, ASSESSMENT RESULTS, CARER INPUT

5. EXAMINE CHILD TO IDENTIFY ANY SIGNIFICANT PROBLEMS

6. FURTHER ASSESSMENT

7. PROVIDE TREATMENT

8. PROVIDE INFORMATION & EDUCATION TO CARER

9. UPDATE / REINFORCE HEALTH PLAN

10. UPDATE MEDICAL HISTORY

11. SHARE REVISED PLAN

child protection

health professional

MONITOR

CONTROL
## PUBLICATIONS ARISING FROM THE THESIS

<table>
<thead>
<tr>
<th>Publication Title</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Webster, S.M., &amp; Temple-Smith, M.J. (2012), A whisper or a roar? The Australian research conversation about health in out-of-home care. <em>Developing Practice, 30</em>, 63-72.</td>
<td>374</td>
</tr>
</tbody>
</table>

Prepared by Susan M. Webster as an Appendix to a Thesis submitted in total fulfilment of the requirements of the degree of Doctor of Philosophy, University of Melbourne May 16, 2014.
A WHISPER OR ROAR? THE AUSTRALIAN RESEARCH CONVERSATION ABOUT HEALTH IN OUT-OF-HOME CARE

BY SUSAN WEBSTER
General Practice and Primary Health Care Academic Centre, The University of Melbourne

MEREDITH TEMPLE-SMITH
General Practice and Primary Health Care Academic Centre, The University of Melbourne

Introduction
Tapping into the academic ‘conversation’ is a vital process for researchers entering a new subject area (Clark 2007). Conversation about health needs and health care of children and young people living in out-of-home care in Australia can be traced back to the early 1800s when ships’ surgeons and superintendents of orphan schools kept detailed records to report on the growth, health and mortality of children cared for in the colonies (Gandevia & Simpson, 1978). This article tunes in on the conversation almost 200 years later.

The conversational volume in the early part of the last decade appears to have been more a whisper than a roar, with few conversants. Between 1995 and 2004, just 17 academic studies examined any aspect of child wellbeing in the child protection field; only eight of these were about health (Higgins, Adams, Bromfield, Richardson & Aldana, 2005). This level of research failed to provide an adequate evidence base for Australian policy and practice (Tomison, 2000, Cashmore, Higgins, Bromfield & Scott, 2006, Bromfield & Osborn, 2007).

National audits in 2005-2006 (Higgins et al., 2005, Bromfield & Osborn, 2007) sought to provide impetus and clear direction for Australian child protection research, including research about health needs and health care of children and young people in out-of-home care. We have examined research published since then, asking:

1. What types of organisations have invested in research?
2. Which academic disciplines have been involved?
3. What new knowledge has research generated in the last five years about health in out-of-home care in Australia?
4. What are the current threads of the academic conversation?

To avoid duplicating a systematic review of research about residential and specialised models of care (Bromfield & Osborn, 2008), and given only six per cent of children and young people in out-of-home care in 2010 were in residential care (AIHW, 2011), this study focused on home-based out-of-home care (i.e. foster and kinship care).
Method
Between April and December 2010, six databases (Web of Science, EBSCO, Informit, PsycArticles, SCOPUS, PubMed) were searched for any journal article published in 2006-2010 reporting Australian research on an aspect of child or adolescent health in out-of-home care, including physical, mental, emotional, behavioural, cultural or developmental health. Research on health care systems or health decision making in out-of-home care were included, as were relevant editorials, letters to the editor and critical analyses.

Articles were categorised using the Medical Journal of Australia typology for journal articles1 (Table 1). Interestingly, the only category in which no articles were identified was Clinical Update.

Increased research activity despite modest funding
The search identified 53 publications which included 44 research reports of 34 different studies. Unfortunately, the quantum of funding was not disclosed in any reports. Despite the increased number of studies and publications since the national audits, closer analysis suggested only modest financial investment in research in health in out-of-home care.

Some studies appeared to have been commissioned to independent research bodies (Jackson, Frederico, Tanti & Black, 2009, Frederico, Jackson & Black, 2008, Milburn, Lynch & Jackson, 2008, Tarren-Sweeney, 2006b, Cashmore & Paxman, 2006). More studies were funded by charities (12%) than through national competitive research rounds (8%) (Table 2).

Table 1: Published articles (2006-2010) relating to health/health care for Australian children aged 0-17 years living in out-of-home care, listed by Medical Journal of Australia typology, 2010

<table>
<thead>
<tr>
<th>TYPE OF ARTICLE</th>
<th>NUMBER</th>
<th>PERCENTAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Editorial</td>
<td>4</td>
<td>7.5 %</td>
</tr>
<tr>
<td>Research</td>
<td>44</td>
<td>83 %</td>
</tr>
<tr>
<td>Review</td>
<td>3</td>
<td>5.5 %</td>
</tr>
<tr>
<td>Clinical Update</td>
<td>-</td>
<td>0%</td>
</tr>
<tr>
<td>Personal Perspective</td>
<td>1</td>
<td>2 %</td>
</tr>
<tr>
<td>Letter to the Editor</td>
<td>1</td>
<td>2 %</td>
</tr>
<tr>
<td>TOTAL</td>
<td>53</td>
<td>100%</td>
</tr>
</tbody>
</table>
Table 2: Number of Australian research studies (2006 – 2010) relating to health needs/health care for children in out-of-home care, categorised by research funding source (percentages have been rounded).

<table>
<thead>
<tr>
<th>FUNDING SOURCE</th>
<th>RESEARCH GENERATING ORIGINAL DATA</th>
<th>%</th>
<th>RESEARCH USING SECONDARY DATA</th>
<th>%</th>
<th>TOTAL</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHMRC</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ARC Linkages</td>
<td>1</td>
<td>3%</td>
<td>0%</td>
<td>0%</td>
<td>1</td>
<td>3%</td>
</tr>
<tr>
<td>ARC Linkages + RHD</td>
<td>-</td>
<td>0%</td>
<td>1</td>
<td>3%</td>
<td>1</td>
<td>3%</td>
</tr>
<tr>
<td>ARC + Charity</td>
<td>1</td>
<td>3%</td>
<td>0%</td>
<td>0%</td>
<td>1</td>
<td>3%</td>
</tr>
<tr>
<td>Criminology Research Council</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Australian Housing &amp; Urban Research Institute + Charity</td>
<td>-</td>
<td>0%</td>
<td>1</td>
<td>3%</td>
<td>1</td>
<td>3%</td>
</tr>
<tr>
<td>Australian Rotary Research Fund</td>
<td>1</td>
<td>3%</td>
<td>0%</td>
<td>0%</td>
<td>1</td>
<td>3%</td>
</tr>
<tr>
<td>Charitable trust only</td>
<td>3</td>
<td>9%</td>
<td>1</td>
<td>3%</td>
<td>4</td>
<td>12%</td>
</tr>
<tr>
<td>Research Higher Degree Studies</td>
<td>4</td>
<td>12%</td>
<td>2</td>
<td>6%</td>
<td>6</td>
<td>18%</td>
</tr>
<tr>
<td>State governments</td>
<td>7</td>
<td>20%</td>
<td>3</td>
<td>9%</td>
<td>10</td>
<td>28%</td>
</tr>
<tr>
<td>No funding disclosed</td>
<td>2</td>
<td>6%</td>
<td>6</td>
<td>18%</td>
<td>8</td>
<td>24%</td>
</tr>
<tr>
<td>TOTAL</td>
<td>19</td>
<td>56%</td>
<td>15</td>
<td>44%</td>
<td>34</td>
<td>100%</td>
</tr>
</tbody>
</table>

66 developing practice issue 30: Summer 2012
### Table 3: Number of Australian research studies (2006 – 2010) relating to health needs/health care for children in out-of-home care, categorised by first author’s academic discipline (percentages have been rounded).

<table>
<thead>
<tr>
<th>ACADEMIC DISCIPLINE OF FIRST AUTHOR</th>
<th>NUMBER OF RESEARCH STUDIES GENERATING ORIGINAL DATA</th>
<th>%</th>
<th>NUMBER OF RESEARCH STUDIES INVOLVING SECONDARY DATA</th>
<th>%</th>
<th>TOTAL</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child Protection Policy</td>
<td>-</td>
<td>0%</td>
<td>1</td>
<td>3%</td>
<td>1</td>
<td>3%</td>
</tr>
<tr>
<td>Health Informatics</td>
<td>-</td>
<td>0%</td>
<td>1</td>
<td>3%</td>
<td>1</td>
<td>3%</td>
</tr>
<tr>
<td>Law</td>
<td>1</td>
<td>3%</td>
<td>-</td>
<td>0%</td>
<td>1</td>
<td>3%</td>
</tr>
<tr>
<td>Paediatrics</td>
<td>3</td>
<td>9%</td>
<td>1</td>
<td>3%</td>
<td>4</td>
<td>12%</td>
</tr>
<tr>
<td>Primary Health Care</td>
<td>1</td>
<td>3%</td>
<td>-</td>
<td>0%</td>
<td>1</td>
<td>3%</td>
</tr>
<tr>
<td>Psychiatry#</td>
<td>2</td>
<td>6%</td>
<td>-</td>
<td>0%</td>
<td>2</td>
<td>6%</td>
</tr>
<tr>
<td>Psychology#</td>
<td>3</td>
<td>9%</td>
<td>5</td>
<td>15%</td>
<td>8</td>
<td>24%</td>
</tr>
<tr>
<td>Social Work</td>
<td>10</td>
<td>29%</td>
<td>5</td>
<td>15%</td>
<td>15</td>
<td>44%</td>
</tr>
<tr>
<td>Statistics / Economics</td>
<td>-</td>
<td>0%</td>
<td>1</td>
<td>3%</td>
<td>1</td>
<td>3%</td>
</tr>
<tr>
<td>TOTAL</td>
<td>20</td>
<td>56%</td>
<td>14</td>
<td>44%</td>
<td>34</td>
<td>100%</td>
</tr>
</tbody>
</table>

# Although 19 studies generated original data, one study produced two papers by different authors from different disciplines (Carbone 2007, Sawyer 2007), and is recorded twice.

**Which disciplines have been involved?**
Social workers and psychologists were first authors for most studies (Table 3).

**What new knowledge has emerged?**
Importantly, five studies compared the extent of health needs within their sample with the broader Australian population. Overall, prevalence of health problems was much higher in children in out-of-home care than in the Australian population, comparable to that found in US and UK studies (Fernandez, 2008, Milburn et al., 2008, Nathanson & Tzioumi, 2007, Carbone, 2007, Sawyer et al., 2007). The prevalence of mental health problems, for example, was two to five times greater in children in out-of-home care (Jackson et al., 2009, Fernandez, 2008, Sawyer et al., 2007).

Australian children in out-of-home care were also more likely to have multiple health concerns at entry to care than those not in care, with 70 to 90 per cent requiring multiple referrals for further assessment and treatment (Kaltner & Rissel, 2010, Carbone et al., 2007, Nathanson, Lee & Tzioumi, 2009).

Some studies utilised standardised tools, allowing identification of health conditions severe enough for treatment (Fernandez, 2008, Tarren-Sweeney, 2006). Whilst such data showed severity rates were higher among study children than the wider community, the use of tools was repeated only occasionally across studies, limiting the value of the data.

The incidence, complexity and effect of health problems in out-of-home care in Australia significantly lower children’s quality of life to levels comparable to those experienced by children with diabetes, asthma or cystic fibrosis (Carbone et al., 2007).

**What are the current threads of the conversation?**

Critical analysis articles, editorials, letters to the editor and conclusions and recommendations of individual research studies provided useful windows to the current conversation, which seems to include four main threads about future directions.

**Support for systematic health assessment in out-of-home care**

More systematic measurement of health needs for all children in care is needed. Children require pre-emptive, population-based assessment of all aspects of their health at their entry to care (Crawford, 2006, Tarren-Sweeney, 2010). Further, different assessments are carried out, depending on the child’s developmental stage. Infants and young people leaving care, for example, have particular but different monitoring needs (Milburn et al., 2008, Zhou, 2010).

Some sub-populations warrant additional assessment, monitoring and research e.g. children with intellectual disabilities, Aboriginal and Islander children, immigrant and refugee children (Tarren-Sweeney, 2010, Tilbury, 2009).

**Improved training for health professionals**

Tarren-Sweeney urges health professionals to be clinically competent to assess this cohort. Australia needs to build professional frameworks for clinical specialisation in child welfare and out-of-home care. He argues that acute-based services are a poor match for these children, who need greater continuity and certainty of care than hospitals are designed to provide (Tarren-Sweeney 2010). General practitioners are currently at the forefront of health care for those in out-of-home care.

While GPs with special interests in child/adolescent health are motivated to provide assessment and continuity of care to children in out-of-home care,
they need support to enhance their clinical skills and case-based knowledge (Webster & Temple-Smith 2010).

**Call for more focused and sustained clinical research**

Several researchers have argued for more systematic measurement of the outcomes of assessment and treatment for children in out-of-home care, both in terms of service access and response to treatment/therapy (Chambers et al., 2010, Tarren-Sweeney, 2010, Ronan & Feather, 2009, Tilbury, 2006).

Tarren-Sweeney's research has gone beyond measurement of prevalence to examine the complexities of children's health problems, such as eating disorders, inappropriate sexualised behaviour and mental health (Tarren-Sweeney, 2010, 2008a, 2008b). He argues that many children with complex problems are unlikely to respond to normal treatment for single conditions such as depression. He found that professionals show considerable diagnostic disagreement and uncertainty in framing the complex psychopathology seen in out-of-home care, and that international mental health classification systems are inadequate for this group.


Clinical research on parents' health and children's birth histories is also of interest to further understand biological factors affecting child health (Chambers et al., 2010, Frederico et al., 2008, Ingall, 2006, Tarren-Sweeney, 2006). Why some children in care have good mental health despite adversity is not well understood; further research on resilience mechanisms is needed.

Clinical research not only requires extension for improved understanding, but also to support evidence-based assessment and interventions (Ronan, Canoy & Burke, 2009).

**Need to address service system challenges**

Researchers have identified systemic problems including:

- The exclusion of health care management from accountability measures in child protection (Tilbury, 2006)
- Variable recognition by statutory guardians of the duty of care owed to children in relation to health (Tarren-Sweeney, 2010)
- Difficulties in engaging carers in health assessment processes (Chambers et al., 2010)
- Collection and retrieval of child health records (Nathanson et al., 2009, Crawford, 2006)
- Geographical and other barriers to health service access and lack of monitoring of child health needs (Smith, 2008).

The most visible systemic shortcoming is the poor capacity to address health for each and every child, despite the rate of clinical problems in the out-of-home care population warranting systematic, universal assessment. Clinical researchers have argued that Australian authorities cannot meet best practice standards without a significant service delivery expansion (Tarren-Sweeney 2010, Crawford, 2006).
Conclusion

Analysing the academic conversation has allowed us to consider the content, the speakers and the silences.

Australian studies have appropriately focused on the health needs of children and young people. Researchers recognise the urgency of examining how these needs are met (Tilbury, 2006, Tarren-Sweeney, 2010) but no research has systematically reviewed systems of health management in out-of-home care.

Despite the high health burden in the Australian out-of-home care population, this issue has attracted scant research investment from medical disciplines or national health research bodies. This seems stark when considering the National Health and Medical Research Council’s (NHMRC) overall expenditure on child abuse research against expenditure for health conditions with a comparable impact on child health.²

From a health sector perspective, the emerging national picture is that research varies widely in aims and magnitude, and lacks any unifying thread beyond the sustained interest of a modestly-sized group of individual researchers and clinicians. With the exception of the work of Fernandez and Tarren-Sweeney, the body of research on health appears fragmented and somewhat isolated from any broader state, territory or national research agenda.

In the last five years, the conversation has become a murmur rather than a whisper. In the next decade, a roar of research is warranted.

ENDNOTES


2. NHMRC funding between 2000 and 2010 for research into conditions with a comparable impact on children’s quality of life was $16.6 million for cystic fibrosis, $20.2 million for juvenile diabetes and $48.4 million for childhood asthma. These investments compared with $1.16 million for child abuse. Downloaded on 16 Dec 2010 from URL: http://www.nhmrc.gov.au/grants/dataset/list/index.htm

Bibliography


Articles


Articles


Improving the health of Australian children entering out-of-home care

Assessing health status is only the beginning

Decisions to remove children from their biological parents are never taken lightly. Such decisions are reinforced by the growing body of evidence of the adverse short- and long-term outcomes of child maltreatment, which are increasingly seen to be mediated through the effects of abuse on early brain development.

Given the prevalence of physical, developmental and psychosocial morbidity in this population, most clinicians would agree that every Australian child and young person taken into the protection of out-of-home care following abuse or neglect should receive a comprehensive assessment of their physical, developmental, psychosocial and mental health needs. To maximise each young Australian’s chance of achieving optimum health after abuse or neglect, the first national out-of-home care standards, introduced from 1 July 2011, challenge state and territory governments to work more closely with doctors to reach and maintain new health assessment and treatment goals.

At 30 June 2010, 35,895 Australians aged 0–17 years lived in out-of-home care. Of these, 12,002 had entered care during the previous financial year. The health status of these children has become a matter of increasing concern in Australia over the past decade. A recent study of 122 children attending a specialist clinic for children in out-of-home care found that only 5% had no recognised health issues. Health issues ranged from the relatively simple, such as uncertainty about immunisation status, to the complex, such as the developmental, emotional and behavioural problems that are often the sequelae of earlier trauma, and poor attachment. Professional, medical, families and research studies of children in out-of-home care have each pointed to an increased risk of poor short- and long-term physical and mental health outcomes.

Most Australian jurisdictions expect the child protection system to ensure the conduct of health checks of children entering out-of-home care. In reality, practice has not always met the expectation. Recent audits in two states suggested that less than 25% of children receive comprehensive assessment in a timely way or have acceptable health records and child health care management plans in place.

Even when health needs are identified, many young people in out-of-home care do not have these needs met. Current practice will need to change substantially in most Australian states and territories if the new standards are to be met within the next 3 years.

We face significant challenges in improving the management of the health of children and young people in out-of-home care.

The first, overarching hurdle lies in replicating the work of vigilant, emotionally attached parents who steer most Australian children successfully through the sea of the Australian health care system. Health professionals rely on parents to provide medical histories, monitor wellbeing, locate appropriate health services, explain health concerns, consent to assessment and treatment, and monitor outcomes. When children and young people are dislocated from this parental relationship, there is a high risk that the understanding about the individual child’s health needs, health history and continuity of health care may be lost, despite the dedication and best efforts of carers and case managers.

Second, health service providers face their own challenges. Although initial assessments of health status addressing immunisation, vision and hearing can be straightforward, determining which children need more comprehensive assessments and require multidisciplinary input is far more complex. Which triage tools are the most appropriate? One model has been described and included in a care plan, who should take on the case management role to ensure that they are addressed in a timely and ongoing way? Should this be a health professional or staff employed by welfare departments, or the non-government organisations providing out-of-home care? And then, who will advocate for additional service provision to meet the needs identified?

Incompatible information technology and records management systems, along with medicolegal issues, can make the transfer of health information between health professionals and child welfare agencies highly problematic, notwithstanding that legislative changes in some states now support information exchange in circumstances related to the child’s safety. Finally, given that entry into care usually occurs some years after maltreatment is first identified, should more effort be made to assess the health status of children in contact with the statutory child protection system earlier?

Effective interventions offered at this time may not only prevent the later transition into care but radically improve the long-term health and wellbeing outcomes of children and young people who have been maltreated.

Competing interests: No relevant disclosures.

Provenance: Commissioned externally peer reviewed.

Editorials


10. Webster SM, Temple-Smith M. Children and young people in out-of-home care: are GPs ready and willing to provide comprehensive health assessments for this vulnerable group? Aust N Z Prim Health 2010; 16: 298-303.
Children and young people in out-of-home care

Improving access to primary care

This article forms part of our 'Access' series for 2012, profiling organisations that provide primary healthcare to groups who are disadvantaged or have difficulty accessing mainstream services. The aim of this series is to describe the area of need, the innovative strategies that have been developed by specific organisations to address this need, and make recommendations to help GPs improve access to disadvantaged populations in their own community.

Childhood abuse and neglect is more common than juvenile diabetes or cystic fibrosis and has similar negative impacts on health and quality of life. Abused or neglected children are being directed by legal orders into statutory care (commonly called out-of-home care) at increasing rates, particularly Aboriginal and Torres Strait Islander children. On entry to care, details of the child’s medical and family medical history alongside an intuitive parental appreciation of the child’s health and wellbeing may be unavailable. This poses a challenge to general practitioners asked to assess or treat children entering care. General practitioners experience many uncertainties about their role with these ‘children of the state’. The introduction of the first National Clinical Assessment Framework for Children and Young People in Out-of-Home Care offers new clarity about how GPs can be involved in improving access to primary healthcare for this vulnerable population.

Keywords
vulnerable populations (health); general practice; child; health; health services; child abuse

Case study
Stacey, aged 2 years 9 months, presented to the general practitioner 22 days after commencing foster care as Stacey’s case manager had advised her foster mother, June, that new standards required a health check. June had no records about Stacey but had a foster child healthcare card and a letter giving consent for release of Stacey’s health information. June stated that she found Stacey to be very quiet, but put this down to ‘settling in’. The only specific concerns June had about Stacey’s health were related to food faddiness and activity induced ‘whinging’. The practice nurse requested further medical details from Stacey’s case manager. She also asked about consent procedures for immunisation after an Australian Childhood Immunisation Register search indicated that Stacey was not fully immunised. Stacey’s case manager emailed information from Stacey’s file showing an assessment by the local child health nurse at age 2 years, which noted possible developmental delay, suspected hearing difficulties and poor diet. There was no record of follow up. In a long consultation with June and Stacey, the GP identified information gaps regarding Stacey’s:
• past development and behaviour
• medical history
• family history
• where, and with whom Stacey had lived during the past 12 months
• whether she had experienced abuse or neglect.

The GP performed hearing, vision and developmental screening and found a possible deficit in hearing and language and possible social skill delay. Physical examination excluded signs of chronic undiagnosed asthma but raised concerns about middle ear effusions, overweight and anaemia. The GP referred Stacey to the local child health nurse, a paediatrician and an audiologist. Catch-up immunisations were planned. The case manager was asked to obtain consent for a blood test to investigate for possible iron deficiency anaemia. A follow up appointment was scheduled with the GP to develop a health management plan for Stacey.

Childhood abuse and neglect is more common than juvenile diabetes or cystic fibrosis and has similar negative impacts on health and quality of life.² In 2011, more than 37 000 (7.3 per 1000) children and young people in Australia were living with foster careers or relatives in out-of-home care (OHCAC), most commonly because of issues...
Children and young people in OOHC exhibit a higher prevalence of chronic and complex conditions, involving physical, neurological, developmental, psychological and behavioural difficulties when compared to the average child in Australia. Lack of routine health checks, undermedication and poor oral health, along with undiagnosed and/or untreated conditions are also more common in this group. In addition, long-term adverse physical and mental health consequences of child abuse and household dysfunction contribute to lower educational achievements, poor employment prospects, teenage parenthood, drug and alcohol addiction and higher rates of eventual incarceration. Improved healthcare is an important weapon to help reduce these poor outcomes and break the cycle of health and social disadvantage.

When children enter OOHC for the first time, details of their medical and family medical history alongside an intuitive parental appreciation of the child’s health and wellbeing may be unavailable. This poses a challenge for general practitioners who may be asked to assess or treat children entering care. However, the time of entry into care provides an important opportunity for GPs to screen this cohort for health and mental health problems, developmental delays and psychosocial risk factors for adverse neuro-developmental outcomes. Children entering OOHC need a thorough assessment of conditions or difficulties that may be causing current ill health or have the potential to cause future ill health. In addition, it is vital to identify and work to strengthen factors that will protect the health and development of those children, who also have a need for improved continuity of primary healthcare.

General practitioners may experience uncertainties about their roles in the care of ‘children of the state’. However, they are skilled to recognise and respond to a range of health challenges, to triage effectively and to initiate appropriate referrals within local service systems. As such, the capacity of general practice to offer continuity of primary healthcare is pivotal in changing health trajectories in this patient group. Importantly, the introduction of the first National Clinical Assessment Framework for Children and Young People in Out-of-Home Care offers new clarity about how GPs can be involved in improving access to primary healthcare for this vulnerable population.

The current response
In some regions of Australia, community paediatricians provide assessments of the health, development, growth, behaviour and psychological wellbeing of children entering OOHC for the first time. Evaluation of oral health, hearing, vision, educational progress and safety form part of this assessment, which is usually undertaken within a few months of children entering care. Referral for intervention occurs when deficits or remediable problems are identified. A small number of hospital or local health service OOHC clinicians also provide comprehensive, often multidisciplinary specialist paediatric health assessments for children entering OOHC, with referral to general practice for ongoing primary care. In addition, some state government health departments have identified the need to prioritise health needs assessments for children and young people in OOHC. New South Wales OOHC health coordinator positions have been created within NSW Health to improve children’s access to, and integration of, health services. The South Australian government has set wide ranging health standards for children and young people in OOHC that outline priority arrangements for assessment and therapeutic services.

The cost and limited availability of specialist paediatric services relative to general practice means sometimes GPs are asked to provide initial health screening of children and young people entering OOHC and refer to specialist services as needed. Triage at the general practice level can be both practical and cost effective. Several Australian state governments have made periodic efforts to more fully engage GPs in primary health screening for children in OOHC, with mixed success. One example was a project developed by the Victorian Department of Human Services to test a GP approach to screening children entering OOHC for factors that might lead to poor health and developmental outcomes. These GPs then referred for specialist services when physical and mental health problems were identified. An advisory group, convened by General Practice Victoria and including GP representatives from every Department of Human Services region in Victoria, assisted in the design of the project, which comprised a Royal Australian College of General Practitioners accredited professional development activity. Practice support was available through divisions of general practice and a GP fee-for-service for comprehensive health assessments at entry to OOHC. Behavioural assessments for each child were provided through specialist agencies such as Berry Street’s, ‘Jake Taste’ intensive therapeutic service. While the project demonstrated that it is possible for state governments to engage GPs in new systems of care if effective support is provided, some complex challenges also emerged.

For children, frequent changes of OOHC placement disrupt continuity of healthcare. Mechanisms are needed to keep track of children and maintain links with healthcare providers. Legal hurdles can impede integrated patient information exchange. Processes for child health record management, including histories, consents and healthcare plans, need careful design.

For GPs, ongoing professional development, practice supports including IT compatible tools, negotiation of clinical pathways and improved secondary consultation opportunities are needed to support quality in this clinically challenging area of general practice. Previous lack of recognition by the Commonwealth Government of the special needs of children and young people in OOHC and of the contribution GPs make to their healthcare has been described as a significant barrier to improving the scope and quality of care offered by general practice.

Recommendations for GPs
Clarity about general practice roles in OOHC has been significantly enhanced with the recent release by the Commonwealth Department of Health and Ageing of the first National Clinical Assessment Framework for Children.
Table 1. Categories of current MBS items available to meet the primary healthcare needs of children and young people in OOHC by GPs*  

<table>
<thead>
<tr>
<th>MBS item categories</th>
<th>MBS item numbers</th>
<th>Preliminary health check</th>
<th>Comprehensive health and developmental assessment</th>
<th>Development of a health management plan</th>
<th>Ongoing assessment and monitoring</th>
</tr>
</thead>
<tbody>
<tr>
<td>Standard consultations</td>
<td>Level B (22)</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td></td>
<td>Level C (36)</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td></td>
<td>Level D (44)</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Population health</td>
<td>Children aged 0–4 years (701, 703, 705, 707)</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td></td>
<td>Aboriginal or Torres Strait Islander children aged 0–14 years (715, 10566)</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td></td>
<td>Child with intellectual disability (701, 703, 705, 707)</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td></td>
<td>Refugee or humanitarian entrant (701, 703, 705, 707)</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Mental health</td>
<td>Preparation of GP Mental Healthcare Plan (2290, 2701, 2715, 2717)</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td></td>
<td>Review of GP Mental Healthcare Plan (2712)</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td></td>
<td>GP Mental Healthcare Consultation (2713)</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Asthma</td>
<td>Asthma Cycle of Care (2546, 2647, 2552, 2553, 2558, 2559, 2664, 2666, 2668, 2673, 2675 or 2677)</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Diabetes</td>
<td>Diabetes Cycle of Care (2517–2526 and 2620–2635)</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Chronic conditions</td>
<td>Preparation of GP Management Plan (721)</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td></td>
<td>Review of GP Management Plan (732)</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td></td>
<td>Coordination of Team Care Arrangement(s) (723)</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td></td>
<td>Coordination of a review of Team Care Arrangement(s) (732)</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td></td>
<td>Contribution to multidisciplinary care plan prepared by another health or care provider or to a review of such a plan (725)</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
</tbody>
</table>

MBS item numbers available at www.medicoaustralia.gov.au/provider/medicare/mbs.jsp
can offer continuity of primary care can work in partnership with a state funded service such as an OOHCH clinic, or a community nursing or other service specifically established to meet the needs of children entering OOHCH. In this situation, the OOHCH services have capacity to obtain previous child and family public health system records and coordinate comprehensive multidisciplinary needs assessments. The results and recommendations can inform ongoing GP management.

Summary

There is a strong need in most areas of Australia to further integrate health service planning for the OOHCH population and significant scope exists for improved GP involvement in communication, coordination and development of clinical pathways at the local level. We suggest that Medicare Locals or similar organisations need to take responsibility for ongoing effective liaison between general practice, state health services and child protection and OOHCH organisations. Strong leadership from general practice and a partnership approach is vital to improve access to primary healthcare for this very vulnerable population.

References


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The red tape waltz

Where multi-centre ethical and research governance review can step on the toes of good research practice

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How could it happen that the very processes intended to assure ethical research in Australia might, themselves, undermine good research practice?

This paper describes one PhD candidate’s recent experiences of multi-centre review for a Human Research Ethics Committee approved, low/negligible risk, qualitative study, at the crossroad of health services research and organisational research.

A retrospective review of international literature about multi-centre review processes revealed that many of these experiences were not unique and might have been expected, notwithstanding Australian efforts at harmonisation of multi-centre review. This paper examines not only the burden of red-tape that was applied to a small doctoral study, but also the way in which the red-tape threatened the anonymity of potential study participants and risked exposing them to undue pressure and distress.

These experiences support the view that harmonisation initiatives have not yet developed as the Australian National Health and Medical Research Council may have hoped and that further attention is needed to harmonise research governance processes.
Introduction

The Australian Harmonisation of Multi-centre Ethical Review (HoMER) initiative for single research projects located across multiple sites envisaged a streamlined national approach that would reduce the delays and costs of duplicate applications for ethical review. HoMER’s ultimate goal was recognition by all jurisdictions of a scientific and ethical review performed by any Human Research Ethics Committee (HREC) in any jurisdiction.¹

Australian processes for ethical review of human research might well be likened to a waltz: a formal dance in which two partners holding each other move around a large room, turning as they go and repeating a movement of three steps.² In this case, the three steps are application, scientific/ethical review, and research governance review. A challenge for researchers is to identify who exactly is their waltz partner during any particular step, as the HREC and the Research Governance Office (RGO) may both claim to lead the dance. When these partners cut in on each other, can the researcher keep up? In academia, debate about ethical review processes has simmered for decades in Australia, as well as the UK, USA and Canada (which have similar though different systems in place). Protagonists have accused each other of annoyingly ‘waltzing off’ with something of value that is not theirs. Researchers report HRECs waltzing off with their precious research funding, time and resources.³ HRECs report


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Researchers waltzing off into the field with too little regard for managing ethical and organisational risks.4

Images matter. They colour how we approach the dance. Ethical and research governance review processes have conjured up diverse images in the academic literature: the Byzantine labyrinth,5 the lion’s den,6 the black hole,7 the Tower of Babel.8 Each image has been a far cry from the graceful waltz. Codes of Ethical Conduct have laid the groundwork for a focus on compliance, which in its turn has led to the use of detailed rules: the power of the “Weberian orthodoxy.”9 The proliferation of institutional review processes since the 1990s has generated a new language—e.g., ‘ethics creep,’ ‘secret ethics committee business,’


5 K. G. M. M. Alberti, ‘Multicentre research ethics committees: has the cure been worse than the disease? No, but idiosyncrasies and obstructions to good research must be removed,’ British Medical Journal 320 (7243), 2000, 1157–1158.
site specific approval." This may in part have encouraged Hunter's reference to building the new Tower of Babel, or perhaps he alludes to the rampant development of ethical review bureaucracies. Such images line the Australian ballroom, which currently hosts the Red Tape Waltz; images indicative of the soured view of many researchers.

Red tape has been a common reason for criticism of multi-centre ethical and research governance review processes. Notwithstanding harmonisation initiatives, researchers have continued to report research delays of days, weeks and months. They have documented additional burdens including volume of paper used, staff time, communication costs and ethics application fees.

On the other side of the dance partnership, a range of factors underpin the strong push for institutional review: increasing awareness of ethical


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implications, demands of journal editors and funding bodies\textsuperscript{14} and institutional concerns about organisational indemnity,\textsuperscript{15} legal liability and monitoring.\textsuperscript{16}

The way in which ethical review processes should be instituted has been contested since Pappworth and Beecher blew the whistle in the 1960s.\textsuperscript{17} Since that time Australian national reviews have noted a lack of agreement about appropriate solutions.\textsuperscript{18} Debates about institutional ethics review processes pertinent to this paper have centred on:

- the limitation of the biomedical paradigm for social science research studies;\textsuperscript{19}
- entanglement of ethical and research governance issues;\textsuperscript{20}
- delineation of local issues necessitating local ethical review;\textsuperscript{21}
- mutual recognition between HRECs;\textsuperscript{22}
- review exemption for low/negligible risk studies;\textsuperscript{23}

\textsuperscript{14} Taran Thune, 'The Training of "Triple Helix Workers"? Doctoral students in university-industry-government collaborations,' \textit{Minerva: A Review of Science, Learning, and Policy} 48 (4), 2010, 463–483; Loblay, 'Human research ethics.'

\textsuperscript{15} Christie et al., 'Adverse effects.'

\textsuperscript{16} AHEC 2006, reported in Watson et al., 'Hospital ethics.'

\textsuperscript{17} Maurice H Pappworth, 'Human Guinea Pigs: A History,' \textit{British Medical Journal} 301 (6766), 1999, 1456–1460.

\textsuperscript{18} Jenkin et al., A streamlined national approach.'

\textsuperscript{19} Bamber and Sappey, Unintended consequences; Helen Mary Richards and Lisa Jennifer Schwartz, 'Ethics of qualitative research: Are there special issues for health services research?' \textit{Family Practice} 19, 2002, 135–139.

\textsuperscript{20} Vajkic et al., 'Governance approval,'; Loblay, 'Human research ethics,' 2008, Helen E. Fraser, Ainsley E. Martlew, and Deborah J. Frew, 'Model for a single ethical and scientific review of multicentre research in New South Wales,' \textit{Medical Journal of Australia} 187 (1), 2007, 7–8; Wald, 'Bureaucracy.'

\textsuperscript{21} Ravina et al., 'Local IRB,'; P. Wainwright and J. Saunders, 'What are local issues? The problem of the local review of research,' \textit{Journal of Medical Ethics} 30 (3), 2004, 313–317.

\textsuperscript{22} Boul et al., 'A guide to multicentre ethics;' Mallick and O’Callaghan, 'Research governance delays;' Hunter, 'The ERC,'; Driscoll et al., 'Ethical dilemmas;' Christie et al., 'Adverse effects;' Watson et al., 'Hospital ethics.'

\textsuperscript{23} L. M. Kopelman, 'Minimal risk as an international ethical standard in research,' \textit{The Journal of Medicine and Philosophy} 29 (3), 2004, 351–378.
• skill and knowledge gaps for research higher degree students and researchers regarding ethics;\textsuperscript{24}

• the place of ethical review in the research infrastructure supporting university, government and industry collaborations.\textsuperscript{25}

As the volume of multi-centre research has increased in Australia, crucial drivers have steered change to ethical review processes. Key drivers have been inconsistent practices and perceived inefficiencies among HRECs as tabled in national reviews, as well as difficulties for researchers described in academic literature.\textsuperscript{26}

HoMER was developed by the National Health and Medical Research Council (NHMRC), and endorsed in 2006 by the Australian Health Ministers’ Advisory Council, to facilitate recognition of a single scientific and ethical review process within and across all Australian jurisdictions. While the NHMRC has produced a variety of tools and guidance materials to support a national approach, implementation of such a national approach to single ethical review processes still depends heavily on the readiness of jurisdiction and institutions to embrace change.\textsuperscript{27}


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What Does This Paper Contribute?

This paper describes a contemporary Australian experience, since the introduction of HoMER, of multi-centre ethical and research governance review of a university HREC approved, low/negligible risk study being conducted for a PhD by research. The paper explores how issues in the ongoing academic debate impacted on this study, at times threatening good research practice. A new issue is also introduced: the inadvertent risk to the anonymity of participants posed by extensive research governance review. Just as the waltz was considered shocking when first introduced due to the intimacy of the embrace between the dance partners,28 the embrace between researcher and reviewer may, in some cases, still be considered too close.

About the Study

The PhD study sat at the crossroad between health services research and organisational research. It sought to explore the thoughts and experiences of health professionals and policy advisors about factors that enhance or inhibit their current work relating to a low-prevalence but high need population group known to be underserved by the health system. In particular, information about the policies, processes and systems used by professionals in their workplace along with their own attitudes to their work was sought. The research design was strongly influenced by Checkland’s Soft Systems Methodology.29 This methodology is used to explore the nature and influence of personal decision making, personal sense-making and the ideas of individuals about the purposes of their own work in the context of broader systems of policy, program or other types of work design.

A qualitative method involving individual, 60-minute face-to-face interviews with health professionals and policy advisors was used within an embedded case study approach. The PhD candidate visited case study sites

in different parts of Australia in order to conduct interviews. The case study approach also included analysis of policy and program documents freely available in the public domain and a small number of procedural documents voluntarily provided by organisations at the request of the researcher. No access was sought to any records relating to individuals.

The study had two levels of approval from the candidate’s university. Firstly, PhD Confirmation of Candidature signified approval of the study’s merit and design. Secondly, subsequent approval by the university HREC as a low or negligible risk study signified both agreement with the Confirmation decision about research merit and design, and that ethical issues had been satisfactorily managed within the design. The study was accepted as being of low or negligible risk as the foreseeable risk was the inconvenience of interview participation by time-poor professionals, balanced against the knowledge, insight and understanding that could be gained from their expert professional input about their everyday professional experiences. Recognition of the low or negligible ethical risk attached to this study is salient in the unfolding dance story. Clutching the university HREC approval and an outline of the HoMER initiative, the PhD candidate stepped blithely and naively into the ballroom in May 2011 expecting to move in a sprightly and self-assured manner through the waltz of organisational review. In preparation the candidate’s rehearsals had included:

- working through the university’s Checklist for Research Students and their Supervisors about Research Integrity and the Responsible Conduct of Research;
- participation in two university colloquia and postgraduate round-tables conducted by senior faculty members on human research ethics;
- face-to-face discussion about the study with the Human Ethics Advisory Group in the university department.
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In hindsight however, failure to have studied the academic literature about multi-centre ethical review processes before entering the ballroom left the PhD candidate inadequately prepared for the ball.

In Australia, each organisation or institution remains responsible for their own research governance. Funding requirements of the National Health & Medical Research Council about compliance with ethical standards have shaped the way in which governance is exercised since the mid 1980s.30 Australia’s HoMER initiative aspired to improve and streamline research review approaches. However evidence uncovered in a subsequent literature review suggested that even when harmonisation systems have been introduced, researchers cannot assume that organisations have implemented them.31 Such were the lessons for a PhD candidate.

The Multi-centre Review Experience

Types of Review
The first phase of the study design required organisational consent by nine different state government departments, statutory authorities or health services in various parts of Australia before recruitment of individual participants could commence. The surprise for the PhD candidate was in the implications of the trunk and branch organisational structures of the government departments for ethics and research governance review. In two departments, all local branches had the status of stand-alone organisations for the purposes of obtaining organisational consent. This is illustrated in Figure 1. Consequently, the consent application process almost doubled to involve nine trunk and 17 branch organisations; 26 organisations in total.

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30 Israel and Hay, Research Ethics.
Figure 1: Number and type of organisational consents required for PhD study

Review processes

The first foray onto this dance floor revealed that each of the 26 organisations required a unique set of steps. No two dances were the same. The majority of organisations required only a written approach to the senior manager for a decision about whether staff could be invited to take part. Four of the nine trunk organisations required additional ethical review steps. Two involved a step best described as strategic review: i.e., formal or informal review by an internal research office or senior manager, which may precede or follow ethical review. Consent to recruit within an organisation could be granted or denied at a strategic review, notwithstanding any likely or actual decision by the HREC. Most organisations requiring ethical review also required separate research governance steps, some of which were idiosyncratic – e.g., the need for researchers to undergo a police check.

In effect this left the PhD candidate to waltz 26 different dances. Table 1 summarises the review requirements to obtain organisational consent. In this table, organisations were classified as recognising the decisions of the university HREC if:
## THE RED TAPE WALTZ

<table>
<thead>
<tr>
<th>Review requirements to obtain consent from trunk organisations to participate in research study</th>
<th>Number of organisations with this type of requirement (n=9)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Required Chief Executive consent only</td>
<td>5</td>
</tr>
<tr>
<td>HREC recognised university approval of merit and design without further review</td>
<td>5</td>
</tr>
<tr>
<td>HREC recognised university ethical approval without further review</td>
<td>5</td>
</tr>
<tr>
<td>Required strategic review as preliminary step to HREC or RGO application</td>
<td>1</td>
</tr>
<tr>
<td>Required additional ethical approval application</td>
<td>3</td>
</tr>
<tr>
<td>Required research governance review</td>
<td>3</td>
</tr>
<tr>
<td>Required strategic review after HREC approval</td>
<td>1</td>
</tr>
<tr>
<td>Required additional research governance review for branch organisations</td>
<td>2</td>
</tr>
<tr>
<td>Periodical reports required to HREC</td>
<td>2</td>
</tr>
</tbody>
</table>

Table 1: Organisational consent processes for trunk organisations

<table>
<thead>
<tr>
<th>Types of review required to obtain consent from branch organisations to participate in research study</th>
<th>Number of organisations requiring this review type (n=17)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Required Chief Executive consent only</td>
<td>1</td>
</tr>
<tr>
<td>Recognised trunk organisation approval of merit and design without further application</td>
<td>0</td>
</tr>
<tr>
<td>Recognised university ethical approval without further review</td>
<td>0</td>
</tr>
<tr>
<td>Recognised trunk organisation ethical approval without further application</td>
<td>0</td>
</tr>
<tr>
<td>Required copies of trunk HREC application, attachments and approvals</td>
<td>17</td>
</tr>
<tr>
<td>Required research governance review</td>
<td>17</td>
</tr>
<tr>
<td>Required Researcher CV</td>
<td>17</td>
</tr>
<tr>
<td>Issued local organisational guidelines for review to researchers</td>
<td>8</td>
</tr>
<tr>
<td>Required additional detailed budget information</td>
<td>1</td>
</tr>
<tr>
<td>Required Researcher insurance documentation</td>
<td>2</td>
</tr>
<tr>
<td>Required Researcher police check</td>
<td>1</td>
</tr>
<tr>
<td>Required Researcher photo ID badge</td>
<td>2</td>
</tr>
<tr>
<td>Required Researcher to sign confidentiality agreement</td>
<td>2</td>
</tr>
<tr>
<td>Required periodical report to RGO by Researcher</td>
<td>1</td>
</tr>
</tbody>
</table>

Table 2: Organisational consent processes for branch organisations
no additional review of the merit or design of the study was required;
no more than written evidence of the university HREC approval was requested; and
no additional, local lodgement of an ethics application was involved.

Table 2 illustrates the review requirements of the branch organisations to obtain agreement that staff members could be invited to take part in the study.

Review Results
Ten months after lodging the first of these 26 applications for organisational consent to participate, the outcomes were as follows:

- 3 non-university ethical approvals as a low or negligible risk study.
- 6 trunk organisation consents.
- 7 branch organisation consents.
- 3 branch organisations declined to participate.
- 7 branch organisations remained silent in response to the application, notwithstanding at least one follow up by the researchers.

The average time taken to process trunk organisation approval applications where an ethics review was required was 79 days (range 51–110 days). A seemingly straightforward, minor administrative amendment to one ethical approval took 119 additional days to be approved.

The average time taken to process branch organisation approval applications was 82 days (range 18–175 days). Only those branch applications that were declined were processed within 60 days.

Discussion

Debates in the academic literature subsequently shed some light on why such extensive review was required of a small, low cost study deemed to be of low or negligible ethical risk.
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The Influence of the Biomedical Paradigm

The influence of a biomedical paradigm in HRECs’ conceptualisation of risk of harm in human research and the implications for review, has been a major concern for social scientists since the application of codes of research conduct.32 The types of multi-centre application forms completed in this study anticipated methods related to basic science, clinical medicine and science, preventive medicine or public health as well as health services research. Indeed, Fox 2005 describes the two types of studies anticipated by Australian multi-centre review systems as:

- scientific studies organised by national, disease specific groups in areas such cancer, diabetes or neurology; or
- trials sponsored by pharmaceutical or biotechnology industry.

In such a paradigm, the fundamental role of ethics committees to protect research subjects from unethical research and physical harms is rightly held as an independent, deeply personal role taken seriously at the local committee level and therefore hard to relinquish.33

However, this study clearly did not fall into either of the types identified by Fox. None of the organisations which required additional ethical review offered a separate process tailored to review social science or qualitative research studies outside of the biomedical paradigm. An alternative, more

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tailored process may have considered a pre-approved, low and negligible ethical risk study in quite a different way.  

**Identification of Local Issues Warranting Further Local Review**

Lack of recognition of the university HRECs’ approval resulted in three additional ethics applications being lodged.

Wainwright and Saunders from the Centre for Philosophy, Humanities and Law in Health Care at the University of Wales argue that there is ‘an inherent tension in the idea that a study is ethical in one place but not in another.’ They urge a clearer separation between local ethical review and local governance review, summarising that what should be considered as local issues which might impact on ethical safety should be largely confined to:

- the suitability of local researchers;
- the appropriateness of the local environment for research;
- unique local issues such as non-English language or culture.

No such issues were anticipated or subsequently raised by HRECs or RGOs in this study. Instead, there was evidence of a push for compliance with omnibus processes. This type of push has been reported previously.

**Recognition of Responsible Institution**

The majority of review processes to which this study was subjected appeared to be premised on the researchers being employed by, or affiliated with, the reviewing organisation. Lack of mutual recognition resulted in organisations taking on the mantle of comprehensive review and research monitoring, as if no other institution had responsibility. In a small number of cases, insistence

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35 Wainwright and Saunders, ‘What are local issues?’ 314.

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that participants be advised to report complaints to the local HREC rather than the University HREC reflected ambivalence about which was the responsible HREC for the study. Two trunk organisations and one branch organisation required annual reports to their own HREC and/or RGO, presumably to fulfil a monitoring role, notwithstanding that the university HREC had an accepted responsibility to monitor the study. Given that HRECs are often over-worked and under-resourced it could have reasonably been expected that after the introduction of HoMER, organisations would welcome the shift of monitoring responsibility to the university HREC as the responsible institution.

Clarification of Review Steps
In each waltz it was necessary to visit the website of the RGO to check the local dance steps. It soon became evident that websites were not always up to date and the currently accepted steps could only be ascertained by phoning the RGO. Invariably the RGO staff seemed open and helpful, readily pointing to new draft versions of steps, additional steps not yet included in written guides, or common trip hazards for applicants to avoid.

Application forms often combined all of the review steps into one document, to be used and followed by all dance partners. Forms included questions about both ethical and research governance issues.

Entanglement of Ethical and Research Governance Issues
Prior to HoMER research governance and ethics were historically and undesirably ‘folded into one process’. Since the introduction of HoMER there has been a focus on developing separate processes for reviewing the human resource, financial, legal, strategic, regulatory and contractual aspects of research.

37 Walsh et al., 'Improving the governance.' Don Chalmers, 'Viewpoint: Are the research ethics committees working in the best interests of participants in an increasingly globalized research environment?' Journal of Internal Medicine 269 (4), 2011, 392–395.
In this study, where additional organisational ethical and research governance review was required, the key contact for researchers was usually through a RGO.

Several factors contributed to a sense of entanglement. Ethical review processes clearly took place at the trunk and branch level. However research governance generally rested on applications for specific site approval. Defining ‘sites’ in both geographical and organisational terms was problematic in this study. In the trunk and branch configuration of government departments, there were also twigs and leaves: the small organisational units which were of particular interest in the study. Initial mistakes were made through inappropriately naming sites at this twig or leaf level. Site approval applications had to be amended to branch level in some cases in order to satisfy the correct authorising protocol of the organisation.

The simultaneous and parallel processes of ethics review and governance review created the second thread of entanglement. On the one hand researchers were encouraged to apply simultaneously for ethics and research governance approval, probably as a concession to researcher concerns about the time taken to complete all approval processes. The inadvertent risk was of miscommunication associated with lack of understanding about these processes among prospective participants. In an isolated case, without any communication with the PhD candidate, suspicions were raised among prospective participants when an employee who heard about the study before it had been given ethical approval at the trunk level (but while the parallel application process was on foot) advised prospective participants not to become involved as no ethics approval had been sought. In fact, the relevant ethics application had been appropriately lodged four weeks prior to this miscommunication.

Inconsistency of application processes between sites added to the confusion for PhD candidate. While branch organisations accepted standardised application forms endorsed by their trunk organisation many did not use their trunk organisation’s online application system for signatures and lodgement but insisted on hard, signed copies being posted. Some RGOs required additional information such as further specific detail about budgets, research interview questions or researcher curriculum vitae. It was not always clear if such
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requests related to ethical review or governance review. In a small number of
cases special conditions became apparent during the application process – e.g.,
a requirement for a police check.

Identifying Authorising Personnel
Often the first challenge was to learn the identity of the proper dance partners.
While the RGOs and Chairs of the HREC were in the same ballroom as the
PhD candidate, other required partners were usually dancing in another, distant
room and had to be named, called, and invited to dance. This would have been
easier if the candidate belonged or was well known in this other ballroom. In
fact most organisational review processes assumed that either the candidate did
already belong there or had a series of agents in the guise of co-investigators,
located there to act as matchmakers between researchers and suitable dance
partners. Application forms specifically asked for the name and contact details
of a local co-investigator.

In the case of this small PhD study, the assumption about local co-invest-
itigators did not hold and this posed a difficult challenge.

The study recruitment steps were to:

1. Obtain relevant organisational agreement to participate in the study.
2. Request that organisations disseminate study information packs to
   all staff members who met the study criteria – i.e., had a particular
   knowledge of, and experience with, the population group of interest.
3. Interested individuals would contact the researchers directly to
   indicate their interest in taking part in the study.

In this study, the expectation of many RGOs was that the PhD candidate
should enter the distant ballroom unannounced, identify and invite the people
they wanted to dance with, and then bring their names to the main ballroom
on a signed dance card in the form of a site approval form.

This was played out in very specific terms in a ‘Catch 22’ conversation with
one particular RGO. The staff member representing this RGO was not familiar
with the organisation’s services or structure relevant to the study and could not
suggest any appropriate people to approach to seek site approval. In a telephone conversation, they suggested that the candidate contact the main person they wished to recruit to the study and ask that person to name their manager who could then be approached to give authorisation. It was confusing to be told there would be absolutely no problem with this from the RGO viewpoint. The HREC-approved research design included obtaining an organisational consent prior to recruitment as part of the strategy to protect participant anonymity – i.e., once approval was in place participants need not disclose their involvement to their employer. Recruiting prior to organisational consent seemed, to the candidate, to go against the principles of ethical and governance review processes with their expected fidelity to research design. Only five of the 17 branch organisation RGOs provided a matchmaking service to identify and contact the appropriate people to authorise site approvals.

**Risks to Good Research Practice**

Protection of human participants is an accepted responsibility under the Australian Code for the Responsible Conduct of Research (2007).39

Returning to the waltz analogy, in many cases people being recruited to the study were likely to be networked either formally or informally through organisational, special interest or discipline specific networks. Relying on an outsider to scout around in the distant ballrooms of multiple sites looking for appropriate people to authorise prospective dance partners, held additional unforeseen risks for potential study participants.

**Misinformation**

The first risk was the development of an uncontrollable chain of whispers about the research study. Long delays in granting authority to disseminate written invitations, consent forms, plain language statements etc. about the study, left the door open for misinformation to circulate around organisational networks.

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The misinformation suggested that the study was seeking access to patient records, or organisational performance records when, in fact, it only sought information on processes and systems. This type of misinformation unduly alarmed some potential participants who subsequently refused to even receive information about the study. Misinformation about ethical approval status may also have affected potential participant’s ideas about the reputation and trustworthiness of the PhD candidate.

Undue pressure

Secondly, while trying to negotiate the preliminary review and approval processes, from time to time the PhD candidate risked harassing the very people they wished to engage. Where the authorising person was also a potential study participant, any level of follow up by the candidate in relation to authorisation of signatures could have been construed as harassment or undue influence to participate. This was particularly keenly felt when individuals were not fully aware of their own RGO procedures and inadvertently made errors, which the RGO left the candidate to follow up. These included delays, lost paperwork, signatures in the wrong section of a form, missing signatures and confusion about who needed to sign or where signed forms should be lodged.

Distress

Unexpectedly, before the study had RGO approval, the candidate was contacted by a small number of people in one large organisation who wished to take part in the study and were concerned as to why colleagues had been invited but they had not. Despite the candidate explaining the need for local site approvals, people may still have felt confused, particularly when their organisation’s ethical and research governance review processes were clearly unfamiliar to them.

Authorising personnel sometimes appeared embarrassed or apologetic about internal administrative errors in the authorising process. The candidate was occasionally put in the unusual and unwelcome position of coaching authorising personnel about their organisation’s internal processes. Embarrassment was natural.
Threat to anonymity

When a study uses a purposive sampling frame in organisational research, reliance on researchers to navigate the dance between RGO, HREC, managers and participants, ahead of a study being authorised, may threaten the anonymity of potential and actual future participants. Protection of identity was important in this study. Health service policies and resourcing decisions for under-served groups can be politicised and contested issues. In Australia there may be relatively small groups of health professionals or policy advisors involved with any particular under-served population. It was expected that anonymity would maximise the opportunity for professionals from the purposive sample to be frank about their everyday experiences and judgements. Identification of participants can be a particularly sensitive issue in qualitative research and in organisational research where there may be fear that the image of an organisation might be compromised or jeopardised if identifiable views are published.

In many cases the omnibus ethical and governance review application forms asked about all other organisations undertaking ethical review, the names and positions of internal people who were main contacts for the study at each site, and the names and details of all departments and services involved in the research. On the one hand these questions seemed fair and reasonable. However, in the complexity of the review processes it is estimated that this study was reviewed by more than 150 different people across various organisations in Australia. Consequently, information which identified individuals was used and stored in numerous systems completely outside the control of the PhD candidate. In the processing of authorisations such information may have been passed by hand, mail or in electronic form among administrative, finance, clinical, program and

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40 Richards and Schwartz, ‘Ethics of qualitative research,’ J. Giordano, M. O’Reilly, H. Taylor, and N. Dogra, ‘Confidentiality and autonomy: the challenge(s) of offering research participants a choice of disclosing their identity,’ Qualitative Health Research 17 (2), 2007, 264–275.

other personnel outside of the RGO and HREC. In this situation the candidate was powerless to manage the sharing of information which might potentially, even unwittingly, disclose the identity of subsequent actual participants or enable people to reasonably guess who they were. This had not been foreseen and had not been identified as a potential risk in the approved plain language statements. Once this risk became apparent, the candidate refused to supply such detailed information. The problem of being asked unnecessarily to name study participants has been noted previously.\textsuperscript{42}

**Conclusion**

This paper describes the review experiences of a small, low/negligible risk qualitative doctoral study in Australia. Duplication of ethical review, unexpectedly long time frames for obtaining institutional approval, lack of mutual recognition of decisions of the responsible HREC and entangled ethical and governance review processes were similar to those previously reported. This paper raises a new theme relevant to good research practice. The study experiences illustrate that current multi-centre review processes under HoMER can pose unintended risks to professionals drawn from a purposive study sample. In this study risk to anonymity, and risk of distress, misunderstanding or undue pressure appeared disproportionate to the benefits that repetitious ethical and governance review made to the quality of the study design or its ethical acceptability.

This study supports the recent call\textsuperscript{43} for more attention to harmonisation of research governance processes for multi-centre studies to accompany ongoing efforts to implement HoMER. This is a particular issue for trunk and branch organisations.

The waltz, with its easy to learn rhythm, pattern and foundation steps, has been considered the 'backbone' of ballroom dancing since the 19th century. The ballroom of Australian research needs ethical review processes which are easy

\textsuperscript{42} Green et al., 'Impact of institutional review.'

\textsuperscript{43} Vajkic et al., 'Governance approval.'
for a novice researcher to master and easy for prospective research partners to understand, and yet which can stand as the backbone of ethical research.

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