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# 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 fussiness and activity induced 'wheeze'. 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 skills delay. Physical examination excluded signs of chronic undertreated 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.<sup>1</sup> In 2011, more than 37 000 (7.3 per 1000) children and young people in Australia were living with foster carers or relatives in out-of-home care (OOHC), most commonly because of issues

of abuse or neglect. Most were subjects of a legal care and protection order. In 2010–2011, 11 613 children, the majority aged 0–9 years, were admitted into such care. The rate at which children live in OOHC has increased over the past 5 years, most significantly for Aboriginal and Torres Strait Islander children.<sup>2</sup>

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.<sup>3</sup> Lack of routine health checks, underimmunisation and poor oral health, along with undiagnosed and/or untreated conditions are also more common in this group.<sup>4</sup> 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.<sup>5</sup> 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 these children, who also have a need for improved continuity of primary healthcare.<sup>6</sup>

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<sup>7</sup> 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 clinics also provide comprehensive, often multidisciplinary specialist paediatric health assessments for children entering OOHC, with referral to general practice for ongoing primary care.<sup>8–12</sup> 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.<sup>13</sup>

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 representation 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, 'Take Two' 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.<sup>14</sup>

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.<sup>12</sup>

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.<sup>14</sup> 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.<sup>15</sup>

## 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

and Young People in Out-of-Home Care.<sup>5</sup> This document alerts all health professionals to the health issues in this cohort needing particular attention and also flags the appropriateness of GP participation in every step in the continuum of care of these patients. The framework clearly articulates the entitlements of children in OOHC to an extensive suite of Medicare Benefits Scheme items available for initial and comprehensive assessment, as well as ongoing

planning, care and review by GPs and other health professionals. Based on Appendix C of the framework,<sup>5</sup> *Table 1* provides a summary picture of the categories and types of MBS item numbers available for the different stages of primary healthcare for the OOHC population. A suite of specialist and allied health services item numbers is also available.

Following the development of this explicit national policy, two alternative pathways

are available to enable GPs to be practically involved in the care of children and young people in OOHC. General practitioners with a special interest in child and adolescent health may wish to coordinate comprehensive health needs assessment and a full continuum of care. Those with strong links to local specialist paediatric and community health services and who employ a practice nurse may be particularly well placed to do so. Alternatively, a GP who

**Table 1. Categories of current MBS items available to meet the primary healthcare needs of children and young people in OOHC by GPs<sup>5</sup>**

MBS item categories	MBS item numbers	Preliminary health check	Comprehensive health and development assessment	Development of a health management plan	Ongoing assessment and monitoring
Standard consultations	Level B (23)	✓			
	Level C (36)	✓	✓	✓	✓
	Level D (44)	✓	✓	✓	✓
Population health	Children aged 3–4 years (701, 703, 705, 707)	✓	✓		
	Aboriginal or Torres Strait Islander children aged 0–14 years (715, 10986)	✓	✓	✓	✓
	Child with intellectual disability (701,703,705,707)	✓	✓		
	Refugee or humanitarian entrant (701,703,705, 707)	✓	✓		
Mental health	Preparation of GP Mental Healthcare Plan (2700, 2701, 2715, 2717)			✓	✓
	Review of GP Mental Healthcare Plan (2712)				✓
	GP Mental Healthcare Consultation (2713)				✓
Asthma	Asthma Cycle of Care (2546, 2547, 2552, 2553, 2558, 2559, 2664, 2666, 2668, 2673, 2675 or 2677)			✓	
Diabetes	Diabetes Cycle of Care (2517–2526 and 2620–2635)			✓	
Chronic conditions	Preparation of GP Management Plan (721)			✓	✓
	Review of GP Management Plan (732)				✓
	Coordination of Team Care Arrangements (723)			✓	✓
	Coordination of a review of Team Care Arrangements (732)				✓
	Contribution to multidisciplinary care plan prepared by another health or care provider or to a review of such a plan (729)				✓

MBS item numbers available at [www.medicareaustralia.gov.au/provider/medicare/mbs.jsp](http://www.medicareaustralia.gov.au/provider/medicare/mbs.jsp)

can offer continuity of primary care can work in partnership with a state funded service such as an OOHC clinic, or a community nursing or other service specifically established to meet the needs of children entering OOHC. In this situation, the OOHC 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 OOHC 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 OOHC organisations. Strong leadership from general practice and a partnership approach is vital to improve access to primary healthcare for this very vulnerable population.

## Resources

- National Clinical Assessment Framework for Children and Young People in Out-of-Home Care: <http://health.gov.au/internet/publications/publishing.nsf/Content/ncaf-cyp-oohc-toc>
- Victorian Department of Human Services, Child Development and Trauma Guide: [www.dhs.vic.gov.au/for-service-providers/children-youth-and-families/child-protection/specialist-practice-resources-for-child-protection-workers/child-development-and-trauma-specialist-practice-resource](http://www.dhs.vic.gov.au/for-service-providers/children-youth-and-families/child-protection/specialist-practice-resources-for-child-protection-workers/child-development-and-trauma-specialist-practice-resource).

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