



Breaking down the silos within health services to strengthen the primary, secondary and tertiary prevention net

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Child Advocacy Service

Looking out for kids



Purpose of Presentation

- To present two processes used by the Child Advocacy Service to break down hospital silos to bring about a seamless approach to child protection in the RCH Health Service District.
 - (i) The Service model - Supporting health practitioners working with the ‘grey’ cases
 - (ii) A cross-hospital quality review process based on a health performance framework



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Context 1

Health Services : Inside the Silos...

- Many departments that focus on different aspects of child or adult health
- A range of disciplines
- Generalists, Specialists, subspecialties
- Hospital or Community trained staff
- A hierarchy of trainees

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Context 2 - RCH&HSD

- Includes 3 major services:
 - RCH
 - Community Child Health Service
 - Child and Youth Mental Health Service
- Is a separate district located on a campus with two other major hospitals
 - RBH ~ Adolescent Psychiatry Unit
 - RWH ~ Sexual Assault Service (14 yrs+)
- Has two other hospitals in the district
 - Prince Charles ~ Indigenous Health Service
 - Riverton Statewide Early Parenting Centre

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Context 3

The Child Advocacy Service

- Established by the RCH&HSD in 1999 to:
 - Provide leadership in child protection
 - Develop an integrated model of services
 - Advocate for quality care for children
 - Promote children's well-being generally

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The logo for 'Working Wonders' is located in the top left corner. It features the words 'Working' and 'Wonders' in a playful, hand-drawn font. The letters are filled with various colors: 'W' is green, 'o' is purple, 'r' is pink, 'k' is yellow, 'i' is blue, 'n' is green, 'g' is purple, 'W' is pink, 'o' is yellow, 'n' is blue, 'd' is green, 'e' is purple, 'r' is pink, 's' is yellow. A thick red diagonal line runs from the top left towards the bottom right, partially overlapping the logo and the main text area.

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Core Values of the Service

- Protecting children and young people
- Advocating for children and young people
- Promoting health and well-being
- Strengthening families
- Succeeding through partnership
- Achieving excellence in practice

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Services include:

- CP consultation, intake and referral
- 24 on-call medical assessments
- Child Advocacy Clinics
- Health assessments for children in care
- Advocacy - court reports, expert evidence
- Education and training
- Coordination & participation in SCAN Teams
- Policy development

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Context 4 Establishment Issues

- Funding from Golden Casket Lottery
- Location moved from RCH to community
- CAS became a program of the Community Child Health Service along with:
 - Primary Care Program (0-18 years)
 - Riverton Statewide Early Parenting Centre
 - Child Development Program

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Establishment Issues

- Change of name
- Major staffing and operational change
- Significant policy development and education was required
- Building a team
- Broadening the clinical expertise/mix

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The CAS Clinical Team

Core Team

- Clinical Nurse
- Paediatricians
- Admin Officer
- Fellows
- Registrar
- Director of CAS

Clinical Team

- CA Social Worker
- Speech Pathologist
- Occupational Therapist
- Child Psychiatrist

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Child Advocacy Continuum of Care The Service Model

Step 1:

Referral by health practitioner

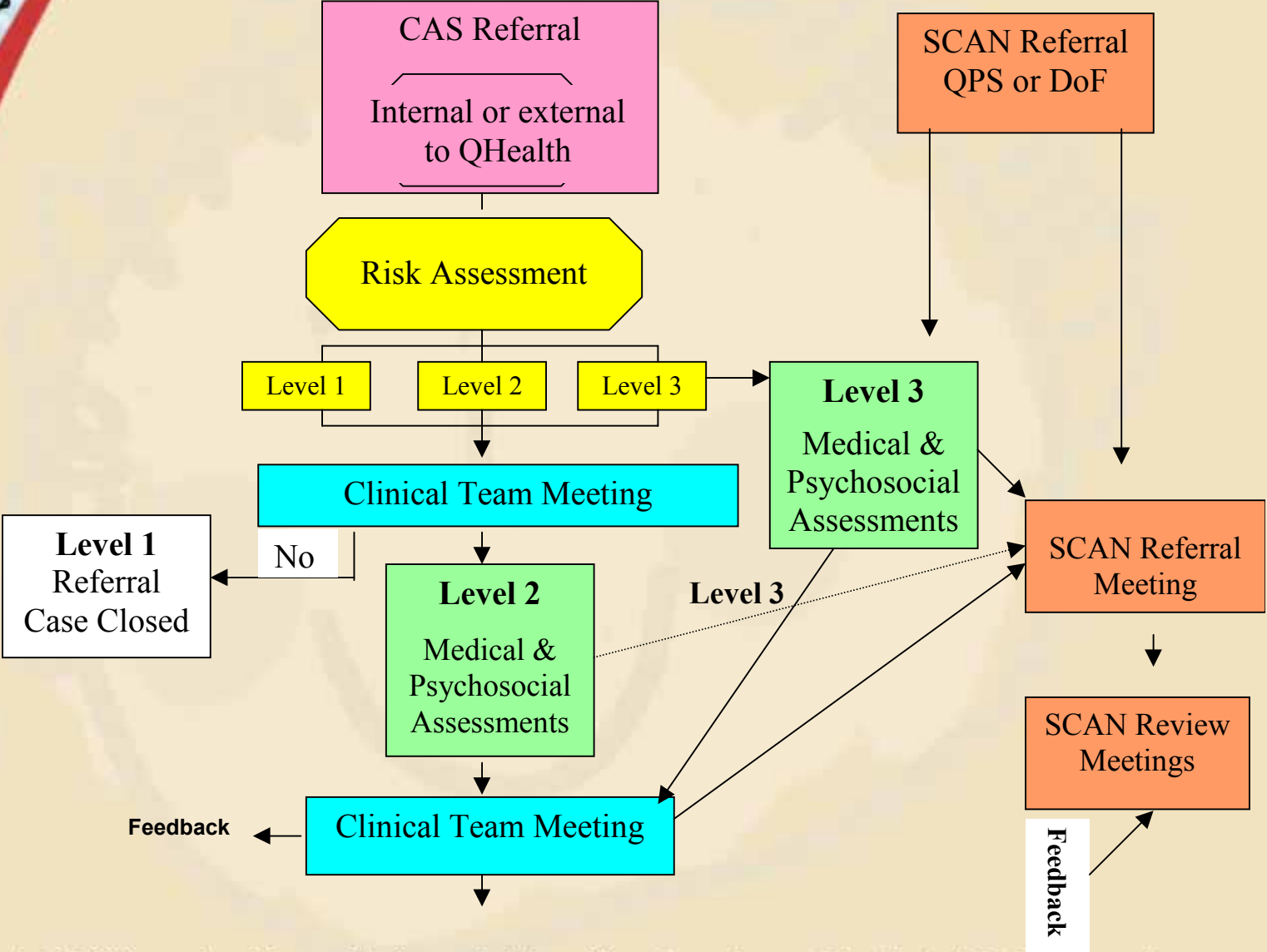
Step 2:

Service assesses the intake and makes a judgement about the severity of harm or risk to a child or young person

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Child Advocacy Service Intake and Ongoing Case Management Process



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Level 1

A situation involving parent and/or child behaviour problems or mental health issues which do not have a child protection element and would best be dealt with by other health services, counselling, community agencies, or parent education.

Level 3

- Child has experienced significant harm or is at risk of significant harm and
- Child does not have a parent able and willing to protect them from harm
- Involvement of statutory agencies is needed
- Child should have a medical examination
- Referral to SCAN Team is required
- Follow-up by statutory authorities and Health may be required with or without parental consent

Level 2 - “Grey Cases”

- A situation where harm is occurring to a child’s physical and/or mental health but the harm is not ‘of a significant nature’ and therefore does not meet the criteria for involvement of statutory authorities.
- Timely intervention by health practitioners is desirable to rectify harm and/or prevent further harm occurring to the child.
- May require a report to DoF for ‘PA’.
- Parental consent and cooperation is required for health surveillance.



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Continuum of Care 2

Step 3:

Presentation of all intakes at the weekly clinical team meeting

Medical and psychosocial assessments may occur before and/or after this meeting



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Role of Clinical Meeting

- Multidisciplinary review of all referred cases
- Check information on available medical charts
- Reach consensus on diagnosis & treatment
- Formulate recommendations re initial response
- Identify who will provide feedback to referrer
- Ensure utilisation of community resources

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Step 4: After the team meeting....

- Feedback to referrer re:
 - case/care plan
 - notification issues
- CAS Clinic appointments scheduled
- Allied Health appointments scheduled
- SCAN meeting scheduled (Level 3s)
- Clients should be sent information about the clinic before appointment



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The integrated Child Advocacy Service Model has an increased focus on supporting practitioners working with the 'grey cases'.

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These 'grey' cases tend to involve...

- Failure to thrive/neglect/poor living conditions
- Unexplained developmental delay
- Emotional abuse
- Parents with thoughts of harming a child
- Exposure to domestic violence
- Parents with intellectual disability, mental illness and/or substance abuse

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Why are they so difficult?

- Firstly, many PHC staff are sole practitioners
- These cases are often between 'prevention' & 'protection'
- 'identification' & 'definition' is more shadowy
- Grey cases present PHC staff with dilemmas:
 - Preventing child abuse Vs protecting children
 - Do I carry this case or report it?
 - Which 'hat' will I wear?

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Why are they so difficult?

- present the greatest challenge when trying to get other agencies to accept their definition
- access to resources needed by these children are held by services not in their control
- other agencies often respond as gatekeepers
- health workers end up feeling that their assessment is devalued/undervalued
- Once families are referred to a CPT or DOF, there is a sense that a new dynamic takes over

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How has the service model addressed these issues?

- It has provided an avenue and model of care that has allowed primary health care staff to raise concerns at an earlier point:
 - this fits with their prevention framework
- It has established a shared responsibility and response across disciplines, specialties geographical settings and service cultures
- There is more support, brokerage for staff involved in prevention & early intervention

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Benefits of an Integrated CP Service

- Early referral of concerns assists with case/care planning
- Staff report that their identification, reporting and assessment skills have increased
- Increased health services to targeted and selected populations
- Dual emphasis on prevention and treatment
- Focus on a district service reduces over emphasis on tertiary services

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The logo for 'Working Wonders' is written in a colorful, hand-drawn style. The word 'Working' is in blue and 'Wonders' is in green. A small red heart is above the 'i' in 'Working'. The letters are outlined in black and have various colors like pink, yellow, and green. In the background of the logo, there is a photograph of a building and a sign that says 'Children's Hos'.

Benefits of an Integrated CP Service

- Mix of staff and locations enhances communication
- Multi-system access (resources & records)
- Children are screened early & continuously
- Coordinated care reduces fragmentation
- Policy framework - provides clarification

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Barriers to Integration

- Collocation difficulties
- Different “cultures” and client focus in silos
- Key components are still not ‘engaged’
- Different philosophies of different disciplines
- Lack of shared records
- Lack of cross-training
- Limited resources have to be prioritised along the prevention / protection continuum

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Quality Assurance Activities

‘Achieving excellence in practice’

- Journal Club - Literature Reviews
- Peer Review - Colposcopy
- Quality Audit - Statement of a Witness
- Chart Review - CSA outpatient assessment
- Chart Review - Outpatient assessment of CAN
- DEM Injury Audit - Children <12 months
- Radiology Meeting
- STD Testing Evaluation
- Quality Review Meeting (CCHS, RBWH, RCH)
- Child Death Reviews (multiple Districts)

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Quality Review Committee

- Emerged out of a “case gone wrong”
- Several hospitals, programs are involved
- Uses a problem / case based approach
- Focus is on systems - not individual workers
- A process redesign / fishbone approach
- A log of case-related system issues is kept
- System problems are analysed against the National Health Performance Framework

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National Health Performance Framework

- Effective
- Appropriate
- Efficient
- Responsive
- Accessible
- Safe
- Continuous
- Capable
- Sustainable

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Case Study – New Born Baby

- Maternity hosp. referred new mother to PCP
- Mother could not be located initially
- Because child in RCH
 - Crying infant & Inappropriate feeding
- PCP located her when back in the community
- Many psychosocial risk factors identified
 - Mother: DV, depressed, ID
 - Partner: MI, main carer
 - Infant: underfed, weight loss

Systems Issues & Redesign

- Persistence by PCP with follow-up (++)
- RCH did not advise PCP of admission
- Neither RCH or RWH referred to Riverton
- RWH did not pick up feeding issue – Why?
 - Early discharge
 - Use of premixed formulas
- “Process redesign”
 - Use of parenting room
 - Referral to Riverton or PCP Day Stay



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Health System Performance

- Care was not *appropriate* to client's needs
- Care was not *accessible* i.e., provided at the right time and place
- Care was not *continuous*
- Care was *effective*
- Care was not *responsive*

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Benefits of Quality Review

- Increased understanding of each service
- Increased communication between services and disciplines
- Improvement of processes within services
- Increased understanding of child protection issues and systems
- Use of the HSP Framework and a systems problem log has increased accountability to the change process

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