Voices in the wilderness

Co-location meeting the needs of children in protective care

Graham Swanson MD MSc FCFP **Michael Mills** MD FCFP **Amie Davis** MD CCFP
Anne Kittler MD CCFP **Vivian R. Ramsden** RN MS PhD MCFP(Hon)

Abstract

Objective To explore how access to a family medicine clinic co-locating with the Children's Aid Society (CAS) of Hamilton in Ontario helped meet the unique needs of children in care.

Design Qualitative research using semistructured face-to-face and telephone interviews.

Setting The CAS of Hamilton.

Participants Nineteen foster parents.

Methods Stakeholders were invited to participate with flyers posted in the clinic, notices that were mailed to foster parents, personal invitations that were distributed during clinic visits, and an internal memo that was distributed to the CAS staff. Informed consent and assent where appropriate was obtained before an interview was started. Interviews were audiorecorded when and where feasible, transcribed, and subsequently underwent inductive, thematic analysis. Common themes evolved by consensus.

Main findings Foster parents valued the family medicine clinic co-locating with the CAS. The co-location helped children in care to know that there were others in similar circumstances. Foster parents learned from and shared parenting skills with one another, which resulted in developing confidence in the care they provided. The clinic became a neutral place for children in care, foster parents, and birth parents. The clinic team gathered the children's complete health records and was responsible for sharing this information when appropriate.

Conclusion Access to a family medicine clinic designed specifically for children in care that co-located with the CAS enhanced not only the planning, management, and evaluation of care, but also provided a consistency that was not found in other parts of the children's lives; this helped generate trusting relationships over time. The co-location provided a strong spoke in the circle of care.

EDITOR'S KEY POINTS

- Care might be less than optimal for children in the child welfare system presenting with common conditions because they often seek care from several doctors and medical clinics. To meet the unique needs of these children and young adults, the Children's Aid Society of Hamilton in Ontario established a medical clinic on its premises to provide continuous, patient-centred primary care services specifically for children placed into care.

- Access to the clinic let children know that there were other children in similar circumstances and also provided the foster parents with a supportive community of other foster parents and clinic staff, which helped them to develop confidence.

- Access to a common meeting area allowed for continuity. Over time an atmosphere of trust developed among the children, parents, social workers, staff at the society and the clinic, and clinic physicians. Several foster parents saw these relationships as "monumental."

This article has been peer reviewed.
Can Fam Physician 2016;62:e694-8

Des voix dans le désert

Rapprocher les services permet de mieux répondre aux besoins des enfants en famille d'accueil

Graham Swanson MD MSc FCFP **Michael Mills** MD FCFP **Amie Davis** MD CCFP
Anne Kittler MD CCFP **Vivian R. Ramsden** RN MS PhD MCFP(Hon)

Résumé

Objectif Déterminer de quelle façon le fait de pouvoir consulter une clinique de médecine familiale sur les lieux mêmes de la Société d'aide à l'enfance (SAE) de Hamilton, en Ontario, a permis de mieux répondre aux besoins particuliers des enfants pris en charge par un organisme de protection de la jeunesse.

Type d'étude Étude qualitative à l'aide d'entrevues semi-structurées en personne ou au téléphone.

Contexte La SAE de Hamilton.

Participants Dix-neuf parents d'accueil.

Méthodes L'invitation à participer a été lancée aux parents au moyen d'affiches installées dans la clinique, d'avis postés aux parents d'accueil, d'invitations personnelles distribuées durant les visites à la clinique et d'une note interne distribuée aux membres du personnel de la SAE.

Principales observations Les parents d'accueil appréciaient le fait que la clinique soit située sur les lieux mêmes de la SAE. Cela permettait aux enfants de constater qu'ils n'étaient pas les seuls dans leur situation. Pour leur part, les parents ont pu partager leur expérience de parentage les uns avec les autres, ce qui a accru leur confiance en leur capacité de s'occuper des enfants. La clinique est devenue un endroit neutre pour les enfants, les parents d'accueil et les parents biologiques. L'équipe de la clinique a réuni les dossiers médicaux complets des enfants et se chargeait d'en communiquer le contenu lorsqu'approprié.

Conclusion Le fait qu'une clinique de médecine familiale sur les lieux mêmes de la SAE soit destinée spécifiquement aux enfants placés a permis non seulement d'améliorer la planification, la gestion et l'évaluation des soins, mais aussi fournir une continuité qui, autrement, n'existait pas dans la vie des enfants; avec le temps, ils ont pu développer une relation de confiance. Utiliser un lieu commun a fortement amélioré le cercle des soins.

POINTS DE REPÈRE DU RÉDACTEUR

- Les enfants pris en charge par un organisme de protection de la jeunesse et qui consultent pour des problèmes de santé communs risquent d'être traités de façon sous-optimale parce qu'ils consultent souvent plusieurs médecins et cliniques médicales. Afin de répondre aux besoins particuliers de ces enfants et jeunes adultes, la Société d'aide à l'enfance (SAE) de Hamilton, en Ontario, a installé une clinique dans ses locaux pour dispenser spécialement à ces enfants des services de santé primaires continus, axés sur le patient.

- En visitant la clinique, les enfants ont pu constater qu'ils n'étaient pas seuls dans ces conditions; les parents y ont aussi trouvé le soutien d'un groupe d'autres parents d'accueil et du personnel de la clinique, leur permettant ainsi de renforcer leur confiance.

- Le fait d'avoir un lieu de rencontre commun a favorisé la continuité. Avec le temps, il s'est développé une atmosphère de confiance entre les enfants, les parents, les travailleurs sociaux, le personnel de la société et de la clinique, et les médecins de la clinique. Plusieurs parents d'accueil ont considéré qu'une telle relation était extraordinaire.

Cet article a fait l'objet d'une révision par des pairs.
Can Fam Physician 2016;62:e694-8

In 2008, the Canadian Paediatric Society advocated for permanency in planning for all children in care.[1] Children and adolescents who are placed into care often have complicated and serious medical, mental health, oral health, developmental, and psychosocial problems.[1-6] The American Pediatric Society and the Canadian Paediatric Society recommended the establishment of a "medical home" for these children, which allows for continuity of care across the continuum from planning to treatment to evaluation of the planned care.[1,7] Although the Children's Aid Society (CAS) of Hamilton in Ontario is a not-for-profit agency that, by law, is required to "protect children from physical, sexual and emotional abuse, and harm,"[8] putting children into care can be disruptive. Frequently, continuity, which is identified as being critical to establishing long-term trusting relationships, is a challenge.[9] Meeting the unique needs of these children presenting with common conditions and requirements such as sexually transmitted diseases, asthma, skin conditions, and pregnancy protection might be less than optimal, as they often seek care from several doctors and medical clinics.

The CAS of Hamilton established a medical clinic in a built-to-purpose space on its premises, which was designed specifically for children placed into care. Initially conceptualized as a pediatric consultation service, the clinic shifted to being facilitated by family physicians in 2009. Thus, in keeping with the principles of family medicine,[10] the clinic provided comprehensive, continuous, patient-centred primary care services that were designed to meet the unique needs of children and young adults placed into care. The team (consisting of 3 family physicians and 2 clinical assistants) tracked, collated, and computerized all patients' medical information, conducted intake assessments of all new cases of children being placed into care, performed annual reviews on all patients, liaised with community-based specialist consultants, and coordinated patients' care. The clinic was funded by a combination of provincial government fee-for-service revenues and the CAS operating budget. When the CAS budget was reduced to providing only mandated, legally designated core activities, the clinic was then scheduled to close.

To highlight the clinic's strengths and to consider opportunities for change, a program evaluation was undertaken to answer the following questions: What worked? What could be enhanced to improve the health and well-being of children in care? Our goal in this article was to explain how access to a family medicine clinic co-located with the CAS helped meet the unique needs of children in care.

METHODS

The purpose of qualitative research is to describe, explore, and explain that which is being studied.[11] Qualitative methods have become an important way of integrating stakeholder knowledge and experience into developing new knowledge and enhancing evidence-informed practice.[12] The survey tools were cocreated and modified for stakeholder groups with Lohfeld and Associates,[13] a team experienced in undertaking qualitative studies.

Stakeholders were invited to participate with flyers posted in the clinic, notices that were mailed to foster parents, personal invitations that were distributed during clinic visits, and an internal memo that was distributed to CAS staff. As part of a larger survey, clinic staff also identified and interviewed community physicians who were familiar with children in care or who were the supervising preceptors of family medicine residents attending the clinic. Their responses were not part of this manuscript.

Semistructured face-to-face or telephone interviews with foster parents were the method of data collection. Informed consent and assent where appropriate was obtained before an interview was started. Interviews were audiorecorded when and where feasible, transcribed, and subsequently underwent inductive, thematic analysis. When it was not feasible to audiorecord the interview, the notes taken during the interview were entered directly into the questionnaire by the interviewer. One member of the research team (G.S.) reviewed all of the transcripts and written reports. Two members of the team (M.M., A.D.) each reviewed 5 transcripts or written reports randomly chosen from all the reports. Similar themes were identified by all the reviewers and consensus was reached through discussion. Ethics approval was obtained from the Hamilton Integrated Research Ethics Board.

FINDINGS

Face-to-face or telephone interviews with 19 foster parents formed the basis of this analysis. **Table 1** presents participant characteristics. Several themes emerged from the interviews, highlighting the benefits of the clinic's co-location with the CAS.

Access to a common location. Access to a common location was a recurrent theme in the conversations with foster parents. Bringing children in care to one location for their medical care provided a forum for children to meet and get to know other children in similar circumstances.

> They cannot go to a normal doctor's office and sit with really lots of normal kids that don't have any of the mental problems that these kids all have .... They are all associated with each other. They all see each other at the visitor's [lounge], at the big waiting rooms, so a lot of the kids know each other. So it's like old home week.

> They feel normal there; every other person in there is in the same boat.

Table 1. Characteristics of foster parents: *N* = 19.

CHARACTERISTIC	VALUE
Male sex, n	3
White ethnicity, n*	11
Mean age, y†	53
Mean no. of y with children in care‡	12
No. of children in care, range	1-200

*N = 13.
†N = 11.
‡N = 17.

Acceptance of children's behaviour. Children's behavioural difficulties were acceptable at the clinic, which is less often the case in a family doctor's office setting.

> [In] a waiting room in a mainstream medical clinic, I am usually there with special needs children, a child with fetal alcohol syndrome that is screaming and banging their head on the tile floor, and in the mainstream [medical clinic] the other people are looking at me as if I am a monster, looking at me as if I am a bad mother.

Consistency. Children in care are frequently moved; thus, access to the clinic provided a consistency not found in other areas of their lives. "It's the continuity. There are so many variables in this child's life that to have one thing that is continuous is wonderful."

Support and care. Access at the clinic provided support and care for the foster parents. "When I go into the clinic, the other mothers are looking to me like, 'Oh my goodness, I had a baby like that last year. I'm probably going to have a baby like that this year. Let me offer some help here.'"

Accessible staff instills confidence in foster parents. The clinic staff were accessible to the foster parents and their support helped the foster parents develop confidence in the job they were doing.

> [Without the clinic] I wouldn't have as much of a peaceful confident time in being a foster parent. Because I rely on them to help me out of situations .... It would help me being more confident in being a foster parent in knowing they're around.

> They know the kids better than we do as foster parents. I cannot foster properly without them.

> They give me peace to know I can talk so someone at the clinic and know they know what they're talking about.

One parent's tensions were eased with the intervention of the clinic staff. "The [birth] parents were there early and found out who I am because they have mental issues as well .... They met me with the kids and kind of surprised me."

Neutral space. Access to the clinic was a neutral space where foster parents and birth parents could meet while maintaining the privacy of their own personal space.

> I would not have invited the birth mother to my family doctor's [office]. Were the clinic not there she would not have been part of that initial first visit.

> It keeps it a bit more at arm's length from my personal life, the children in care, and my personal life.

> The doctors [at the clinic] are used to dealing with foster and [birth] parents, so they know how to treat us in a situation that could be tense.

Enhancement of communication and care. The clinic co-locating with the CAS made it easy for social workers and child protection staff to meet with foster parents, birth parents, and the children during medical care visits. This in turn facilitated communication and record keeping, leading to a better understanding of the issues and planning and maintaining care.

> It is best for everybody in the CAS family to be all here in the same place, the same doctors, all the files are together and the knowledge of the kinds of kids we get in care and the kinds of issues we deal with and that kind of thing.

> It's centralized. It is there for them [CAS staff] as opposed to them having to deal with umpteen different family doctors in different parts of the province I guess as I am [more than an hour away].

> When I go to my family doctor's or the hospital or to a walk-in clinic I'm there on my own; when I go to the clinic the social worker is in the building and usually attends and a support person is there as well .... It's monumental. It's huge.

Convenience. Access to consultants and the sharing of information was also easier when the medical records were all in one place.

> Psychiatric consult is different; knowledge they have of the child's files, an intimacy you can't get elsewhere. Workers come down and talk to the doctors separately from the child's appointment.

> When we had a very difficult child here who had mental health issues, the agency set up a consult with the [child psychiatrist] and they sat in a room at a table

> [of] 8 to 10 people. [The CAS doctor] was part of that. So that you would never get anywhere else.

> I was able to speak to the CAS doctor and because he already had interviewed the former foster mother he was able, with my knowledge, he was able to prescribe ... for ADHD [attention deficit hyperactivity disorder].

Opportunities for change. The foster parents expressed some opportunities for change in the future.

> The only thing the CAS does is the yearly physical; my family doctor does everything else.

> Regulations say any newborns or [others who] come into care, come in for a medical exam; doesn't happen in time allotted so go to family MD [medical doctor] and then have to go back to med[ical] clinic.

> My expectations are that there should be a doctor available during regular hours .... I would prefer that the clinic be open during regular 9 to 5 hours.

DISCUSSION

Access to a common meeting area was important for planning the care for children in care. The clinic's co-location with the CAS also facilitated children finding common ground and foster parents finding support from others and the clinic staff. This access to a supportive community helped the foster parents to learn ways of coping with the children and develop confidence in the care that they provided.

Access to a common meeting area also allowed for continuity. Over time an atmosphere of trust developed among the children, parents, social workers, CAS staff, and clinic physicians and staff. Several foster parents saw these relationships as "monumental," being the only consistency in the children's lives. Joseph and colleagues[9] suggested that finding permanency in one foster home could improve consistency and help establish trusting relationships. There are many reasons why children in care are frequently moved around but these reasons were not explored in this study. However, the foster parents desired and advocated for having a consistent medical clinic team consisting of physicians, nurses, and reception staff.

Limitations

There are limitations to this study. The interviewers varied the order and wording of questions, which might have introduced bias to the responses. However, similar themes did appear across questions irrespective of question wording. Parents who feared the closure of the clinic and who had had positive experiences might have volunteered for the study more readily than foster parents who were neutral or negative about the clinic, creating a participant bias. Responses were from foster parents who used the clinic and foster parents who used a family doctor or a pediatrician practising outside the clinic. The consistency of the responses from both groups, the recurrent themes, and the number of individuals who participated lend strength to the confirmability of the findings.

Conclusion

Access to a family medicine clinic designed specifically for children in care that was co-located on the premises of the CAS of Hamilton provided benefits not only for planning, management, and evaluation of care, but also created consistencies that generated trusting relationships over time. The clinic's co-location with the CAS provided a strong spoke in the circle of care.

Dr Swanson is retired from actively practising family medicine and currently provides care to patients at the Carpenter Hospice in Burlington, Ont, who do not have a family physician, and is Associate Clinical Professor in the Department of Family Medicine at McMaster University in Hamilton, Ont. **Dr Mills** is a hospitalist at the Joseph Brant Hospital in Burlington, and is Assistant Clinical Professor in the Department of Family Medicine at McMaster University. **Dr Davis** is Assistant Clinical Professor in the Department of Family Medicine at McMaster University, is Site Director of the Halton McMaster Family Health Centre, and practises at the Hamilton Maternity Centre and Halton McMaster Family Health Centre in Burlington. **Dr Kittler** practises family medicine in Edmonton, Alta. **Dr Ramsden** is Professor and Director of the Research Division in the Department of Academic Family Medicine at the University of Saskatchewan.

Acknowledgment

The Children's Aid Society of Hamilton in Ontario funded the research. We thank the Children's Aid Society of Hamilton, the foster parents, and Lohfeld and Associates.

Contributors

Drs Swanson, Mills, Davis, and **Kittler** contributed to formulating the original research question, developing the questionnaire, and reaching theme consensus. **Dr Swanson** transcribed the audiotapes and wrote the first draft of the manuscript. **Drs Mills, Davis,** and **Kittler** provided editorial guidance for preparing the manuscript for submission. **Dr Ramsden** offered guidance to the rest of the team, helping them understand how to analyze qualitative data and guiding the process of writing a qualitative manuscript; she provided editorial comment and advice that allowed the team to prepare this manuscript.

Competing interests

Dr Mills was past Medical Director and **Drs Davis** and **Kittler** worked at the Children's Family Medicine Clinic at the Children's Aid Society of Hamilton in Ontario. **Dr Swanson** supervised residents who were learners at the clinic. All authors wish the clinic was not forced to close due to funding restrictions.

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