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Health pathways for children at risk in the Ille et Vilaine administrative division: A French perspective

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ABSTRACT

Background: A regional hospital group located in northeastern Brittany (France) won a national call for improving the care provided to children at risk.
Objective: Our work analyzed and compared the health paths of children at risk in this administrative territory of the French healthcare system. This work, thanks to its territorial approach, can help to better understand and identify mechanisms for improving the quality of care as well as the mechanisms that contribute to disruptions and inequalities in the access to a Child protection system.
Methods: This qualitative study was based on a field analysis where 28 people were interviewed. The inclusion criteria were being: in one of the four domains of child protection (justice, health, social services and education), in one of the five target service areas (n = 21) and an expert in the field of children at risk (n = 7).
Results: The results showed that the health pathway of abused children was unequal and followed a silo trajectory, with multiple breaks in the support provided. We found many barriers to multi-professional collaboration: institutional, professional, individual and regional.
Conclusion: In terms of recommendations, we underline the relevance of models that promote greater integration. The article ends with a discussion of evidence to this effect.

1. Introduction

In countries with advanced economies, 10% to 15% of children are victims of violence (Gilbert et al., 2009). Child abuse can have many implications for overall health in the short, medium and long term (Felitti et al., 1998; Kristen, Jennifer, Daphne, & Molly, 2007; Tursz, 2013). These life events have also been associated with a significant economic burden (WHO, 2002). The health of children at risk is also monitored less regularly (Giannitelli et al., 2011; Kayser et al., 2011). Beyond their basic needs, children have specific needs related to the situations of neglect and violence that they experienced, and these needs must also be addressed (Martin-Blanchais, 2017). In France, according to the current legislation, all children at risk should have access to care, protection and the possibility of ascertainment and assessment. Any child using the healthcare system should be cared for by different health professionals in hospital or liberal practice. Once a child has been brought into the system, he or she should be seen by a professional according to his or her specific needs (e.g., Pediatric Emergency care for physical injuries). Sometimes, this professional should refer the child to another professional of the first or second line (in this example, it can be a liberal Child Psychiatrist). The lack of coordination between these health professionals can lead to breaks in the accompaniment offered (Euillet, Halifax, Moisset, & Séverac, 2016). Furthermore, in child protection, other professionals from social and educational sector may need to contact doctors and encouraged parents to bring their children in for consultations. Not all children in risk are sick, but they all have health dimensions as recognized as “a state of complete physical, mental and social well-being” (World Health Organization, 2006) to preserve. They all also have the right to appropriate care in order to avoid over-traumatization (Balençon, Fouré, & Vabres, 2018).

For many years, the French health system has tried to respond to these public health challenges and, more specifically, it has tried to support the most vulnerable persons. A new law (n° 2016–41 of the 26th of January 2016) was a major law to reorganize the health care

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system in this perspective. It created 135 regional hospital groups (*Groupements hospitaliers de territoire*, or GHTs) with the goal to provide "the best care, at the ideal time and in the best place, to each patient" (HCSP, 2017). Indeed, it stated the implementation of health pathways to offer to all patients a graduated and organized care. To this end, the GHTs were asked to collaborate with actors in the regional public health system as the liberal sector or the social professionals, in adopting a patient-oriented approach in order to guarantee equal access to high quality and safe care. The Upper Brittany GHT received a national mandate to develop an innovative model that would better meet the health needs of children at risk. This study was carried out during the project's planning and needs analysis phase. It focused on the objectives of the law on modernizing the health system, in terms of improving equality, and on the relevance of services that prioritize a patient pathway approach. The aim of this study was to better understand the health pathways of children at risk in the Ille et Vilaine administrative division and the mechanisms involved when there are breaks and inequalities in care, within the framework of a regional approach.

2. Methods

2.1. Description of the current system

2.1.1. Definition of the pathway

Originally, the concept of a health pathway was conceived as a mean to improve the support provided to elderly people with multiple chronic diseases. Since then, different types of pathways have been developed: care pathway focused on the health care provided by hospitals and outpatient clinics while health pathway was developed in response to medical, medico-social and social needs and the life pathway wanted to offer responses to the person's needs in terms of their environment (Féry-Lemonnier, 2014).

The current definition of a pathway is "the overall care of the patient and the user in a given region, paying more attention to the individual and his or her choices. It requires the coordinated action of actors in the fields of prevention, health, medico-social and social services. These actors must integrate determinants of health such as hygiene, lifestyle, education, the workplace and the environment." (ARS, 2016) [translation]. This pathway therefore did not simply consist in tracing a path of care and support, but also in examining the obstacles to the use of services, with a view to transforming the offer (ARS, 2016).

This public health perspective recognizes that health is dependent on many determinants related to an individual's environment. In this article, the notion of a health pathway is studied in a comprehensive approach to the child at risk, as defined by the child's life path.

2.1.2. Description of the child protection system

Even if this study focused on the health care system, further explanatory elements of the child protection system need to be developed. In France, child protection aims to "ensure that the fundamental needs of children at risk are taken into account, to support their physical, emotional, intellectual and social development and to preserve their health, safety, morals and education, while respecting their rights" (Law no. 2016-297 on child protection, dated March 14, 2016) [translation]. The system that protects children at risk or potentially at risk is called the "child protection system." It is organized into different pathways based on the seriousness of a child's situation. Child protection finds itself at the crossroads of the four main missions of public authorities: health (GHT and liberal health sector), social services, justice and education. The French system is somewhat unique in that child protection is decentralized and deployed on a regional basis. It is under the authority of regional boards. Health, justice and education remain centralized prerogatives of the state that are exercised very differently in each region. This phenomenon of the decentralization of child protection has led to inequalities in treatment among the regions. Inadequate care for these children has been reported in some administrative divisions (Dulin, 2017).

Any citizen or childcare professional may report a situation to the relevant authorities if it is deemed to present a risk for a child. Depending on the urgency of the situation, either a social assessment should be carried out by the relevant board within the administrative division, or the courts that should take appropriate protective measures, ranging from educational support to a placement. An investigation to qualify the offence and determine the perpetrator should be carried out by the relevant investigation service. The evaluation and monitoring processes differ from one city to another, for example throughout the Department, there are 22 departmental cells with 22 different practices.

At the same time, health professionals must take care of the child at risk in an inpatient or outpatient setting. They may also be called upon to perform the duties of officers of the law, that is carrying out expert assessments within the framework of competencies recognized by the judicial authorities. In addition, education professionals may alert the relevant departments on the basis of the quality of the child's environment. They are also required to support the child, ensuring that his or her educational needs are met throughout their schooling.

2.2. Study design

We conducted a field survey based on a series of interviews with key informants who were professionals and recognized experts in the field of child protection and public policy. This work was completed with an immersive field observation in one of the GHT's specialized child protection units.

2.2.1. Participants

We met with 28 professionals, including 9 from the health sector, 7 from the legal system, 3 from social services and 2 from education. We also conducted interviews with 7 experts in child protection.

2.2.2. Recruitment

In selecting the key-informants, we sought to identify professionals working with children at risk in the health, social service, education and justice systems in five target service areas. The target areas were selected within the limits of the GHT. The characteristics of the target service areas were the following:

- Service Area 1: In the administrative capital of the region, an urban area of 700,000 inhabitants, we targeted a university hospital central to the GHT, a department specialized in children at risk and a unit that holds hearings for minors.
- Service Area 2: One hour's drive from the regional capital in an urban area of 100,000 inhabitants at the intersection of three different administrative authorities, we included a hospital.
- Service Area 3: A 40-minute drive from the regional capital in an urban area of 44,700 inhabitants, we included a hospital.
- Service Area 4: A 40-minute drive from the regional capital in an urban area of 30,000 inhabitants at the intersection of two administrative authorities, we included a hospital and a referring physician in the area of abuse.
- Service Area 5: Selected for the purpose of analyzing the dynamics of smaller cities without a hospital, we included a service area at a 30-minute drive from the regional capital, with no hospital, in an urban area of 6500 inhabitants (see Table 1).

2.2.3. Data source

The data came from semi-directed face-to-face interviews with the exception of one telephone interview. The majority of the interviews (23/28) were conducted individually and lasted 30–90 min. An interview was a group interview (5/28). All the interviews were recorded and transcribed with the exception of four interviews where the professionals did not agree to be recorded. For those, manuscript notes

Table 1
Description of the participants.

Domains	Types of professional	Target service areas
Healthcare	GHT: 3 Pediatricians, 1 Pediatric-Forensics, 1 Administrative professional, 1 Social Worker, 1 Child Psychiatrist	1, 2, 3, 4, 5
	Liberal sector: 1 Pediatrician, 1 General Practitioner	1
Social	1 Referent Doctor, 2 Heads of department	1, 2, 3, 4, 5
Educational	2 Educational Counsellors in Child Protection	1, 2, 3, 4, 5
Legal	1 Court Counsellor	1, 2, 3, 4, 5
	Police station: 6 Officers	1, 2, 3, 5
Expertise	2 Public Health Policy Experts	1, 2, 3, 4, 5
	1 Medical Ethics Expert	1, 2, 3, 4, 5
	1 President of a Pediatric-Forensics Association	National
	1 Pediatrician	Other region
	1 Health Pathway Coordinator	1
	1 President of a Child Protection Organization	National

were taking during the interview. The interviews with the seven experts were longer. The interviews were ended when the data collection reached a saturation point.

2.2.4. Data analysis

The interviews explored three main themes: the current situation in the targeted service area; multi-professional collaboration in the health paths; and, potential solutions for improving the current system. This study did not cover any issues that occurred prior to the child entry into the health system. We focused on the health pathways of child protection system, once the situation of a child in danger or at risk had been identified by the public authorities. The analysis showed a homogeneity in the opinions of the stakeholders, regardless of their fields of intervention. Consequently, we have presented the results as a homogeneous whole, covering all sectors. The credibility of this study's results is grounded in the many points of view we investigated - the combination of the four main missions of the public authorities (health, social services, justice and education) with an experts' perspective - and their convergence.

3. Results

With regard to the health pathway taken by children covered by the child protection system, the main results were an unequal care, delivered in silos, that was characterized by multiple breaks in the support received. The following paragraphs describe in details the weaknesses of the child protection system.

3.1. Inequality

The children at risk faced many barriers limiting the support they received. Since responsibility for health was closely linked to the notion of parental authority, management of the children's care depended on the attention of their parents who, in most cases, were the perpetrators of the abuse. Most of the time, consideration for the health dimension by a health professional was absent throughout the child protection process, or only occurred on an ad hoc basis. All the professionals interviewed reported that children were not sufficiently recognized as beneficiaries of health care. All of the actors were able to identify many inequalities in the pathways of children, including complex access to the health system. They deplored the long waiting times for access to hospital-based or private pediatric psychiatry services, which varied from 9 months to 2 years, depending on the service area. Screening and support for abused children were described as time-consuming and difficult to coordinate within the busy schedules and limited availability of physicians in private and public sectors. Several professionals also highlighted the weaknesses of the training provided in this sensitive area. Access to the pathway was thus fundamentally unequal because it was professional-dependent. These weaknesses were said to be the cause of the inadequate support provided in response to children's health needs. The care of children was also be marked by social inequalities in health. People living in rural areas were obliged to travel greater distances than those residing in the regional capital. Consultations with a psychologist were not covered by general patient rights and health insurance. The implementation of this type of care was therefore dependent on the family's socio-economic level and their desire to see the child gain access to it. Beyond these social inequalities, the case management of children was also negatively affected at different times of the week, such as at night and on weekends when some services were unavailable, so children were less likely to meet with a trained or specialized professional (see Table 2).

3.2. Breaks in care

According to the actors interviewed, multi-professional collaboration within the child protection system was not sufficiently focused on the child's best interests. As the pathways were not designed for continuity, breaks appeared in the support provided to children at risk. Multi-professional collaboration was focused on professional know-how, and too often this excluded integrated practices. Organizing the system by area of competency resulted in numerous children meetings with a series of stakeholders along their pathway. This meant that minors were asked to adapt to the professionals and to recount their trauma several times. This situation was particularly conducive to the child suffering additional trauma.

Table 2
Selected verbatims concerning child protection inequality.

Domains	Verbatims [translation]
Healthcare	"We don't know if the children we follow have been abused unless the parents say so. We can't adjust our care if we don't know, like with old shaken babies." (Paediatrician, liberal physician)
	"Inequalities are even greater when the child is young. Because they can't talk, only parents and professionals can identify children's needs." (Social Worker, GHT)
	"The path of children is divided by the actors. Children have to move, to see many professionals, go back and forth between the institutions." (similar verbatims expressed by various participants: Administrative professional, Social Worker, Pediatrician liberal)
	"Abuse and neglect are a damaging pathology for the child, but not everyone recognizes it." (Pediatric-Forensics)
Social	"There are not always a medical evaluation or psychological follow-up to propose to the children, it is proposed at the demand of the social services professionals." (Doctor referent)
Educational	"Teachers and educators are not trained in health." (Educational Counsellors)
	"There is healthcare at the time of the abuse report and then nothing. One wonders whether people think about the question of health beyond protection." (Educational Counsellors)
Legal	"The first partners we have will be the associations and the town halls. Emergencies arrive on Fridays when social services are closed." (Police officer)
Expertise	"Access to psychiatry is very complicated. Those who have money can pay the psychiatrist, the others are waiting."
	"It takes time to take care of children in danger. Gaining the child's trust takes time, which GPs do not have."
	"Being auditioned in a place that is not appropriate for children is an over-traumatizing factor."

The interviews highlighted many barriers to collaboration between the four intervention areas. These barriers can be classified according to their nature, as political, institutional, professional and individual in nature, but also regional. First, the professionals said they would like to see more policy support from institutions directed at considering the basic needs of abused children and multi-professional collaboration. Several of them lamented the fact that this issue must be repeatedly legitimized to the public authorities before it was addressed. In the case of institutional barriers, all the professionals reported a lack of time and resources to meet with other professionals in order to manage a situation together.

The protection of children was subject to different time frames that varied according to the urgency imposed by the legal system, the time required for care, and the time required to meet social or educational needs. According to the professionals interviewed, insufficient time has been spent collectively for working out these different time–space issues, and no consideration seems to have been given to harmonize the different practices. An institutional obstacle, which was identified by all the professionals who reported abuse, was a lack of feedback on the situations they had reported. On the other hand, from a professional point of view, external partners noted a lack of transparency in the current organization of some institutions. The roles, missions and limits of practice of each stakeholder were not clearly identified by the actors. The professional barrier the most often cited by the key-informants was the lack of information sharing between professionals in different fields. This situation was detrimental to providing support that was tailored to children's needs. Lack of training was also identified by all the professionals as a barrier. All of them recognized the difficulties inherent in working together without a common language. At the level of individual barriers, certain back stories between people and with respect to hierarchical relationships also clearly limited the capacity for change in practices and collaborative work.

Finally, there were also impacts on current collaborations associated with the service area. The centrality of Service Area 1 and its referral structures, located in the heart of the administrative division, facilitated care trajectories. Some areas have developed good collaborative relationships between professionals, such as in the Service Area 5. Professionals cited the importance of the role played by relationships of trust and frequent exchanges in the system's ability to overcome prejudices. The presence of referring physicians at the local level was seen as a necessary condition, but only if it was well known in the region. According to the professionals interviewed, the particular nature of Service Area 2 and Service Area 4, located at the intersection of several administrative divisions, greatly complicated the care of children at risk because the territorial barriers emerged in addition to the barriers imposed by the four major missions, which already tended to operate in silos. Being at the intersection of several administrative divisions, such as Service Areas 2 and 4, was indeed identified as having a significant negative impact on collaboration, since the regional child protection services had different procedures, in particular for the Social and Legal sectors. Service Areas 2, 3, 4 and 5, which were rural, were underserved with urban physicians. Service Area 2 appeared to be particularly ill equipped, with one pediatrician per 100,000 inhabitants (see Table 3).

3.3. Improving the system

According to several of the professionals we met, a comprehensive approach should be applied when thinking about the child protection health pathway. The objective of this approach would be to create a rule making the needs of the child at the core of the system. Most of the professionals would like the children in the child protection system to be heard in a specialized pediatric ward surrounded by experienced health professionals. The objective would be to have a systematic pediatric assessment and a reference to short, medium and long-term medical and psychological follow-up that is adapted to their particular situation (see Table 4).

4. Discussion

The results of this study reveal that with the current organization of the health pathway, the basic and specific health needs of children at risk are not being sufficiently met.

For the most part, these inequalities are aggravated by the lack of staff training, a discontinuity of services, the complexity of access to health services, and the social inequalities in health. It is interesting to note that it was not so much the lack of caregivers in the service area that had the greatest impact on care, but rather the difficulty in achieving multi-professional collaboration within and between service areas.

These results are in line with the evidence in the literature about the difficulties in multi-professional collaboration (Smith & Mogro-Wilson, 2007). But also, the need to think holistically about the care of the child (Wulczyn et al., 2010), to promote multi-disciplinary teams (Herbert & Bromfield, 2019) and integrated primary care (Martin, White, Hodgson, Lamson, & Irons, 2014), in particular for primary-secondary interface (Mitchell et al., 2015).

These results underscore the importance of thinking in terms of structured health pathways, in order to limit the role played by chance in the care of children at risk. The same principle applies to the prevention of situations of institutional abuse in pediatric care (Dulin, 2017). Indeed, the current evidence suggests using integrated models for the organization of care, in the sense of "care and cure," in order to foster multi-professional collaboration and comprehensive child support and prevent additional trauma (Elmquist et al., 2015; National Children's Alliance, 2018). Based on the expertise available within a service area, the chosen approach was to create a pediatric centre specialized in responding to child abuse (Balençon et al., 2018; Vabres et al., 2016), that is a specialized multidisciplinary centre, located in a pediatric hospital environment, dedicated to children and for the coordination a structured health pathway. This center should bring together health care professionals with expertise in child protection, who know the importance of the global approach for children (health, social, educational and legal). The main objective of this center is equality to ensure that every child at risk in the territory has had the right to identification, diagnosis, assessment and care. The health pathway

Table 3
Selected verbatims concerning break in care.

Domains	Verbatims [translation]
Healthcare	"We don't know what we can tell to another professional about a type of case." (Liberal Paediatrician and Liberal General Practitioner)
Social	"Collaboration between social service professionals and paediatricians is not always easy."(Head of Hospital Department)
Educational	"There is no feedback to teachers after a legal report. The next day, they don't know, if the child is absent, dead or protected." (Educational Counsellors)
Legal	"In our city, the collaboration with the social services is going well because we are used to working together, we trust each other." (Police officer)
	"You don't always know who to call, what services to go to." (Another Police officer)
Expertise	"There's a real lack of knowledge about shared professional secrets."
	"The actors do their things in their areas without cross-communication."
	"We're passing the buck, it's not my responsibility."

Table 4
Selected verbatims concerning the improvement of the child protection system.

Domains	Verbatims [translation]
Healthcare	"Be near the hospital so that the child can be hospitalized if necessary following the auditions" (Pediatrician-forensic)
	"There should be a systematic doctor review" (General Practitioner)
	"Focusing on the child and not on the interest of each individual as a professional or institution" (Social worker GHT)
Social	"There should be more indicated pathways with referring doctors clearly identified by the different services." (Head of Department)
	"A basket of psychological, speech-language pathology and psychomotor services would be absolutely necessary." (Head of Department)
	"The importance of putting the issue of health in the socio-education." (Referent doctor)
Educational	"To facilitate collaboration between services and knowledge of each other's missions, especially at the local level" (Educational Counsellors)
Legal	"To intervene before the child is too traumatized" (Police officer)
	"To invite police officers to network meetings, multiply the time for meetings with professionals from the different institutions" (Another Police officer)
	"To create a suitable paediatrics unit for children to facilitate monitoring and comprehensive care." (Court Counsellor)
Expertise	"We must think about the different levels: assessment, care, follow-up at various times."
	"To work on the coordination of liberal-hospital medicine"
	"The importance of having a reference place for doctors who are often isolated on this issue"
	"There is a need for better early detection of at-risk families and for prevention"

would therefore be graduated according to the levels of care required, from a consultation with a family doctor/urban pediatrician to a specialized consultation in this centre, which would then organize the follow-up in the pathway. Not all children will be able to go through such a centre located in highly urbanized area, but the training of other referrals health professionals should ensure access under the supervision of this expert center. The link between the judicial and care dimensions like a process structuring the health pathways to avoid inflicting additional trauma in the care given to children.

The major problem of access to psychiatry is difficult to solve. However, the presence of a psychiatrist on these centers should allow an evaluation of the children's needs. Working groups with the psychiatric professionals of the hospital should be organized to improve the fluidity of the pathway, the access for all and the collaboration with social professionals.

In addition, the center will organize with the other institutions, training for social, health and educational professional in order to improve the collaboration, quality of the services and to homogenize the practices on the territory, in particular in the consequences of abuse and neglect in the field of health and the psychological and physical repercussions in adulthood.

As a referral centre, known by all, it will allow better coordination between professional by organising working groups with the institutions around the structuring of health pathways. The child would not remain static at the centre of the trauma and care. Rather, he or she would have the ability to grow and develop, which would make the implementation of care fundamental, and require that it be adapted on a case-by-case basis.

5. Limitations

This study has some limitations. Selection bias may be present. We would have liked to meet with more social service professionals in the selected areas. Since the child protection professionals were very busy, some of them did not have the time needed to meet with us. Lastly, we would also have liked to meet with victims' associations, but they did not respond to our requests.

6. Conclusion

The public health approach used to analyze this issue has highlighted the limits of France's decentralization of child protection, which greatly complicates organization in the service areas while having a negative impact on children's pathways. The GHT reform has provided a good opportunity to give more consideration to equality in the pathways of children at risk. The GHT of Upper Brittany, through the creation of a centre specializing in child protection, could make a significant step forward in child protection in France.

Declaration of Competing Interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

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