The invisible issue, children, and families in substandard accommodation: how can paediatric interdisciplinary teams help?

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Aims: In the UK the number of children living in temporary accommodation has risen by 80% since COVID-19 [1]. One fifth of Australian children aged 0 to 5 years lived in homelessness/housing instability prior to COVID-19 [2,3]. Little is known regarding the impact of homelessness on the health of children living with homeless families. Moreover, the types of services and interprofessional collaborations needed to address children's needs remains unknown [3,4]. This presentation outlines an innovative model of interdisciplinary collaborative health delivery that addresses these gaps [5]. The model used an embedded Nurse Practitioner 'health hub' to assess children and help parents meet their child's needs.

Objectives: This project captured the: 1. Health of homeless children presenting to homelessness and community services in South Australia. 2. Referral rates and uptake of the children 3. Interdisciplinary health needs of the children living with homeless families

Methods: A mixed methods study design was conducted. Health severity scales, extended health assessments, case note reviews, and interviews with parents and staff, to determine the health impacts of homelessness on children and the children's interdisciplinary health needs. The conditions identified were coded using a severity scale of 1 to 3; 3= severe, the child needing immediate care/intervention, 2= moderate, the child needs a referral but can wait for public hospital/clinic, 1= minor, the child does not need immediate referral). Referrals were made to: Paediatricians, dentists, physiotherapists, immunisation nurses, General Practitioners and other allied health professionals.

Results: Overall interim results show 62% of children presenting had health conditions (e.g. chronic dental caries, craniosynostosis with developmental delay) requiring interventions, while 38% were assessed as having good health requiring no intervention. Table 1 above illustrates the presenting conditions of the children attending the Nurse Practitioner led clinic. A consultation with the NP for an in-depth health assessment and often were the first comprehensive health assessment the children had received since birth. We found 18% children had a developmental delay (6 times the national average), 17% had behavioural and/or mental health issues, 17% required an ENT intervention, 24% had dental issues and 24% had a variety of presenting conditions. The correlational analysis and odds ratio results along with the interdisciplinary model of care and the case note analysis will be presented at the RCPCH conference. The intervention/evaluation reflects the complexity and depth of the unmet need in these children.

Conclusion Overall the children are disconnected from health. This research identified that: • A significant number of children required medical interventions. • Children living in housing insecurity are at risk of missing out on care that is essential to their development and health • These children lack access to mainstream services • Health care costs act as a barrier to services • There is a poor referral uptake by children living in housing insecurity • There is a lack of information on the number of homeless children, particularly Aboriginal children It is imperative that the health needs of

children living with housing instability are measured and the responses of health professional interventions are tracked.