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RESEARCH ARTICLE

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Critical success factors for school-based integrated health care models: Learnings from an Australian example

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Abstract

Issues Addressed: Integrated school-based health services have the potential to address the unmet health needs of children experiencing disadvantage, yet these models remain poorly evaluated. The current article examines an integrated social and health care hub located on the grounds of a regional Australian public primary school, the Our Mia Mia Wellbeing Hub, to identify critical success factors for this service and others like it.

Methods: Semi-structured qualitative interviews were conducted with $N = 55$ multi-sector stakeholders comprising parents, students, school staff, social and health care providers, and local Aboriginal community members. Interview transcripts were analysed according to a grounded theory approach.

Results: Six themes emerged from the analysis, reflecting important success factors for the model: service accessibility; service coordination; integration of education and health systems; trust; community partnerships; and perceptions of health.

Conclusions: Findings highlighted Our Mia Mia as a promising model of care, yet also revealed important challenges for the service as it responds to the varied priorities of the stakeholders it serves.

So What?: Through capturing the perspectives of a large number of stakeholders, the current study provides valuable insight into key challenges and success factors for Our Mia Mia; these learnings can guide the development of other emerging school-based health services and integrated care hubs.

KEYWORDS

community-based intervention, health promoting schools, program evaluation, qualitative methods, rural and regional health

1 | INTRODUCTION

To address the complex health needs of children experiencing disadvantage, substantive improvements in service accessibility are critically needed.[1,2] Locating health care services on school grounds reflects a promising strategy to achieve this goal. School-based integrated health care (SIH) models provide children with timely access to services by bringing care directly to families, in locations they have established connections to and where they naturally spend much of their time.[1,3] Through partnering with families, schools and

communities, and integrating across education and health systems, these models are able to transgress challenges faced by traditional models of care to address the unmet health needs of children and families experiencing disadvantage.[1,4,5] These models represent a promising strategy to advance health equity.[2,6] This article will explore an Australian example of a SIH model, and will map the perspectives and priority areas of stakeholder groups so these insights can be considered by other emerging health hubs.[7]

SIH models are an innovative strategy to provide services to children, adolescents and families who experience barriers to accessing mainstream health care. Paradoxically, populations experiencing disadvantage who have the highest need for health and social services are the least likely to access them; this phenomenon is known as the *inverse care law*.[8–10] Disadvantaged groups often fall through the cracks in a health system poorly suited to meet their needs; by the time vulnerable children access services their concerns have typically escalated, increasing their risk of adverse lifelong health and wellbeing outcomes.[11–13] SIH models aim to reduce barriers by providing affordable health care to families in locations that are familiar and convenient.[1,4] By locating services on school grounds, such models improve access by reducing the time associated with travelling to regular health appointments and thereby increasing time spent in the classroom.[1] In this way, SIH models synergistically improve both the health and educational outcomes of children through bringing together health and education agencies to enact coordinated solutions.[2,14]

In addition to accessibility, a critical success factor for these models is their flexibility to integrate across systems and providers of care. SIH models support various health professionals to collaborate with each other and with school staff to coordinate interventions effectively and augment the child's care. SIH models are uniquely positioned to provide wrap-around support that addresses the multiple determinants of health.[4] Furthermore, service coordination, shared referral pathways and the collocation of services simplify the process of help-seeking for parents. This is particularly critical for parents experiencing disadvantage, who often lack the skills or resources to navigate a fragmented and bureaucratic health care system. To this end, parents can be further supported by a care navigator, who can recommend an appropriate array of services tailored to a family's specific needs and guide them through the process of accessing care.[15,16] Care navigation is therefore one of the most critical factors underlying the efficacy of SIH models.

In addition to improving service accessibility and care integration, locating health care on school grounds has the additional benefit of facilitating community trust and support. Traditional models of care are often de-contextualised and poorly suited to the specific needs of the populations they serve.[5,17] In contrast, SIH models provide *place-based care* by partnering with communities to respond to local needs and serving a population of families and professionals who share a connection to a commonplace and have relationships with one another.[4] Nurturing these community partnerships, and remaining responsive to stakeholder priorities, underpins the success of SIH models.

School-based health care has grown in popularity in the United States, however, there are fewer of these services available in Australia.[1,18] Whilst researchers have evaluated examples of these models, a lack of broadly accepted terminology to describe various iterations of school-based health services makes it difficult to firmly establish their efficacy. Furthermore, these models are necessarily reflective of the specific needs of the communities they serve; whilst learnings can be applied across contexts, there is a need for both local and coordinated research within Australia. One Australian study piloted an integrated service delivery model which brought a child psychiatry service to a special education school in Sydney[19]; another piloted embedding a primary care nurse in a high school's learning and support team.[20] Other than these few initiatives, to our knowledge, little research has been done in Australia to evaluate the efficacy of school-based health care.[18] Furthermore, the literature that does exist tends to examine the delivery of care by independent service providers; an approach that contributes to fragmented health care.[5] Integrated care hubs, where services are colocated and coordinated, are increasingly promoted as an efficient model of service delivery for marginalised communities, yet are remarkably poorly evaluated.[21] Particularly needed is an evaluation of the acceptability of these models for the stakeholders they serve, a critical consideration if these services are to be sustainable and truly impactful. Qualitative research approaches, which capture the nuances and complexities of stakeholder perceptions, are valuable in this regard. Hence, Australian research examining the acceptability of SIH models, through consumer and community consultation, is critically needed.

The current study aims to respond to these identified gaps in the literature, to evaluate an example of a SIH model located in a primary school on the South Coast of New South Wales, Australia.[7] The Our Mia Mia[22] Well-being Hub is located on the grounds of Nowra East Public School (NEPS) though its services are available to families from other preschools, and primary and high schools in the region. This region was ranked in the lowest decile on the most recent socio-economic indexes for areas[23] NEPS itself services a particularly disadvantaged population of children; 86% of the school's families sit in the lowest quarter of the index of community socio-economic advantage scale. The region also has a large Indigenous population with approximately 52% of NEPS's students identifying as Aboriginal and/or Torres Strait Islander; "Our Mia Mia" was the cultural name gifted by the school's local Aboriginal community.[7] Australia's indigenous Australians experience stark social, educational and health inequities, in addition to complex cultural, structural and financial barriers to accessing social and health care. Our Mia Mia emerged from consultations between the NSW Department of Premier and Cabinet and the local community, where it was identified that health care service accessibility was a key target for addressing intergenerational disadvantage in this population.[7] The hub provides a space for service providers to colocate, including general practice, paediatrics, dentistry, psychology, speech pathology and occupational therapy, in addition to a gamut of social services including Centrelink, Service NSW and legal aid.

This article will discuss Our Mia Mia as an Australian example of a community-driven partnership between schools, families, and health and social services that have resulted in a SIH hub. We will examine learnings from qualitative interviews with various stakeholders involved with the hub, to map the key priority areas, expectations and reservations of stakeholder groups. In doing so, we aim to provide

insight into important considerations for these models, to guide the evolution of the hub and shape the development of similar emerging health hubs.

2 | METHODS

2.1 | Ethics, recruitment and sampling

The hub's evaluation was initially funded through the Department of Education's Disability Strategy Innovation Program, the research protocol was approved by the UNSW Human Research Ethics Committee (HC220023).

Qualitative data was collected from a purposive sample of 55 individuals ($n = 45$ females) involved with Our Mia Mia, across the following stakeholder groups: School principals ($n = 6$); the Director of Education for the Shoalhaven Community of Schools (CoS); directors ($n = 2$) and an area manager ($n = 1$) of local preschools; teachers ($n = 13$), school psychologists ($n = 6$), parents ($n = 7$) and students ($n = 5$) at schools and preschools across the CoS; health and social service providers at Our Mia Mia ($n = 11$); Aboriginal Education Officers ($n = 1$), Aboriginal Education Consultative Group members ($n = 2$), and staff at an Aboriginal agency in the area ($n = 1$). Purposeful recruitment began by speaking with principals across the CoS. Subsequently, snowballing, opportunistic and convenience sampling strategies were used to identify other key stakeholders.

Information about the study was presented to potential participants and written informed consent was obtained, which included consent for audio recording.

2.2 | Data collection

Interviews were conducted by the first and last authors of the current study. They are Caucasian and Latino, respectively, and do not identify as Aboriginal or Torres Strait Islander. Both authors self-identify as aligning with liberal socio-political worldviews. Their political opinions were not voiced during the interview process but we acknowledge that these values shape processes of data collection and analysis.

Interviews ranged in length, however, most lasted approximately 30–45 min. Interviews were conducted in person or via video call. Most interviews involved one interviewer and one interviewee, with the exception of interviews with children, which were conducted in a small group setting. Here, 4-5 children (ages 6-10) and their caregivers took part in an hour-long interview conducted by both interviewers. Interviews were transcribed by the first author using audio recordings; when consent to audio recording was not provided or audio recording was not possible for other reasons, notes were taken during the interview and later used for analysis. Two interviews were transcribed in this way.

A semi-structured interview guide was developed initially with open-ended questions to guide discussions. However, the conversation was allowed to flow organically, and the interview schedule was not followed rigidly. Questions varied according to the stakeholder being interviewed, however, similar themes were addressed across interviews. Interviewees were asked about their involvement and experiences with the hub; their overall perception of Our Mia Mia; elements of the service they felt were successful; elements they felt apprehensive about or challenges they envisioned; and their vision for the future of Our Mia Mia and its impact. Some of these questions were simplified when discussing the content with children. The length of interviews meant that individual experiences and perceptions could be explored in-depth to capture the complex and diverse array of opinions.

2.3 | Data analysis

Transcripts were used for the purposes of data analysis. A grounded theory approach to analysis was used, as appropriate when a scarcity of relevant literature and a lack of established theories make it difficult to develop a coding strategy in advance.[24] Initial purposive sampling was followed by theoretical sampling, such that participants who were best able to contribute to the emerging theory, and whose perspectives were missing, were selected for interviews. Analysis was completed by coding emergent themes from the transcripts and categorising and grouping these themes interpretively to form higher-level categories. This was followed by theory formulation, such that previously coded data was revisited through the frame of the emergent themes. This process was continued until theoretical saturation was reached. Themes were shared with the last author along with the original data for comparison and critique.

3 | RESULTS

Six main themes emerged from the analysis, reflecting the priority areas of a large group of stakeholders with diverse perspectives on Our Mia Mia. These themes pertained to service accessibility; service coordination; integration of education and health; trust; community partnership; and perceptions of health. These themes will be discussed as key learnings to guide the development of similar SIH models.

3.1 | Service accessibility

Many stakeholders described Our Mia Mia's primary strength as its provision of easily accessible services to families who experience complex barriers to accessing care. Locating services within school grounds eliminates the challenge of organising transport to appointments; this concurrently minimises the time children spend away from the classroom; improves their likelihood of attending appointments; and reduces demands on parents. Parents reiterated that Our Mia Mia's convenient location "doesn't just benefit the children it benefits the adults too. Its weight lifted off your shoulders; that appointment, you don't have to stress about it, you don't have to drag yourself into town for it."

Additionally, the cost was described as a particularly prohibitive barrier to accessing care, given that many families face financial

hardship yet require expensive specialist care. Our Mia Mia meets these needs by providing services for free. One parent noted that "without the hub no one would get any help … if I had to go out [to access services], I wouldn't be able to pay for them." Affordable service provision is a critical success factor for SIH models and underscores their suitability for disadvantaged communities.

In addition to cost, long wait times to access specialist care obstruct the timely provision of support and frustrate service providers and consumers alike. Parents noted that for some services in the region "you can wait 12 months for one appointment," whereas at the hub, "you're in the next day." At Our Mia Mia, due to its proximity to clinical services, appointments can be filled on short notice to avoid wasting a service provider's limited time. Maintaining short waiting times, whilst expanding service access to neighbouring schools in the area, will likely be a key challenge for the hub as it evolves. Broadly, increasing service accessibility was considered the core improvement brought by Our Mia Mia and will likely remain a primary objective moving forward.

3.2 | Service coordination

Stakeholders highlighted that Our Mia Mia facilitates effective service coordination and provides families with integrated support in a way that traditional models of care typically fail to do. The colocation and effective coordination of services through a centralised hub streamline the support process, such that a paediatrician can provide a diagnosis and the resulting referral to specialist care can be actioned into support for a child all in one place. Strong follow-up procedures and open lines of communication between care providers improve compliance to prevent children from "falling through the cracks," and families are supported to access effective and integrated care that will give them the best outcomes. Health practitioners reported that coordinating treatment with other health providers and educators has allowed them to more effectively manage patient health concerns through integrated care; "it's unreal for me as a practitioner for my clients to be able to access all that wrap-around care that I know is going to get them the best outcomes" (Psychologist). Health providers noted that this has imbued their work with an increased sense of purpose; "it's very satisfying to feel like we're actually making a difference" (Paediatrician).

Effective service coordination is augmented at Our Mia Mia through care navigation. The fragmented nature of traditional health care was identified by stakeholders as a complex barrier to accessing care. Silos across disciplines make support pathways confusing for parents, teachers and service providers alike. Parents often do not know what support services are available, how these services interact, and the bureaucratic requirements of accessing care. Our Mia Mia's hub coordinator is highly knowledgeable about these systems, and can therefore act as a care navigator, shepherding families through the process of accessing services. This role was perceived across stakeholder groups as key to the success of the service; "it's about making it a clear path … [Our Mia Mia] hasn't cut a road from A to B, it's cut a freeway" (General Practitioner). Particularly for parents experiencing disadvantage, who have poor health literacy, or who struggle with organisational tasks, this high level of support was reflected upon as a core strength of the hub: "there's no hassle, there's not forgetting [appointments], there's not putting it off until tomorrow, it's done then and there."

3.3 | Integrating health and education systems

In addition to coordinating between health providers, Our Mia Mia is uniquely positioned to integrate across education and health systems. Typically, health services do not communicate with schools, leaving teachers feeling frustrated about their inability to support students with health concerns; "we need to know how we can best work with those children. And we just don't get that information back through. So that's a real barrier to progress and making a difference for those children" (Classroom teacher). In contrast, at Our Mia Mia, school staff are supported to work together with a suite of health professionals to provide students with wrap-around care. Teachers are able to identify concerns and collaborate with school counsellors to prepare the required documents to refer a family to Our Mia Mia; hence need is identified early and health professionals are provided with valuable referral data. Teachers also benefit from the collaboration, as diagnoses from health professionals often enable teachers to access diagnosis-specific resources to better support student learning. Furthermore, open lines of communication allow teachers to remain informed of their student's treatment progress and to seek expertise from health professionals. This has addressed teacher despondency about the inability to effectively support children; "It's completely changed my life. I love it…The whole feel of the school has completely changed" (School counsellor). Many reported their optimism that Our Mia Mia will have profound impacts on student learning; "if we're alleviating those [health concerns] … and kids are engaging with school, then we can make a difference" (School Principal). Through breaching the education and health systems, Our Mia Mia has brought together agencies to provide coordinated solutions to improve the education and health outcomes of disadvantaged children in the region.

Whilst much of Our Mia Mia's immense success is attributable to its integration across education and health sectors, this equally represents one of its greatest challenges. Our Mia Mia operates between the two heavily regulated sectors of education and health, each with its own governance structures and operational standards. Health professionals in particular noted the imperative to comply with requirements pertaining to privacy, confidentiality and data storage and felt Our Mia Mia's "governance will have to get tighter" to ensure appropriate standards are met. This need however must be balanced against the imperative to ensure that the service does not become too rigid, "because the flexibility of it is what makes it work" (Health care provider). Keeping Our Mia Mia agile enough to continue to meet the needs of the population is critical.

3.4 | Trust

Our Mia Mia's success in ensuring the trust of families and communities was a major theme that arose from the data. Stakeholders regarded Our Mia Mia's integration into the school as an asset in this regard, as families generally have trusting relationships with at least one school staff member, who can encourage them to attend Our Mia Mia. Due to its location on school grounds, Our Mia Mia is also regarded as less clinical and intimidating; "it's a familiar, safe place… [there's] security in the recommendations coming from teachers… it's reducing that fear people have of the unknown." (Health care provider). For parents who feel apprehensive about attending medical services for fear of judgement, Our Mia Mia proves less daunting: the staff is approachable; the ambiance is casual, and parents are often sitting around and passing through for a chat. One parent described Our Mia Mia as "a safe haven for anyone who wants to go there" and another noted that they "love coming in and seeing the other parents around". Stakeholders however also raised concerns that whilst Our Mia Mia should remain "a place for people to come and feel welcome," it is important to "keep in mind that there are people there [for] appointments, lots of people like that to be confidential" (Aboriginal school staff member). Some stakeholders felt that "there's no way you can be confidential in that space" (Health care provider). Broadly, health care providers at Our Mia Mia recognised that the model is pioneering and progressive. This brought immense optimism about Our Mia Mia's potential for impact alongside a cognizance that novel challenges will likely emerge, and will need to be navigated carefully to ensure that Our Mia Mia remains a trusted service.

Of critical importance is the establishment of Our Mia Mia as a culturally safe place for Aboriginal families. Aboriginal Australians experience a cultural mistrust of government services which must be sensitively navigated to ensure that these communities feel safe, respected and welcome at Our Mia Mia. In establishing Our Mia Mia as a culturally-safe service, it is important to be aware of the power embedded in service positions, to understand family dynamics and historical contexts, how families are treated in the service, and how families' information is protected. Many stakeholders regarded Our Mia Mia as culturally safe, and commented positively on the outdoor space for yarning; the welcoming staff who took time to build rapport with families; and the display of cultural art and the acknowledgement of country. Others felt that more could be done to make Aboriginal communities feel welcome and safe at Our Mia Mia. Suggestions were made to display the Aboriginal flag and Our Mia Mia cultural name at the hub's entrance, as important symbols of cultural safety: "When you see that flag as an Aboriginal person, you know that represents … who you are; your mob, your community" (Aboriginal school staff member). Many stakeholders noted the critical importance of seeing Aboriginal people in positions of power at the service; employing an Aboriginal staff member with strong cultural knowledge and skills in connecting with families was highlighted as paramount. Our Mia Mia's responsiveness to these priorities is critical to maintaining the trust of these communities.

3.5 | Community partnerships

Our Mia Mia is the product of an effective partnership between the community, families, education, health and non-government organisations. From its beginnings, Our Mia Mia has been supported by community partners who donated both time and resources to support its establishment. Our Mia Mia's longevity and potential for impact relies upon both this grassroots support and on the willingness of those in positions of power to advocate for the hub. Unanimous support from local principals and their regional director is a notable point of strength for Our Mia Mia. This group of principals is bound by a sense of ownership over Our Mia Mia and a hopeful vision for how it might improve the well-being of their school communities; "what we're doing is pulling together for the kids in our area across those [school] boundaries" (school principal). These principals are largely interested in evidence of the Our Mia Mia's impact on educational outcomes.

The hub also has the firm support of a diverse community of health professionals. The service began with a single paediatrician who witnessed Our Mia Mia's potential and advocated for the hub amongst their health colleagues, resulting in an expanding network of health professionals. Because Our Mia Mia has grown organically, its suite of services has been tailored to the needs of its community. Families, therefore, feel that Our Mia Mia is a place for them; their solidarity represents a strength of the model. However, an agile sense of direction has at times proved challenging. Since its establishment, Our Mia Mia has shifted from delivering services only to Aboriginal students towards servicing the whole school community. In this redirection, some stakeholders felt disenfranchised; "the initial focus was for Aboriginal families … I think that focus got lost along the way" (Aboriginal school staff member). In contrast, the local Aboriginal Education Consultative Group (AECG), whose members comprise community Elders, felt that "opening it up to all the students in the school and the parents, was a great idea. How are we going to reconcile through our children and families, as Aboriginal people, if we ask for segregation ourselves?"

The firm support of the AECG has been an important asset for Our Mia Mia as it seeks to maintain the trust of the school's Aboriginal families. To nurture this support, Our Mia Mia's staff consult extensively with the AECG and involves them closely in decision-making processes. The AECG's support relies heavily on their optimism about Our Mia Mia's role in addressing the health and education inequities experienced by Aboriginal children: "if we ever want to close the gap, this health service is what might make it." Maintaining this support relies on evidence of impact; "I do like accountability, and I would like to see, are we closing that gap. Show me, tell me why… Otherwise, what's the point?". Whilst divergence in the visions and priorities of stakeholders is inevitable for services like Our Mia Mia, these robust community partnerships are a source of strength.

3.6 | Perceptions of health

The hub brings together systems and stakeholders with divergent philosophies around health and well-being. Schools often assume a

strengths-based approach and therefore can perceive the language of deficits and diagnoses to be overly negative. Yet, for health professionals, diagnoses are often an indispensable element of the treatment process and are key to unlocking interventions. For Aboriginal communities, health and well-being are understood to be rooted in connection to country; community; family and kinship structures; culture and ancestry; mind, body and spirit.[25] Some stakeholders felt that Our Mia Mia currently reflects an illness-oriented medical conceptualisation of health which does not align with this cultural vision of socio-emotional wellbeing: "what went from a community-based wellbeing hub, a place of belonging and feeling culturally safe and having different programs… has sort of now twisted around to become a medical service" (Aboriginal school staff member). Particularly critical is the need to protect against a reputation for over-diagnosing children or over-prescribing medications, as these perceptions may be alienating for some parents. Hence the hub faces a unique challenge in navigating this divergence in how its many stakeholders understand health and wellbeing. Equally, Our Mia Mia represents a promising opportunity to reconcile these differences through facilitating dialogue and collaboration between different groups and offering an opportunity to unite in a shared vision for how Our Mia Mia can improve the lives of the families it serves.

4 | DISCUSSION

This article highlights the perceptions of a sample of stakeholders regarding a SIH model in a regional Australian school. Six primary themes emerged from interviews, shedding light on both the immense potential and challenges associated with innovative models and highlighting how stakeholder priorities must be balanced to ensure these services can ensure substantive impacts. Much like previous research examining SIH models in the US, many stakeholders interviewed for the current study identified Our Mia Mia's primary strength as its success in improving the accessibility of social and health care services. Overwhelmingly, stakeholders felt that Our Mia Mia successfully reduces barriers to accessing care by providing families with timely access to free or affordable services, in a convenient location that is opportunistic as it is proximal to the school where they spend much of their time. Through eliminating the challenges of organising time, transport and finances to attend appointments, Our Mia Mia reduces burdens on parents whilst maximising children's school attendance and participation. This is a well-documented strength of these models, and one of their most direct and tangible benefits.[18]

Many parents also lack the knowledge, confidence or skills to navigate the complexities of the health care system. This aspect of accessibility has been less thoroughly explored in previous evaluations of school-based health care but emerged as an important finding in the current study. Service coordination at Our Mia Mia underpins the accessibility of care. Families are supported by the hub coordinator, who guides them through the process of accessing support and its bureaucratic requirements. Furthermore, Our Mia Mia brings together a multitude of health professionals, colocates them on school grounds, and facilitates the coordination of their interventions. This collaborative effort contributes to the effective management of complex social and health problems; benefiting both families and service providers, for whom the proximity of other professionals enhances the quality of care they can provide. Health professionals reported that working through this effective model of care has been highly rewarding for them, as their clients are supported to meaningfully engage with services and experience substantive health improvements. These are important secondary benefits that have not been well documented in previous research focusing on improvements to health or education outcomes.[1] This is a valuable contribution to the current study and highlights the importance of conducting qualitative research to capture the less tangible impacts of innovation in health care provision. These benefits are particularly important given current Australian efforts to integrate health and social services in schools, which can be seen through the application of the WHIN program in Broken Hill,[26] and the integration of paediatric health services into an urban special purpose school focusing on behavioural concerns.[27] Another example is the establishment of the Australian School-Based Health Alliance in 2022.

A central benefit of SIH is the integration of health with education and social care. This coordinated approach responds to previous criticism that educational reform is fundamentally limited by failing to recognise the impact of poor health on a student's motivation and ability to learn.[14] Furthermore, previous research has documented significant teacher stress regarding the expectation to provide students with both health care and education in ways they feel unprepared, under-resourced and unqualified to undertake.[18] Our Mia Mia responds to these concerns by pulling together the education and health sectors for a coordinated solution, supporting teachers to participate actively in linking students up with health care. This collaborative effort facilitates timely service activation and provides teachers with a sense of optimism that they can meaningfully support student wellbeing. Equally, whilst this collaboration was perceived as key to Our Mia Mia's success, stakeholders also noted that navigating the regulatory standards of these sectors will likely be a primary challenge for Our Mia Mia moving forward. Service providers noted the imperative to meet health's operational standards, yet equally recognised that Our Mia Mia's strength lies in its flexibility. Balancing these priorities is a critical challenge for Our Mia Mia and models like it.

Ensuring community trust emerged as another critical consideration for the hub. Our Mia Mia's relationship to the school, its casual ambiance, and its approachable staff were described as critical assets in establishing Our Mia Mia as a trusted place. For families who feel uncomfortable in traditional health clinics, Our Mia Mia provides a much-needed pathway to accessing treatment in a space that feels safe and comfortable. Yet for health professionals accustomed to working with tightly regulated systems and procedures, the fluidity of the service can prove challenging. Aboriginal stakeholders also highlighted concerns that the social nature of the space can be alienating for parents who wish to attend appointments confidentially. Responsiveness and sensitivity to the stated needs of Aboriginal stakeholders, pertaining not only to confidentiality but also to the look

and feel of the hub, underpins the trust of these stakeholders. Preventing the service from becoming overly clinical and intimidating, whilst also ensuring that it is perceived as a culturally safe place where sensitive information will be treated professionally, are important considerations for Our Mia Mia and as it forges a new path in health care provision.

Balancing the stakeholder priorities is especially important given that Our Mia Mia relies on the support of its community partners. Particularly critical is maintaining the support of stakeholders in positions of power, who can advocate for the hub in the wider community. For example, Our Mia Mia's successful engagement of Aboriginal families has relied on its close partnership with the AECG, whose members support the hub and endorse it as culturally safe. A sense of ownership and belonging at Our Mia Mia underpins this grassroots support, highlighting the critical importance of consultation to ensure that all groups continue to feel heard and valued in decision-making processes at Our Mia Mia. These findings closely align with learnings from another community-engaged health care strategy in rural Australia, which highlighted the importance of responsiveness to the needs of the specific community; the flexibility to adapt and respond to new learnings throughout implementation; and consideration of what efficacy means for the range of stakeholders involved.[5]

Whilst previous literature has outlined many of the overarching benefits and challenges associated with SIH models, little research has thoroughly investigated how these factors are understood and prioritised by various stakeholders engaging with these models of care. The current study points to a rich tapestry of secondary benefits which extend far beyond Our Mia Mia's direct objective to improve the health and educational outcomes of students, as well as challenges and complexities associated with bringing together a diverse group of stakeholders who naturally vary in their vision for Our Mia Mia. Indeed, this is a primary challenge for SIH models if they are to be acceptable to the communities they serve, and hence likely underpins whether Our Mia Mia and similar models will be able to create the meaningful and lasting impact they seek.

4.1 | Strengths and limitations

This qualitative study sought to understand the suitability of a place-based model of health care for serving a regional school population; as such, the findings should not be hastily generalised to other contexts. However, considered together with the international literature suggesting the suitability of SIH models for marginalised populations, the findings from this study are likely transferable to similar regional and rural settings in Australia; schools with large Aboriginal populations; and areas experiencing socio-economic disadvantage.

This study has a number of important limitations to consider. Two interviewees declined to be audio-recorded, limiting the thoroughness of the data provided. Returning transcripts to all interviewees for confirmation was also not possible. Another limitation of the study pertained to the sample of stakeholders interviewed. Based on the recruitment strategies, most stakeholders interviewed for the current study had close, ongoing connections to Our Mia Mia. It was more difficult to contact individuals who had disengaged from the service or who had poor relationships with the school, Our Mia Mia or its staff; it is likely that this has positively skewed the results of the current study. Despite this, researchers actively pursued interviews with individuals who had less positive relationships with Our Mia Mia, and across all interviews, asked stakeholders to consider both the successes and challenges associated with the Our Mia Mia model. Lastly, despite an effort to interview children who had attended the hub the discussion with children was very superficial, and parents were quick to take over. As such we decided not to comment separately on the child data. Future studies should consider limiting the ability of parents to contribute by enacting rules or separating parents physically.

Though these aforementioned limitations represent important considerations, the current study has a number of key strengths. The findings are strengthened by the large cohort of participating stakeholders representing a number of diverse groups, each having considerably different experiences with the service. The length of interviews and the flexibility of the interview schedule meant that stakeholder perceptions were explored in considerable depth. The nuance and complexity of this data, captured by the qualitative approach and the depth and breadth of interviews conducted, represent a valuable contribution to a fairly limited literature. Further, findings from the current qualitative study will later be supplemented by quantitative findings from the larger research program.

4.2 | Implications and future directions

In addressing the complex health needs of children and families experiencing disadvantage, there have been calls for health care strategies that promote contextualised health care, improve access to services, and support cross-sectorial collaborations.[5] The Our Mia Mia hub is an example of one such strategy which provides care where the needs exist, by bringing health care to school grounds. Our Mia Mia provides disadvantaged families with easily accessible, coordinated care which integrates across systems and services, in a setting they trust. Currently, Our Mia Mia is undergoing evaluation as it is expanding its services to neighbouring schools in the area; the data collected as part of this wider project will supplement these findings to provide further insights into the strengths and weaknesses of the model. As the service expands to preschools and high schools, becoming a fixture in the community, the full benefits of continuity of care and relationship-building may become evident. Equally, as the service expands, a number of challenges may become more pronounced, including increased demand at the service; maintaining community ownership throughout expansion; balancing the visions of an increasing number of stakeholders, and funding continuity. Continued research examining these challenges for Our Mia Mia and similar SIH services will be critical to upscaling the model effectively.

5 | CONCLUSIONS

The current study supports the view that Our Mia Mia is an effective, acceptable, and replicable model, representing an exciting opportunity to provide timely support to disadvantaged children whose health needs are inadequately met by traditional models of care. Stakeholders noted Our Mia Mia's success in removing barriers to accessing care; improving care coordination; facilitating cross-sectorial collaborations; and nurturing stakeholder trust and community partnerships. The findings also captured a number of complex challenges for Our Mia Mia as it forges a new path in health care provision. Remaining responsive to the priorities of stakeholders likely represents Our Mia Mia's primary challenge, and underpins its sustainability and potential for impact. Our Mia Mia nonetheless provides an overwhelmingly promising model of effective service delivery. By leveraging the strengths of families, community, education and health systems, to provide accessible, integrated health care to underserviced populations, these models have immense capacity to improve the health, well-being and educational outcomes of Australia's most marginalised children.

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CONFLICT OF INTEREST

The authors declare the following financial interests/personal relationships which may be considered as potential competing interests. Authors Andrew Leslie, Brendan Jubb and Aunty Ruth Simms are currently employed at the Our Mia Mia (OMM) Wellbeing Hub. Authors Charlotte Burman, Valsamma Eapen and Antonio Mendoza Diaz are researchers partnered with the OMM to conduct the ongoing research evaluation.

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