

# Community Paediatric Review

Current issues in children's health and development



Centre for Community Child Health

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## Involving fathers in Community Child Health Services

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Men in my antenatal classes give three common reasons why they intend to father differently than they were fathered: community expectations, partner pressure, and their own wish for connection with their child.

- 1. Community expectations:** highlight the fact that fathers are expected to be involved in the day-to-day care of their baby, not simply to be a provider and protector.
- 2. Partner pressure:** *"She'll kill me [if I don't]"*: the second reason is offered with some humour by the fathers-to-be. The wives or partners of these men will insist on their taking a different, more hands-on approach than fathers of previous generations.
- 3. Their own wish to connect with their child:** *"Because I want to have a good relationship with my kid, that's why I am doing this,"* is usually expressed by one of the men, and the others nod in affirmation and this captures perhaps the most profound change in our understanding of a father's role.

Not that fathers of previous generations did not have good relationships with their children; the men in these groups are frequently adamant that their own fathers were "good fathers" (after all, they turned out OK) and enjoyed positive relationships with their children. However, there is a recently developed awareness that the pathway to having good relationships with children and teenagers starts early, and these men want to be involved in caring activities when their children are infants.



From the perspective of professionals working with families, there has also been a fundamental shift in how we view the role of fathers. Where once the inclusion of a father in the discussion of infant care may have been seen as irrelevant to good practice, it is now more likely to be considered desirable — not only for the father, but for the family too. At the national Father-Inclusive Practice Forum held in 2005, examples of service delivery that included fathers were presented from around Australia. These programs illustrated the various models of service delivery where work had been conducted to actively include fathers, not simply 'run a program for fathers'. Government and non-government services reported changing their referral processes, staffing, publicity, program design, hours of operation and service location to encourage fathers' participation; not simply participation in a separate, men-only service, but in a father-inclusive service that regarded fathers and mothers as a team raising their children.

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There is a remarkable parallel in the progression of these two groups — fathers and professionals — toward the goal of father-inclusion. Both fathers and professionals working with families agree that in principle, fathers should be as involved as mothers in the care of children and infants. However, both groups also drastically underestimate how difficult it will be to put the ideal into practice, and both groups face discouragement or criticism for not achieving equality. In spite of the rhetoric of equal parenting, the reality is that fathers return to work, on average, within two weeks of the birth of their baby. For mothers, the average is closer to six months.

Regardless of the intentions of the couple, as the father returns to full-time work and the mother remains at home to provide full-time care of the newborn, inevitably it will be the mother who does the lion's share of the work and who gains a deeper understanding of the moods and personality of their baby. The reality of time available to be shared in the first months, added to the reality of breastfeeding, pushes most fathers toward the role of "helper" to the mother and away from taking joint responsibility for the full care of their infant.

For professionals, the story is remarkably similar. In working with family-related services over the last decade, from antenatal settings to schools, I have been struck by how warmly professionals endorse the ideal of fathers' participation. In workshops and informal discussions with nurses, midwives, early childhood staff and teachers (almost all females and mostly mothers), the support for fathers to be more engaged in the services' support for families is often unanimous. However, when we look at the progress in refashioning maternity services and community-based family services toward family-centred care that is inclusive of fathers, it is difficult to see signs of significant change. Systemic issues such as the unrealistic time demands in service provision, mother-focussed service designs and professional training that has largely ignored the role of fathers, have resulted in service delivery models where it is difficult to even notice fathers.

Awareness of fathers is important, but without a more coherent understanding of why and how to involve fathers, we are unlikely to see the institutional change required to include fathers in what would be truly family-centred practice. The "why" has been answered through the last decade of research on child development; while many study results are qualified or preliminary, sufficient evidence of the potential positive effect of fathering on their children's development exists to justify the inclusion of fathers in all parenting services.

Attachment theory, for example, is the basis of much of our support for families with infants. The earliest formulations emphasised the mother-infant dyad as the site of primary attachment and as the place where the template for subsequent attachment figures was established. There is now widespread acceptance that a secure father-infant

attachment is formed independently of the mother-infant relationship and that both have consequences for the child's development. Children with two depressed parents, for example, are at greater risk of social, psychological and cognitive deficits while fathers' depression at eight weeks postpartum has been found to double the risk of behavioural and emotional problems in children at 3½ years of age, independently of mothers' depression status. This recent evidence strongly suggests that the father's emotional health should be assessed with the mother's.

An effective screening for new fathers, however, will require a keen appreciation of the context for fathers' help-seeking behaviour with professionals. A recent description of the "usual" arrangements leading up to the birth, highlights how fathers might not establish any meaningful relationships with health practitioners and they may miss out on important knowledge regarding infant development.

## Case study

*When Michelle and Anthony visit Michelle's general practitioner after a positive pregnancy test, Anthony expresses his support but asks few questions. When asked about the couple's intentions for pregnancy care, Anthony's quick glance towards Michelle flags his uncertainty. For the following visits, Michelle attends the clinic alone. Anthony does participate in the ultrasound consultation and he joins in when prompted during the antenatal classes, but he accepts that the emphasis throughout is appropriately on the mother and ensuring a successful birth. During the birth, he wonders if he is in the way and is grateful that the mother and baby are healthy at the end. After the birth, when the home-visiting nurse arrives, Anthony goes to make coffee and misses most of the discussion. His return to work precludes him attending the doctor's checkups for mother and baby (Fletcher et al, 2006).*

The new father's lack of professional contact, reinforced by his early return to work, the centrality of breastfeeding and social conventions which mean that fathers don't expect to know much about infants, all contribute to a strong polarity within the mother-father team. While new fathers may be willing or even eager to be involved, they generally rely on the mother to "know" about the baby and what should be done. The trust in mothers to know what to do has a major influence on two aspects of help-seeking by fathers. Although there is discussion in the literature of mothers as gatekeepers to fathers' participation (keeping the fathers at a distance to preserve the mothers' control of infant care) the more common occurrence is that fathers look to mothers to know what they (the fathers) need to do. In my own research following new fathers through the birth of

their first child, I noticed how often the fathers' survey, which asked about the fathers' perceptions of events, was completed in discussion with their wife or partner.

More importantly, the trust between new mothers and fathers, which is built into his reliance on the mother to "know", creates a serious dilemma for the father in the case of any serious difficulty with the infant or child. If the problem is not resolved quickly, the mother is likely to be frustrated and unsure as to the best course of action. Problems such as mastitis or post-natal depression in the mother, irritability or illness in the infant, or chronic illness or disability in the child are relatively common and in each case create a dilemma for the father. In these situations, where treatments are often not efficacious and social factors play an important part, the father can continue to trust her (the mother's) judgement and cope with her distress as well as the effects of the problem, or he can branch out on his own to seek advice from professionals and form his own opinion as to the causes of the problem and optimum treatment regimes. In the case of maternal post-natal depression, the situation of the father is exacerbated by the common wish of mothers not to discuss their difficulties with others outside of the immediate family. In these cases, the father may have been specifically told by the depressed mother not to discuss "her" business with others.

### How to involve fathers in your service

- Be actively inclusive. Make it clear that you expect his involvement from the beginning. At the first meeting or phone call, convey the expectation that his opinion counts and that his involvement will be needed to ensure successful outcomes for the infant or child.

- Share best practice. Ask colleagues how they manage to engage with fathers in their clinics or sessions; sharing strategies can help make everyone's job easier.
- Leave information. When conducting home visits assume that some fathers will notice information (pamphlets, stickers for the fridge, coasters, placemats) after you have left.
- Father-specific resources. Seek out material to give him or leave for him. There are several resources available free or at low cost that convey important information about fathers' roles.
- Explain importance of father-infant relationships. Expect to assist him to clarify the importance of father-infant relationships—he may be unaware of recent research on the impact of father-infant interaction on child development.
- Identify referral pathways for fathers. Many generic services do not have father-inclusive procedures or practices but they may respond to your inquiry by reviewing their offerings.
- Professional development. Look for professional development in the competencies of father-engagement. Both male and female practitioners can improve their skills and help build a father-inclusive workforce.

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# Keeping fathers in mind

Offering services that are well used by fathers, as well as mothers, has long been an ambition of child and family health nursing. However, it is also an ambition that has proved to offer significant challenges. Fathers may be unintentionally marginalised by standard child and family health nursing practice. Research shows us that this is the case — fathers are much less likely to engage with child and family services than mothers (Tehan & McDonald, 2010). There are many reasons for this, including considerable societal barriers that are beyond any one service to tackle, but there are also steps that individual services can take to create a service that is welcoming to all the significant adults in a child's life, including fathers\*.

## Fathers have an important role

Australia's future prosperity depends on the collective investments that we make in all of our children's development. Supporting fathers in their role is one way to help all children to grow up healthy, get a good education and become productive members of society. The early attachment that babies form with both their fathers and their mothers, underlies later emotional regulation skills and their ability to develop relationships with peers and other adults (Too Small to Fail, 2014; Lamb and Tamis-Lamonda, 2004). Fathers who nurture and play with their babies have children who grow up to have higher IQs (Pappas, 2013), and sensitive and supportive fathers are associated with children who have fewer behaviour problems and higher social skills, as reported by their teachers (Fletcher, 2008).

## For literacy development

The role of fathers in children's early literacy development has been shown to be particularly powerful. When fathers read to their children from an early age, children develop better literacy skills and have improved school readiness when compared to other children (Gadsden & Ray, 2003). Even when fathers have limited schooling, their involvement has a positive influence on their child's academic achievement (Gadsden & Ray, 2003).

## Supporting father-inclusive practice

Fathers come from a range of cultural backgrounds and those backgrounds affect their help-seeking behaviours. Hey Dad! for Aboriginal and Torres Strait Islander fathers recognises the specific influence of culture on fathering and supports fathers to be more involved with their children.

Hey Dad! For Indigenous Fathers, Uncles and Pops is a culturally appropriate, evidence-based parenting program, created with the aim of 'building individual and community skills and providing men with the confidence to be strong role models for their kids' (Parker, 2009).

\* In this article 'fathers' is used for all significant male caregivers in a child's life, whether they are the biological father or not. It can include grandfathers, stepfathers, and other father figures.

## Dad and Partner Pay

The Dad and Partner Pay Policy, introduced by the Australian federal government in July 2013, is designed to encourage more dads to spend more time with their children immediately after birth by making it less financially punitive (CFCA, 2013). Dad and Partner Pay is available to all eligible working fathers and partners, including same-sex partners and adopting fathers.

Not all new fathers and mothers are aware that they may be eligible for Dad and Partner Pay. There's a handy guide on the Raising Children Network that covers who's eligible and what to do to access the program: [http://raisingchildren.net.au/articles/dad\\_and\\_partner\\_pay.html](http://raisingchildren.net.au/articles/dad_and_partner_pay.html)

Investing in early childhood is a savvy use of our resources, because we know that what happens during these years has a significant lifelong impact. Working with fathers to help them to be an active and involved part of their child's life — including the child health services their child needs — is a vital part of that investment.

## Reflection questions

*What training opportunities are available to help you to develop competencies to work with fathers?*

*Do staff have the opportunity to reflect on stereotypes about fathers and the impact that could have on their practice?*

*What opportunities are available for fathers to give feedback about the programs at your service?*

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# Asthma: an update

While most children with asthma can participate in and enjoy all of their normal childhood activities, asthma is also the most common medical reason for children to be admitted to hospital and a significant community health problem. As we head into winter, it is important for child and family health nurses to be up to date with best practice asthma management, in order to be able to advise and reassure parents.

In an asthma attack, the bronchi in the lungs narrow because the muscles tighten and the walls of the bronchial tubes become inflamed. This narrowing makes it harder to take in air and causes wheezing, coughing and difficulty breathing. While one in 10 Australian children are diagnosed as having asthma ('Asthma and asthma management', 2012), one in four will experience wheezing at some point in their childhood ('Asthma', n.d.). Not all childhood wheezing is necessarily asthma, which can be difficult to diagnose in young children ('Medication for children', n.d.).

## Defining asthma

The most practical clinical definition for asthma is "recurrent episodes of cough, wheeze and shortness of breath that respond to bronchodilator therapy". The precise cause of asthma is not known, though genetic and environmental factors both play a part. It often runs in families and can be related to other conditions such as eczema, hay fever and allergies.

The most common trigger for an acute episode in children with asthma is a viral upper respiratory tract infection.

Asthma attacks have a number of identified predisposing factors; some of these can be readily avoided, while others cannot be avoided or only with great difficulty:

- a genetic predisposition
- allergies to inhaled allergens, particularly house dust mites
- passive exposure to cigarette smoke.

About 80 per cent of children with asthma will experience symptoms when they exercise, which can become an increasing problem in school-age children.

## Asthma or wheeze?

Respiratory infections are very common in young children, occurring between six and eight times a year on average. This leads to high rates of wheezy episodes for young children — by the age of 3, one third of children will experience an episode of wheezing, and by the age of 6, half of all children will have had a wheezy episode. It is important not to over attribute cough and wheeze to asthma, as this frequently results in unnecessary treatment.

Children who experience persistent wheeze can present a diagnostic challenge for their doctors. Serious problems such as recurrent aspiration, cystic fibrosis and cardiac failure are rare, but need to be considered in young children who present with persistent cough and/or wheeze.

## Common triggers for asthma

Most children with asthma have a genetic predisposition. If one or both parents or other members of the family have asthma, eczema, hay fever or allergies, there is an increased chance that the child will have asthma. There are also common triggers. Knowing a child's triggers can enable parents to actively avoid them or to anticipate a period of heightened risk:

- Colds are the most common trigger for an acute attack of asthma, specifically respiratory infections caused by a virus. Children who are prone to asthma are likely to wheeze and cough at these times.

Other common triggers include:

- exercise
- changes in the weather
- cigarette smoke
- dust mites
- pollens
- pets.

If a child has asthma and is regularly exposed to cigarette smoke in their home, consider ways to work with the family to reduce or eliminate tobacco use in order to minimise asthma attacks.

## Breastfeeding and asthma

A population-based study in Canada has demonstrated that longer breastfeeding duration appears to be protective against the development of asthma and wheeze in young children (Dell & To, 2001). Encouraging families to commence and continue to breastfeed is an important part of public health efforts to reduce the prevalence of asthma.



## Therapies

The three types of medication used by children with asthma are relievers, preventers and controllers. All children with asthma require reliever medication, most commonly a short-acting beta-agonist. These are rapidly acting medications that act as a bronchodilator to relax the muscles and open the airway (Relievers, n.d.). Children with more severe or less well-controlled asthma will require preventer and controller medications.

To take medication, all children under 5 will need a puffer and a spacer in order to deliver the necessary dose effectively. For children under 2, a face mask will also need to be used with the spacer and puffer.

### Relievers

Relievers help to relieve symptoms during an attack; relievers alone are sufficient for most children with asthma. The most commonly used is Ventolin, but Bricanyl and Respolin are also used. Prednisolone (a corticosteroid) may sometimes be given for a few days — it acts to reduce the inflammation in the bronchial tubes and thus helps reduce their narrowing.

### Preventers

Children who have frequent interval symptoms or persistent asthma may need a preventer medicine, which needs to be taken every day. Preventers include Flixotide, Pulmicort and Singulair (‘Asthma’, n.d.).

### Controllers

For children whose asthma cannot be managed with preventers and relievers, there is a third category of asthma medication — controllers. These include Seretide and Symbicort; they work in a similar way to the more familiar Ventolin, but are longer lasting.

## Management plans

All children with asthma should have an individualised management plan. Many community health centres across Australia have specialist trained asthma nurses who work with families to develop a management plan for their child. There is no cure for asthma, but it can generally be well managed with medication and active avoidance of known triggers.

### Reflection questions

*How can you work with the child and his/her parents to assist with the child's sense of empowerment with relation to asthma, its prevention, management and understanding of the condition, and taking into consideration the child's developmental stage?*

*How can you work with families where adults in the household are smokers?*

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### About the Centre for Community Child Health

The Royal Children's Hospital Centre for Community Child Health (CCCH) has been at the forefront of Australian research into early childhood development and behaviour since 1994.

The CCCH conducts research into the many conditions and common problems faced by children that are either preventable or can be improved if recognised and managed early.

### Community Paediatric Review

Community Paediatric Review supports health professionals in caring for children and their families through the provision of evidence-based information on current health issues.

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# Fact sheet

Centre for Community Child Health

## Welcome to fatherhood!



**Congratulations on becoming a father! This is a very exciting time and while your new child doesn't come with an instruction manual, there are some things that may be useful to know.**

### Dads and children's development

The investments we make in Australia's children help create a strong and prosperous future. As a father, you play a huge role in your child's development.

In the very early weeks and months, one of your baby's first tasks is developing strong emotional attachment with you and your partner. Developing strong attachment helps your baby to begin to learn the skills that will later help them to manage emotional ups and downs and develop relationships with other children and adults.

Being a sensitive and supportive dad is associated with fewer behaviour problems and higher social skills in their child.

### For literacy development

Reading with your baby, right from the start of life, is a great way for you to help your baby to go on to develop strong literacy skills later in life. Storytelling and singing to your baby will have a positive impact on your child's academic achievement in later years.

When you read with your baby from an early age, your child is more likely to develop better literacy skills and be ready for school. Even if you are not much of a reader yourself, getting involved in storytelling and singing to your baby can have a positive influence.

### Dad and Partner Pay

One of the biggest challenges of new fatherhood is the feeling that you're responsible for providing for a new person – and that means earning money. Dad and Partner Pay is designed to make it easier for new dads to spend more time at home with your partner and the new baby by making it less financially punitive to take time away from work.

Find out more about Dad and Partner Pay – it's available to all eligible working fathers, including adopting and same-sex fathers. Visit the Raising Children Network [raisingchildren.net.au/articles/dad\\_and\\_partner\\_pay.html](http://raisingchildren.net.au/articles/dad_and_partner_pay.html) to find out more. There's lots of other terrific resources on the site for dads that you can check out.



# Asthma

**If your child has been diagnosed with asthma it can be very concerning. The good news is that most children with asthma can participate in and enjoy all of their normal childhood activities — including sport — and that asthma is a condition that can be well managed with medication.**

**There is no cure for asthma, so it's important to understand particular risk factors and be aware of situations where those risk factors may bring on an attack of asthma.**

## Asthma is common

Asthma is very common — one out of every 10 Australian children is diagnosed as having asthma — but one in four will experience wheezing at some point in their childhood. Respiratory infections are very common in young children — young children can have up to eight respiratory infections a year. When a child has a respiratory infection that often means wheezing.

An asthma attack is a very common reason for children to be taken to hospital. In an asthma attack, the bronchi in the lungs narrow because the muscles tighten and the walls of the bronchial tubes become inflamed. This narrowing then makes it harder to take in air and causes wheezing, coughing and difficulty breathing.

## Causes of asthma

Unfortunately, we usually don't know exactly what causes the child's asthma. We do know that both genetic and environmental factors play a part. Often asthma runs in families, so if you or your partner has it there can be an increased chance that your children will have it too. Asthma can also be related to other conditions such as eczema, hay fever and allergies.

## Asthma triggers

The most common trigger of an acute episode is a viral upper respiratory tract infection.

A child who has asthma is likely to have particular factors that are a trigger for them, but there are important and common triggers. You child may have:

- a genetic predisposition
- allergies to inhaled allergens, particularly house dust mites.

Being exposed to cigarette smoke is a very common trigger for an asthma attack. If you, your partner or other significant adults in your child's life smoke then it's important to quit in order to help to minimise the risk of asthma attacks. Cigarette smoke stays on your skin and clothes, as well as in the car upholstery if someone smokes in the car. Simply not smoking near a child with asthma is not sufficient to keep them safe from potential triggers.

## Centre for Community Child Health

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