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ENSURING OUR SERVICES ARE INCLUSIVE

It is well established that the vulnerable groups in our society (those who need our services the most), access services the least. This was first termed the 'inverse care law' (Hart, 1971) in 1971 and remains true today. It is also widely accepted that these groups commonly suffer the worst outcomes, be they Aboriginal or Torres Strait Islander (Duckett, 2007), Culturally And Linguistically Diverse (CALD), or young parents (Sebastian, 2008). It is less commonly noted that the reason these populations do not access services may well be because services are not offered to them in a way that is engaging and inclusive (Moore et al., 2001; Carbone et al., 2004). The reality for many of the parents from these populations is that they suffer judgement, discrimination and prejudice when accessing mainstream health services (Wilkinson & Marmot, 2003).

'Hard to reach' families have long been a factor in the provision of early childhood services. However, the validity of the term 'hard to reach' is increasingly being challenged (e.g. Brackertz & Meredyth, 2008). 'Hard to reach' can be used to mean many groups, but perhaps more critically, it locates the problem with the client or potential client and does not look at the way that services are being provided.

The way that health professionals perceive parents, and are in turn perceived by those parents, can impact not only on initial access, but also on ongoing attendance and the level of client involvement in the service (Carbone et al., 2004). This paper seeks to raise your awareness of your role as a health professional to support vulnerable families accessing your service to feel safe, respected and welcome.

There is a growing consensus that, rather than thinking about certain sections of the community as being hard to reach, it is more useful to think of them as being people whom services find difficult to engage and retain. Slee (2006) argues that we need to look at 'unequal outcomes as social injustices, rather than as products of individual dysfunction or deficit'.

NATIONAL PRIORITY

The Federal Government has acknowledged the problems with accessing services among those who most need them and made social inclusion a priority (www.socialinclusion.gov.au) with the establishment of the Australian Social Inclusion Board. They are funding initiatives to support both families and workers in our sector to get and to give the most out of available resources. In this way, the government is working with the sector to improve participation and retention rates in early childhood health provision.

LOOKING WITHIN

Our own preconceptions and assumptions can play a role in the difficulties faced by some families in maintaining useful contact with provided support services. Similarly, we need to work to discover and subsequently address the assumptions and preconceptions (even misconceptions) of the families that we are trying to engage (Brackertz, 2007).

Winkworth, Layton, McArthur, Thomson and Wilson (2009) recruited financially disadvantaged parents of young children in Canberra to participate in a survey about the extent to which they felt connected to social support. They then conducted interviews with 20 parents from the group

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and explored their experiences of parenting, especially their use and non-use of formal services, in a city with the highest level of social and economic resources in Australia.

Key findings from this study:

- **Most families have high support** – However, around 37% of parents regard themselves as not at all well connected to either informal or formal supports and have a strong sense that single parents are judged by their families, their communities, and the services which are funded to assist them.
- **Formal services can be important sources of social support if they are respectful, flexible and honest.** Parents said they engage with services that are ‘humanising’ – possessed of a broad-minded attitude to service delivery that is genuinely collaborative with the parent.
- **Build the capacity of informal networks** – while informal networks are important for emotional support they also tend to be ambivalent and fragile.

Formal services cannot and should not replace family or informal support, however there is potential for services to get alongside and build the capacity of these informal networks (Katz, 2007).

- **Targeted services could link more effectively with ‘first to know’ agencies** such as Housing, Centrelink, child health services and general practitioners. Some services which are often the first to know what is happening to vulnerable parents are underutilised by more targeted, or secondary level, family support services. Leveraging the contact that ‘first to know’ agencies have with isolated families could particularly apply in the case of general practitioners, child health services, Centrelink and Housing.
- **Normal, non-stigmatising environments (schools, childcare) are well placed to assist parents who do not trust formal services.** Parents indicate that schools and childcare are their lifelines. To gain the trust of isolated families there is a need for skilled and resilient people, working from



universal settings, who can really support parents in non-judgmental ways.

- **Flexible, affordable childcare** – an important issue to emerge from this survey is parents' perception that they cannot obtain childcare to relieve stress when they urgently need it. They expressed frustration and confusion about how it was possible for them to develop skills and to acquire casual employment during the early years of their children's lives in the absence of high quality and flexible childcare.
- **Enough money** – the basic building block of prevention – parents in this survey said that having enough money to live on, and having somewhere safe to live are their highest priorities. A number of parents spoke of the importance of receiving their Centrelink payments and the catastrophic impact of a reduction in payments.
- **Safe environments for children** – parents with very young children are appreciative of public housing but they do not feel safe in particular public housing environments, notably the housing flats. They spoke of an absence of trust in the flats and that they did not feel comfortable making friends in this environment. Several said their isolation was increased by feeling they must decline offers by friends or relatives to visit them in the flats and also that they would not let their children invite friends home from preschool or school.

VULNERABLE FAMILIES' USE OF EARLY CHILDHOOD SERVICES

In reviewing the efficacy of parenting support programs, Moran, Ghate and van der Merwe (2004) note that even the best-designed services may fall at any one of a number of key implementation hurdles:

- the first hurdle is 'getting' parents (persuading parents to attend the service in the first place)
- the second is 'keeping' them (persuading them to attend sessions regularly and complete the course)
- the third is 'engaging' parents: making it possible for them to engage actively with what the service has to offer (listening, taking part in interactive elements, completing 'homework' assignments, reading supporting materials etc).

Clearing each of these hurdles requires considerable effort and strategic planning on the part of service

providers, yet it is clear that in fact, quite often much more effort and thought goes into designing the content of the intervention than in planning how to deal with implementation challenges.

WHAT ARE THE BARRIERS?

Based on a review of the barriers to vulnerable families accessing mainstream services, Katz, LaPlaca and Hunter (2007) identify a number of strategies which can be used by parenting and family support services to engage with parents:

- **Strong and warm relationships between providers and service users.** The relationship between frontline providers and service users has consistently been identified as a major factor influencing the engagement of parents in mainstream services.
- **Practical issues and patterns of delivery.** A particular issue is how services respond to parents whose problems are not deemed sufficiently serious and who 'fall below the threshold of provision'. Parents whose request for help is turned down can become disillusioned with services and are less likely to ask for help in the future. This makes it more likely that they will allow problems to escalate.
- **Service culture.** The overall culture of services and ways we perceive our users can erect barriers to participation. Many parents are put off because of the unequal power relations between parents and services. We may also be unresponsive to the needs and views of users.
- **Information and targeting.** Consultation with service users and their involvement in planning services can be an effective means of reducing barriers to engagement and advancing social inclusion. Information and advice to parents needs to be tailored not only in content but also in the mode of delivery, so that parents from different groups can have equal access.
- **Community development approaches.** Parents can be included in services at a number of levels other than as service users, e.g. decision-making within service delivery, involvement in case planning, and involvement in service evaluation, monitoring service planning, and strategic planning. Community development approaches have enormous potential for increasing the engagement of parents.

ARE ANY OF THESE BARRIERS BEING MET?

In an Australian study of strategies to promote more inclusive antenatal and universal early childhood services, Carbone, Fraser, Ramburuth and Nelms (2004) conclude that, despite the limited data, what was available suggested the majority of children and parents make good use of existing services. However, it was also clear that service use varied along a continuum from very high to very low, and that there was a small but significant minority of families that underused some or all of these services. Carbone et al comment that, given the optional nature of these services, it is understandable that not everyone will choose to use them. While some degree of 'underuse' would therefore be expected across the population, the actual pattern is not uniform: certain (disadvantaged) neighbourhoods have very high rates of underuse, and certain families have very high rates of underuse.

WHAT CAN WE DO?

In seeking to make early child health services more inclusive, we need to recognise that the child is part of a family, and the child's attendance at a program depends upon the family's commitment and capacity to bring the child on a regular basis. And that the child's progress depends upon the family's commitment and capacity to support the child's learning and development.

Our dilemma is that many of the children who are missing out on the opportunities available for development in their early years come from families whose commitment and capacity to bring their children regularly and to support their children's learning is compromised by a number of factors.

These factors include the families' own personal histories and resources as well as their current circumstances, but also involve the nature and accessibility of the services we're striving to provide.

In our daily practice remember the vulnerable are those without power. To reduce the power imbalance and help to make our services more accessible, consider:

- Being mindful of our symbols of power – our uniform, the stethoscope, the office structure (placement of chairs, etc)
- Sitting alongside, not opposite quiet or shy clients (e.g. Aboriginal and Torres Strait Islander parents, young parents, refugee parents)
- Exploring the clients' understanding of a particular subject before you 'educate' them
- Questioning the assumptions you have about the parents – are any of them negative?

Finally if clients do behave differently than you do (and many of them will), and have different values and beliefs, it is really important that we question our right to disagree if the values and beliefs are not causing harm to the parents or their child. We all like to be treated with respect and the best thing we can do to reduce power imbalance is to genuinely respect each parent. With genuine respect the parent may be more likely to trust you, tell you their story and accept (comply) with your advice.

This article was developed in conjunction with Associate Professor Sue Kruske, RN, RM, PhD.

A complete list of **references** for both articles is available from the Centre for Community Child Health's website www.rch.org/ccch (click on 'Resources and Publications', then 'Child Health Newsletters').

The website contains many useful resources for child health nurses including:

- **Practice Resources** have been developed to help professionals working with children and families better understand issues and strategies on 11 topics, including settling and sleep, breastfeeding and eating behaviour. Each topic has an introduction, a summary of the latest research, and practical strategies.
- **Parent Fact Sheets** are written specifically for parents and cover a range of health, social and environmental topics including hygiene and infection control, music experiences and environmental sustainability. Selected sheets are also available in Arabic, Bosnian, Chinese, Croatian, Somali, Spanish, Turkish and Vietnamese.
- **Books, CD-ROMs and posters** are available online or by order.

ADDRESSING FOOD ALLERGIES AND FOOD INTOLERANCE IN EARLY CHILDHOOD: AN UPDATE

Food allergy featured as the lead article in the September 2004 edition of *Community Paediatric Review*, and feedback tells us that it remains topical for child and family health nurses today. Concerns regarding food allergy and/or food intolerance are still raised by parents. There may be a family history of allergies and parents may be anxious that their child may be at risk. Alternatively, parents may be concerned by stories in the media about children who have had severe anaphylactic reactions to nuts.

Often food allergy and food intolerance are discussed as interchangeable problems. However, there are differences. Food allergy is defined as a reaction that is due to an immunological mechanism, usually immunoglobulin E (IgE); the reactions may be immediate or delayed, and mild or severe. A severe reaction may be an anaphylactic reaction. Food intolerance refers to reactions involving known or unknown non-immunological mechanisms (Wilson, 2009).

WHO IS AT RISK OF DEVELOPING A FOOD ALLERGY?

Food allergy is estimated to occur in approximately 1 in 20 children. The majority of food allergies are not severe and will disappear with time (ASCIA, 2009).

If the child's parents have allergy, in particular the mother, the child has a 40-80% risk of developing any allergy, such as asthma, eczema or hayfever. However, the allergy that a child develops might not be the same as the parents' allergies. Despite this, most children with food allergy do not have parents with food allergy (Australian Society of Clinical Immunology and Allergy [ASCIA], 2009).

PREVENTION OF FOOD ALLERGY – WHAT CAN YOU DO?

The following advice (based on information from the Australian Society of Clinical Immunology and Allergy website) may be offered if parents are concerned that food allergy may be a problem for their baby.

- Breastfeeding is recommended for at least six months and is encouraged for at least 12 months and for as long as the mother and infant wish to continue.
- It is considered that breastfeeding during the period that foods are first introduced may help

prevent the development of allergy to those foods.

- Introduce solid foods from the age of 4-6 months* and when the baby is showing signs that he or she is ready. When introducing the baby to solid food, new foods can be introduced gradually. Aim to offer one new food every 2-3 days.
- Breast milk or an appropriate infant formula should remain the main source of milk until 12 months of age, although cows' milk can be used in cooking or with other foods.
- Cows' milk is not recommended as a main milk drink until after 12 months.
- The introduction of solids *before* four months may be associated with an increased risk of food allergy.
- Exclusion of allergenic foods from the maternal diet has not been shown to prevent allergies in children.
- There is no need to delay the introduction of particular foods such as egg, peanuts, nuts, wheat, cows' milk and fish for the prevention of allergy or eczema.
- If infant formula is required in the first months of life before solid foods are introduced, there is some evidence that hydrolysed formulas may reduce the risk of allergic disease in high-risk infants – e.g. where there is a history of allergy in



their parents or siblings. In Australia and New Zealand, only partially hydrolysed formulas (usually labeled 'HA' or Hypoallergenic) are recommended for allergy prevention. These are different to extensively hydrolysed formula (EHF), which is only available on prescription for treatment of cows' milk allergic children. A discussion with a Pediatrician or Accredited Practising Dietitian may be helpful when considering hydrolysed formulas.

*Please note: The National Health and Medical Research Council (NHMRC) currently recommends that babies are exclusively breastfed for the first six months of life. After six months, solids can be introduced in conjunction with breastfeeding.

DIAGNOSING FOOD ALLERGIES AND INTOLERANCES

About 90% of food *allergies* are caused by seven foods: cows' milk, hens' eggs, soybeans, peanuts, tree nuts (e.g. almonds, brazil, cashew), wheat, and fish and shellfish.

The most common food *intolerances* are caused by dairy products, food additives (including flavour enhancers such as monosodium glutamate i.e. MSG), strawberries, citrus fruit, tomatoes, red wine and other foods containing histamines (Raising Children Network, 2009).

Children who are displaying the symptoms of food allergy or intolerance generally need to be reviewed by a doctor who may refer the child to an allergist for testing. Tests for **sudden-onset allergies** include:

- **Skin-prick test (SPT):** a small amount of the suspected allergen (the substance that causes an allergy) is placed on the skin and then pricked with a lancet. A wheal (hive) will form at the test site if the child is allergic to the suspected allergen.

- **Blood tests:** a blood test called the radio allegro sorbent test (or RAST) can be used, along with the SPT.
- **Elimination diet:** this can be useful if the SPT and RAST have detected an allergy to certain foods. The child will be asked to stop eating the food for two weeks. If reproducible symptoms appear when the food is reintroduced, the test is regarded as positive.
- **Oral food challenge:** the child will eat the food and the allergist will watch to see what happens. This test carries a risk of causing a severe allergic reaction and should only be conducted by a specialist in a supervised setting.

If a child has a **delayed-onset allergy**, testing is more difficult. The most commonly used test is an elimination diet. A new test, called the **food patch test**, is being trialled – a patch with an extract of the allergen being tested for is put on the child's skin to see whether dermatitis develops (ASCIA, 2009).

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