Submission
No 16

IMPROVING ACCESS TO EARLY CHILDHOOD HEALTH AND DEVELOPMENT CHECKS

Name: Ms Sharon Walbran

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Parliamentary inquiry into improving access to early childhood health and development checks

My Background

I am a Child and Family Health nurse with over 35 years' experience working across the breadth of the role. This vast experience enables me to consider historical changes in the role of the Child and Family Health Nursing service and the impact this has had on early childhood health and developmental checks, and the provision of Child and Family Health nursing support to families.

I currently work for NSW Health as a full time Child and Family Health Nurse in the Sydney metropolitan area. I work in a dual role where I work in a Child and Family Health Clinic, and in a sustained home visiting service which supports vulnerable families experiencing domestic and family violence, drug and alcohol misuse, financial hardship, significant mental health diagnoses, young mothers, childhood trauma, child protection concerns, children with significant medical issues and other vulnerabilities.

I work alongside a multidisciplinary team of health professionals including paediatric speech pathologists, paediatric occupational therapists, paediatric physiotherapists, paediatric dieticians, community paediatricians, mental health services, drug and alcohol services, youth health services, child protection services and non-governmental organizations that support communities, such as domestic violence support agencies, Benevolent Society, Burdekin and many others.

I also, participate in a weekly antenatal SAFESTART multidisciplinary team meetings with the staff at the local hospital maternity unit to collaborate and collect antenatal referrals of families that have been identified as requiring extra support both antenatally and postnatally.

I am making this submission, as an individual health worker and not representing my employer.

My contact details are:

Name: Sharon Walbran

Mobile:

Email:

TERMS OF REFERENCE ONE
Changes needed to address gaps in outcomes for vulnerable children, including those in rural and remote communities, Aboriginal communities, and culturally and linguistically diverse communities.

Recommendation 1: KEY RECOMENDATION

Proper consultation with vulnerable communities, actual frontline workers (not just the clinical leaders who have not worked on the frontline for years) along with all stakeholders at the beginning of any attempt to support communities.

Rationale:

- The community knows what they need, and how best they can be supported.
- The frontline workers intricately know what happens at the service delivery point of contact and how best to improve it.
- This will enable appropriate health service provision that is likely to successfully meet the local community needs and be more efficient.
- Avoids wasting government funds and human resources on programs that do not work.

Recommendation 2:

Sufficient government funding of Child and Family Health Nursing (CFHN) services rather than funding GP practice nurses to do children's PHR developmental checks .

Rationale:

- CFHNs are registered nurses with postgraduate study in Child and Family Health Nursing. They are highly skilled and often have other nursing qualifications in midwifery, paediatric nursing, mental health nursing, lactation, immunization, counselling, infant mental health, and other training. They work autonomously within the multidisciplinary community health team.
- CFHNs specialize in supporting families with young children, and they are the only fully trained health professional to do the personal health record (blue book) developmental checks on children from 0-5 years of age.
- CFHNs provide a more comprehensive PHR check than GP practice nurses. The CFHN not only assesses the child's growth and development, but provides anticipatory guidance to promote children's development, health, and wellbeing. They promote immunization, breastfeeding, healthy diet, and dental health. They support infant mental health through observing and promoting the infant parent relationship and support parents transition to parenting, parental mental health, along with identifying families with vulnerabilities, and ensuring they get appropriate support, whilst identifying, monitoring, and acting on child protection concerns. CFHNs, also, assist families to navigate the complex health system by referral and advocating for children's and family's access to

appropriate support services. (Grant, Mitchell and Cuthbertson 2017). GP practice nurses simply weigh and measure the child and tick the developmental questions in the PHR book and have less skills in identifying concerns.

- CFHNs are a non-stigmatizing entry point into the community health services therefore, families often accept a nurse to support them, at times when they will not accept more stigmatized services eg mental health, drug and alcohol or DV support services. CFHNs build the initial relationship with the families and 'hold' and support the family whilst no other services are involved, until the families accept referrals, or the CFHN advocates for the family to access support services.
- CFHNs are very well linked and have vast knowledge of multidisciplinary community health services and can liaise and advocate for families easily. If a GP practice nurse identifies a concern they are encouraged to refer back to the CFHN for thorough assessment of the child, adding an extra step and complexity to the referral pathway for children to access services.
- Parents, especially those from vulnerable families, seek medicare bulk billing medical centres, and are less likely to wait lengthy periods of time (often hours) in a busy bulk billing medical centre, just to have a child's developmental check done.
- Adding PHR developmental checks to the GP practice workload, gives them an additional task and puts more pressure on the GP practice appointment wait times, and the medicare system in general.

Recommendation 3:

Locate CFHN services in multiple accessible sites closer to local communities.

For example, in or close to shopping centres, local council buildings, community centres or purpose-built family centres.

a. **Create a space where the CFHN service can be located within a centre where parents can meet casually for other reasons eg coffee shop, attend playgroups and other children's activities, Parents can meet with the CFHN service located within. Parents could use this space as a meeting place and could drop in, breastfeed, change their baby, ask questions, book appointments, meet other parents.**
The centre could have group rooms where the nurses and other allied health clinicians could conduct a range of groups, parents could run playgroups, and the multidisciplinary team clinicians could provide outreach services.

b. **Provide CFHN outreach services to supported playgroups, multicultural playgroups, local communities, however this has difficulties as there is generally inadequate available space to provide the full CFHN service.**

Rationale:

- Over the decades, CFHN services previously located in multiple sites within local communities, (generally in local council buildings or shopping centres), have been relocated into significantly fewer, larger multidisciplinary community health centres (State Govt health facilities). This disadvantaged families, as the CFHN services became less accessible and less visible to communities and the relationship between the local CFHN and the local GP practices dissolved.
- This caused a significant drop in attendance at CFHN services and consequently, less child PHR developmental checks completed, along with less health promotion and parental support and a decline in parental knowledge of the CFHN service.
- Currently, CFHNs do a universal health home visit on almost all families who have a newborn baby, however by the 6-8 week developmental check there is a significant drop off in numbers and, an even further drop off by the 6 mth developmental check.

Recommendation 4:

Sufficient government funding of CFHN sustained nurse home visiting (SNHV) programs that meets the needs of <u>all</u> vulnerable families.

ie Govt fund the robustly evidenced SNHV programs ie MESCH and right@home programs rather than a 'watered down' Sustaining NSW Families (SNF) program

Rationale:

- The Sustaining NSW Families (SNF) program is limited in the following ways:
  - It supports women who are mild to moderately depressed (a milder subset of vulnerabilities) and does not cater for women with higher levels of vulnerabilities eg drug and alcohol misuse, domestic and family violence, mental health diagnosis.
  - Families are unable to enter the program past 28 days and women identified as depressed or highly anxious after 28 days, or who move into the local area and unable to access the program.
- A recent scholarly literature review that I conducted (APPENDIX 1), revealed that the licensed MESCH and right@home SNHV programs were more robustly evidence based than the SNF SNHV program, and they are getting successful outcomes with families with a range of vulnerabilities, including those with much higher-level vulnerabilities, including child protection concerns, which the SNF program does not include.
- I question, why limited CFHN resources and government funds are spent on the SNF program that is not achieving as high outcomes as the MESCH or right@home program, and that only captures a very limited number of vulnerable clients with a milder subset of vulnerabilities. Is it because of the license cost?
- 'Watered down' program options with limited outcomes, are being chosen

Recommendation 5:

Build flexibility into support programs for vulnerable families

a. **Flexibility in discharge time from programs based on family needs and whether they have engaged with other support services rather than based on set program cut off time frames.**
b. **Perinatal Infant Mental Health Service (PIMHS) to enable postnatal referrals without mothers having an acute mental health episode.**
c. **Flexibility entering SNF program.**

Rationale:

- Currently, some programs that support vulnerable families, (eg SNF, PIMHS and Substance use in Pregnancy and Parenting Services (SUPPS)), stop when the child turns two. I surmise, because the program's pilot study (done to determine the evidence base), had to set a cutoff point for the study timeframe, and when the child turned 2 yrs old was chosen.
- With all the programs discharging families at 2 yrs old, vulnerable families go from being engaged with support services to limited or no support at a time when the child is entering the demanding time of toddlerhood.
- Example 1: SNF program does not allow families to enter the program after 28 days, this prevents women who develop mild to moderate depression postnatally and who are identified after 28 days (which is common) to enter the program.
- Example 2: Currently, PIMHS referral and engagement occurs antenatally and only postnatally if the mother has an acute mental health event and is triaged through adult mental health service. This has created a gap in service for some women. eg mothers with a mental health diagnosis who birth at private hospitals, and/or others where the carer infant relationship is identified as disorganized, placing the child at risk of long term relationship issues with all relationships.

Recommendation 6:

Early identification of vulnerabilities and early antenatal health service engagement

a. **Govt regulation to ensure private hospital maternity units comply with the SAFESTART model of care antenatal screening and refer and engage women with govt health services antenatally and postnatally**

b. **Antenatal engagement – Child, Youth and Family community health services liaising weekly with all antenatal wards and maternity units (both private and public)**

c. **Continue to offer universal health home visits (UHHV) and targeted homevisits, as they enable the family home situation to be better understood.**

Rationale:

- Women who birth in private hospitals don't always get screened for vulnerabilities and if they do, they are discharged without referral to the NSW Health CFHN services resulting in clients missing priority care ie early UHHV, antenatal referral to SNHV, PIMHS and SUPPS.
- Clients disclose sensitive information once they have built a trusting relationship with a clinician, therefore antenatal visits are an opportunity to build a relationship with clients and to screen for vulnerabilities.
- Current scholarly literature recommends a review of the current psychosocial screening tool assessment. A recent pilot study of a different screening tool to identify vulnerable families, that can be used in an antenatal waiting room, may be an alternative option to the current psychosocial assessment. It is surmised this new screening tool identifies families with a high-level vulnerabilities (that is disclosed at a later time). Therefore, may be an improved screening tool (L. Kemp et al., 2022).
- UHHVs/ targeted home visits enable the family context to be better understood, it is easier for families when they are adjusting to a new baby in the home and ensures opportunity for CFHN to engage the family with the CFHN service.

Recommendation 7:

Promote sustained engagement in CFHN services

a. Incidental marketing of the CFHN service and PHR checks

Focus on building relationships with, especially first-time parents, vulnerable families, by more frequent contact in the first 6 mths to support families transition to parenting Eg weekly appts, early entry into new parent groups, 6-8 week long new parent groups, weekly homevisits for vulnerable families, offer education sessions related to age of baby.

b. Accessible services to have PHR checks
  - **CFHN services located in multiple locations within the local community**
  - **More flexible opening hours for CFHC services- early and late appts provision, weekend service**
  - **Drop in appt options**
  - **Online appt booking system**
  - **Outreach to daycare centres, playgroups, etc**

c. Provision of sufficiently sized group rooms for CFHNs and allied health professionals to run groups and education sessions for the community

Rationale:

- Sustained engagement requires a trusting relationship to be developed between clinician and client.
- People build relationships when they have regular contact, however the recommended time frames for PHR checks, are too far apart in the first weeks and year resulting in diminishing family engagement with the CFHN service. This results in families not being able to build a relationship with the service, nor get to understand what the CFHN service provides or the importance of PHR checks.
  Consequently, the initial highly successful (almost 100%) engagement by the CFHN service through the universal homevisit for the first 1-4 weeks PHR check, diminishes by 6-8 week PHR check and even further by 6 mths PHR check.
  Ultimately, resulting in child PHR checks not being done.
- There are limited spaces in the community and in community health facilities for health professionals to run groups for families

Recommendation 8:

Promote engagement of Culturally and Linguistically Diverse (CALD) families

a. Ensure enough interpreters to enable timely appts
b. Allow private Drs and medical specialists access to free health care interpreter services, like the public health system – this is a gap
c. Flexible use of interpreters eg phone, face to face, video call
d. Link refugees on settlement to CFHN services
e. Simplify pathways within the complex healthcare system
f. Recruit/educate CALD healthcare providers who can liaise and advocate for families with support services or make appts
g. Language specific information provision online, in waiting rooms, printed information
h. Systems that value and support continuity of care – familiar nurse
i. Easy pathway or advocacy service to make an appt with CFHN, or any medical appt

Recommendation 9:

Promotional marketing of CFHN services and PHR developmental checks

a. Antenatally- CFHNs attend prenatal classes or antenatal clinics
b. Educate midwives, obstetricians and DRs about the CFHN service
c. CFHNs can market themselves and the PHR checks, as clients experience what the CFHN service offers
d. Social media – tik tok, Instagram (whatever the current social medium that new parents are utilizing) – health service need to keep up with technology trends
e. CFHN, obstetricians and GP waiting rooms, childcare centres, playgroups , Emergency depts of hospitals etc, wherever parents go
f. Parental reminders of the PHR checks eg like the immunization reminder APP
g. Government financial incentives to have the PHR checks completed

Recommendation 10:

Sufficient government funding of allied health services that assess and treat children's developmental delay, mental health or general health ie paed physios, paed OTs, paed speech therapists, child psychologists, paed dieticians, etc

a. **Streamline the referral pathways and make access easier**
b. **Reduce lengthy waitlist times**
c. **Fund community paed dietician positions - this is a gap**

Rationale:

- If a child has a PHR check and the BMI is above or well above the healthy weight range, there is no community paed dietician to refer to, only private dieticians. Currently, public paed dieticians require a referral from a hospital paediatrician

Recommendation 11:

Funding to support early intervention for families with a child who has a long term medical condition that does not meet NDIS funding criteria – this is a gap

a. **Financial support for vulnerable families, that have a child with a medical condition that requires long term treatment and does not meet NDIS criteria eg a newborn baby with a long term medical condition (eg structural talipes) that needs treatment for 5-7 yrs**
b. **Community transport options for vulnerable families that don't have the financial resources to transport their child to enable long term medical treatment and child does not meet NDIS funding criteria**

Recommendation 12:

Fast track the processing of newborn baby medicare cards and family parenting payments – this is a gap

Rationale:

- Parents are having to pay full fees for DRs appts (as they are not being bulk billed on their parents medicare card anymore) until the newborn baby has a medicare card issued. This is resulting in many examples of families delaying commencing the babys immunization schedule, not having their 6 week hip ultrasound and DR followup. The medicare cards are taking over 6 weeks to be processed.

- As mothers have finished work to have their baby, they are reliant on the centrelink payments to compensate for this income loss. This is leaving families with inadequate funds, and they are going without food to cut costs, or parents are seeking free food from charities. These are breastfeeding mothers who require sufficient nutrition to maintain their breastmilk supply, and if they lose their breastmilk supply, they then have to find funds to purchase formula milk to feed their baby.

TERMS OF REFERENCE TWO
Barriers that affect parents' access to routine health and development checks that track their child's progress against developmental milestones

Point 1:

Ongoing erosion of CFHN face-to-face clinical time and increased difficulty to access CFHCs due to health system changes.

Over the decades, health system changes have gradually eroded the CFHN service clinical time with clients, which has resulted in a significant drop in client attendance for the children's routine health and developmental checks.

HOW?

a. **CFHCs moved from community locations to less accessible multidisciplinary community health centres.**
   Over the decades, CFHN services previously located in multiple sites within local communities, (generally in local council buildings or shopping centres), have been relocated into significantly fewer, larger multidisciplinary community health centres (State Govt health facilities). With each move out of the community, the numbers of families attending the child health checks have decreased, and the CFHN service has become less visible to families, and the collaboration between CFHNs and GPs has dissolved.
   Recommendations:
   - **Locate CFHN services back in centres closer to the local communities**
   - **CFHN outreach services**

b. **CHOC electronic medical record (eMR) documentation system implementation**
   The introduction of the CHOC documentation system for CFHNs increased the amount of time CFHNs spent documenting and therefore, the number of appointments available per day for families decreased to compensate for the extra documentation time. Recent documentation changes have resulted in further compensation and loss of client appointment time.
   Recommendations:
   - **Streamline, user friendly, CFHN documentation and online referral systems, developed with extensive consultation with frontline CFHNs who document in the eMR everyday**
   - **Govt fund efficient eMR systems**

c. **Increasing amount of non-nursing duties with no administration support**

The ever-increasing amount of non-nursing duties for the CFHN and clunky, time consuming systems, with no administration support for CFHNs, have also decreased clinical face to face time with clients.

Recommendations:

- **Fund administration support for CFHNs**
- **Streamline systems in consultation with frontline clinicians**

Point 2:

Literature review of barriers to utilization of the universal child and family health services in Australia

I conducted a literature review as follows:

Understanding the barriers to utilization the universal child and family health services in Australia: A literature review . Sept 2019 **(Full unpublished paper – APPENDIX 2)**

I have summarized the results of the literature review in the following table and included my personal recommendations.

NB: Recommendations made for TERMS OF REFERENCE ONE are relevant to this TERM OF REFERENCE TWO

Summary of the barriers to utilization of universal Child & Family Health services in Australia	Personal recommendations

Parent Choice
Continuity of care and conflicting advice
 	
1. Consistency of advice is priority for new parents
  o Prevents confusion and lack of trust in any advice
2. Continuity of care essential
  o Prevent parents' repetition of personal stories
  o Aids navigation of health services
  o Assists building relationships between parents and service providers
3. Some respondents liked a range of advice
	Health systems focus to create systems that promote continuity of care

Parent Choice ***Communication and Knowledge provision*** 1. Parents disengage if experience is negative	Trained professionals- CFHNs are only fully trained, highly skilled professionals that do the childhood PHR developmental checks Ongoing education for health professionals

○ Excessive jargon ○ Negative language ○ Feeling judged, cross examined, under surveillance. ○ Outdated advice ○ Contradictory to parent values or 'home country' ○ Lacking evidence 2. Positive communication experience- builds relationship ○ Non-judgemental ○ Compassionate ○ Encouraging ○ Respectful of client's knowledge and beliefs ○ Sensitive ○ Practical ○ Includes active listening ○ Client involved in decision making ○ Empowering ○ Current, evidence based, with appropriate referral by competent, resourceful health professional	Family partnership training and clinicians who work in partnership with families Culturally sensitive workforce and service Knowledge on referral pathways Simplification of referral pathways
Parent Choice ***Accessibility*** ○ Inflexible opening hours	CFHN service opening hours to include early morning and late afternoon appts and weekend service
○ Lengthy wait times, especially for breastfeeding support, return phone calls, scheduled appointments	Parental online booking systems Streamline systems for booking and referrals allocated breastfeeding support appts
○ Rushed appts, discouraged from offering follow up appts ○ Lack of resources causing limited time for nurses to support families with more than one child	Enable more CFHN clinical time by : Admin support for CFHNs to free them from ever increasing non-nursing duties Less onerous, ever increasing, documentation systems Streamlined referral systems Ensure adequate funding for CFHN services
○ Limited service in remote, rural, outer metropolitan areas	Govt funding and targeted solutions with consumer and frontline staff consultation from beginning

○ Variable service for parents with more than one child
○ Limited or perceived limited access for appts between PHR checks
○ Minimal service for fathers
 	
○ Difficulty travelling on public transport with children
 	
○ CALD families' unique issues:
  ○ Transport issues
  ○ Inflexible clinic times
  ○ Inflexible service options
  ○ Lack of knowledge of health service
  ○ Parent's employment
  ○ Family isolation
  ○ Parents understanding of need for child developmental checks
  ○ PHR not used
○ Refugees
    ○ Lengthy time to understand health system
    ○ Lack of awareness of C&FH nurse knowledge on child development
    ○ Unable to read English information in waiting rooms
    ○ Lack of confidence to leave phone messages to seek appt
    ○ Preference to speak directly to familiar nurse
    ○ Lengthy wait for interpreters
    ○ Unsuitable printed information
	Flexible home visiting service
	CFHNs services in local communities
	Education of parents
	Marketing
	
	Father friendly CFHN documentation / service
	Govt funding and targeted solutions
	with consumer and frontline staff consultation from beginning
	
	Retain all existing CFHCs in the suburbs and local community
	Return CFHN services back into the local communities / suburbs
	Provide outreach services
	
	Govt funding and targeted solutions
	with consumer and frontline staff consultation from beginning
	
	Solutions as described above plus:
	
	Employ culturally specific workers to enable:
	○ Liaison with CFHNs and health services
	○ Family education on the importance of PHR checks
	○ Encouragement and assistance to CALD families to access health services and to navigate the complex health system
	○ Assist families make medical appts and to book interpreters for medical appts
	
	CFHN Outreach services to multicultural playgroups
	
	Widespread availability of multicultural translated information in waiting rooms (CFHC, GP, ED, antenatal clinics, obstetricians rooms), include online information and social media
	
	Flexible health interpreter availability
	Funding for private GPs and specialist medical Drs and allied health clinicians to have access to the free health interpreter service

Maternal Choice ***Maternal Characteristics*** **Likely to utilise CFHN service** ○ Knowledge of health system ○ Health seeking behaviours ○ Higher education	

○ Health literacy ○ Employment ○ Married ○ Older mothers ○ Private health insurance ○ Higher income living in metropolitan areas ○ Mothers who drank ETOH in pregnancy	
Unlikely to use CFHN service	Antenatal engagement by community health services for all families , especially vulnerable families
○ Mothers who smoked in pregnancy	Engagement with Substance Use in pregnancy and parent services (SUPPS) clinician antenatally
○ Young mothers	Antenatal engagement with youth health worker and appropriate youth postnatal program
○ Limited English proficiency	Multicultural support worker advocacy as described above
○ Families with three or more children	Flexible CFHN home visiting service for developmental checks
○ Lack of confidence ○ Socioeconomic disadvantage ○ Mental health concerns ○ Ethnicity ○ Social isolation ○ Poor health seeking behaviours ○ Fear of judgement, esp mothers experiencing drug and OH issues, and domestic violence	Sustained nurse home visiting programs for families with various vulnerabilities The program needs to be flexible to enable intake into the program when the vulnerability is identified or if families move into the area
○ Return to work	CFHC appt times in early am, late afternoon and on weekends, telehealth appts or phonecall appts at lunchtime Outreach to childcare centres
Parent Awareness ***Awareness*** ○ Lack of awareness of Child health services and PHR checks ○ Unaware of ○ Location of service	Antenatal education and engagement with CFHN service Education of maternity staff, GPs, Obstetricians of the CFHN services

○ How to access ○ Role of C&FH nurse ○ Find health service system complex ○ CALD specific ○ Lack of understanding of child development ○ Lack of awareness of PHR check schedule, even though received info from maternity ○ Families with limited supports are less aware ○ Family members can act as deterrent to access developmental surveillance	Simplify access to health systems As previously outlined
Parent Awareness ***Beliefs*** ○ CALD community attitudes may impact access to developmental surveillance and support ○ Lack of understanding of child development ○ Shame, stigma attached to language eg 'language delay', child with 'disability' ○ Denial ○ Fear guilt ○ Fathers overruling decisions	CALD community education As previously outlined

TERMS OF REFERENCE THREE
Recruitment and retention of health professionals to address workforce shortages

This is not new information from a nursing perspective
It is just that no one is listening to nurses, nor acting on nurses' complaints.
I feel the health system is based on cost saving at nurses' expense.

Improve pay and working conditions

- Until pay and working conditions improve there will never be enough nurses
- The current pay rise for NSW nurses is inadequate, a lot of nurses are quite angry with the inadequate rise
- There is inequality of pay rates for nurses across states
- As soon as covid pandemic hit, the first thing that was frozen was pay rises for nurses, therefore, nurses pay rises partially funded the covid response, and nurses got a verbal pat on the back. Very poor!!!

Improve career development opportunities

- Lack of career development and higher pay opportunities
- Inequity of career positions across and within LHDs
- Management too slow to create career opportunities, meanwhile nurses leave and go elsewhere or, if they stay, their career advancement is on hold

Advertise vacancies in timely manner

- Eg took 3 yrs to advertise a CNS2 position in my LHD
- Meanwhile CFHNs are fulfilling the role of CNS2, working above their paygrade and not being paid for the role and going unrecognized professionally.

Consultation with frontline staff before clinical practice change

- Implementation of clinical practice changes without adequate consultation with frontline staff, resulting in changes that either don't work or are less efficient, adding to the nurse's daily work burden

Culture change in health management to more transformative leadership

- A more consultative health management that empowers nurses will prevent or minimize low staff morale and the resulting 'spin offs'

Streamline documentation systems and reduce non-nursing duties

- There is a huge imbalance between clinical time and documentation time, that has been created to the point that nurses are finding the documentation arduous and unnecessary.
- Ever increasing non-nursing duties created from over administration, implemented by others without consultation with frontline workers, taking away from nursing clinical time

- eMR documentation systems are non-user friendly and time consuming

Nurses are tired of constantly 'fighting the system' for work conditions and over so many other ongoing issues
Low staff morale and nurses leaving workforce resulting from all the above
Why would any current nurse encourage a young person to be a nurse?

TERMS OF REFERENCE FOUR
Funding for early intervention programs and screening to ensure children are given support for developmental issues, including telehealth and other models

Recommendation 1:

Adequately fund CFHN services and rebuild the system to do the child development PHR checks

- As outlined previously, the valuable CFHN service that is capable to do this work has been degraded over time by system changes to the detriment of the families and childhood development and health screening and surveillance

Recommendation 2:

Adequately fund for allied health professionals

- ie paed dieticians, paed occupational therapists, paed speech pathologists, paed physiotherapists, psychologists to support parents parenting, to ensure the waiting lists are not too long as families are unable to afford private services.

Recommendation 3:

Fund paediatric dieticians for the community

– this is a gap (previously described in TERMS OF REFERENCE ONE)

- Currently paed dieticians can only be accessed by referral by pediatricians in a hospital
- There are no paed community dieticians to refer to

Recommendation 4:

Fund the establishment of Early intervention specialized preschool programs

- Example model: Dalwood Spilstead Early Intervention Services, Seaforth, NSW, which can provide therapy during the child's preschool day and provides and empowers parents of vulnerable families

Recommendation 5:

Maintain or create Child, Youth and Family Mental Health teams that stand alone from adolescent and youth services

- To focus solely on early intervention work with parents of younger children, because when the service is combined, the more acute eg self-harming adolescent, gets priority intervention over supporting parents with a demanding toddler or toddler with anxiety

Recommendation 6:

Fund sufficient spaces for health workers to run groups

- To enable community health professionals to run groups within the local community eg parenting groups on speech development, parenting toddlers, circle of security parenting. etc

BIBLIOGRAPHY

Grant, J., Mitchell., C & Cuthbertson, L. (2017) *National Standards of Practice for Maternal, Child and Family Health Nursing Practice in Australia*, Adelaide, Flinders Press

Kemp, L., Bruce, T., Elcombe, E.L., Byrne, F., Scharkie, S. A., Perlen, S. M., & Goldfield, S. R. (2022). *Identification of families in need of support: Correlates of adverse childhood experiences in the right@home sustained nurse home visiting program*. PloS ONE [Electronic Resource], 17(10, e0275423. doi:https://dx.doi.org/10.1371/journal.pone.0275423

APPENDICES

APPENDIX 1:	Literature review level 3 vulnerability interventions
by S. Walbran	December 2023

The First 2000 Days Framework

The First 2000 days framework is the NSW Health policy document that recognizes the importance of the first 2000 days in a child's life as a critical time that determines a child's future health outcomes, schooling success and long-term wellbeing. The framework guides NSW health professionals to provide universal, evidence-based, streamlined care to support children's development and health, and to partner with other family support agencies when needed (NSW Department of Health, 2019).

Strategy three of the framework leads the health service to identify and provide extra care to those at risk. An integrated service system stepped approach of support is provided where the care becomes more intensive when the risk is greater. Significant risk factors include substance misuse, domestic and family violence, mental health issues, child protection concerns, intellectual disability, poverty, social isolation, trauma background, unstable housing and financial stress (NSW Department of Health, 2019).

Identification of risks

To enable early intervention for families, it is important that risks are identified early (L. Kemp et al., 2022). Currently, NSW, Maternity and Child and Family Health (CFH) Services aim to identify family vulnerabilities through universal psychosocial assessment and depression screening as per the NSW Health SAFESTART Strategic Policy (NSW Department of Health, 2010) and by domestic violence routine screening (NSW Department of Health, 2023a) . Evidence suggests that although most women agree with the idea of the questions being asked (Rollans, Schmied, Kemp, & et.al, 2013), others find the questions intrusive , especially when revisiting previous trauma or disclosing previous histories of domestic violence, mental health issues or child sexual abuse (Rollans et al., 2013) (Hooker, Small, Humphreys, & et al., 2015). Privacy and a trusting relationship facilitates disclosure of sensitive issues including domestic violence (Adams, Hooker, & Taft, 2019). Evidence is beginning to suggest that universal screening and first contact or minimal contact disclosure of sensitive risks are not identifying the vulnerable families needing extra support (L. Kemp et al., 2022).

A pilot study of a screening tool using non-sensitive socio-demographic questions, which was implemented in a non-private antenatal waiting room, found significant but weak correlations between the screened risks with adverse childhood experiences risk disclosures. This tool may be an option to enhance early identification of families and enable engagement with interventions when first or minimal contact screening occurs and maternal disclosure is unreliable (L. Kemp et al., 2022).

Engagement

Families with must higher risks require more intensive support (NSW Department of Health, 2019), however those families that are at the highest level of need are less likely to access the intervention services that could support them (Fox, Southwell, Stafford, & et al., 2015). A challenging aspect for the CFH nurse when working with families where there are child maltreatment concerns, is that the universal CFH nursing service has voluntary enrolment and parents can choose whether to engage

and when to disengage. This adds complexity to the complex circumstances in which CFH nurses work, when supporting families where there are child protection or domestic violence concerns (Mawhinney & Fraser, 2023).

Research has identified a number of factors that contribute to families maintaining engagement to services (Damashek, Berman, Belachew, & et al., 2023). Programs that promote parent-infant relationships and build parent knowledge on child development (McKelvey & Fitzgerald, 2020) promote retention, along with early determination and alignment with the parents' goals and emotional capacity (Burrell, Crowne, Ojo, & et al., 2018). Mothers' perception of the client-provider relationship is key to engagement maintenance. Other significant factors that promote engagement are cultural competence and a home visitor that is trustworthy, knowledgeable, supportive, effective communicator, personable, flexible, collaborative, nonjudgmental and can work well with their children (Damashek, Kothari, Berman, & et al., 2020). Engaging families antenatally has been found to be an effective core component of sustained nurse home visiting (SNHV) programs (Beatson, Molloy, Perini, & et al., 2021).

Programs

A meta-analysis identified the effective components of child maltreatment interventions as follows: cognitive behavioral therapy, home visitation, parent training, family-based/multisystemic, substance abuse, and combined interventions. It was concluded that existing interventions could be improved by extra focus on building parenting skills and self-confidence and providing emotional and social support (Van der Put, Assink, Gubbels, & et al., 2018).

The Pregnancy Family Conferencing Program is a strength-based, trauma informed program offered antenatally to women where there are significant child protection concerns. A partnership between NSW Health and the NSW Department of Communities and Justice has enabled the program. The program is voluntary and facilitated interagency meetings are held with families to develop coordinated care plans based on family needs and child protection concerns. Where child protection concerns are such that the baby needs to be placed in out of home care the families are enabled to voice their opinion on the process and the decisions on the welfare of their baby (NSW Department of Health, 2019).

SNHV programs have demonstrated promising maternal and child health, well-being and education outcomes (Molloy, Beatson, Harrop, & et al., 2021). A systematic review of SNHV programs which had been tested with randomized -or cluster-randomized controlled trials identified seven different SNHV programs, of which Family Nurse Partnership (FNP), VoorZorg, Maternal and Early Childhood Sustained Home visiting program (MECSH) and MECSH-based right @home programs rated as high-quality studies. Each of the seven programs were difficult to compare as programs vary, however they all demonstrated at least one positive outcome (Molloy et al., 2021). VoorZorg, MECSH and right@home had positive outcomes of critical importance (eg. child maltreatment, domestic violence, smoking, breastfeeding duration, and parenting skills and interactions) (Molloy et al., 2021). The systematic review results were mixed, and it suggested further research required on SNHV program componentry and longer-term follow-ups (Molloy et al., 2021) .

A further systematic review of the seven SNHV programs identified the core components of SNHV programs as follows: antenatal commencement, support until child age 2 years, a minimum of 19 scheduled visits by highly qualified , experienced nurse with program specific training, caseloads of at around 25 families, regular supervision and multidisciplinary team supports (Beatson et al., 2021)

In NSW there are two sustained health home visiting programs: MECSH and Sustaining NSW Families (SNF) (NSW Department of Health, 2023b). Of these, MECSH's eligibility criteria includes a positive response to any of the psychosocial screening questions, along with at risk factors, including late antenatal care, young mothers, and current substance misuse (Kemp, Harris, McMahon, & et al., 2008). Whereas, SNF eligibility criteria includes an EPDS score of 10 or more, and at least 1 or more level 2 risk factors, and excludes families with higher level risk factors, substance misuse, psychotic illness, domestic violence and child protection concerns (NSW Kids and Families, 2015).

MECSH is a licensed SNHV program, developed and implemented in Australia, and has international uptake in the UK, USA and South Korea (Kemp, Elcombe, Sumpton, & et al., 2022; TreSI Part of the School of Nursing and Midwifery, 2023). A recent study of the MECSH program in the UK, especially examined the programs effect on families who had significant adversity and involved with the child protection system (Lynn Kemp et al., 2022). The results identified the program had both a 'curative' and a 'preventative' effect. The curative program elements focus on building parenting skills and social and emotional support, and addressing mental health issues, and included child focused content. Whereas the preventative program elements target parent self-confidence and enablement (Lynn Kemp et al., 2022). These results concurred with a meta-analysis that identified effective components of child maltreatment interventions (Van der Put et al., 2018).

The Australian right@home program is the most extensive and only multi-site RCT of SNHV (Goldfeld, Price, Bryson, & et al., 2017) and has been implemented in Tasmania and Victoria. It is designed around the core MESCH framework and training, and strengthened with evidence based focus modules (5 modules for content on sleep, safety, nutrition, infant-parent relationship and regulation; 2 modules on program delivery based on motivational interviewing and video feedback) (Goldfeld, Price, Smith, & et al., 2019). The most recent follow up evaluation of the right@home program, when the children were aged 4 and 5 years old, concluded that it provided sustained benefits to family functioning, parenting, maternal mental health and family wellbeing for those experiencing adversity (Goldfeld, Bryson, Mensah, & et al., 2022).

Cradle to Kinder is an Australian intensive home visitation program for significantly vulnerable families, including intergenerational disadvantage, which provides a multidisciplinary approach that is trauma-informed, and includes long term case management, evidence-based parenting interventions, and begins antenatally and continues up to child aged 4 years. The program is offered in Victoria to young families experiencing multiple stressors with a high chance of child removal. A multidisciplinary team with a family support key practitioner, supported by maternal and child health nurses and early parenting workers, home visit twice a week for the first 12 months, and thereafter weekly. The team works with the whole family, including extended family. The study findings include improvements in parent self-confidence, parenting skills, child development, caregiver and child wellbeing, family functioning and prevented child removal (O'Donnell et al., 2022).

The Australian Nurse-Family Partnership (NFP) Program is a home visiting program for Aboriginal families from pregnancy up to child aged 2 years and is an adaptation of the US NFP program. The families experienced intergenerational disadvantage, domestic violence, extreme poverty, insecure housing, low education and literacy and many clients experienced four or more adversities. The program has been delivered in Central Australia and the Northern Territory. The program adaptation included an Aboriginal Community Worker to support cultural safety and community engagement, and included multiparous women of any age, otherwise the program was unchanged. The study identified that client complexity and living environment impacted program delivery, however the engagement and retention rate was comparable to or higher than the US NFP program. It was

concluded that program models need to be adapted to the specific client populations and their complexities to enable effective service delivery and to meet program goals (Zarnowiecki, Nguyen, Catherine, & al, 2018)

REFERENCES

Adams, C., Hooker, L., & Taft, A. (2019). The enhanced maternal and child health nursing program in Victoria: A cross-sectional study of clinical practice. *Australian Journal of Primary Health, 25*(3), 281-287.

Beatson, R., Molloy, C., Perini, N., & et al. (2021). Systematic review: An exploration of core componentry characterizing effective sustained nurse home visiting programs. *Journal of Advanced Nursing, 77*(6), 2581-2594. doi:https://dx.doi.org/10.1111/jan.14755

Burrell, L., Crowne, S., Ojo, K., & et al. (2018). Mother and home visitor emotional well-being and alignment on goals for home visiting as factors for program engagement. *Maternal and child health journal, 22*, 43-51.

Damashek, A., Berman, A., Belachew, B., & et al. (2023). Pilot test of a measure to assess clients' perceptions of their home visitors. *Infant Mental Health Journal, 44*(1), 117-124.

Damashek, A., Kothari, C., Berman, A., & et al. (2020). Engagement in home visiting services during the transition from pregnancy to postpartum: a prospective mixed methods pilot study. *Journal of Child and Family Studies, 29*, 11-28.

Fox, S., Southwell, A., Stafford, N., & et al. (2015). Better Chances: A Review of Research and Practice for Prevention and Early Intervention. Canberra: Australian Research Alliance for Children and Youth (ARACY).

Goldfeld, S., Bryson, H., Mensah, F., & et al. (2022). Nurse home visiting to improve child and maternal outcomes: 5-year follow-up of an Australian randomised controlled trial. *PLoS ONE [Electronic Resource], 17*(11), e0277773.

Goldfeld, S., Price, A., Bryson, H., & et al. (2017). 'right@ home': a randomised controlled trial of sustained nurse home visiting from pregnancy to child age 2 years, versus usual care, to improve parent care, parent responsivity and the home learning environment at 2 years. *BMJ open, 7*(3), e013307.

Goldfeld, S., Price, A., Smith, C., & et al. (2019). Nurse home visiting for families experiencing adversity: a randomized trial. *Pediatrics, 143*(1).

Hooker, L., Small, R., Humphreys, C., & et al. (2015). Applying normalization process theory to understand implementation of a family violence screening and care model in maternal and child health nursing practice: a mixed method process evaluation of a randomised controlled trial. *Implementation science, 10*(1), 1-13.

Kemp, L., Bruce, T., Elcombe, E. L., Byrne, F., Scharkie, S. A., Perlen, S. M., & Goldfeld, S. R. (2022). Identification of families in need of support: Correlates of adverse childhood experiences in the right@home sustained nurse home visiting program. *PLoS ONE [Electronic Resource], 17*(10), e0275423. doi:https://dx.doi.org/10.1371/journal.pone.0275423

Kemp, L., Elcombe, E., Sumpton, W., & et al. (2022). Evaluation of the impact of the MECSH programme in England: A mixed methods study. *Journal of Health Visiting, 10*(5), 200-214.

Kemp, L., Harris, E., McMahon, C., & et al. (2008). Miller Early Childhood Sustained Home-visiting (MECSH) trial: design, method and sample description. *BMC Public Health, 8*(1), 424. doi:10.1186/1471-2458-8-424

Mawhinney, B., & Fraser, J. (2023). Engagement and Retention of Families in Universal Australian Nurse Home Visiting Services: A Mixed Methods Study.

McKelvey, L. M., & Fitzgerald, S. (2020). Family functioning and involvement in home visiting: Examining program characteristics as moderators to support retention in services. *Infant Mental Health Journal, 41*(2), 220-231.

Molloy, C., Beatson, R., Harrop, C., & et al. (2021). Systematic review: Effects of sustained nurse home visiting programs for disadvantaged mothers and children. *Journal of Advanced Nursing, 77*(1), 147-161. doi:https://dx.doi.org/10.1111/jan.14576

NSW Department of Health. (2010). PD2010_016 SAFE START strategic policy. In: NSW Department of Health North Sydney.

NSW Department of Health. (2019). PD2019_008 The First 2000 Days Framework. In. NSW Department of health North Sydney.

NSW Department of Health. (2023a). PD2023_009 Domestic Violence Routine screening. In. NSW Department of Health North Sydney.

NSW Department of Health. (2023b). Sustaining Health Home Visiting. Retrieved from https://www.health.nsw.gov.au/kidsfamilies/MCFhealth/programs/Pages/sustained-home-visiting.aspx

NSW Kids and Families. (2015). Evaluation of the Sustaining NSW Families Program. In. Sydney, NSW: KPMG.

O'Donnell, R., Savaglio, M., Halfpenny, N., Morris, H., Dunbar, A., Sharman, C., . . . Skouteris, H. (2022). Evaluating the implementation of Cradle to Kinder: An intensive home-visitation support program for families experiencing disadvantage. *Child Abuse & Neglect, 133*, 105855. doi:https://dx.doi.org/10.1016/j.chiabu.2022.105855

Rollans, M., Schmied, V., Kemp, L., & et.al. (2013). Digging over that old ground: an Australian perspective of women's experience of psychosocial assessment and depression screening in pregnancy and following birth. *BMC women's health, 13*(1), 1-14.

TreSI Part of the School of Nursing and Midwifery. (2023). Early Childhood Connect Investing in Strong Beginnings -About MECSH. Retrieved from https://www.earlychildhoodconnect.edu.au/home-visiting-programs/mecsh-public/about-mecsh

Van der Put, C. E., Assink, M., Gubbels, J., & et al. (2018). Identifying effective components of child maltreatment interventions: A meta-analysis. *Clinical child and family psychology review, 21*, 171-202.

Zarnowiecki, D., Nguyen, H., Catherine, H., & al, e. (2018). The Australian Nurse-Family Partnership Program for aboriginal mothers and babies: Describing client complexity and implications for program delivery. *Midwifery, 65*, 72-81. doi:https://dx.doi.org/10.1016/j.midw.2018.06.019

APPENDIX 2: Understanding the barriers to utilisation of the universal child and family health services in Australia: A literature review

By S. Walbran 2019

Introduction

The experiences encountered by a child in the initial 2000 days of life has been shown by research to have life-long impact on the child (NSWHealth 2019). Identifying developmental problems early and providing intervention can alter the impact on the child and improve both short and long-term outcomes (Eapen *et al.* 2014). In Australia, the universal child and family health services provide the initial support for child health and development (Schmied *et al.* 2011), however, the uptake of the universal child and family health services is limited (Rossiter, Fowler, Homer*, et al.* 2018). This literature review aims to understand the barriers as to why parents do not fully utilise the universal child and family health services.

Background

Recently, NSW Health issued a new policy directive, 'The First 2000 Days Framework', which directs health systems to provide services to support child development and wellbeing in the first 2000 days (NSWHealth 2019). The policy is pertinent to NSW child and family health nurses, based in early childhood health centres, because they provide universal developmental surveillance to children and their families by performing developmental personal health record (PHR) checks at six weeks, six months, one year, eighteen months, two years, three years and four years of age. A brief review of literature evidence reflects that the universal service is not fully utilised, with NSW data results showing 34.1% of one to four year old children attend an early childhood health centre (Schmied *et al.* 2014). In the local Warringah council area, Australian Early Developmental Census (AEDC) data supports the assumption that children are being 'missed', with 13.8% of children vulnerable on one or more areas of development, and 6.1% of children vulnerable on two or more areas of development on starting school (Australian Early Development Census 2018). This evidence led to the development of a project proposal aiming to discover ways to increase the number of child health developmental PHR checks, on children aged six weeks up to age five, performed by the child and family health nurses. This literature review is further exploration of the literature evidence to support the project proposal.

Search Methods

A literature search was conducted using the following:

Keywords: 'child', 'child,preschool', 'infant', 'preschool', 'child health', child health services', 'maternal-child health services', maternal child health centers', 'maternal child health nursing', 'maternal and child health nursing', 'maternal and child health', 'child and family health', 'child and family health services', 'child and family health nursing', 'early childhood health services', 'role of nurse', 'developmental surveillance', 'developmental screening', 'child development', 'health status indicators', 'mass screening', population surveillance', 'public health surveillance', 'healthcare delivery', child health surveillance', 'universal health service', 'developmental checks', 'developmental screening in early childhood', 'early intervention', 'outcomes or benefits or effects or impact or effectiveness', 'access', 'health services', 'utilisation'.

Databases: Ovid Medline, Embase, UTAS Library MegaSearch (includes CINAHL Complete, Informit Health Collection, Scopus, Academic Search Ultimate, Gale OneFile:Health and Medicine, Health Policy Reference center, Complementary Index, Australia/New Zealand Reference Centre Plus and Directory of Open access journals)

Limitations: English; years 2009-2019; all infant (birth to 23 months); 'preschool child (2 to 5 years)';

Other sources: Google, Google scholar, manual search

Journal Articles: 62 articles retrieved initially from the data base search; 42 articles excluded after reviewing the title and abstract (included 10 duplicates) All non-Australian articles excluded; 5 articles excluded after reading article; 15 journal articles included in the literature review.

Summary of results

The literature identified 'parent choice' and 'parent awareness and beliefs' as the main themes for parents not utilising the universal child and family health services.

Parent choice

Continuity of care and conflicting advice

Two qualitative studies captured parental experiences with child and family health services across Australia (Hesson *et al.* 2017) (Rossiter, Fowler, Hesson, *et al.* 2018). Participants for both studies were mainly Anglo-Australian, English speaking and educated women, therefore, the studies don't fully reflect the multicultural diversity within Australian parents, however, they retrieved a national response. Another qualitative study was conducted on women temporarily residing in a parenting unit and of which 63% had anxiety or depression (Corr, Rowe & Fisher 2015). These women had similar profile as the previous two studies, except for an identified diagnosis. These studies identified conflicting advice and continuity of care as a significant issue in child and family health service provision. Studies reported consistency of advice as a priority for new parents (Corr, Rowe & Fisher 2015) and that inconsistent advice from differing care providers led to confusion and lack of trust in any advice (Rossiter, Fowler, Hesson, *et al.* 2018). Continuity of care was expressed as essential to avoid parents having to repeat their health or personal stories (Rossiter, Fowler, Hesson, *et al.* 2018), it aided parents' navigation of health services and assisted building relationships between parents and service providers (Hesson *et al.* 2017), however, some respondents embraced a range of advice (Rossiter, Fowler, Hesson, *et al.* 2018).

Communication and knowledge provision

These studies, also, reported that parents may disengage with health services if their experience is negative. Communication with a professional that uses excessive jargon, negative language or that makes parents feel judged, cross examined or under surveillance was deemed negative (Hesson *et al.* 2017). Conversely, communication perceived as positive was non-judgemental, compassionate, encouraging, supportive, reassuring, respectful of client's knowledge and beliefs, instilled confidence and was sensitive, practical and included active listening (Rossiter, Fowler, Hesson, *et al.* 2018), along with involving client in decision making (Hesson *et al.* 2017). Women highly valued empowering, respectful interactions (Corr, Rowe & Fisher 2015). Further studies highlighted advice that was outdated, contradictory to parent values (Rossiter, Fowler, Hesson, *et al.* 2018) or the 'home country' (Woolfenden *et al.* 2015) or lacking in evidence (Corr, Rowe & Fisher 2015), was perceived by parents as negative and advice that was current, evidence based, with appropriate referral by a competent, resourceful health professional was preferred (Rossiter, Fowler, Hesson, *et al.* 2018).

Accessibility

The results of these qualitative studies are in agreeance that accessibility to child and family health services is problematic for parents (Rossiter, Fowler, Hesson*, et al.* 2018) (Hesson *et al.* 2017). Parents experience inflexible opening hours (Hesson *et al.* 2017), lengthy wait times, especially for breast feeding support, return phone calls and to scheduled appointments (Hesson *et al.* 2017) (Rossiter, Fowler, Hesson*, et al.* 2018), limited service in remote, rural or outer metropolitan areas (Hesson *et al.* 2017), variable service for parents with more than one child (Rossiter, Fowler, Hesson*, et al.* 2018), limited or perceived limited access for appointments in between PHR checks (Rossiter, Fowler, Hesson*, et al.* 2018) and minimal service for fathers (Rossiter, Fowler, Hesson*, et al.* 2018). If the child and family health service was not easy to access, parents find travelling on public transport with children difficult (Rossiter, Fowler, Hesson*, et al.* 2018) (Hesson *et al.* 2017). A national survey of child and family health nurses ,although biased in that 41% of respondents were from Victoria, agreed that parents had difficulty accessing services due to lack of resources, causing limited time for nurses to support families with more than one child (Schmied *et al.* 2014) and this was supported by parents experiencing rushed appointments and being discouraged from taking up subsequent follow up appointments (Corr, Rowe & Fisher 2015).

Culturally and linguistically diverse (CALD) families experience unique issues in accessing child health services. A qualitative study surveyed 37 primary health care providers working in a multiculturally disadvantaged area of Sydney (Garg *et al.* 2018). The health care providers perceived barriers for CALD families accessing the service for child developmental checks were as such: transport issues; inflexible clinic times; inflexible service options; lack of health service knowledge; parents' employment; family isolation; parents understanding of need for child developmental checks and PHR not used (Garg *et al.* 2018). Another qualitative study surveyed both child health workers and refugees, highlighted other access issues to the child health service as such: lengthy time to understand the health system; lack of awareness of the child and family health nurses' knowledge on child development; frustration of being unable to read English information in waiting rooms; lack of confidence to leave phone messages in English when seeking an appointment and preference to speak directly to a familiar nurse (Riggs *et al.* 2012). Lengthy weight for interpreters and unsuitable printed information were also identified issues of access for non-english speaking families (Hesson *et al.* 2017) (Woolfenden *et al.* 2015).

Maternal Characteristics

A quantitative study of Australian infants use of primary health care services showed that certain maternal characteristics supported the use of child health services such as: knowledge of the health system; health seeking behaviours; higher education; health literacy; employment; married; older mothers; private health insurance; higher income living in metropolitan areas and mothers who drank alcohol in pregnancy (Ou, Chen & Hillman 2010). The same study found that mothers who smoked in pregnancy, young mothers, mothers with limited English proficiency and families with three or more children were unlikely to attend child health services (Ou, Chen & Hillman 2010). Studies found lack of confidence (Kelaher *et al.* 2009; Riggs *et al.* 2012; Hesson *et al.* 2017), socioeconomic disadvantage (Ou, Chen & Hillman 2010; Hesson *et al.* 2017; Overs *et al.* 2017), mental health (Woolfenden *et al.* 2015; Hesson *et al.* 2017) ethnicity, social isolation, health seeking behaviours (Woolfenden *et al.* 2015), fear of judgement, especially by mothers experiencing drug and alcohol issues and domestic violence (Hesson *et al.* 2017), and return to work (Garg *et al.* 2018) as limiting factors to attendance to child health services.

Parent awareness and beliefs

Awareness

Both a national qualitative study of Anglo-Australian, English speaking and educated women (Hesson *et al.* 2017) and a qualitative study of CALD families (Garg *et al.* 2017) identified parents lacked awareness of child health services and PHR checks. Parents were unaware of the location of the service, how to access it, the role of the child and family health nurse and they found the health service system complex (Hesson *et al.* 2017). One study of CALD families in South Eastern Sydney found lack of understanding of child development (Woolfenden *et al.* 2015), whereas, another study of CALD families in South Western Sydney found parents had an awareness of the importance of child development and surveillance, however, they lacked awareness of the PHR check schedule, even though some parents received explanation of the schedule when they received the PHR in maternity (Garg *et al.* 2017). A further quantitative study of CALD families found 46% of parents reporting being told of the six month PHR check (Overs *et al.* 2017). Studies found that CALD families with limited supports were less likely to be aware and access child health services (Garg *et al.* 2017) and that family members can enable or act as a deterrent for child access to developmental surveillance (Woolfenden *et al.* 2015).

Beliefs

A qualitative study on CALD families highlighted community attitudes that may impact access to developmental surveillance (Woolfenden *et al.* 2015). Community attitudes such as lack of understanding of child development, shame and stigma attached to language such as 'language delay' or to having a child with a disability, denial, fear, guilt and fathers' overruling decisions are expressed in the study as limiting factors to child development surveillance and support (Woolfenden *et al.* 2015).

Discussion

The literature consistently identified many barriers to the utilisation of the child and family health services. The main barriers being: lack of continuity of care, conflicting advice, negative communication experiences, lack of awareness of PHR checks and role of child and family health nurse or health service, service accessibility difficulties and cultural beliefs. Certain maternal characteristics are predictors of non-attendance and the most disadvantaged families often do not attend. Understanding these barriers is the first step for child and family health nurses to overcome the limited use by parents of the universal child and family health services and to enhance understanding, further research on how to engage with CALD families and disadvantaged families would be beneficial. Following on from understanding, extensive review of health service delivery, trialling and researching a variety of service delivery options, and ensuring evidence-based practice by incorporating literature evidence, local parent and clinician evidence could potentially overcome the barriers.

Conclusion

To support the NSW Health policy directive, The First 2000 days framework, to give children the most optimum start to life by early identification of child development concerns and intervention provision (NSWHealth 2019), child and family health nurses have proposed a project plan to increase the number of PHR checks. However, evidence suggests that many children do not have their PHR checks done by the universal child and family health service.

The literature identified many barriers that prevent parents from attending to the PHR checks. The main barriers being continuity of care, conflicting advice, awareness of and accessibility to service and negative communication experiences. Disadvantaged groups have unique considerations when accessing the health service. Review of health service delivery to overcome the barriers are recommended.

References

Australian Early Development Census 2018, *Percentage of chlidren developmentally vulnerable in 2018*, viewed 03.08.2019, <https://www.aedc.gov.au/data/data-explorer?id=135240>.

Corr, L, Rowe, H & Fisher, J 2015, 'Mothers' perceptions of primary health-care providers: thematic analysis of responses to open-ended survey questions', *Australian journal of primary health*, vol. 21, no. 1, pp. 58-65.

Eapen, V, Woolfenden, S, Williams, K, Jalaludin, B, Dissanayake, C, Axelsson, EL, Murphy, E, Eastwood, J, Descallar, J & Beasley, D 2014, '" Are you available for the next 18 months?"-methods and aims of a longitudinal birth cohort study investigating a universal developmental surveillance program: the 'Watch Me Grow'study', *BMC pediatrics*, vol. 14, no. 1, p. 234.

Garg, P, Eastwood, J, Ha, MT, Eapen, V, Harvey, S, Woolfenden, S, Murphy, E, Jalaludin, B, Dissanayake, C, Williams, K, McKenzie, A, Einfeld, S, Silove, N & Short, K 2018, 'Health professional perceptions regarding screening tools for developmental surveillance for children in a multicultural part of Sydney, Australia', *BMC family practice*, vol. 19, no. 1.

Garg, P, My Trinh, H, Eastwood, J, Harvey, S, Woolfenden, S, Murphy, E, Dissanayake, C, Jalaludin, B, Williams, K, McKenzie, A, Einfeld, S, Silove, N, Short, K, Eapen, V & Ha, MT 2017, 'Explaining culturally and linguistically diverse (CALD) parents' access of healthcare services for developmental surveillance and anticipatory guidance: qualitative findings from the 'Watch Me Grow' study', *BMC Health Services Research*, vol. 17, pp. 1-12.

Hesson, A, Fowler, C, Rossiter, C & Schmied, V 2017, ''Lost and confused': parent representative groups' perspectives on child and family health services in Australia', *Australian journal of primary health*, vol. 23, no. 6, p. 560.

Kelaher, M, Dunt, D, Feldman, P, Nolan, A & Raban, B 2009, 'The effects of an area-based intervention on the uptake of maternal and child health assessments in Australia: A community trial', *BMC Health Services Research*, vol. 9, no. 1, p. 53.

NSWHealth 2019, *PD2019_008 The First 2000 Days Framework*, NSW Health, viewed 14.09.2019, <https://www1.health.nsw.gov.au/pds/ActivePDSDocuments/PD2019_008.pdf>.

Ou, L, Chen, J & Hillman, K 2010, 'Health services utilisation disparities between English speaking and non-English speaking background Australian infants', *BMC Public Health*, vol. 10, no. 1, p. 182.

Overs, B, Woolfenden, S, Williams, K, Jalaludin, B, Axelsson, E, Dissanayake, C, Descallar, J, Harvey, S, Beasley, D & Murphy, E 2017, 'Predictors of developmental surveillance completion at six months of age in south western Sydney', *Child: care, health and development*, vol. 43, no. 2, pp. 307-315.

Riggs, E, Davis, E, Gibbs, L, Block, K, Szwarc, J, Casey, S, Duell-Piening, P & Waters, E 2012, 'Accessing maternal and child health services in Melbourne, Australia: reflections from refugee families and service providers', *BMC Health Services Research*, vol. 12, no. 1, p. 117.

Rossiter, C, Fowler, C, Hesson, A, Kruske, S, Homer, CS, Kemp, L & Schmied, V 2018, 'Australian parents' experiences with universal child and family health services', *Collegian: Journal of the Royal College of Nursing, Australia*, vol. 26, no. 3, pp. 321-328.

Rossiter, C, Fowler, C, Homer, CSE, Hesson, A, Schmied, V & Kruske, S 2018, 'Australian parents' use of universal child and family health services: A consumer survey', *Health and Social Care in the Community*.

Schmied, V, Fowler, C, Rossiter, C, Homer, C, Kruske, S & The CHoRUS team 2014, 'Nature and frequency of services provided by child and family health nurses in Australia: results of a national survey', *Australian Health Review*, vol. 38, no. 2, pp. 177-185.

Schmied, V, Kruske, S, Barclay, L & Fowler, C 2011, 'National framework for universal child and family health services'.

Woolfenden, S, Posada, N, Krchnakova, R, Crawford, J, Gilbert, J, Jursik, B, Sarkozy, V, Perkins, D & Kemp, L 2015, 'Equitable access to developmental surveillance and early intervention–understanding the barriers for children from culturally and linguistically diverse (CALD) backgrounds', *Health Expectations*, vol. 18, no. 6, pp. 3286-3301.