Submission No 36

IMPROVING ACCESS TO EARLY CHILDHOOD HEALTH AND DEVELOPMENT CHECKS

Organisation: Centre of Research Excellence in Translating Early Prevention of Obesity in Childhood (EPOCH-Translate CRE)

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Translating Early Prevention of Obesity in Childhood

Submission to the NSW Legislative Assembly Committee on Community Services for Improving access to early childhood health and development checks

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About CRE EPOCH-Translate

We present the following on behalf of the NHMRC Centre of Research Excellence in Translating Early Prevention of Obesity in Childhood (EPOCH-Translate CRE). This is a research collaboration across Australia with NSW members from The University of Sydney, Sydney Local Health District and the National Health and Medical Research Council[2]. EPOCH-Translate CRE focuses upon policy- and practice-relevant evidence to support breastfeeding, healthy infant feeding and physical activity, with the aim of promoting healthy growth in early childhood and preventing obesity in early life.

Our submission addresses points 1 and 2 of the terms of reference.

1. Changes needed to address gaps in outcomes for vulnerable children, including those in culturally and linguistically diverse communities.

Recommendations to address changes needed to address gaps in outcomes for children in culturally and linguistically diverse communities

1. To make growth and development checks accessible, we emphasize **the accessibility to child and family health nurse services**, whose services extend beyond undertaking growth and health checks.

   This includes adequate consultation time to discuss complex issues that require further attention during consultations, in addition to standard health checks and advice. Migrant families from culturally and linguistically diverse backgrounds may be experiencing additional challenges, such as emotional, family and financial stress.

2. To support culturally and linguistically diverse communities, we emphasize **the importance of child and family health nurse staffing** and **availability of interpreters and cultural support workers,** in-person and via telephone, with gender suitable to the main carer.

   We also **emphasize the inclusion of partners and extended families in child and family health programs** to promote inclusive knowledge sharing.

3. To address gaps in outcomes of care for culturally and linguistically diverse communities, we support:

- **Increasing child and family health nurse staffing**, particularly of bi-cultural child and family health nurses, **cultural support workers, and interpreters**
- **Establishing or enhancing active outreach telephone support** from bi-cultural and bi-lingual health workers to establish contact, engage families, and support continuity of care
- **Establishing formal connections between NSW health services, bi-cultural doctors and cultural community organisations** to build trust and referrals between services and increasing access to child and family health services.
- **Developing in-language resources** with translators, cultural support workers and community members

EPOCH-Translate CRE's body of research has included work with the Population Health and Evaluation Hub in Sydney Local Health District. This group has developed and implemented the Healthy Beginnings program[3], an early intervention home visiting trial delivered by Sydney and Sydney South-West LHD staff to support healthy infant feeding and prevent childhood obesity. The Healthy Beginnings trial included eight home visits to support healthy feeding practice, nutrition, physical activity and parent-child interactions – these were delivered in addition to the universal health service where health and development checks are completed.

Our work is undertaken with child and family health nurses (CFHNs) in primary health care. CFHNs in NSW provide universal health services to infants and young children, 0-5 years age. This includes the "Blue Book" health, development and milestone checks, monitoring health and development, development screening, and home visiting. Home visiting supports increased accessibility to health services, including culturally and linguistically diverse families. Growth monitoring is one of these checks, which can help identify abnormal growth trajectories, including failure to thrive and rapid weight gain (a risk factor for obesity).

The Healthy Beginnings program has led to further translational research, including the cultural adaptations of Healthy Beginnings, a pilot feasibility study, to deliver Healthy Beginnings in-language for Arabic- and Mandarin-speaking families. This adaptation included sociocultural approaches, such as the centrality of family involvement in care; increased visual communication; and health aspects to breastfeeding and nutrition separate from childhood obesity[4]. It also included bi-cultural CFHNs delivering the program through four staged intervention phone calls; biweekly text messages supporting infant nutrition for four weeks; and culturally adapted information booklets developed by health professionals, bi-cultural workers, translators and community members.

Findings from the cultural adaptation of the Healthy Beginnings program addressed key points that support CALD communities, when gaps in outcomes can result from lack of culturally appropriate care and engagement with health services.

We highlight the need to:

1) Support cultural understanding through staffing and information resources

Mothers valued the involvement of bi-cultural CFHNs to communicate the Healthy Beginnings content and the in-language booklets for information that could be shared with family and friends, particularly for promoting healthful behaviours and new information.

> "When I gave my mother the booklets to read, she got convinced and said, 'this is your era and we are from a different era'. So now she understands why you feed the way you do." (Mother)

Both mothers and CFHNs felt increased engagement when services were provided in-language:

> "I find that [the nurse's] help is very good, because it is helpful to talk with someone, and for her to give me a call and spend quite good time with me. This conversation gave me some comfort." (Mother)

> "I think maybe because I'm speaking their language, it's the first […] people they want to talk to. So, I would actually, I know it's probably a luxury, but recommend to have a full-time nurse and be able to do these things full-time. That would be wonderful. That will be providing more service for them." (CFHN)

2) Increase availability of in-language staff and services

Factors that limited participation with the program included bi-cultural nurse availability of one day per week and call scheduling:

> "If there are more available times or opportunities that I can talk that will be much better, because I like to talk with [the nurse], and I think she only works on Thursdays."

Few mothers described attending their usual CFHN services at community health centres for demonstrations of parenting behaviours and growth measurements. Those who did not attend their usual CFHN services reported barriers, such as not knowing the location, uncertainty of CFHNs' language and difficulty with medical jargon:

> "With the [CFHN at the community health centre], although you speak English, can have simple English conversation, sometimes the medical terms are not easy, you also have to go through a lot of travelling time, and pre-book an appointment."[5, 6]

The findings from Healthy Beginnings complement the work of other research from Sydney LHD and South Eastern Sydney LHD with mothers with CALD and limited English proficiency backgrounds, and their experiences with CFHN services[7]. Mothers reported preference for home visiting and face-to-face CFHN services, supported by interpreter services. Lack of confidence to join English language group sessions or contact clinics to book services using English language was a barrier to engaging with CFHN services. We also highlight findings in a review of communication strategies for CALD communities[8], such as native language audio or video format resources; employment of bilingual or bicultural staff; and simple language readability written resources.

2. Barriers that affect parents' access to routine health and development checks that track their child's progress against developmental milestones.

Recommendations to address barriers that affect parents' access to routine health and development checks

4. To address barriers to health care access of routine health and development checks, we support **increasing child and family health nurse staffing.**

Increased staffing will increase parents' access to routine health checks, by:
- Enabling child and family health nurses to **provide further home visits or appointments**, for families with increased clinical need.
- Enabling child and family health nurses to **deliver more home visits**, particularly in local health districts, like South Western Sydney Local Health District, which cover rural and regional areas with increased travel distance
- **Extending accessibility to child and family health clinics** for consultations
- Increasing the ability of child and family health nurses across the local health districts to **provide care for a larger caseload.**

5. To support increased needs identified in health and development checks, we support **providing targeted programs to families,** similar to the Victorian Enhanced Maternal and Child Health Program[1]**.**

The Victorian Enhanced Maternal and Child Health Program is provided in addition to universal child and family health services. It addresses needs that cannot be met by the universal services alone, due to time constraints and complexity of families. A targeted program will support:
- Initial and ongoing health and development screening and assessment
- Delivering evidence-based interventions for family-specific needs
- Coordinating care with families with higher levels of risk
- Engaging and collaborating with other services.

Our body of research has included work with child and family health nurses (CFHNs) in SLHD and SWSLHD to support obesity prevention practices. Growth monitoring using growth charts and BMI charts, to identify rapid weight gain, are part of regular CFHN health checks.

Nurses were surveyed on the key barriers that affected the promotion of healthy weight gain in infants and young children. Over 60% agreed that lack of time was an important barrier, and 49% felt they did not have sufficient time to properly address healthy lifestyle behaviours with families of young children. In interviews, nurses expanded on the limited clinical time to work with families of young children.

1) Extend the duration of the CFHN consultation to address the range of child health check issues.

CFHN consultations varied in duration, ranging from thirty minutes in a clinic appointment to two hours in a home visit. However, for families with acute concerns—such as domestic violence—

and issues that required more intensive support—such as breastfeeding—other issues such as growth checks could fall by the wayside.

The CFHN home visiting caseload was related to this issue, particularly in SWSLHD. The SWSLHD area is extensive[9] – CFHNs reported long travel distances to provide home visits, which subsequently affected the number of families that could be supported on a daily basis.

> "So I do think it's obviously very important, I do think it's a priority, it's just whether you get the opportunity. […] Our clinic times can be a bit of a barrier. Sometimes with the older children, we only get half an hour to actually discuss quite a few issues. […] For example, it seems like they've got more behavioural issues, there's only a limited amount of time that can be spent talking about that.
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> […] Having longer consultation times [would help address this barrier]. They tend to give you longer time for the younger children, and as the children get older, they believe that you need a shorter (laughs) amount of time."

2) Increase the number of opportunities to receive a CFHN consultation.

Related to the above, families with more intensive support needs were only able to have one visit related to their baby or child's health and development checks (e.g. 1-4 weeks, 6-8 weeks, 6 months, 12 months, 18 months, per the Blue Book schedule). Nurse manager approval was needed to follow up on care; CFHNs were aware that lack of continuity impeded comprehensive care to support families.

> "Additional support might be helpful. I think in many cases for those of our parents that are experiencing issues in these areas—it would be helpful if we could do more than one visit. Sometimes we only have enough time allocated to address or bring the problem to the parents' attention without having, you know, immediate access to … [address] those, and bringing them back for ongoing support for the same nurse or continuity with the same nurse."
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> ("So more opportunities to have consultations with mothers?")
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> "Yeah, I think so, to have… more home visits as a result of clinical judgement, for families that are … struggling with either feeding or behaviour issues […] so we can make a bit more positive change. […] Generally speaking, those second and third visits are only reserved for vulnerable clients or children who are at risk of serious harm."

CFHNs also felt that the time between scheduled health and development checks impeded the ability to identify and prevent growth and development issues, i.e. the gap between the 6-8 week, 6 month, 12 month, 18 month, 2 year, 3 year and 4 year scheduled checks.

> "Again, that's the problem with older children, because we only see them once a year, they may have been okay at the two year check, and then they come back for the three year check and they've crossed two [weight] percentiles [indicative of increased risk of unhealthy weight gain]."

3) Extend clinic hours to improve accessibility to CFHN consultations.

CFHNs reported that child and family health clinics could be available Monday to Saturday, but half-day clinics limited the number of families who could be supported.

4) Increase CFHN staffing to meet community needs.

CFHNs reported insufficient staffing to meet community needs, related to increased birth rates and families with regular vs. increased support needs.

> "Our problem is there aren't enough nurses to see the people that want to see us. The changes that they make to our service are not really making us more accessible to the clients that want to see us. […] We always use evidence-based practice and now they're going to a program where, which is sustained home visiting [for families at risk of poorer maternal and child health and development outcomes], which is all very well, which limits our accessibility to regular families. So what I'm saying is—they're changing the service to use our time for less people [with increased need], than more people. And they're not actually creating the number of people that are working in the service. […] I'm not saying the change isn't needed, what I'm saying is that it's not going to improve access to just […] regular families with children."
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> "As our area's growing, I'm finding it's actually harder to get parents in, because the appointments aren't there."
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> "It's a bit of both [staffing and time available in consultations]. Staffing versus the amount of—the birth rate and the mounting level of vulnerability in our area."[10, 11]

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