Community Paediatric Review

A national publication for child and family health nurses and other professionals

The Royal Children's Hospital Melbourne

Centre for Community Child Health

Vol 20 No. 2 November 2012

Refugee families and the child and family health service

In 2010-11, Australia accepted 13,799 refugees. However, there has been little research into the experiences that families from refugee backgrounds have with Australia's child and family health services.

The child and family health service plays a vital role in linking refugee families to communities and services more broadly. Research into refugee families and their engagement with family and child health services is complicated by the following factors:

- much of the recent research does not differentiate between people of refugee background and non-refugee immigrants, and/or is a broader discussion of a range of vulnerable, deprived, disadvantaged and low-income groups
- refugees can be accepted into Australia under many different visa categories, complicating the ability to identify who is a refugee
- furthermore, due to real and perceived stigma and discrimination, simply asking the name of a client's visa is not a way around the visa complexities as people may not want to identify as being of refugee background.

There is a great need to better understand the experiences and needs of disadvantaged families, and in particular the factors that facilitate or hinder decisions to access child and family health services.

While there has been limited study into how well refugee families take up child and family health services, one Victorian evaluation by KPMG showed a dramatic drop off over time among vulnerable families, when compared to Australian-born mothers. KPMG's evaluation found that approximately 80 per cent of CALD mothers received the first home visit, which dropped to approximately 35 per cent at the 3.5 year visit. For Australian-born mothers (not including the Indigenous population) the rates were 95 per cent and 65 per cent respectively (KPMG, 2006).

Two recent studies have looked at refugee families' interactions with child protection services (Lewig et al, 2009) and child health services (Riggs et al, 2012). Both studies highlighted practice areas that are of particular concern to professionals working with refugee families:

- facilitating access to services
- maintaining engagement with services
- the challenges inherent in culturally competent practice, including the particular challenges of using interpreters.

Both studies offer insight into the experiences of families from refugee backgrounds, and the findings can assist child and family health nurses to establish and maintain relationships with families from refugee backgrounds.

Visa categories

Refugees are resettled in Australia under the Refugee and Humanitarian Program. Refugee and Humanitarian Program visas are offered to offshore applicants before they arrive in Australia. In 2010-11, Australia granted 8,971 people offshore visas, from nearly 55,000 applications (DIAC, 2011). More than 40 per cent of those were for children between the ages of 0-17 (DIAC, 2011).

'Asylum seeker' is the term used to describe people who arrive in Australia without a visa or with a short-term visa who then seek to stay. In 2010-11, 4,828 people were assessed to be asylum seekers and granted onshore visas (DIAC, 2011).

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It is important to note that from these two broad categories there are a number of subcategories of visa. The categories and subcategories that are available can change. For example, Australia used to offer a Temporary Protection Visa or TPV that was discontinued in 2008.

Some of the common visa categories for refugees in Australia are:

- Refugee visa, which includes the sub-categories of In-country Special Humanitarian, Emergency Rescue, and Woman at Risk
- Special Humanitarian Program (SHP)
- Permanent Protection Visa (PPV).

(Lewig, Arney & Salveron, 2009)

Further, there are also people with a 'refugee-like background' who settle in Australia under the Family Reunion program. Often the person's background – such as country of birth, country of origin and year of birth – can be a clearer indicator for practitioners of a need to consider the challenges common to clients with refugee-like background.

Challenges for families from refugee backgrounds

The health and psychosocial needs of refugee families are extremely complex. Many families of refugee background are faced with challenges that stem from pre-arrival experiences that can include:

- experiences of torture and trauma
- changes in family roles
- separation of family members
- poor access to primary healthcare
- missing/lack of traditional support networks
- settlement difficulties
- unemployment
- financial instability.

An additional challenge is the particular health needs of refugee children. Children who are under 11 when they come to Australia as refugees receive minimal health screening and are not subject to any pre-departure immunisation requirements. Health services in Australia have reported that they're seeing a number of conditions in refugee children that are not commonly seen in the Australian-born population, including:

- incomplete immunisation
- latent tuberculosis
- parasitic infestations
- rickets
- iron deficiency.

(Davidson et al, 2004)

These factors make it very important to ensure that refugee families are able to find out about the services available to them, and are able to engage and sustain engagement with them.

However, connecting with the child and family health service in Australia can be complicated. Riggs et al (2012) found:

- There are limited opportunities for utilising services, and significant barriers that affect continued engagement with services for all families.
- Understanding the complexities of a new healthcare system, and the unfamiliar concepts of preventive health and early intervention, can be extremely challenging.
- Establishing a relationship with a nurse/service can be challenging.
- The factors above are all exacerbated by the lack of English and the difficult circumstances common in resettlement, including the need to manage the urgent priorities of housing, employment, schooling for children and so on.

Barriers to access

One of the key barriers to access and to services working to provide access is the lack of capacity to identify people of refugee backgrounds in child and family health services records.

"Cultural differences, language difficulties, lack of awareness of available services, and lack of health-provider understanding of the complex health concerns of refugees can all contribute to inhibited access to healthcare."

(Riggs et al, 2012)

Riggs et al's study (2012) found that:

- Refugee families who have children born in Melbourne have reasonable initial access to family and child health services due to the formal birth notification sent from all hospitals to the local Maternal and Child Health Services.
- There is a clear gap in settlement services to link parents who arrive in Australia with young children.
- In Victoria at least, there is no strategic, coordinated or formal mechanism for on-arrival settlement services to identify families with young children and link them systematically with their local MCH service.

It is critical that nurses can identify whether clients are of refugee background in order to tailor their services appropriately. However, as outlined earlier, the visa system is complex and simply asking families what visa they are on is often not a straightforward identifying factor. There is the additional consideration that people may not identify as refugees. Establishing and routinely collecting client records that include country of birth and year of arrival could allow refugee-background clients to be identified and their ongoing retention in the family and child health services to be monitored.

Maintaining engagement with services

There is a range of challenges and barriers that affect access to and continued engagement with the child and family health service for families of refugee backgrounds. Common barriers stem from socioeconomic disadvantage (such as not having access to private transport), challenges stemming from pre-arrival experiences, and differences in language and culture.

There is a need for managers and practitioners to take a flexible approach to service delivery. Consideration of access issues need to inform the planning around opening hours, availability of appointments and the provision of outreach, home visiting and clinic-based services.

Where there is capacity, services that can offer home visits or visits to venues where refugee families gather can support ongoing and long-term retention of families. By engaging with families in a sensitive and culturally competent manner, nurses can avoid exacerbating any feeling of vulnerability among refugee mothers and develop the foundation for a sustained relationship.

A report from the Australian Centre for Child Protection (2009) identified a range of factors that services should consider when working to improve access and engagement for refugee and other vulnerable populations:

- In your practice, demonstrate personal characteristics including respect, humour and adaptability.
- In your practice, demonstrate professional characteristics including the ability to build trusting relationships with families and improve the social supports, negotiation and participation skills of families.
- Gather accurate information about the cultural and religious backgrounds of families.
- Be aware of the pre-migration and post-migration experiences of refugee families.
- Understand that concepts of 'mental health' and 'counselling' may be unfamiliar to refugee families.
- Where necessary, engage community and religious leaders as supports when working with families.
- Use appropriate interpreters and cultural consultants.
- Collaborate with services designed specifically for families of migrant and refugee backgrounds.
- In your service, provide organisational support that allows practitioners to be culturally competent in their practice including: communication with refugee families and communities; and staff training and resources (including time to become familiar with the backgrounds of clients).
- Ensure support is available for parents in the form of:
  - parenting information for newly arrived families
  - preventative, educational and early intervention programs
  - culturally responsive childcare
  - access to social gathering places.

(Lewig, Arney & Salveron, 2009)

Culturally competent practice and appropriate use of interpreters

One of the key challenges identified in both the Riggs et al and the Australian Centre for Child Protection reports was the appropriate use of interpreters as part of culturally competent practice.

Looking specifically at family and child health services, Riggs et al (2012) found:

- For those who could understand spoken English, most were not confident speaking English – especially to strangers – over the phone or leaving voicemail messages.
- Most parents reported wanting to learn and practise English, but many were not able to due to full-time child rearing roles.
- There is a need for alternative ways to make appointments for mothers who are not confident using the phone or leaving voicemail.
- Bilingual community workers or interpreters could assist by phoning parents to book them in for appointments and helping with either community transport or organising other options to get to appointments.
- Group visits should also be encouraged; however, mothers need to feel comfortable to raise issues with nurses, facilitated by an interpreter or bilingual community worker where they exist, and/or by providing mothers with the opportunity to meet privately with the nurse during the group visit.
- Co-locating the family and child health service and other social and health services with flexible English language classes may be a useful means of supporting access and promoting positive settlement for families of refugee backgrounds.

The challenges inherent in using interpreters as part of your practice are covered extensively in the Australian Centre for Child Protection report (2009). Best practice literature identifies working well with interpreters and choosing appropriate interpreters as crucial elements when working with refugee families.

Their report cites the following guidelines for practitioners when working with interpreters:

- Always use a trained interpreter. It is not appropriate to use partners or the client's children to interpret.
- Use an interstate telephone interpreter if the client is concerned about confidentiality within his/her community group.
- Use short sentences and focus on one point at a time. Talk directly to the client, not the interpreter.

(Women's Health Policy and Projects Unit, 2007).

Working successfully with refugee families

Different models have shown promise in improving access to family and child health service:

- use of bilingual workers/refugee mentors
- playgroups to build service awareness and engagement and social support
- strategies to promote self efficacy, group appointments and co-location of services.

A program that involved mentors was shown to work well for promoting family and child health services with Burmese Karen families in Melbourne, but more research is needed to assess whether this is likely to enhance or hinder mothers' capacity to access services independently when they become more settled. Similarly, this model may provide fewer opportunities for mothers to discuss their individual concerns, compared with the individualised service provided to English-speaking parents. There are similar concerns where an interpreter is not used.

Correa-Velez's research (2011) advocates for continuity of care, quality of interpreter services, educational strategies for both women and healthcare professionals, and the provision of psychosocial support to women from refugee backgrounds.

Riggs et al (2012) found that "learnings from our research suggest that there may not be one 'model' of best practice for promoting maternal and child health for refugee background families". However, the research suggested a suite of flexible and adaptable strategies to reflect clients' cultures, languages, existing social groups and resources. Their research looked at child and family health services in Melbourne, but has suggestions that can apply nationally:

- Offering a drop-in service with interpreter services available at allocated days/times could provide an opportunity for other healthcare providers to meet clients and introduce themselves and their service, as well as an opportunity to conduct community health promotion sessions.
- Reorienting existing services to allow nurse visits to venues where parents are already meeting, such as playgroups and English-language centres, could be an opportunity to promote MCH services and provide a first contact point. Positive encounters at these venues could then lead to parents wanting to make individual appointments with a familiar nurse.
- Introducing a central telephone booking service with the aim of improving access, does not appear to meet the expectations and needs of clients.
- Formal processes are needed between settlement programs and MCH services to link families arriving with children.
- The provision of refugee-focused training for service providers and a strategically coordinated approach is likely to facilitate access, build rapport and ongoing engagement and retention with the service.
- Innovative culturally competent strategies to organise individual MCH service appointments should be trialled and evaluated to develop a MCH system that promotes refugee maternal and child health.

Ensuring that child and family health services are accessible and engaging for refugee families means that a population group with particularly acute needs is given the opportunity to make the most of these universally available services.

Reflection questions

What do you see as the main barriers for families from refugee backgrounds accessing and continuing to use your child and family health services?

How does your service identify families of refugee backgrounds? What data does your service collect?

Considering the findings of the Riggs report, how does your service endeavour to address access issues? Does your service offer 'open' or 'drop-in' sessions?

How do you ensure that your practice when working with interpreters meets the needs of the family?

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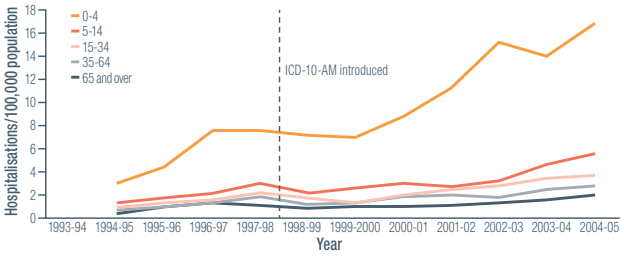
Food allergies: reducing the risk

In Australia and around the developed world, allergy rates are increasing and community concern about allergy is high; a recent study found that more than 10 per cent of Australian children had a severe food allergy and around a third of families reported that someone in their household had a food allergy (Koplin et al, 2012).

As the graph below shows, the rise in hospitalisations due to anaphylaxis is common across all age groups, but particularly marked for children under five. The rise appears to run parallel with improving economic conditions across the developed world, indicating that along with the benefits of improved economies and living conditions, there may be also be downsides (Tang & Allen, 2012).



Hospital admissions for anaphylaxis caused by food by broad age group, Australia, 1994-1995 to 2004-2005 (Poulos et al, 2007).

Concern about food allergy and intolerance affecting children is common in families where there is a family history of allergy and intolerance. However, with rates rising so dramatically, concern is increasingly widespread, even in families with no history of food allergy. There are steps that families can take to reduce the risk of food allergy and intolerance in their children, particularly during pregnancy or when the family is ready to start introducing solids.

Recognising food allergies

There are two main types of food allergy: immediate and delayed.

Immediate food allergies usually cause recognisable symptoms like hives or swelling very quickly after the child eats the food. Immediate allergic reactions can vary from mild through to more severe reactions such as anaphylaxis. Delayed food allergies are primarily indicated by symptoms in the gut, hours after the food has been eaten. Delayed food allergies can be subtle, making them difficult to recognise; they are also thought to be increasing in prevalence (Tang & Allen, 2012).

There are eight foods that cause more than 90 per cent of food allergies. They are:

- eggs
- milk
- peanuts
- soy
- wheat
- tree nuts
- fish and shellfish – although these are more commonly developed in adulthood.

(Tang & Allen, 2012)

Food allergy and food intolerance

An allergic reaction always involves an immune response. An intolerance to food is any reaction to food that is not an allergic reaction, eg a reaction that does not provoke an immune response. Food intolerance can include everything from an episode of food poisoning through to an ongoing difficulty with digesting a particular type of food, such as lactose intolerance (Tang & Allen, 2012).

Along with a rise in rates of food allergy, there has also been a rise in rates of food intolerance. At the same time, avoiding certain food groups or types of food has become more popular in recent years for a range of reasons. For some people, the term 'allergy' has become a synonym for 'intolerance' and even for simply 'choosing to avoid'.

It's important to make the distinction between allergy and intolerance. While an intolerance can cause great discomfort, the severe allergic reactions associated with food allergy can endanger lives.

What can families do to reduce the risk of food allergy?

There is not yet any known way to stop food allergies developing or eliminate the risk. However, based on the best and latest data, there are steps that allergists at The Royal Children's Hospital in Melbourne recommend as safe and easy ways to reduce risk.

Breastfeeding

Tang and Allen (2012) advise breastfeeding babies for at least the first six months of life. This is recommended not only for the many known benefits of breastfeeding for mothers and children, but because it may help to prevent food allergy. It is important to introduce solid food alongside breastfeeding.

Start solids at around six months

There is a range of recommendations for the optimum time to introduce solids into babies' diets. Based on the available evidence, Tang & Allen (2012) recommend starting solid foods at around six months. Tang & Allen's recommendation is based on research that indicates that the period around six months may offer an ideal window in which to introduce complementary foods, including foods that are considered to be allergy risks.

Get a bit grotty

There is some evidence that we are too clean in the modern era. Evidence is still forming, but Tang & Allen (2012) suggest that letting children be exposed to 'good bugs' could be protective against food allergy. They expand on this by encouraging parents to let children play in the dirt and get dirty, and suggest avoiding using anti-bacterial cleaners on kitchen surfaces.

Get some sunlight

Recent developments in research into the cause of allergic reactions have suggested that low vitamin D levels are connected to an increased risk of food allergy (Koplin et al, 2012).

Mothers who had low vitamin D levels in pregnancy are likely to give birth to children with low vitamin D. There are some foods that are reasonable sources of vitamin D – including oily fish, eggs and dairy products that have been supplemented – but the best way to get vitamin D is to expose our skin to the sun to encourage vitamin D production.

There are no guidelines for sun exposure that apply to children, but for fair-skinned adults, the recommendation is six to eight minutes exposure, around four to six times a week. Dark-skinned people will require more time, around 15 minutes. About 15 per cent of the skin's surface needs to be exposed for this amount of time – that equates to hands, face and arms. These guidelines are suggested for time in the sun before 10am and after 2pm in the summer months. Exposure between 10am and 2pm in summer – without any protection such as sunscreen – sees the rise in melanoma risk outweigh the vitamin D benefits (Osteoporosis Society of Australia, 2011). Families who are concerned about vitamin D deficiency should see their doctor for a blood test.

The sun's strength varies dramatically across the country depending on season, climate and latitude. The Cancer Council provides more specific advice for each state and territory: www.cancer.org.au. Sun Smart also provides daily advice for different locations www.sunsmart.com.au/vitamin-d/tracker-tool

Food allergies: common misconceptions

With the rise in the occurrence of serious food allergy incidents, health professionals are also likely to see evidence of rising concern about food allergy. This can be accompanied by misconceptions about what mothers and families should and could do to protect their children from food allergy. Addressing these misconceptions is an important part of child and family health nursing practice.

It's not useful or effective for mothers to avoid allergenic foods in their diet to try and prevent their child developing an allergy. Having an opportunity to be exposed to a wide range of foods in utero and/or while being breastfed is essential for babies to learn to develop an appropriate immune response to foods (Tang & Allen, 2012).

There are many misconceptions about food allergy and its causes, including people who believe that food allergy isn't real and is simply a product of children's hysteria or parents' overprotectiveness. If parents are concerned that their child has a food allergy, it is important to refer them to a nutritionist, allergist or to their GP for further investigation.

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About the Centre for Community Child Health
The Royal Children's Hospital Centre for Community Child Health (CCCH) has been at the forefront of Australian research into early childhood development and behaviour since 1994. The CCCH conducts research into the many conditions and common problems faced by children that are either preventable or can be improved if recognised and managed early.

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

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