

Child and Youth Health Practice Manual



Acknowledgements

Child health nurses have been providing primary health care services to families in Queensland since 1918. In 2014, families access services through a range of child and youth health primary care providers. This statewide manual is the result of input and effort from many of these health professionals sharing their passion for excellence in primary health care for families in Queensland. Their assistance with the content for this manual is greatly appreciated.

We acknowledge the Traditional Custodians of the land on which we walk, work and live.

We pay respects to Elders past, present and future.

We pay respects to the cultural authority held and shared by colleagues across Queensland.



© State of Queensland (Children's Health Queensland Hospital and Health Service) 2014

Licence

This annual report is licensed by the State of Queensland (Children's Health Queensland Hospital and Health Service) under a Creative Commons Attribution-NonCommercial-ShareAlike (CC BY-NC-SA) 3.0 Australia licence.

CC BY Licence Summary Statement

In essence, you are free to copy, communicate and adapt this manual for non-commercial purposes, as long as you attribute the work to the State of Queensland (Children's Health Queensland). If you remix, transform, or build upon the material, you must distribute your contributions under the same license as the original. To view a copy of this licence, visit <http://creativecommons.org/licenses/by-nc-sa/3.0/au/>

Suggested referencing

Content from this manual should be attributed as: Child and Youth Health Practice Manual, Statewide Child and Youth Clinical Network – Child Health Sub-Network. Children's Health Queensland Hospital and Health Service, 2014.

Manual history and review plan

The *Child and Youth Health Nurses Practice Manual* was developed in 2006-2007. The manual was preceded by previous versions, including the *Child Health Nurses Clinical Practice Manual*, developed by QE II Hospital Health Service District, Bayside District Health Service, and Logan/Beaudesert District Health Service in 1997.

The development of the accredited Certificate IV in Aboriginal and/or Torres Strait Islander Child and Youth Health course ran concurrent with the manual development in 2006-2007 which, for the first time, included components related to Aboriginal and Torres Strait Islander Child and/or Youth Health Workers practice.

This 2014 version of the manual now covers practice in the broad area of child and youth health related to:

- Child and/or youth health nurses
- Aboriginal and Torres Strait Islander Child and/or youth health workers and practitioners
- Child health psychologists/social workers, also known as early intervention clinicians / early intervention parenting specialists

The redrafting of the manual in 2014 has been supported by the Statewide Child and Youth Clinical Network – Child Health Sub-Network and has been proudly sponsored by Children's Health Queensland Hospital and Health Service.

The review of the *Child and Youth Health Practice Manual* has incorporated the latest evidence relating to contemporary practice issues and in line with The National Framework for Universal Child and Family Health Services. Consultation with child and youth health professionals across Queensland was undertaken during the review and key stakeholder input integrated into the manual where appropriate. A comprehensive literature review on each topic within the manual was not possible. The review of literature was focused on the years 2010 - 2014 and inclusive of evidence based clinical practice guidelines, government documents, professional frameworks and professional College Statements.

The following databases were also searched:

The Cochrane Collaboration
Clinicians Knowledge Network using the KKN Discovery Interface which searches: DynaMed, Medline, CINAHL, Academic OneFile, Informit Health Collection, and Expanded Academic – Initial Indexed Search.

Redraft completion date: 31 October 2014

Recommended review: 2019

Photography:

Page 61.

© Can Stock Photo Inc. www.canstockphoto.com

contents

Acronyms and abbreviations	x
How to use this manual	xi

Introduction

Audience	1
About these roles	1
Key principles underpinning the child/youth health practice framework	3

Section 1: Antenatal

Developmental surveillance and health monitoring

The healthcare context	7
The pregnancy health record	8
Antenatal assessment	8
Physical assessment	8
Social and emotional wellbeing	9
Edinburgh post natal depression scale.....	9
Domestic and family violence	10
Substance use/misuse in pregnancy	11
Recognition of child abuse and neglect	11

Health promotion

Engaging families	12
Quality information and education	13
Maternal nutrition, oral health, physical activity	13
Infant nutrition	15
Injury prevention/safety promotion/safe sleeping	17
Immunisation	17

Early identification

Vulnerability factors	18
Aboriginal and Torres Strait Islanders	18
Families from culturally and linguistically diverse backgrounds.....	19
Young parents	19
Parents with a learning difficulty	20

Responding to need

Access to higher level services.....	21
Multidisciplinary early intervention.....	21
Home visiting	21
Child protection	22

Section 2: Birth to five years

Developmental surveillance and health monitoring

The healthcare context	25
Engaging families.....	25
The personal health record and child health information booklet.....	26

0 TO 12 MONTHS

Well child health checks	27
Other health checks	27

Family health assessment

Practice tips: Conducting a family health assessment.....	29
Table: Examples of positive and problem indicators relating to parent-child interaction.....	30
Practice tips: Conducting and scoring the EPDS.....	32
Practice tips: Conducting the domestic violence screen	34

Infant health assessment

Universal newborn hearing screen	35
Neonatal screening test.....	36
Physical assessment	36
Practice tips: Conducting a ‘head-to-toe’ assessment	37
Plagiocephaly	37
Assessment of vision and eye function.....	39
Assessment of hearing and ear health (0-12 months)	40
Table: Hearing and ear health screening recommendations	40

Growth monitoring

Growth charts	42
Allowance for gestational age	43
Weight	43
Length/Height.....	43
Head circumference	44
Practice tips : Weighing and measuring an infant.....	45

Developmental assessment

Validated screening tools	47
Communication and interaction.....	48
Table: Age appropriate interaction, speech and language skills (birth to one year)	49
Practice tips: Conducting a developmental assessment	51

Assessing infant nutrition

Stages of feeding development.....	52
Development of oral feeding skills	52
Nutritive/non-nutritive sucking	52
Table: Feeding development (birth to one year)	53

Assessment of breastfeeding

Initiation and establishment of lactation.....	59
Nipple care and management.....	60
Practice tips:Promoting optimal positioning of the infant at the breast.....	61
Expressing breast milk.....	62
Storing breast milk.....	62
Management of milk supply.....	63
Breast compression.....	63
Practice tips: Supporting a mother with breast compression.....	64
Management of inadequate milk supply.....	65
Supplementary feeds.....	66
Practice tips: Supporting a mother to use a nursing supplementer.....	67
Oversupply.....	68
Mastitis.....	68
Drugs and breastfeeding.....	69
Multiple births.....	69
Feeding through pregnancy and tandem feeding.....	70
Tongue tie.....	70
Weaning.....	71

Safe use of infant formula

Practice tips: Supporting a mother to formula feed her infant.....	72
Infant formula requirements.....	72
Choosing infant formula.....	72
Making the formula.....	72
How to bottle feed.....	73

Introduction of solid foods

How and when.....	74
Foods to avoid.....	74

Health concerns

Colic.....	75
Gastro oesophageal reflux.....	76
Gastro oesophageal reflux disease.....	76

ONE TO FIVE YEARS

Well child health checks.....	78
Other health checks.....	79
Engaging families.....	79
Family health assessment and monitoring.....	80

Child health assessment

Physical assessment.....	81
Table: Physical assessment specifics (one to five years).....	82
Practice tips: Completing a vision screening.....	83

Practice tips: Completing a hearing and ear health screen	85
Table: Hearing and ear health screening recommendations (one to five years).....	85
Otoscopy	86
Tympanometry	87
Audiometry	88

Growth monitoring

Growth charts	90
Allowance for gestational age	90
Weight	91
Length/height.....	91
Head circumference	91
BMI.....	91

Developmental assessment

Physical development	92
Table: Typical developmental patterns (one to five years)	93
Cognitive development	93
Table: Common behaviours (one to five years).....	94
Socio-emotional development, language and literacy.....	94
Table: Communication difficulties (one to five years)	95
Screening tools	96

Assessment of nutrition

Breastfeeding	97
Feeding through pregnancy and tandem feeding	97
Weaning	97

Health promotion

The personal health record and child health information booklet.....	99
Engaging families.....	99
Group parenting sessions.....	100
Practice tips: Facilitating a group parenting session	100

0 TO 12 MONTHS

Needs of the infant

Promotion of optimal infant nutrition	101
Breastfeeding.....	101
Baby friendly health initiative seven point plan for community health centres	101
Marketing in Australia of Infant Formula Agreement.....	102
Returning to work and breastfeeding.....	103
Formula feeding	103
Supplementation: fluoride.....	103
Introducing a feeding cup	103
Introducing solids	104

Cues of interest or disinterest	104
Foods to avoid or offer with caution.....	104
Infants with a family history of allergy	105
Vegetarian or vegan diets.....	105
Growth.....	105
Cognitive development.....	106
Parent-infant interaction.....	107

Normal infant behaviour (birth to one year)

Patterns of sleep.....	109
Table: Sleep-wake behavioural states	110
Table: Guide to sleep patterns (birth to one year)	101
Activities to support development.....	110
Sleep	111
Crying	112
Physical activity/play.....	113
Emotional wellbeing.....	114
Speech, hearing and vision.....	115
Oral health.....	116

ONE TO FIVE YEARS

Needs of the child

Promotion of optimal nutrition.....	117
Table: Cues of interest/disinterest	117
Breastfeeding.....	118
Returning to work and breastfeeding	119
Extended breastfeeding.....	119
Growth.....	119
Cognitive Development	120
Parent-child interaction	120

Normal child behaviour and activities to support development

Sleep.....	121
Physical activity, exercise and play.....	122
Toilet training.....	123
Mealtimes.....	124
Oral health.....	125
Speech, hearing and vision	126
Emotional wellbeing.....	127

Immunisation

Vaccine management	129
--------------------------	-----

Safety, illness and injury prevention

Table: The six 'E's	130
Falls.....	131

Drowning/near drowning	131
Motor vehicle accidents (including driveway accidents).....	132
Choking/asphyxiation/poisoning	133
Burns.....	134
SIDS	135
Assault/witnessing violence	136
Illness prevention	137
Early identification	
The healthcare context	137
Vulnerability factors	138
Aboriginal and Torres Strait Islander families.....	139
Cultural needs.....	139
Mortality and morbidity	140
Ear health, literacy and learning	142
Family wellbeing	144
Children from culturally and linguistically diverse or refugee backgrounds	145
Low family income/unstable housing/low parental education level	147
Family structure: young, single, same sex attracted, re-partnering parents, step and blended families.....	148
Children living in non-parental or out of home care environments	149
Children of parents with disability/physical illness.....	150
Isolated families.....	152
Smoking, alcohol, substance misuse	153
Family violence/past abuse/parent abused as a child	154
Parental mental health and wellbeing	155
Responding to need	
The healthcare context	157
Home visiting	158
Case management	158
Ellen Barron Family Centre	158
Brief practice intervention	159
Premature infant	159
Cow's milk protein allergy	161
Weight faltering/malnutrition	163
Obesity in childhood	164
Sleep dysrhythmia	166
Post natal depression	167
Disruptive behaviour/aggression/regulatory disorders	169
Parental grief and loss	170
Protecting children	
Shaken baby syndrome	173
Fractitious disorder imposed on another	173
Table: Sample framework of protective and risk factors.....	174
Dealing with requests for information from Queensland Police Service.....	175

Safety plans.....	175
Practice tips: Developing a safety plan.....	176

Section 3: Five to twelve years

Developmental surveillance and health monitoring

The healthcare context.....	179
Practice tips: Working within school settings.....	180
Well child health checks.....	181
Child health assessment.....	181
Physical assessment.....	181
Practice tips: Visual acuity screening.....	182
Practice tips: Ears and hearing screen.....	184
Developmental assessment.....	185
Cognitive development.....	185
Moral development.....	185
Spiritual development.....	185
Social development.....	185
Developing a self-concept.....	186
Screening tools.....	186
Common health concerns.....	186
Speech and communication concerns.....	187
Bedwetting and daytime wetting.....	188
Soiling and constipation.....	190
Pediculus Capitis (head lice).....	191

Health promotion

Engaging families.....	194
Quality information and education.....	194
Nutrition and health eating patterns.....	195
Physical activity.....	197
Oral health.....	198
Emotional wellbeing.....	199
Immunisation.....	200
Illness prevention.....	201
Sun safety and skin cancer prevention.....	202
Injury prevention.....	203

Early identification

The healthcare context.....	204
Social determinants of health and wellbeing (priority groups).....	204
Practice tips: Working with a school aged child from a family at risk to provide additional support.....	206
Aboriginal and Torres Strait Islander children and families.....	206
Cultural needs.....	207
Common health concerns.....	208

Family wellbeing	210
Children from culturally and linguistically diverse families	211
Female genital mutilation	211

Responding to need

The healthcare context	213
Case management	214
Brief practice intervention	215
Weight faltering/malnutrition	215
Obesity in childhood	217
Bullying/cyberbullying/cybersafety	219
Disruptive behaviour/aggression/regulatory disorders	220

Protecting children

Table: Factors that may increase risk	222
Factitious disorder imposed on another	222
Dealing with requests for information from the police	224

Section 4: Twelve to eighteen years

Health and developmental surveillance

Social determinants of health and wellbeing	227
Service access barriers	228
The healthcare context: school-based	229
School-based youth health nurse service provision	229
Specific exclusions to the SBYHN role	229
Rapport building with young people in the school setting	230
Establishing consent	230
Explaining confidentiality	230
Other factors which influence rapport building	231
Rapport building with adolescent boys	231
Culturally competent care	232
Engaging Aboriginal and Torres Strait Islander young people	232
Youth health assessment	233
HEEADDSSS assessment	233
Risk and protective factors	234
Recognition of child abuse and neglect	235

Health promotion

Health promoting schools approach	236
Capacity building	237
School health audit	237
Health promotion strategies	238
Curriculum, teaching and learning	238
School organisation, ethos and environment	238
Partnerships and services	239
Health promotion strategies and resources	239

Evaluation of health promotion activities	240
Key adolescent health issues and suitable health promotion strategies and resources	241
Nutrition and physical activity/obesity prevention	241
Mental health and wellbeing: Body image and disordered eating	242
Mental health and wellbeing: Anxiety, depression, intentional non-suicidal self-harm and suicide ideation	244
Bullying/cyberbullying/cybersafety	246
Sexuality and health relationships	248
Substance use	250
Sun safety and skin cancer prevention.....	252
Asthma.....	254
Oral health	255
Injury prevention	257
Immunisation	259
Early identification	
Strategies to identify need and risk.....	260
Vulnerable groups	261
Pregnant and parenting students	261
Refugee students	261
Aboriginal and Torres Strait Islander young people’s health	262
Young people in out-of-home care.....	263
Responding to need	
Care planning.....	264
Facilitating a family-centred approach to care planning	264
Care coordination for clients with complex care needs.....	265
Small group programs to address identified need.....	266
Other service initiatives to respond to identified need in the school community.....	266
Distribution of condoms within the school setting	267
Pregnancy testing within the school setting.....	267
Dealing with requests for information from police	268
Appendix	
Appendix 1: Australian Family Strengths Nursing Assessment Guide	269
Appendix 2: Building Healthy Brains: The 11 Key Messages	270
Appendix 3: Family Health Assessment form	271
Appendix 4: DVI Assessment form	275
Appendix 5: Edinburgh Postnatal Depression Scale	276
Appendix 6: Edinburgh Postnatal Depression Scale scoresheet.....	278
Appendix 7: Developmental Profile Two Month Assessment form	279
Appendix 8: Sample referral pathway.....	281
Appendix 9: Sample business plan (SBYHN Program)	283
Appendix 10: Sample Local Consultative Team Meeting Report (SBYHN Program)	287
Appendix 11: Adolescent Health Record History form	289
Appendix 12: HEEADSSS Assessment form	290
Appendix 13: Adolescent Mental Health Assessment form	292
Appendix 14: Sample case review form	294

Acronyms and abbreviations

ABA	Australian Breastfeeding Association
ACIR	Australian Childhood Immunisation Register
ADHD	Attention deficit hyperactivity disorder
ALCA	Australian Lactation Consultant Association
AHPRA	Australian Health Practitioner Registration Agency
ASQ	Ages and stages questionnaire
BFHI	Baby Friendly Health Initiative
BMI	Body mass index
CALD	Culturally and linguistically diverse
CDC	Centre for disease control
CCM	The Chronic Conditions Manual
CINAHL	Cumulative Index to Nursing and the Allied Health Literature
CKN	Clinician's Knowledge Network
CPA	Child protection advisor
CPLO	Child protection liaison officer
DASS	Depression, Anxiety and Stress Scale
dB	Decibels
DETE	Department of Education, Training and Employment
dTpa	Diphtheria, tetanus and acellular pertussis vaccine
DV	Domestic violence
EIC	Early intervention clinician
EIPS	Early intervention parenting specialist
EPDS	Edinburgh (Postnatal) Depression Scale
FGM	Female genital mutilation
FASD	Foetal alcohol spectrum disorder
GORD	Gastro-oesophageal reflux disease
GP	General practitioner
HEADSS	A framework for psychosocial health assessment. Each letter represents a theme: H ome; E ducation/ E mployment/ E ating and E xercise; A ctivities and peer relationships; D rug use/ C igarettes/ A lcohol; S ex/ S exuality; S uicide/ D epression/ m ood; S afety; S pirituality
HPSF	Health Promoting Schools Framework
HPV	Human papilloma virus
HHS	Hospital and health service
Hz	Hertz
MCCM	The Management of Chronic Conditions Manual
MAIF	Marketing in Australia of infant formula
MOU	Memorandum of understanding
NIPS	National Immunisation Program Schedule
PaRROT	Pathways to Rural and Remote Orientation and Training
PCCM	Primary Clinical Care Manual
PEDS	Parent's Evaluation of Developmental Status
PHR	Personal Health Record book
PND	Postnatal depression
QHEPS	Queensland Health Electronic Publishing Service
QLFSS	Queensland Hearing Loss Family Support Service
RN	Registered nurse
SBYHN	School-based youth health nurse
SIP	School immunisation program
SIDS	Sudden infant death syndrome
SUDI	Sudden and unexpected deaths of infants
VIVAS	Vaccination information and vaccination administration system
VSP	Vaccine service provider
WHO	World Health Organisation

How to use this manual

The introduction provides foundational practice principles that underpin working within community settings with families, children and young people. It explains the context for practice and broadly discusses safe practice and professional issues. It is assumed that the reader has a knowledge of contemporary child and youth health, and primary health care.

This manual is divided into sections. Sections can be accessed according to need, knowledge and skills. Each sub-section is designed to read separately, therefore the reader of the Manual in its entirety will notice some repetition. It is recommended that the beginning practitioner cover each section. Colour coded tabs identify the continuum of care from antenatal to 18 years, in age groupings for easy navigation.

The manual is structured around the four core service elements of the National Framework for Universal Child and Family Health Services¹. These are as follows:

1. Developmental surveillance and health monitoring

This core element encompasses a holistic health monitoring process including:

- Physical, social, emotional and cognitive wellbeing
- Growth monitoring
- Vision and hearing screening
- Assessment of immunisation status based on the current National Immunisation Program Schedule.

2. Health promotion

Health promotion is a core element of child and youth health care. It encompasses increasing the health awareness of families and addressing the social determinations of health, e.g., injury and illness prevention. Child and youth health professionals use a range of health promotion strategies during their everyday practice including:

- Health education
- Anticipatory guidance
- Support for families
- Community capacity building.

3. Early identification

This core element identifies factors known to increase the risk of a child experiencing poor health and wellbeing outcomes by:

- Partnering with families with an identified risk, using goal setting and a strengths based model
- Facilitating / coordinating additional support services according to need.

4. Responding to identified need

This core element supports child and youth health professionals to provide:

- relevant practice based interventions
- information, support and assistance to families
- referral to additional services
- a response to child protection concerns.

The following table outlines how topics are allocated under the four core service elements for the purpose of









National Framework Core Service Element ¹

Age group	Developmental surveillance and health monitoring	Health promotion	Early identification	Responding to need
Antenatal	<ul style="list-style-type: none"> ■ Antenatal assessment ■ Pregnancy health record 	<ul style="list-style-type: none"> ■ Engaging families ■ Quality information and education 	<ul style="list-style-type: none"> ■ Aboriginal and Torres Strait Islander families ■ Culturally and linguistically diverse families ■ Young parents ■ Parents with intellectual disability 	<ul style="list-style-type: none"> ■ Multidisciplinary early intervention ■ Home visiting ■ Safety of the unborn child
Birth to five years Some sub-sections are divided into: <ul style="list-style-type: none"> ● birth to one year ● one to five years 	<ul style="list-style-type: none"> ■ Well child health checks ■ Family health assessment ■ Infant health assessment ■ Infant feeding and nutrition ■ Health concerns ■ Clinical practice tips: <ul style="list-style-type: none"> ○ Conducting a family health assessment ○ Using the EPDS tool ○ Using the DVI tool ○ Conducting a 'head to toe' physical assessment ○ Weighing and measuring ○ Conducting a developmental assessment ○ Promoting optimal positioning of the infant at the breast ○ Breast compression ○ Using a nursing supplementation system ○ Supporting a mother formula feeding ○ Vision screening ○ Hearing and ear health screening 	<ul style="list-style-type: none"> ■ Engaging families ■ Group parenting sessions ■ Quality information and education ■ Normal infant/child behaviour ■ Activities, parenting skills and tips to support development ■ Immunisation ■ Injury and illness prevention ■ Clinical practice tips: <ul style="list-style-type: none"> ○ Facilitating a group session 	<ul style="list-style-type: none"> ■ Aboriginal and Torres Strait Islander families ■ Culturally and linguistically diverse families ■ Families with low income, unstable housing, low parental education level ■ Family structure: Young, single, same-sex attracted and re-partnering parents, step- and blended families ■ Children living in non-parental care environments ■ Infants of parents with a disability or physical illness ■ Isolated families ■ Families experiencing substance use issues ■ Families with current violence or past abuse ■ Families where there is a parental mental health or wellbeing concern. 	<ul style="list-style-type: none"> ■ The premature infant ■ Cow's milk protein allergy ■ Weight faltering / malnutrition ■ Obesity in childhood ■ Sleep dysrhythmia ■ Post-natal depression ■ Protecting children ■ Safety plans ■ Clinical practice tips: <ul style="list-style-type: none"> ○ Developing a safety plan

National Framework Core Service Element ¹

Age group	Developmental surveillance and health monitoring	Health promotion	Early identification	Responding to need
5 to 12 years	<ul style="list-style-type: none"> ■ The Health Care Context ■ Well child health checks ■ Child health assessment ■ Health concerns <ul style="list-style-type: none"> ○ Speech and communication concerns ○ Daytime and bedwetting ○ Soiling and constipation ○ Head lice ■ Clinical practice tips: <ul style="list-style-type: none"> ○ Working within School Settings ○ Visual Acuity Screening ○ Hearing and Ear Health Screen 	<ul style="list-style-type: none"> ■ Engaging families ■ Quality information and education ■ Normal child behaviour ■ Activities, parenting skills and tips to support development ■ Immunisation ■ Injury and illness prevention 	<ul style="list-style-type: none"> ■ Vulnerable groups ■ Children and families of Aboriginal and Torres Strait Islander descent ■ Children and families from a culturally and linguistically diverse background ■ Clinical practice tips: <ul style="list-style-type: none"> ○ Working with a school aged child/family needing additional support 	<ul style="list-style-type: none"> ■ Case management ■ Brief practice intervention ■ Weight Faltering/malnutrition ■ Obesity in childhood ■ Bullying/cyberbullying/cybersafety ■ Disruptive behaviour/aggression/Regulatory Disorders ■ Protecting Children
12 to 18 years	<ul style="list-style-type: none"> ■ Social determinants of health and wellbeing ■ The healthcare setting ■ Rapport building with young people in the school setting ■ Youth health assessment 	<ul style="list-style-type: none"> ■ Health Promoting Schools approach ■ Health promotion strategies ■ Health promotion strategies and resources for targeted health issues 	<ul style="list-style-type: none"> ■ Strategies to identify need and risk ■ Vulnerable groups 	<ul style="list-style-type: none"> ■ Care planning ■ Other service initiatives to respond to identified need in the school community ■ Dealing with requests for information from Queensland Police

The following icons are used throughout the manual to identify specific information in the manual or to refer to further information and resources available, either within the manual or from another publication, resource or website:

	Further information in another part of the manual
	Alert
	Clinical practice tips
	Online resources and materials
	Queensland Health Electronic Publishing Service (QHEPS) (intranet) resources and materials
	Refer to the <i>Chronic Conditions Manual</i>
	Refer to the <i>Primary Clinical Care Manual</i>
	Refer to the Pathways to Rural and Remote Orientation and Training www.health.qld.gov.au/parrot/default.asp



Additional reading

While it is assumed that the reader has a foundational knowledge of contemporary child and youth health and primary health care principles, additional reading on these concepts may be found in the following texts:

Barnes, M., & Rowe, J. (2013) *Child, Youth and Family Health: Strengthening Communities*, (2nd ed.). Chatswood, NSW: Elsevier Australia.

Davis, H. & Day, C. (2010) *Working in Partnership with Parents*. (2nd ed.). Pearson: London.

Hockenberry, M. & Wilson, D. (2013). *Wong's Essentials of Pediatric Nursing* (9th ed.). St Louis, Missouri: Mosby Elsevier.

Hockenberry, M. & Wilson, D. (2011). *Wong's Nursing Care of Infants and Children*, (9th ed.). St. Louis, MISSOURI: Elsevier Mosby.

Wright, L. & Leahey, M. (2013). *Nurses and families: A Guide to Family Assessment and Intervention*, (6th ed.). Calgary, Canada: 4th Floor Press.

Introduction

Audience

This manual is a guide for child health professionals providing health care to children, young people and their families in the community and covers contemporary clinical practice issues and guidelines. It is aimed at Queensland Health child health staff who work within the community setting with families, children and young people (0-18 years). This includes:

- Child health nurses
- School-based youth health nurses,
- Aboriginal and Torres Strait Islander child and youth health workers,
- Aboriginal and Torres Strait Islander child and youth health practitioners,
- Child and youth psychologists / social workers or early intervention clinicians / practice specialists.

These professionals have a foundational knowledge of primary health care principles, the ecological framework, family centred practice and cultural sensitivity.

About these roles

The below table outlines some broad information about these roles, however it is recognised that individual roles will vary according to the local context:

Health professional	Registration/qualifications	Example of key duties and responsibilities
Child health nurse	<p>Registration as a registered nurse AHPRA and possession of an annual practicing licence.</p> <p>A child health nurse is a registered nurse who has been educationally prepared to provide specialist care for children and their families in the areas of:</p> <ul style="list-style-type: none">• Child growth and development• Parenting support• Working in partnership with families and other agencies in primary health care settings. <p>A relevant qualification in child, youth and family health is highly regarded.</p>	<p>Provide clinical child health nursing services for children and young people from birth to 12 years, within the context of their family and community.</p> <p>Provide direct client services with individuals and groups, including families with additional needs e.g. home-visiting programs.</p> <p>Work collaboratively with relevant government and non-government agencies to address contemporary health issues.</p>
Child health nurse (school-based)	<p>Registration as a registered nurse with the AHPRA and possession of an annual practicing licence.</p> <p>A relevant qualification in child, youth and family health is highly regarded.</p>	<p>Provide a range of promotion, prevention and early intervention activities to support the health and wellbeing of children in Queensland schools.</p> <p>Support children identified at-risk through brief intervention and referral to relevant support services.</p> <p>Work collaboratively with school communities and relevant government and non-government agencies to address contemporary health issues.</p>

Health professional	Registration/qualifications	Example of key duties and responsibilities
School-based youth health nurse (SBYHN)	Registration as a Registered Nurse with the AHPRA and possession of an annual practicing licence. A relevant qualification in child, youth and family health is highly regarded.	Provide a range of promotion, prevention and early intervention activities to support the health and wellbeing of young people in secondary schools across Queensland. Support young people identified at-risk through brief intervention and referral to relevant support services. Work collaboratively with school communities and relevant government and non-government agencies to address contemporary health issues.
Aboriginal and Torres Strait Islander child health worker	Diploma in Aboriginal and/or Torres Strait Islander Primary Health Care from a registered tertiary institution/facility, or equivalent.	Support and liaise with health care professionals to enhance the provision of primary health care to Aboriginal and Torres Strait Islander people. Delegated by registered health professionals to deliver health care, health education and promotion and prevention programs to Aboriginal and Torres Strait Islander people and communities according to local HHS guidelines.
Aboriginal and Torres Strait Islander child health practitioner	Registered with AHPRA and possession of an annual practicing licence. Certificate IV in Aboriginal and Torres Strait Islander Primary Health Care Practice or equivalent.	Provide clinically focused advice and support in order to improve health outcomes for Aboriginal and Torres Strait Islander people. Deliver specific primary health care programs. Assess and treat Aboriginal and Torres Strait Islander people.
Early intervention clinician (EIC)/ early intervention parenting specialist(EIPS)	Psychologist: Registration with AHPRA and an AHPRA approved tertiary qualification in Psychology. Social worker: A recognised degree in social work and eligibility for membership with the Australian Association of Social Workers.	Deliver high level, specialist early intervention/parenting and related services and programs for families with children with complex needs. Provide support to Health Service Community Child and Youth Health staff and key stakeholders on relevant early intervention and parenting issues. Work collaboratively with relevant government and non-government agencies to address contemporary health issues.

For the purpose of this manual:

- The term **'child / youth health professional'** will be used to refer to a:

Child health nurse, Child health nurse - School-based, School-based youth health nurse, Aboriginal and Torres Strait Islander health worker, Aboriginal and Torres Strait Islander health practitioner, unless specifically stated otherwise.

- The Child Health Psychologist/Social Worker/ Early Intervention Clinician/Parenting Specialist are integral to many Child, Youth and Family Services within Queensland and will be abbreviated as **'EIPS/EIC'**.

Key principles underpinning the child/youth health practice framework

- Working in partnership with families across communities requires effective communication and coordination to bring all the necessary skills and expertise together for the benefit of the child or young person. Partnerships with families and other health care providers form as a direct result of this communication and collaboration.
- Elements of partnerships include:
 - a supportive, purposeful, professional relationship
 - shared vision and decision making
 - clear roles and recognition of the complementary expertise of families and health professionals
 - showing mutual trust and respect
 - recognising common and overlapping goals
 - encouraging diversity to support innovation
 - effective, clear communication and information sharing.

Information sharing should comply with relevant laws and policy pertaining to privacy and confidentiality.

- A family-centred approach to care is based on the needs and priorities of the child and family and highlights key strengths to supports their capacity for self-management and self-determination.
- Interventions are evidence based.
- A child safety focus remains central to the health professional's decision-making framework. An ecological perspective is taken when formulating a reasonable suspicion of child abuse and/or neglect. Recognition rests with the identification or presentation of signs, disclosures, behaviours, symptoms or injuries, considered within the context of the child's and/or family's circumstance and protective factors that may reduce the risk of harm.
- Child/youth health professionals maintain appropriate professional boundaries within therapeutic relationships to deliver safe and effective care.
- There is a clear delineation of responsibilities between professional roles. The child/youth health professional will refer to their local role description to ensure they have a clear understanding of how this impacts their individual role and working environment. For example: Aboriginal and Torres Strait Islander Child Health Workers often function independently as delegated by a licensed health care provider, such as a Child Health Nurse. The Aboriginal and Torres Strait Islander Child Health Worker will therefore be accountable to the Child Health Nurse for the activities that are delegated to them.
 - It is the responsibility of each child/youth health professional to know and operate within their scope of practice according to:
 - › Queensland Government code of conduct,
 - › Local Hospital and Health Service guidelines, e.g., standards, policies, procedures,
 - › Professional body guidelines, e.g. Competencies for the Specialist Paediatric and Child Health Nurse² (currently under review), National School Nursing Professional Practice Standards³,

Australian Psychology Society,

› Legislative frameworks, e.g. AHPRA .

- Many child/youth health professionals practice solely in increasingly complex practice environments where families may have complex needs. Additional support for the child/youth health professional is required and should be made available, such as: clinical or professional supervision, practice reflection and/or mentor support.
- Child/youth health professionals recognise the need to build community capacity to promote family health and wellbeing.
- Models of care for child, youth and family health will be specific to each HHS. These models will be guided by broader policy documents and legislative frameworks, such as:
 - National framework for universal child and family health services, Australian Government (2011)¹
 - Queensland Universal Child Health Framework, Queensland Health (2011)⁴
 - Queensland Universal Child Health Framework – Implementation Guide, Queensland Health (2014)⁵.



Child health professionals are encouraged to complete Family Partnership training
See <http://qheps.health.qld.gov.au/ccyfhs/html/statewide-child-health.htm>

Section 1

Antenatal



Information about the antenatal stage of the continuum of care has been included in this manual to enhance the child health professional's awareness of antenatal services and to promote communication and collaboration between care providers to support a smooth transition of care between maternity and child and family health services ^{1,6}.

Developmental surveillance and health monitoring

Antenatal care incorporates health surveillance and monitoring of the mother and foetus including screening for physical, social and emotional wellbeing, and assessment of risk and protective factors.

The healthcare context

Universal health services based on primary health care principles and collaborative maternity care models are designed to meet the needs of pregnant women and their families within Australia. Services are offered in a variety of settings dependant on the available resources within the local environment. Maternity care providers work in public and/or private practice settings such as:

- Hospitals
- Clinics – midwife, GP obstetrician, obstetricians, and share-care GPs
- Outreach services, for example: home visiting, community centres, Royal Flying Doctor Service.

There are a variety of models of maternity care available to meet the diverse needs of consumers, communities, and the level of clinical care required for the individual woman (e.g. primary care or tertiary care). Models of care include:

- Midwife care – midwives are the primary providers of care; this may be through a caseload model (one midwife), group practice (a small number of midwives sharing a caseload) or team midwifery (a team of midwives working together).
- Shared care – several health professionals are involved in the care including GP, obstetrician, hospital doctors and midwives.
- Obstetrician care – the obstetrician is the main provider of care due to the clinical care required for the woman, or where families choose to access obstetric care through the private sector ⁶⁻⁸.

A maternity care plan is recommended to support collaborative care principles ⁶. This means:

- The woman is at the centre of her own care.
- Care is based on the best available evidence.
- Women actively participate in care by being given information about their care options prior to making choices.
- Women's cultural, emotional, psychosocial and clinical needs are considered within the context of their local environment.
- Collaborating health care providers communicate using sensitive language to support professional trust and mutual respect for each other's roles, committing to an agreed care plan, combining knowledge and expertise.
- Optimise the health of the mother, baby and their family ⁶.

A child and family health professional may engage with a family during the antenatal period to:

- inform them about services after birth,
- establish a rapport and engage with a family with additional needs,
- to minimise the effect of risk factors and build protective factors and resilience, and
- promote communication and collaboration between care providers supporting transition of care

between maternity and child and family health services ^{1,6}.

Other health professionals may have an integral role in the antenatal care team ⁴, for example:

- Aboriginal and Torres Strait Islander health workers
- Maternity liaison officers
- Bilingual or multilingual health workers
- Psychologists
- Social workers
- Nutritionists/Dieticians
- Drug and alcohol workers
- Mental health workers.

The pregnancy health record

The pregnancy health record (may be carried by the woman according to the local context) provides a complete record of pregnancy care and is an endorsed document for effective information sharing between care providers from early pregnancy to birth. There are sections in the record for all members of the health team to complete ⁹.



National Health and Medical Research Council | www.nhmrc.gov.au

National Guidance on Collaborative Maternity Care | www.nhmrc.gov.au/guidelines/publications/cp124

Brochure for families:

Your health professionals working together with you and your baby: Collaborative Maternity Care Information
www.nhmrc.gov.au/_files_nhmrc/publications/attachments/cp124_maternity_brochure_update081110.pdf

Antenatal assessment

Physical assessment

Antenatal assessment monitors physical and developmental health of the mother and foetus. This includes:

- Comprehensive clinical assessment in early pregnancy and a schedule of follow up antenatal visits according to the woman's clinical needs
- BMI monitoring
- Obstetric ultrasound scan is offered prior to 20 weeks' gestation for foetal morphology and later if indicated e.g., to assess foetal growth
- Routine blood screening, for example: blood group, antibody screen
- Referral may be required, for example, blood screening identifies Human Immunodeficiency Virus; BMI monitoring identifies obesity ^{9,10}.

Universal antenatal assessment includes the consideration of psychosocial risk factors known to increase the likelihood of mental health difficulties for the woman, her partner and baby during pregnancy and in the immediate postnatal period. This includes:

- maternal mood disorder
- alcohol, tobacco and other drug use
- family and domestic violence ⁷

Consideration of risk to the unborn child is inclusive within this screening process ⁷.

Social and emotional wellbeing

During the perinatal period a mixture of physiological and psychosocial factors put women at increased risk of experiencing perinatal depression¹¹ including:

- past or present mental health disorders
- a family history of mental health disorders
- pregnancy and birth complications
- problems with the baby's health
- a lack of practical and/or emotional support
- current life events and/or major stressors, e.g., relationship difficulties, financial stress
- past or present physical, sexual or psychological abuse
- being a single parent
- cultural kinship, community responsibilities and obligations
- quality of her own childhood experiences, e.g., attachment with her own mother
- having unrealistic expectations about motherhood, for example, that:
 - mothers bond with their babies straight away
 - mothers know instinctively what to do
 - motherhood is a time of joy^{11,12}.



One in every twenty new fathers in Australia are thought to experience paternal anxiety and/or depression during the perinatal period. Health professionals encourage discussion about the wellness of their significant others and when and how to seek support¹².

- The Australian Family Strengths Nursing Assessment Guide (See appendix 1) may be used by health professionals as a tool to explore family strengths and encourage activities to enhance effective family functioning and build resilience¹².

Recent research into perinatal depression recommends^{7,11,12,14,15}:

- Using key psychological questions to assess risk and in planning perinatal care; in particular, level of support, past history of anxiety and depression and current stressors.
- Depression screening is an important part of routine antenatal and postnatal care.
- Screening is recommended using the **Edinburgh Postnatal Depression Scale** (EPDS). The tool alone does **not** provide a diagnosis; if the scoring indicates a concern, referral to a doctor is indicated, combined with the health care professional's ongoing support. See appendix 5 and 6.
- All pregnant women should be provided with information and resources on emotional health in the perinatal period.
- The health care provider should consider the impact of the woman's social and emotional wellbeing on the maternal-foetal relationship and if concerns are raised, referral during the antenatal period is appropriate.
 - Refer to local care pathways guiding appropriate referrals and service links. This may include links to Perinatal and Infant Mental Health Services or the Child Health multidisciplinary team. See appendix 8.
- Resources need to address particular groups, such as, Mothers of Aboriginal and Torres Strait Islander or CALD backgrounds, Mothers having multiple births.

- Screening for social and emotional wellbeing needs to be accompanied by ongoing training and support of health care professionals, e.g. using and scoring EPDS.
- If left untreated, the impact of poor social, emotional and mental health on the mother, her children and relationships can be profound.



The Australian Family Strengths Nursing Assessment Guide may be used by health professionals as a tool to explore family strengths and encourage activities to enhance effective family functioning and build resilience. See appendix 1

See Practice tips: Conducting and scoring the EPDS on page 32.



National Health and Medical Research Council | www.nhmrc.gov.au

Clinical Practice Guidelines: Depression and related disorders – anxiety, bipolar disorder and puerperal psychosis – in the perinatal period. | www.nhmrc.gov.au/guidelines/publications/exto6

Queensland Centre for Perinatal and Infant Mental Health | www.health.qld.gov.au/qcpimh/default.asp

Training and professional support and development specific to perinatal-infant mental health

Beyond Blue | www.beyondblue.org.au

Raising Children Network | <http://raisingchildren.net.au> (information for families on pregnancy and birth)

PANDA | www.panda.org.au (information for families on antenatal depression)

Domestic and family violence

Domestic violence occurs when one person in a relationship uses their power to control the other person, in any way, including physical, emotional, verbal, sexual, financial, social, cultural, and spiritual abuse¹⁶.

Routine screening for domestic violence is a core component of antenatal care. It is vital that information obtained on antenatal assessment is used in a supportive and protective way and that health professionals take a child protection perspective⁷⁻¹⁷.

The experience of domestic and family violence can result in poor obstetric outcomes for mothers and infants. Unborn infants, infants and young children are at a significant risk of negative impacts to their physical, psychological, emotional, social, behavioural, developmental and cognitive wellbeing and functioning as a result of experiencing domestic violence. This increases their potential for longer term effects and also the intergenerational cycle of violence^{18,19}.

Families are particularly vulnerable to domestic violence during pregnancy and relationship separation²⁰.

All health professionals providing care to families during pregnancy need an awareness of the signs and symptoms of violence and provide women with appropriate advice and support. Safety planning should be discussed with the woman when it is safe to do so (e.g. when she is alone) and accompanied by local information and resources^{16,17,21}.



Where there are safety concerns refer to further information on page 22 and see appendix 4.



Department of Communities, Child Safety and Disability Services

www.communities.qld.gov.au/disability/support-and-services

Domestic Violence Hotline | T: 1800 811 811 | www.dvconnect.org

Queensland Centre for Domestic and Family Violence Research | www.noviolence.com.au/index.html



Child safety (QHEPS) | <http://qheps.health.qld.gov.au/csu/Factsheets.htm>

Substance use/misuse in pregnancy

- Assessment of smoking, alcohol consumption and use of other drugs either pre-pregnancy or during pregnancy presents an opportunity to:
 - discuss services that can support the woman to stop or reduce substance use
 - provide the woman with evidence-based information designed to minimise the harm associated with the use of substances
 - establish a professional, trusting and empathetic relationship that encourages the continuation of pregnancy care ¹¹.
- Smoking cigarettes during pregnancy is associated with significant morbidity and mortality for mother and unborn child/child. Pregnancy often motivates parents to change their smoking habits, so it is an important time to discuss options with the woman and her family. Referral to support agencies and 'Quit' resources are also recommended ²².
- Assessment of alcohol and drug use in pregnancy (present use and previous history of use) should be included in routine antenatal history taking for all women, including:
 - prescribed medications /over-the-counter medications
 - alcohol
 - tobacco, including passive smoking
 - other substances (cannabis, stimulants, inhalants and un-prescribed use of benzodiazepines) ^{23,24}.
- Both the pattern and frequency of use are important:
 - occasional use
 - regular recreational or non-dependent use
 - habitual, regular or dependent use
 - binge use ^{23,24}.
- Consideration of the impact of misuse of substances on the developing foetus is important, e.g., Foetal Alcohol Spectrum Disorder, Neonatal Abstinence Syndrome ^{23,24}.
- Cultural knowledge, skills and behaviours are essential to communicating and engaging respectfully when working with Aboriginal and Torres Strait Islander peoples ²⁴.



Quitline | www.health.qld.gov.au/quitsmoking

Centre for Excellence in Indigenous Tobacco Control | www.ceitc.org.au/ceitc-publications-and-resources

Raising Children Network | <http://raisingchildren.net.au>

A variety of resources, e.g., Alcohol and pregnancy in pictures, Parenting as a drug user.

Recognition of child abuse and neglect

Antenatal assessment may provide health professionals indicators of the need for parental support and/or intervention to facilitate adequate parenting and protection of the unborn child. These risk indicators do not prove abuse or neglect but they do require further assessment, interpretation and consultation ¹⁷. Refer to further information on page 22.



Department of Communities, Child Safety and Disability Services

www.communities.qld.gov.au/disability/support-and-services

Queensland Centre for Domestic and Family Violence Research | www.noviolence.com.au/index.html

Fact sheet: *Babies & toddlers – Keeping them safe* | www.noviolence.com.au/public/factsheets/babies.pdf



Child safety (QHEPS) | <http://qheps.health.qld.gov.au/csu/Factsheets.htm>

Health promotion

Pregnancy is an opportune time to provide health promotion messages and anticipatory guidance on a wide variety of topics at a time when many parents are receptive. Ideally pregnancy education prepares new parents for their life with a child, including strategies that will create support networks with in their community. Whenever possible, health education and promotion should include both the woman and her partner/support persons.

Engaging families

As well as working with mothers-to-be, marketing positive health messages to the whole family and the wider community strengthens support for parenthood and can positively impact on the health of a child ¹.

Family structures are varied including:

- Extended families, e.g. grandparents, aunts, elders
- Single parent, step and blended families
- Foster families
- Gay, lesbian, bisexual and transgender parents ²⁵.

Health professionals recognise each member of the family and acknowledge the significance of their role. For example, research shows the importance of recognising a fathers' unique contribution to a child's development and the family system as a whole ²⁶.

It is recommended that services facilitate the involvement of fathers and significant others by considering a range of strategies including:

- Create a physical and attitudinal environment that welcomes the father/ partner/extended family. This may include having relevant visual materials and resources ²⁷.
- Recognise fathers/partners who are involved in the woman's life and highlight the importance of such activities as: talking to the baby to enhance their role and facilitate engagement ²⁷.
- Involve fathers/partners in appropriate decision-making, e.g., Discuss the benefits of breastfeeding and encourage support of breastfeeding practices, this has been shown to have favourable outcomes relating to infant breastfeeding practices ²⁸.
- Discuss transition to parenthood issues including parenthood roles, lifestyle and relationships changes ³³.
- Change service environments to address potential barriers to partners/extended family attending services, e.g. vary program times and formats to improve access, include 'neutral' messages for 'parents', attract male staff, use male inclusive literature and magazines in the waiting room ²⁷.
- Having Aboriginal and Torres Strait Islander male staff available facilitates inclusiveness of Aboriginal and Torres Strait Islander fathers/partners ^{27,29}.



One in every twenty new fathers in Australia are thought to experience paternal anxiety and/or depression during the perinatal period. Health professionals encourage discussion about the wellness of their significant others and when and how to seek support ¹².



Father Inclusive Practice | **Government of Western Australia** | Download from: www.communities.wa.gov.au/Documents/About%20us/CF106%20Father%20Inclusive%20Practice%20Policy%20Paper%202012.docx

Australian Indigenous HealthInfo Net | www.healthinonet.edu.edu.au

How dads can help (Growing Strong resource) | www.health.qld.gov.au/ph/documents/hpu/how_dads_help.pdf

Family Action Centre – Newcastle University | www.newcastle.edu.au (resources on father-inclusive practice)

Quality information and education

Providing evidence-based health education in the antenatal period supports participative decision making⁷, topics include:

- maternal nutrition and oral health
- social and emotional wellbeing during pregnancy
- infant nutrition and breastfeeding
- injury prevention and safety promotion (including SUDI and SIDS)
- immunisation for baby/parents/carers
- routine screening for baby, e.g., ear and hearing health
- becoming a parent, incorporating:
 - social and emotional wellbeing during early parenthood
 - relationship changes
 - infant care, bonding and attachment
 - factors impacting on parenting
 - services that are available after birth to support parenting
- Cultural beliefs and practices of Aboriginal and Torres Strait Islander women, and women from CALD groups⁷.
- Group information sessions, provided to prospective parents in groups, effectively encourages networking and building possible supportive contacts for the longer term⁷.



See appendix 2: Building Healthy Brains



Queensland Health | www.health.qld.gov.au
www.health.qld.gov.au/breastfeeding/mother_familiesh.asp
www.health.qld.gov.au/ph/documents/hpu/growing_strong.asp

Clinical practice guidelines antenatal care - Module 1

www.health.gov.au/internet/publications/publishing.nsf/Content/clinical-practice-guidelines-ac-mod1

Raising Children Network | <http://raisingchildren.net.au/>

Healthy Start | www.healthystart.net.au

'Healthy Start for Me and My Baby' - an interactive resource designed for pregnant women with learning difficulties
 Download from www.healthystart.net.au/index.php/resources/practical-tools/healthy-start-for-me-and-my-baby



Refer to the *Chronic Conditions Manual*



Refer to the *Primary Clinical Care Manual e.g., Woman and antenatal health.*

Maternal nutrition, oral health, physical activity

Healthy eating during pregnancy is important for the woman's health and the health of her unborn child. The health care professional will provide guidance on a healthy intake as well as food safety considerations during pregnancy.

- Eating a variety of nutritious foods during pregnancy is important for pregnant women, due to the number of outcomes that link diet quality to pregnancy and birth outcomes. Many recommended

dietary intakes (RDIs) of nutrients are increased during pregnancy³⁰. Metabolic adaptations and a high quality, balanced, dietary intake is generally sufficient to meet the increased nutrient needs. The exception to this is folate³⁰ and iodine³¹, where routine supplementation is now recommended for the majority of women in Australia.

Apart from the recommended folate and iodine supplements, it is best to obtain nutrients from a varied diet consisting of nutritious foods from all the food groups³⁰.

- Clinical problems associated with excessive intake of nutrients are nearly always associated with intakes of supplements³⁰.
- As the immune system in pregnancy is suppressed, pregnant women are more susceptible to foodborne illness. Foods that should be avoided include: unpasteurised dairy products and soft, semi-soft and surface ripened cheese (e.g., brie, camembert, ricotta, fetta and blue cheeses), cold seafood, sandwich meats, pate, bean sprouts and packaged or pre-prepared salads⁸¹.
- Women are advised to visit a dentist either before or soon after they become pregnant so any problems can be treated immediately. Pregnant women should inform their dentist that they are pregnant. During pregnancy dental problems such as gingivitis (early gum disease) and dental caries (tooth decay) may be more common due to physical changes associated with pregnancy, such as: fatigue, nausea and vomiting⁷.
- Reinforce nutrition and oral health care messages such as: eating small amounts of low-fat and low-sugar foods throughout the day; drinking plenty of tap water and adopting regular oral hygiene practices, such as twice daily brushing with a soft toothbrush and a fluoride toothpaste³².
- Explain to parents that babies are born without decay-causing bacteria in their mouths, therefore it is important that parents reduce the possibility of transferring these bacteria to their newborn by having regular dental check-ups and maintaining good oral health⁷.
- For most pregnant women at least 30 minutes of moderate physical activity per day should be encouraged; this can be in 2 x 15 minute or 3 x 10 minute bouts. Healthy women who have uncomplicated pregnancies can continue their previous exercise program after consultation with their maternity care provider. It is also now considered safe for a woman to start an exercise program during pregnancy, after consultation with their maternity care provider. If there is any doubt about changes in pregnancy and continuation of physical activity women should be encouraged to seek advice^{33,34}.
- The following are benefits associated with physical activity during pregnancy:
 - decreased risk of the onset of gestational diabetes (physical activity is also an important part of the management plan should gestation diabetes occur)
 - improved posture
 - less insomnia, stress, anxiety and depression
 - helps reduce constipation, bloating and swelling
 - builds resistance to fatigue^{33,34}.
- The purpose of weight gain during pregnancy is to optimise maternal and infant outcomes. Obesity in pregnancy is one of the most common, and potentially one of the most modifiable, risk factors for adverse pregnancy outcomes³⁵ and has associated long-term adverse outcomes for mothers³⁶ and children³⁷. Health professionals should advise pregnant women of the recommended gestational weight gain according to their prenatal BMI documented at their first antenatal appointment. Weight gain should be discussed and monitored regularly during antenatal care³⁸.
- Use culturally-specific resources for where available⁷.



National Health and Medical Research Council | www.nhmrc.gov.au/

Iodine supplementation for pregnant and breastfeeding women

Healthy eating during pregnancy | www.health.qld.gov.au/nutrition/resources/antenatal_ngpl.pdf

Australian Dietary Guidelines ^[3] **Eat for Health** | www.eatforhealth.gov.au

Healthy teeth for life | www.health.qld.gov.au/oralhealth/healthy_teeth/fact_sheet.asp

Food Safety – Healthy eating in pregnancy | www.health.qld.gov.au/foodsafety/documents/fs-31-preg.pdf

Culturally appropriate tools for nutrition education:

‘Growing Strong : Feeding You and Your Baby’ has a number of resources developed to assist health staff talk with Aboriginal and Torres Strait Islander families about nutrition for mother, babies and young children. It includes antenatal nutrition issues and food safety.

www.health.qld.gov.au/ph/documents/hpu/growing_strong.asp

Multicultural fact sheets in a range of languages:

www.health.qld.gov.au/multicultural/public/child_hlth.asp#Breast%20feeding

Infant nutrition

Mothers, partners and their support networks need appropriate and consistent information in the antenatal period to enable them to make an informed decision about how their baby will be fed. Forming an intention to breastfeed the baby in the antenatal period, a woman’s sense of self efficacy and the support of her partner/family are known to improve breastfeeding outcomes ²⁸. There is no specific evidence-based, physical preparation for breastfeeding required in the antenatal period ⁴¹. The health care professional will examine the breasts and discuss any concerns, e.g. previous breast surgery, nipple shape. The most important preparation is discussion and education to all mothers, fathers and significant others around ^{28,39,41}.

- benefits of breastfeeding
 - risks of not breastfeeding
 - the importance of exclusive breastfeeding up to around the infant is six months
 - practical aspects of breastfeeding (e.g. antenatal breast care issues, how to promote a good latch to the breast after birth, frequency of feeding)
 - normal newborn behaviour including feeding cues
 - how long to continue breastfeeding/returning to work and breastfeeding
 - support networks
 - information sources and support agencies specific to feeding, e.g., Australian Breastfeeding Association, LCA NZ.
- While breastfeeding is recognised as the normal and natural way to feed infants, some women will choose not to breastfeed ⁴⁰. Some studies have reported women feeling as though they were judged by staff and felt like a ‘bad mother’ and that they had ‘failed’ at an early task of mothering by not breastfeeding. These feelings may impact on the mother’s self-esteem and mental health ⁴⁰. Sensitive enquiry by health care professionals ensure an informed decision-making process has been undertaken by the mother not to breastfeed. Clear documentation of this discussion is important so that the mother doesn’t have to repeat it with other healthcare professionals ⁷.
 - Use culturally appropriate tools for education on breastfeeding and infant nutrition such as *Growing Strong: Feeding You and Your Baby* ⁴². This resource was developed to assist health staff talk with Aboriginal and Torres Strait Islander families about nutrition for mother, babies and young children. There are a range of resources available. Additionally, a range of multicultural breastfeeding fact sheets are available in a number of different languages ⁴³.
 - Information and education to pregnant women and families who choose to feed their baby with infant formula can be provided in a non-judgemental way during a one-on-one consultation ⁴⁴.

- The *Eat for Health* nutrition guideline discusses the health benefits of breast milk for both the baby and the mother. A comprehensive list of factors that may hinder or predict the initiation and/or duration of breastfeeding is available in these guidelines ⁴¹. Other topics specific to infant nutrition should include information about Vitamin K administration after birth.
- The Ten Steps to Successful Breastfeeding ⁴⁴ is the global standard by which health services are assessed and accredited as ‘baby friendly’. A baby friendly health service is one where mothers’ informed choice of feeding is encouraged, respected and supported. To achieve the standard, midwives and other carers must possess:
 - training and education around supporting breastfeeding,
 - a sound knowledge of infant feeding,
 - sound skills in assisting women with breastfeeding, and
 - a commitment and positive attitude to facilitate breastfeeding ⁴⁴.

The **Ten Steps to Successful Breastfeeding** are outlined in the Baby Friendly Health Initiative (BFHI) and have been shown to positively influence breastfeeding outcomes ⁴⁴:

1. Have a written breastfeeding policy that is routinely communicated to all health care staff.
2. Train all health care staff in skills necessary to implement this policy.
3. Inform all pregnant women about the advantages and management of breastfeeding.
4. Place babies in skin to skin contact with their mothers immediately following birth for at least an hour and encourage mother to recognise when their babies are ready to breastfeed, offering help if needed.
5. Show mothers how to breastfeed, and how to maintain lactation even if they should be separated from their infants.
6. Give newborn infants no food or drink other than breastmilk, unless medically indicated.
7. Practice rooming-in, allow mothers and infants to remain together 24 hours a day.
8. Encourage breastfeeding on demand.
9. Give no artificial teats or dummies to breastfeeding infants.
10. Foster the establishment of breastfeeding support groups and refer mothers to them on discharge from the hospital or clinic.



National Health and Medical Research Council | www.nhmrc.gov.au

Vitamin K for newborn babies: Information for parents (2010) | www.nhmrc.gov.au/guidelines/publications/ch38

Queensland Health – Baby Friendly Health Initiative | www.health.qld.gov.au/breastfeeding/bfhi.asp

Culturally appropriate tools

‘Growing Strong: Feeding You and Your Baby’ | www.health.qld.gov.au/ph/documents/hpu/growing_strong.asp

Multicultural fact sheets in a range of languages:

www.health.qld.gov.au/multicultural/public/child_hlth.asp#Breast%20feeding



Fact sheets

Baby feeding cues / 10 ways we support mothers and babies to breastfeed

www.health.qld.gov.au/breastfeeding/documents/feeding_cues.pdf



Refer to the *Chronic Conditions Manual*



Refer to the Pathways to Rural and Remote Orientation and Training

www.health.qld.gov.au/parrot/default.asp

Injury prevention/safety promotion and safe sleeping

Parents will be purchasing nursery and other equipment for their baby during the pregnancy and thus it is important to provide information regarding the selection of safe products that meet Australian Standards or voluntary safety guidelines.

Offer evidence-based information on safe infant sleeping and refer parents to resource support/brochures, e.g. SIDS and Kids ⁴⁵.

Suggest that parents use a Home Safety Checklist – a safety audit of their home – before the baby arrives. This will identify risks and give parents time to prepare the home ⁴⁶.



Kidsafe Queensland | www.kidsafeqld.com.au
 Fact sheets – www.kidsafeqld.com.au/publications/fact-sheets
 Home safety checklist – www.kidsafeqld.com.au/home-safety
 Multicultural fact sheets in a range of languages:
www.health.qld.gov.au/multicultural/public/child_hlth.asp

Immunisation

- Some diseases can cause serious illness in pregnant women, the unborn child or the newborn baby. Immunisation before, during and after pregnancy can protect against such disease. It is therefore an appropriate time for discussion regarding immunisation programs ⁴⁷. This includes assessment of the immunisation status of mother, partner, close family members particularly:
 - adult boosters e.g. dTpa (Boostrix® , Adacel®)
 - influenza vaccination
 - measles, mumps and rubella (MMR) vaccination after birth if required (MMR can be given to breast feeding women) ⁴⁷.
- For further advice about vaccination in pregnancy, advise to discuss the issue with the GP/Medical Officer ⁴⁷.
- Discussions about infant vaccinations offered at birth and the recommended immunisation schedule are also important as some vaccines have a strict time frame for administration ⁴⁸. The National Immunisation Program Schedule Queensland is updated regularly in line with the national schedule ⁴⁸.



The Australian Immunisation Handbook
www.immunise.health.gov.au/internet/immunise/publishing.nsf/Content/Handbook10-home
The National Immunisation Program Schedule
www.health.qld.gov.au/immunisation/documents/nips_antigens.pdf
Queensland Health immunisation information | www.qld.gov.au/health/conditions/immunisation/index.html
 Immunisation scheduled medicines course – Queensland Health-legislated course offered through Cunningham centre



Refer to the *Primary Clinical Care Manual*

Early identification

Where antenatal assessment identifies factors that increase the risk of poor health and wellbeing of the unborn infant, mother and/or family, health care professionals are recommended to use a strengths based approach and refer to the multidisciplinary team members according to their scope of practice framework.

Vulnerability factors

Additional need/s may be identified when the following factors are present:

- low socioeconomic groups
- family violence
- history of abuse or neglect as a child
- poor maternal nutrition/obesity
- substance misuse
- recent major life stressors
- past or present mental health issue
- social isolation
- Aboriginal and Torres Strait Islander families
- CALD groups including migrants
- unintended pregnancy
- young parents
- single parents
- assisted reproduction techniques
- history of perinatal loss or loss of an infant / child ^{7,25}.

Provide evidence-based, culturally and socially appropriate, accessible and supportive antenatal care that promotes health, particularly to women in these priority groups.

Aboriginal and Torres Strait Islanders

- Aboriginal and Torres Strait Islander women are twice as likely to have a baby born with a low birth weight and the greater risks of morbidity and mortality that comes with being of low birth weight (12.3% compared to 5.9% born to non-Aboriginal and Torres Strait Islander mothers). Aboriginal and Torres Strait Islander infants aged 0-4 years died at over twice the rate of a non-indigenous child ⁴⁹. This group of families need sensitive, respectful care.
- Aboriginal and Torres Strait Islander children have the world's highest rates of middle ear disease. The associated conductive hearing loss has a significant impact on child development. Specific information and resources on promoting ear and hearing health particularly to Aboriginal and Torres Strait Islander families is imperative ⁵⁰.
- Aboriginal and Torres Strait Islander child health worker/practitioner have specific knowledge and skills to engage with these women and families, this may include consideration of values that recognise connection to land and country and an overarching philosophy of 'Women's Business' ⁵¹.
- Where possible, provide antenatal care in outreach clinics and community centres that are welcoming and non-judgemental ⁵².
- Follow local refer pathways according to need. This may include referral to:
 - Aboriginal and Torres Strait Islander health workers and community agencies
 - Perinatal and infant mental health services
 - Adult mental health services
 - Sexual health services
 - Drug and alcohol support services ^{7, 52}.



Culturally appropriate tools

'Growing Strong: Feeding You and Your Baby' | www.health.qld.gov.au/ph/documents/hpu/growing_strong.asp

Australian Indigenous HealthInfo Net | www.healthinfonet.ecu.edu.au

Safety for Piccanninny (booklet)

www.emergency.qld.gov.au/publications/pdf/Piccanninny_booklet.pdf

Families from culturally and linguistically diverse backgrounds

- Women from culturally and linguistically diverse (CALD) backgrounds, including refugees or asylum seekers, may present with co-existing health issues, malnutrition, past traumatic life experiences and are at greater risk of poor health outcomes for their infant⁴³. Research culturally specific antenatal and birthing issues for CALD women and incorporate this knowledge into practice⁵³.

Follow local referral pathways according to need. This may include referral to:

- CALD health services and support networks
- Transcultural mental health services
- Perinatal and infant mental health services
- Adult mental health services
- Drug and alcohol support services^{7, 52}.
- Where possible, provide antenatal care in outreach clinics and community centres that are welcoming and non-judgemental⁵².



Multicultural Clinical Support Resource

www.health.qld.gov.au/multicultural/support_tools/mcsr.aspp

Multicultural health - Cultural dimensions of pregnancy, birth and post-natal care^[4]

www.health.qld.gov.au/multicultural/health_workers/cultdiver_guide.asp#pregnancy

Queensland Transcultural Mental Health Centre

www.health.qld.gov.au/metrosouthmentalhealth/qtmhc/default.asp

Multicultural fact sheets in a range of languages:

www.health.qld.gov.au/multicultural/public/child_hlth.asp#Breast%20ofeeding

Young parents

Young parents (less than 20 years) experience a greater rate of foetal morbidity and mortality, often seek antenatal care later in the pregnancy and are at risk of greater social disadvantage than the general population⁷. It is important that consideration is given to promote best practice for this population.

This may include:

- Youth friendly environments are vital to encourage young people to access antenatal care. Provide additional support to young people in settings such as: schools (SBYH nurse) and community centres (e.g., young parents support programs)⁵².
- Use posters, pamphlets and reading material that are youth-friendly and ensure waiting areas convey a welcoming environment for all people⁵².
- Enable young women to explore choices for their future, e.g., ongoing education; youth health professional acts as an advocate for the young person in this regard⁵².

- Young prospective fathers experience considerable anxiety around relationship difficulties, lifestyle changes, financial resources and role expectations ^{26,29}. Antenatal care that alienates fathers by concentrating predominantly on women and birthing and the father's birth support role (overlooking father's broader role) may accentuate these anxieties ^{27,52}.
- Provide young fathers with information about:
 - normal pregnancy and baby development
 - a young father's role
 - creating support networks and how to use them
 - Aboriginal and Torres Strait Islander young men need appropriate support in understanding what it means to be a 'Young Aboriginal/Torres Strait Islander Father' ²⁹.
- Follow local refer pathways according to need. This may include referral to:
 - Young Parents Support Groups
 - Perinatal and infant mental health services
 - Youth mental health services
 - Drug and alcohol support services ^{7, 52}.



Raising Children Network | <http://raisingchildren.net.au/>
 Parenting as a teenager - http://raisingchildren.net.au/articles/parenting_as_a_teenager.html

Parents with learning difficulties

Women with learning difficulties and their infants have a higher risk of poor health outcomes in the perinatal period ⁵⁴.

- It is important to use additional strategies that will enable parents with learning difficulties to acquire the skills for parenting. Strategies include:
 - use visual aids as prompts for learning e.g., picture stories, doll to teach child care in an interactive way
 - plan learning sessions so parents can actively participate and learn practical skills
 - provide verbal information in clear, direct and short statements
 - use a variety of methods to reinforce and repeat information
 - ask parents to explain back to you what the new information means
 - be flexible ⁵⁴.
- Follow local refer pathways according to need. This may include referral to:
 - Early intervention parenting specialist (EIPS/EIC) within the child health multidisciplinary team
 - Disability support services
 - Perinatal and infant mental health services ^{7, 52}.



Healthy Start | Parenting Research Centre | www.healthystart.net.au
 (Resources about supporting parents who have learning difficulties)

Responding to need

Where antenatal care identifies the need for further assessment and/or intervention relating to the health of the mother or unborn baby, families will be referred for a higher level of care.

Access to higher level services

- Higher level services may be required during the antenatal period such as:
 - tertiary maternity care, e.g., premature birth
 - district CPLO, e.g., concerns of risk to the unborn child.
- Information sharing and care coordination is vital⁶.

Multidisciplinary early intervention

- Multidisciplinary early intervention offers the family access a broader range of health care providers during the antenatal period at a time when early intervention can have a positive effect on health outcomes^{6,52}. This may include:
 - child health nurse
 - EIPS/EIC (social workers and psychologists)
 - Aboriginal and Torres Strait Islander child health workers
 - nutritionists/dieticians
 - mental health services - including specialist perinatal and infant mental health services
 - alcohol and drug services
 - oral health services.
- Case management with quality documentation (including collaborative care plans) will facilitate communication among the team and the family. Focusing the care plan on the family's needs and goals will drive this process^{6,52}.
- Information sharing is important to ensure the continuum of care following the birth of the baby; a strong connection with the local maternity unit will facilitate this. In some hospitals, an Aboriginal and Torres Strait Islander hospital liaison officer is available to support families with more complex needs to transition to community services once the baby has arrived^{6,52}.

Home visiting

- Evidence-based home visiting programs provide the opportunity for identified families to access a higher level of care when key risks are identified⁵², such as:
 - family violence
 - maternal mood disorder
 - financial stress.

Contact by a child health professional ideally commences in the antenatal period, followed by professional home-based support for the first twelve months of the infant's life^{52,55,56}.

- Aboriginal and Torres Strait Islander families are offered a culturally appropriate model of home visiting⁴⁹.
- Sustained home visiting programs have shown trends of improved health outcomes specific to breastfeeding and the woman's experience of motherhood and the children's mental development⁵⁵.
- Ensure local referral pathways are followed so that families are provided with services according to their specific needs⁶.

Child protection

Health care professionals recognise the importance of identifying concerns around the need of protection of the unborn child after they are born and will refer to their local Child Protection Advisor/Liaison Officer, or equivalent if they have concerns ^{17,276}.

- Registered nurses, midwives, doctors and other health professionals have a duty of care to report a reasonable suspicion that an unborn child may be at risk of significant harm following their birth ^{17,276}. Staff are responsible to recognise and report a reasonable suspicion that any child may be in need of protection and follow mandatory reporting requirements ^{17,276}.
- Ongoing work with the family where the unborn child/child is at risk of harm requires the child health professional to:
 - continue to work with the family to increase their capacity to meet and plan for the health and protective needs of the child following their birth
 - work in partnership with a range of service providers
 - establish consultation links with the CPA/CPLO and continue the consultation process throughout your contact with the family regardless of the outcome of any reporting
 - be proactive in seeking advice and clarification from services involved with the family ^{6,17, 52}.



Dealing with requests for information from Queensland Police Service

Staff may at times be approached by Queensland Police for information; be requested to provide a statement or be interviewed by police; or be approached by the Queensland Police Service to attend court to give evidence. Should any of these situations occur, it is essential to first discuss the matter with your line manager who will seek advice from HHS management/ medico-legal services as required, and direct you to specific HHS policies and procedures addressing the matter.



Queensland Centre for Domestic and Family Violence Research

Fact sheet: *Babies and toddlers: Keeping them safe*
www.noviolence.com.au/public/factsheets/babies.pdf

The Queensland Child Protection Guide is a decision support guide available to assist professionals
www.communities.qld.gov.au/chilfsafety/partners/our-government-partners/queensland-child-protection-guide/online-child-protection-guide



Queensland Health Child Safety QHEPS site

<http://qheps.health.qld.gov.au/csu/Factsheets.htm>

Section 2

Birth to five years



Providing optimal, evidence based health care during the early years of life has the potential to significantly improve health outcomes for the child. Integration of services at local and regional levels, across government and non-government sectors is promoted to support equity of access to services, as well as provision of additional services to those in greater need, such as Aboriginal and Torres Strait Islander families ^{1, 57}.

Universal child and family health services play a key role in identifying biopsychosocial health factors that are known to impact on parenting. Delivering services that include health education, anticipatory guidance and parenting skill development and support are aimed at promoting the parent-child relationship and the best health outcome possible for the child ^{1, 58}.

Developmental surveillance and health monitoring

This section includes:

- the setting in which services are provided,
- infant/child health surveillance and monitoring - physical, social, emotional, cognitive growth and developmental health
- family health assessment and monitoring.

Some of these topics are broken down into '0 to 12 months' and 'One to five years'.

The healthcare context

A best practice health care model for parents with children is one that aims to ensure access to services that are:

- appropriate to the individual family needs
- prioritised according to need
- provided in the most appropriate setting for the family.

Consultations may be provided in numerous settings such as: community-based clinics or centres, community locations, family homes and by a variety of modes e.g., face-to-face, phone, group work ^{1, 59}. Universal child and family health services work in partnership to provide integrated service delivery and 'seamless' transitions for families from one service to another ¹. All infants born in Queensland will be given a Personal Health Record (PHR) which aims to support families in their transition to parenthood and in accessing services ⁶⁰.

Engaging families

As well as working with children and their parent/s, marketing positive health messages to the whole family and the wider community strengthens support for parents and can positively impact on the health of a child ¹. Family structures are varied including:

- Extended families e.g. grandparents, aunts, Elders
- Foster families
- Single parent, step and blended families
- Gay, lesbian, bisexual and transgender parents ²⁵.

Health professionals recognise each member of the family and acknowledge the significance of their role in the child's life. For example, research shows the importance of recognising a fathers' unique contribution to a child's development and the family system as a whole ²⁶. It is recommended that services facilitate greater involvement of fathers by considering a range of strategies. These strategies can be considered in the context of the varied family structures of each family. Strategies include:

- Create a physical and attitudinal environment that welcomes the father/ partner/extended family. This may include having relevant visual materials and resources ²⁷.
- Recognise fathers/partners who are involved in the infant's life and highlight the importance of such activities as: talking to, singing to, and telling stories to the infant. This enhances their role and facilitates engagement ^{27,29}.
- Involve fathers/partners in appropriate decision-making e.g. Discuss the benefits of breastfeeding and encourage support of breastfeeding practices, this has been shown to have favourable outcomes relating to infant breastfeeding practices ²⁸.
- Discuss transition to parenthood issues including parenthood roles, lifestyle and relationships changes ²⁷.
- Change service environments to account for possible barriers that prohibit partners/extended family attending services e.g. vary program times and formats to improve access, include 'neutral' messages for 'parents', attract male staff, use male inclusive literature and magazines in the waiting room ²⁷.
- Having Aboriginal and Torres Strait Islander male staff available facilitates inclusiveness of Aboriginal and Torres Strait Islander fathers/partners ^{27,29}.

Family members are encouraged to attend appointments with the child and attendance at group based parenting programs is also encouraged e.g., Parenting groups, (e.g., Triple P) have been found to result in positive outcomes for parents/carers with less depression, anxiety, stress, anger, guilt and more confidence and partner satisfaction reported in short term ⁶¹.



Father Inclusive Practice | **Government of Western Australia** | Download from: www.communities.wa.gov.au/Documents/About%20us/CF106%20Father%20Inclusive%20Practice%20Policy%20Paper%202012.docx

Growing Strong resources | www.health.qld.gov.au/ph/documents/hpu/how_dads_help.pdf

Family Action Centre, Newcastle University | www.newcastle.edu.au
(Resources for staff on father-inclusive practice)

The personal health record and child health information booklet

The PHR provides a template for parents to record their child's age-related progress and includes: growth, development and immunisations. Families are encouraged to bring the PHR to all appointments for completion by the health care professional. Inserted in the cover of the PHR is a booklet *Child Health Information – Your guide to the first 12 months*, which offers evidence-based information on a range of topics such as: infant development, nutrition and safety ⁶². Health care professionals are recommended to encourage families to use this resource. A schedule of visits – 'Well Child Health Checks' are part of the PHR ⁶⁰.



Personal Health Record



Child Health Information booklet

0 TO 12 MONTHS

Well child health checks

Contact visits between families and child health professionals are recommended as part of the minimum standards for conducting evidence-based early detection. Surveillance focuses on individual children and includes gathering information from screening tests, physical examinations and discussions with parents and other caregivers ¹. Promotion and monitoring of immunisation can also be undertaken at this time.

The schedule of well child health checks recommended in the first year include:

Age	Health check/intervention	Healthcare professional
Soon after birth	Full physical examination	Maternity care provider/hospital staff
Before discharge	Neonatal examination Neonatal Screening Test Universal Hearing Screen Immunisation as per NIPS	Maternity care provider /hospital staff Healthy Hearing Program team
	* If discharged from hospital within 72 hours of age a further neonatal exam is required at day 5-10	General practitioner
0-4 weeks	Well child health check Check immunisation record against NIPS	Doctor or midwife or child health nurse
2 months (6-8 weeks)	Well child health check Check immunisation record against NIPS	Doctor or child health professional*
4 months	Well child health check Check immunisation record against NIPS	Doctor or child health professional*
6 months	Well child health check Check immunisation record against NIPS	Doctor or child health professional*
12 months	Well child health check Check immunisation record against NIPS	Doctor or child health professional*

* An Aboriginal and Torres Strait Islander child and youth health worker may undertake the health checks as delegated by the RN or Doctor ⁶⁰.

Other health checks

As part of the *Chronic Conditions Manual*, population screening through health checks are offered to all children when they present at primary health care centres in rural and remote areas. These health checks form the early detection component of the chronic disease strategy to identify risk factors and early markers which lead to the development of chronic diseases.



Refer to the *Chronic Conditions Manual*, e.g., *child health checks, vision and hearing*



Refer to the Pathways to Rural and Remote Orientation and Training
www.health.qld.gov.au/parrot/default.asp

Parents may wish to access additional services to complement well child health checks, such as:

- self-weigh facilities (e.g., at child health clinics)
- information on the world wide web
- telephone support
- information and support groups – child health clinic and other parent groups, playgroups, ABA, Young Parents Program ¹.

Family health assessment

The health of the family, in particular a parent / primary care giver and their ability to fulfil the role of ‘parent’ is crucial in optimising infant development¹. Nurturing an infant in the early years has a decisive and long-lasting impact on how children develop, their capacity to learn, their behaviour and ability to regulate their emotions, and their risks for disease in later life¹.

- There is no universal standard of what ‘good’ parenting is, however there are characteristics that appear to enrich the parenting role such as:
 - An ability to parent in a sensitive and responsive way
 - Knowledge of the basic needs of a child (both physically and emotionally) and the ability to be available and provide for those needs
 - An ability to prioritise their child’s needs over their own e.g. a child’s safety and protection
 - The ability to be consistent yet flexible when necessary, in response to the changing demands within family life^{63,64,69}.
- The purpose of family health assessment is to:
 - identify biopsychosocial risk factors relating to the health and wellbeing of the child
 - engage with the family using a partnership approach to develop a therapeutic relationship followed by a strength based approach to build parent capacities and skills
 - formulate an individualised care plan with the family according to their level of need^{1,25,65}.
- A comprehensive family health assessment is foundational to child health monitoring and surveillance²⁵. Child health professional utilise advanced communication skills to engage with families and address sensitive issues, including domestic violence and mental health issues.
- Social circumstances and family functioning also impact on the health outcomes of children. Populations groups that may experience higher rates of infant morbidity and mortality in Australia include:
 - Aboriginal and Torres Strait Islander families
 - Families with CALD backgrounds
 - Families with low incomes; unstable housing
 - Family structured with single parents, parents with multiple re-partnering experiences, step families, blended families
 - Children living in non-parental or out-of-home care environments
 - Low level of parental education often when other factors are present. e.g. financial stress, ethnicity
 - Families with chronic illnesses and/or disability^{1,25}.
- The following Clinical Practice Tips are offered to support effective clinical practice during:
 - conducting a family health assessment
 - conducting a Domestic Violence screen, and
 - using the Edinburgh Postnatal Depression Scale.



Practice tips: Conducting a family health assessment

A family health assessment is commenced at the first visit and may take a number of visits to complete during relationship-building with the family ^{1,25,65,66}. Once this is complete updates can be made to the assessment or the complete assessment should be redone at the discretion of the child health care professional (Refer to your local guidelines) ²⁵.

The consultation and interview will include the following stages ⁶⁷:

- 1. Engagement** – commence the interaction with the family using the AIDET principles.

A	Acknowledge	<ul style="list-style-type: none"> ▶ Acknowledge the client and family ▶ Use body language that demonstrates a welcoming and friendly approach
I	Introduce	<ul style="list-style-type: none"> ▶ Introduce yourself and colleagues ▶ If this is a home visit await permission to enter the house and establish where the consultation will take place ▶ Explain processes and the role you will play
D	Duration	<ul style="list-style-type: none"> ▶ Estimate time to complete appointment ▶ Give families some idea of what is involved
E	Explanation	<ul style="list-style-type: none"> ▶ Ask clients/families if they have any concerns regarding what is happening. ▶ Listen
T	Thank you	<ul style="list-style-type: none"> ▶ Thank client and families for their cooperation ▶ Ask if there's anything they would like to add.

- 2. Orientation** - discuss the assessment and interview process and set the scene for the family and infant health assessment. It is important to let the parents know:
 - what kinds of questions will be asked and why
 - record keeping, confidentiality and privacy
 - informed consent processes
 - the concept of working together in partnership
- 3. Establishing the relationship** – help the parent to feel relaxed, focus on the child in a warm and positive way. Explain your role and clarify their expectations. This may involve some negotiation and re-clarification as necessary. Seek permission to progress.
- 4. Assessment** - discuss the presenting issues and concerns and let them 'tell their story'. Explore the problems/issues they discuss and focus further on engaging the parent and establishing the relationship. Obtain background information and the health/social history. Consider the relationship between family interactions and a health issue by exploring the typical response to a health problem.
- 5. Encourage the helping relationship** - facilitate the parent to identify and explore solutions and goals, provide motivation and collaborate on areas for change/goals.
- 6. Ending** – finish the consultation, summarise as necessary and discuss the next steps with the family. Thank the family for their time and the information they have shared with you.

- The initial family assessment will explore the following indicators of health and wellbeing:
 - cultural background and health beliefs
 - parental education level
 - financial situation
 - housing stress
 - family structure
 - family functioning
 - parental physical wellbeing – lifestyle factors such as exercise, usual nutritional intake; chronic disease, e.g., epilepsy, diabetes, physical disability
 - parental mental wellbeing – current state of health including interaction between parent and infant; intellectual impairment, history of mental illness
 - domestic and family violence and/or abuse as a child
 - substance use/misuse
 - critical events/transition times
 - partner attitudes surrounding pregnancy, birth and parenting
 - social circumstances ^{25, 66}.

- The initial infant health assessment includes information such as:
 - pregnancy details – unintended pregnancy, assisted reproduction, history of perinatal loss, multiple pregnancy
 - birth details – gestational age, weight, length, head circumference, APGAR, birth events, admission to neonatal nursery
 - infant health – feeding at birth and at hospital discharge, hearing screen completed, prematurity, low birth weight / macrosomia, congenital malformations, hospital discharge details
 - head to toe infant examination
 - parent-infant interaction and attachment ^{25, 66}.

Examples of positive and problem indicators of parent-child interaction ^{11,68,69}

Positive indicators	Problem indicators
<p>Parent</p> <ul style="list-style-type: none"> ■ Responsive to the child’s communication cues most of the time ■ Maintains eye contact when culturally appropriate ■ Communicates in a kind, loving, empathic manner most of the time ■ Engages with child appropriately, e.g., welcomes the child, encourages the child to explore, comforts the child when it’s needed ■ Appears to enjoy ‘being with’ the child ■ Provides practical support to the child as needed ■ Provides appropriate guidance when the child needs it in a sensitive way 	<p>Parent</p> <ul style="list-style-type: none"> ■ Unable to identify the child’s communication cues ■ Unable to respond consistently and appropriately to the child’s communication cues ■ Lack of empathy ■ Does not ensure the child is safe/overprotective ■ Hostile, rejecting language toward the child ■ Rough handling of the child ■ Inappropriate representations of child’s behaviours, e.g., manipulative, rejecting, vindictive

Positive indicators	Problem indicators
<p>Child</p> <ul style="list-style-type: none"> ■ Alert, yet relaxed demeanour ■ Maintains eye contact when culturally appropriate ■ Engages with caregivers appropriately, e.g. engages, dis-engages to explore, re-engages ■ Seeks comfort from caregiver ■ Enjoys being cuddled, sitting on parent's lap ■ Generally predictable with needs, e.g., eating, sleeping, interaction cycles appropriate to age stage ■ Mimics parental behaviours, e.g. infant smiles and babbles; pretend play in the child 	<p>Child</p> <ul style="list-style-type: none"> ■ Has difficulty communicating needs to the parent ■ Overly friendly/overly fearful with strangers ■ Child avoids looking at/towards the parent ■ Does not seek out the parent for comfort ■ Child appears apprehensive around the parent



When risk factors are identified additional care may be required, see Early identification, page 139.

See appendix 3 for a sample of a Family Health Assessment



Family Health Assessment – A guide for child health nurses and other child health clinicians ³⁰

<http://qheps.health.qld.gov.au/ccyfh/docs/fam-health.pdf>

AIDET and SBAR toolkit

<http://qheps.health.qld.gov.au/childrenshealth/html/nursing/nursing-aidetsbar.htm>



Practice tips: Conducting and scoring the EPDS



Training for health professionals using the **Edinburgh Postnatal Depression Scale** is available from **Beyond Blue** (www.beyondblue.org.au - under 'resources')

- The EPDS is used in the antenatal and postnatal period primarily for screening for depression. The tool provides a means to open a conversation with the parent regarding their current feelings (the client is asked to answer each question in terms of the past seven days). The answers to the questions are used as a guide but do not provide a diagnosis; clinical judgement should always be used ¹¹.
- Inaccuracy of scoring of psychological tests can result in incorrect recommendations. Health professionals should use a scoring template and check their adding-up process to reduce scoring errors ⁷⁰.
- If the scoring indicates a concern, referral to a GP/MO/Mental Health Service is indicated:
 - Total score of 13 or more
 - A score of 1, 2 or 3 on Question 10 as it relates to thoughts of self-harm ¹¹.



If the client has scored 1, 2 or 3 to Question 10, the health care professional is required to assess the current safety of the mother/father, infant and other children in her/his care and take appropriate action ¹¹. This will include staying engaged with the client whilst seeking further advice/support from an acute mental health service provider and developing a safety plan with the client and her/his family and support agencies.

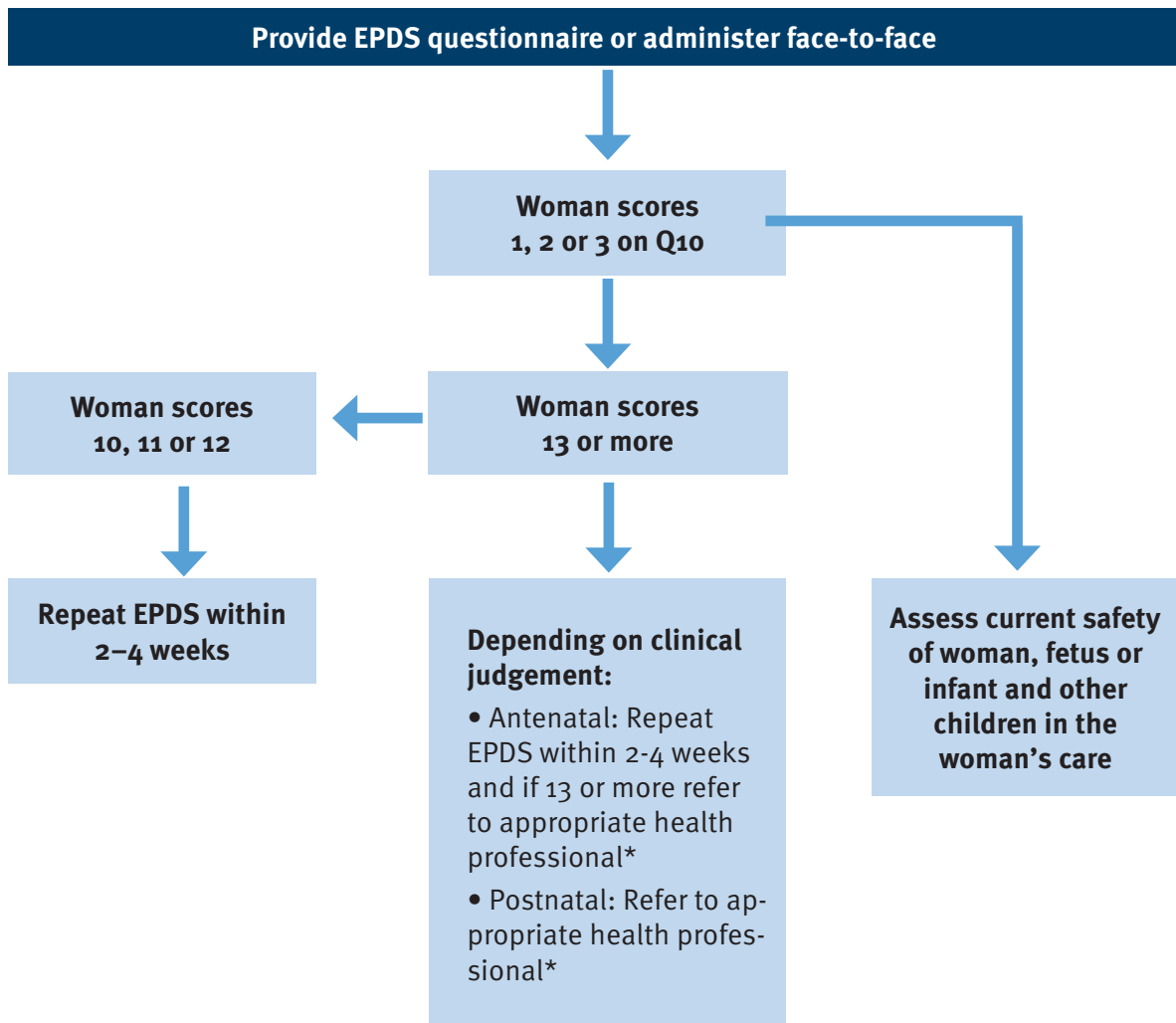
A total score of 15 or more is an indicator of major depression and the health care professional should ensure timely access to mental health assessment and management ¹¹.



Child safety concerns will require a Report of Suspected Child in Need of Protection, see page 173.

- Questions 3, 4, and/or 5 are related to 'worry'. The health professional may discuss these scores with the client and use their clinical judgement to consider if further referral may be warranted for symptoms of anxiety ¹¹.
- A total score of 10-12 requires a repeat of the EPDS within a two to four-week period ¹¹.
- In some cases it may be appropriate for the EPDS to be administered verbally, e.g. difficulties relating to language, literacy, cultural factors ¹¹.
- Referral is combined with ongoing support by the child health professional .

Appropriate responses to various EPDS scores



Notes: * Ideally, referral will be to the woman's usual GP; referral and information exchange require consent from the woman

Excerpt from: *Beyondblue, Clinical practice guidelines for depression and related disorders - anxiety, bipolar disorder and puerperal psychosis - in the perinatal period.* 2011, Melbourne: beyondblue: the national depression initiative ¹¹.



See appendix 5 and 6



Practice tips: Conducting the domestic violence screen ⁷⁴

- Undertake the screen when the parent is alone
- Children over the age of three should not be present
- Training supports the health care professional in discussing concerns regarding family violence screening with a parent and improves the health professional's confidence in responding effectively when domestic violence is disclosed
- Rapport building is important - a parent may not disclose information about domestic violence until she/he has built up sufficient trust and confidence in the health professional
- Affirm with the parent that they have made an important step in telling their story and that both he/she and the infant / other children have a legal right to protection (including support of child protection services)
- Be guided by the DVI tool in the use of open-ended questions to explore the disclosures of domestic violence, this should be done immediately and without delay
- Family and child safety is the prime consideration
- Work with the parent to enhance safety planning



In rural and remote areas the parent may be concerned by knowing everyone within a small community. This may result in limitations to disclosures and it may be appropriate to encourage follow up support through recognised DVI telephone support.



Child safety concerns will require a Report of Suspected Child in Need of Protection. See page 173.



See appendix 4



DV-alert (Domestic Violence Response Training) | www.dvalert.org.au
Free accredited training program for health professionals

Infant health assessment

Universal newborn hearing screen

Why, when and how:

- In the healthy infant, once amniotic fluid drains from their ear after birth, the auditory acuity will be similar to that of an adult. The response to sound is usually demonstrated with a Moro or startle reflex. Observing a startle reflex does not confirm the infant has normal hearing and does not replace the need for hearing screening and assessment ⁷².
- The **Healthy Hearing Program** aims to identify children with sensorineural or permanent hearing loss as soon as possible after birth. The screening is performed using Automated Auditory Brainstem Response technology during the birth admission. If hearing problems are detected early and early intervention through the fitting of hearing aids and/or communication development support begins before babies are six months old, they have a stronger chance of heading off future communication, health and learning problems ⁷².
 - Infants who were not screened during their birth admission, or those who require follow up, are identified and managed after discharge.
 - It is important for all children to have their hearing screened in the early neonatal period. The child health professional is recommended to check in the PHR book that this screening has been conducted and follow up with the parents if it has not been done ⁷².
 - It is extremely important to follow up with the parents of any child who has not passed newborn hearing screening, (i.e. 'refer' result for one or both ears) and has not attended for diagnostic audio-logical assessment. A proportion of children who pass the screen, but have risk factors for progressive or delayed onset hearing loss may also be offered an audio-logical assessment in their first 12 months ⁷².
- Screening for hearing impairment for all children beyond the neonatal period should occur immediately upon suspicion of hearing concerns. Early identification of hearing loss is critical ⁷².

When additional care is required / referral process:

- Post-diagnostic medical guidelines have been developed for the medical assessment of children diagnosed with a hearing loss.
- The **Queensland Hearing Loss Family Support Service (QHLFSS)** is a state-wide service which has been established to provide family-centred support and counselling for families where children are diagnosed with a permanent hearing loss ⁷³. The QHLFSS has a team of family support facilitators operating from two service hubs, one located in Brisbane and one located in Townsville, including outreach services within Queensland. QHLFSS will offer support from birth through to completion of Year 1 at school ⁷³.
- General information and translated brochures which describe the program and provide contacts within each area are available on the Healthy Hearing website ⁷².



Healthy Hearing Program | www.health.qld.gov.au/healthyhearing/default.asp

www.health.qld.gov.au/healthyhearing/pages/Resourcesinfo.asp

Queensland Hearing Loss Family Support Service | Tel: 1800 352 075

www.health.qld.gov.au/healthyhearing/pages/family.asp

Neonatal screening test

Why, when and how

- The Neonatal Screening Test is designed to identify newborns with a high probability of having a particular disorder. Disorders that are screened for include:
 - phenylketonuria
 - primary hypothyroidism
 - cystic fibrosis
 - galactosaemia
 - rare metabolic disorders relating to amino acid / organic acid /fatty acid metabolism, such as homocystinuria, methylmaloric acidemia and MCAD deficiency.

Early detection and treatment impacts on improved health outcomes in the event that any of these disorders are diagnosed⁷⁴.

Infant screening occurs following parental explanation and consent with the collection and analysis of a bloodspot sample on a newborn screening card usually via a heel prick. The blood sample is ideally collected between 48 and 72 hours after birth⁷⁴.

- During the initial consultation by the child health professional, the health professional will check that the test has been conducted and recorded in the PHR. If there is no record of the test, contact the newborn screening laboratory on **07 3636 7051** to ensure the test has been completed.
- Families are only notified if results are 'positive' indicating that further clinical evaluation is required via their GP / paediatrician to determine whether or not they are affected by a disorder⁷⁴.

Physical assessment

Why and when

- Any contact with a child gives the child health professional an opportunity to gain valuable information about their developmental progress and health status. The child can be observed when speaking or interacting, at play or during a routine health screening or surveillance.
- A physical assessment is conducted and combined with history taking and interviewing to enable the health professional to develop a holistic assessment of the individual health status of an infant. The extent of examination varies depending on the circumstances of each health contact⁵⁸.
- Following birth the maternity care provider completes a complete 'head to toe' examination and it recommended to be repeated within the first seven days of life; this may be done by the maternity care provider or GP if the infant is discharged prior to 72hrs of age⁵⁸. Early detection of cardiac disease, undescended testes, developmental dysplasia of hip and specific examination of the eyes in the newborn period should occur as a routine part of early detection by medical practitioners⁵⁸. Follow on physical assessments are undertaken by the child health professional according to the well child checks schedule in the PHR and at other contacts at the discretion of the child health professional.



Queensland Health Guideline: Assessment of infant/child nutrition, growth and development within the primary health care setting. http://qheps.health.qld.gov.au/patientflow/docs/scycn_nutrit_guide.pdf



Refer to the Pathways to Rural and Remote Orientation and Training
www.health.qld.gov.au/parrot/default.asp



Refer to *Chronic Conditions Manual*



Refer to *Primary Clinical Care Manual*



Practice tips: Conducting a 'head-to-toe' assessment

General considerations ^{24,58,66}

- Ensure environment factors are considered, e.g. reduce loss of body temperature in a newborn by conducting the assessment in a warm area and covering body areas that are not being examined.
- Work place health and safety factors, such as:
 - protective equipment for the examiner (e.g. gloves)
 - infection control measures (e.g. cleaning of environment in between infants)
 - suitable height of the examination table.
- To be most effective in observing the health status of the child a methodical, systematic approach ensures maximum information is obtained with a minimum of time and effort
- The health professional can gain a range of information from the general appearance of the infant prior to the examination, such as: infant's response to parent / examiner, state of alertness and activity, range of spontaneous movements, body odour, how the infant is dressed. The examination generally commences at the head and systematically moves down to the toes, however, each body part can be done in any order depending on the infants activity at the time of the examination.
- The health professionals' foundational theoretical knowledge and training facilitates the interpretation of the findings from the physical examination to be deemed 'normal', 'abnormal' or requiring further examination. These clinical judgements guide the health professional about when to refer for further assessment (e.g. GP/medical officer).

Below are some specific components of the total head to toe assessment outlined in more detail:

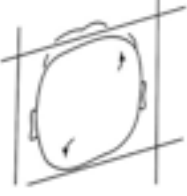

Head examination

- The skull is palpated to assess anatomy of the sutures and fontanelles. Fontanelles should be flat and firm and are often used as a clue to an infant's hydration status. The triangular posterior fontanelle generally closes by around eight weeks. There is a varying range of normal sizes of the anterior fontanelle among infants of different ethnic backgrounds and the average time of closure is 13–14 months, with all infants expected to have a closed anterior fontanelle by two years ⁷⁵.
- General observation of the contour of the head is important to detect plagiocephaly. Plagiocephaly can be either **positional** (also called non-synostotic deformational) or **synostotic** ⁷³.

Synostotic plagiocephaly results from a premature fusion of one or more cranial sutures. This is a rare condition and can result in an unusual head shape, including facial changes. It may be associated with developmental delay and possible raised intracranial pressure. Treatment may include helmet and/or surgery ^{77,78}.

Positional plagiocephaly (PP) is a common, mostly preventable and often a self-resolving condition, where the skull becomes misshapen as a result of external forces that mould the skull in the first year of life ⁷⁶.

The following table outlines some of the differences between the two:

Positional plagiocephaly (PP)	Synostotic plagiocephaly
<ul style="list-style-type: none"> ■ Oblique head shape  <p>Lateral PP</p> <ul style="list-style-type: none"> ■ Flattening on one side of the head with corresponding prominence on the opposite side resulting in a parallelogram-shaped skull (see diagram above). ■ No sutural ridging ■ Ear shift forward on the same side of lateral PP ■ The flatness can be on the side (lateral PP) or there can be a central flattening of the back of the head (posterior PP or Brachycephaly) ⁷³. 	<ul style="list-style-type: none"> ■ Overall head shape may be a trapezium shape (see diagram below) with characteristics such as a pointed triangular forehead  <p>Lambdoid synostosis</p> <ul style="list-style-type: none"> ■ Suture abnormalities, e.g. ridging palpated greater than what would be expected after birth moulding ■ Ear shift backwards on the flattened side of the skull ■ Infants should be referred for further investigation ■ If the child health professional detected any signs or symptoms of increased intracranial pressure or poor brain growth immediate referral to a Medical Officer for further assessment is recommended ⁷³

- There is a higher prevalence of right-sided positional plagiocephaly and it has an increased incidence in:
 - males
 - history of gestational uterine constraints (e.g. multiple birth)
 - torticollis (tightening of the neck muscles)
 - Any condition causing neurodevelopmental delay and poor head movement / head control
 - infants that sleep well
 - sleep positioning
 - cultural factors ⁷⁶⁻⁷⁹.
- Emerging evidence suggests infants with PP are less active, have variable tone and have some areas of developmental delay when compared with their age-matched peers. It is not clear however, whether the PP results from these characteristics or whether the PP is the cause of these characteristics. None the less, this demonstrates the importance of prevention and early intervention strategies and the need for health care professionals to be aware of an increased possibility of developmental delay among infants with a history of plagiocephaly ^{77, 78}.

Referral

- The child health professional is recommended to refer the child to a MO/GP for further assessment if plagiocephaly is identified. All infants with plagiocephaly should be examined for craniosynostosis, congenital torticollis and cervical spine abnormality ⁷⁹.
- Outcomes and treatment will depend on the severity of the PP. Often conservative strategies implemented early will result in good outcomes, with some cases where developmental/motor delay has been identified on assessment, referral to the broader multidisciplinary team via a MO. Physiotherapy and use of a moulding device (helmet) may be considered ⁷⁹.



Early intervention is key in the prevention of long-lasting changes in the skull shape.

The child health professional is ideally placed to promote preventative measures and implement early management strategies including referral for further assessment ⁷⁶.

See page 114.

Assessment of vision and eye function ¹⁴¹

- The current standards for conducting evidence-based early detection recommend vision assessment and examination of the eyes in the newborn period by medical practitioners ¹.
- Universal health check at key ages as per PHR, include an examination of the infant's eye ¹. The health professional should consider the following:
 - at birth the eye is structurally immature which limits the eyes' ability to accommodate and fixate on objects for any length of time. The pupils will react to light, the blink reflex is responsive and the corneal reflex can be activated. The newborn has the ability to momentarily fixate on a bright or moving object that is within 20 cm and in the midline of the visual field
 - examination should include observing the eyes for symmetry, location of the eyes in relation to the nose, structural abnormality
- **Fixation and following objects (6 and 12 months):** use an interesting toy to track in a 'H' pattern about 30 cms away from the child to see if the child is tracking the object and then gradually move away to about 6 meters from the child with the toy. The child should be able to track the object without any abnormal eye movements
- **A red eye reflex: completed by trained staff, at 1-6 weeks, 2,4,6,12 months.** Using an ophthalmoscope, the pupil will appear red (the blood at the back of the retina) as evidence that the retina is intact and the lens and cornea are clear.
- The **corneal light reflex (complete at 6 and 12 months)** can be tested as follows:
 - Infant can be sitting on the lap of the parent.
 - Hold a small flashlight directly in front of the child's eyes, aimed towards the bridge of the nose but level with the two eyes at a distance of 30 cm.
 - Observe light reflection in both eyes. If each eye is properly fixing on the light, the reflections of the light on the cornea will be on the same, more or less central part, of each cornea. It is normal for the light reflex to be slightly nasal to dead centre (positive angle Kappa).
 - What you are looking for is asymmetry of the corneal light reflexes. Document findings (e.g. corneal light reflexes R = L, or corneal light reflex test).
- A range of conditions may be identified, e.g. strabismus, congenital cataract, congenital glaucoma
- **Referral**
Refer for GP review if you detect any abnormalities or have any concerns, also consider referral for infants with history of prematurity and/or oxygen therapy, e.g. unclear red reflex, unequal corneal light reflex.



Refer to *Chronic Conditions Manual*



Refer to the Pathways to Rural and Remote Orientation and Training
www.health.qld.gov.au/parrot/default.asp

Assessment of hearing and ear health: 0–12 months ¹⁴¹

- An **appropriately trained** Registered Nurse/Health Worker/Practitioner may undertake an ear and hearing health screen for children less than four (4) years of age by Otoscopy and tympanometry.
- Do not proceed with ear health and hearing screening if there is ear pain, notable discharge or the skin is broken or inflamed. These children are referred to MO/GP/Nurse Practitioner or refer to the guidelines in the Primary Clinical Care Manual.
- Ask the parent/carer if they have any concerns about their child’s hearing, ear health, speech and language development and developmental progress using the questions outlined below.
- Always start with the right ear as a point of reference.
- Determine if the child requires otoscopy and/or tympanometry. When both are required the sequencing of tests will be:
 1. otoscopy
 2. tympanometry.

Hearing and ear health screening recommendations

Age	Questions to ask	Procedure
During the birth admission / early neonatal period		Universal Newborn Hearing Screen
One to six weeks	<ul style="list-style-type: none"> ■ Did your baby have a universal newborn hearing screen? ■ Did your baby require any follow up following the newborn hearing screen? ■ Is your baby startled by loud noises, e.g. a loud clap? ■ Has your baby been free of ear infections or discharge? 	Visual examination of the external pinna for shape, structure, size, skin colour, any lesions. Gently palpate the area around the ear, i.e., area over the mastoid bone behind the ear, under and around the front of the ear for swelling, inflammation or suspected tenderness
Two months	<ul style="list-style-type: none"> ■ Do you think your baby can hear you? ■ Has your baby been free of ear infections or discharge? 	Otoscopy
Four months	<ul style="list-style-type: none"> ■ Are you happy about your baby’s hearing? ■ Does your baby turn towards sound or voices? ■ Does your baby settle with familiar sounds or voices? ■ Has your baby been free of ear infections or discharge? 	Otoscopy
Six months	<ul style="list-style-type: none"> ■ Are you happy about your baby’s hearing? ■ Does your baby turn towards sound or voices? ■ Has your baby been free of ear infections or discharge? 	Otoscopy Tympanometry
Twelve months	<ul style="list-style-type: none"> ■ Has your child been free of ear infections or discharge? ■ Are you happy about your child’s ears and hearing? ■ Are you happy with your child’s speech and language development? 	Otoscopy Tympanometry

- Refer to further Practice tips: Conducting Otoscopy and Tympanometry on page 85.

Examination of the hip (6-8 weeks and 6 months) ^{58,276}

- Infants should be examined for hip function and to rule out Developmental Dysplasia of the Hip (DDH).
- Infants beyond a few weeks old have greater hip stability than infants soon after birth, therefore child health professionals need to observe for subtle changes and loss of hip abduction:
 - Lay the undressed (waist to feet) child on examination table in a supine position.
 - When relaxed extend the infants legs to ensure the pelvis is horizontal and equal leg length.
 - The examiner's middle finger of each hand is then placed over the greater trochanter (outer side of the hip joint). The examiner's thumbs are simultaneously placed on the inner side of the thighs. The hip and knee joints are flexed to right angles.
 - The examiner then attempts full abduction only of both legs.
 - Note the presence of limited abduction or unequal abduction, shortening of the thigh, unequal skin folds.
 - Documentation should detail findings of the examination in the clinical record, e.g. equal leg length, symmetrical abduction of both legs.
- **Referral**
There is a narrow window of opportunity for safe, simple treatment of DDH, child health professionals should refer any abnormalities to General Practitioner/Medical Officer, for example: limited abduction of both or either leg, leg lengths unequal.



Developmental Dysplasia of the Hip screening training program, Royal Children's Hospital Melbourne
<http://surgicalmultimedia.com/DDH/player.html> ⁸⁰

Examination of the testes (6-8 weeks) ⁵⁸

- Male infants should be examined to ensure testes have descended
 - Ensure hands are warm (when stimulated by cold or touch the cremasteric muscle reflex causes the skin of the scrotum to shrink and pulls the testes high into the pelvic cavity)
 - Lay the undressed (waist to feet) child on examination table in a supine position.
 - Observe the genitalia for any overall variation from normal, e.g., swelling
 - Block the possible ascent of the testes by placing the thumb and index finger on the upper part of the scrotal sac along the inguinal canal. The testes are then gently palpated between the index finger and thumb of the other hand.
 - Identify the presence of testes/fluid in the scrotum.
 - Repeat for the other side.
 - Document findings (e.g. right and left testes descended into scrotum)
- **Referral** – If palpation reveals any abnormality, refer to General Practitioner/medical officer.

Femoral pulses (6-8 weeks) ⁵⁸

- Femoral pulses should have equal and strong pulsation.
- Lay the child on examination table in a supine position with nappy off.
- With legs extended place the index and middle fingers into the groin to palpate the femoral pulses simultaneously for fullness and equality.
- Document findings, e.g., femoral pulses equal and strong.
- Referral – Refer any abnormality of pulses, e.g., weak, absent, unequal.



See appendix 7 for a sample an Infant Assessment Form



Refer to *Chronic Conditions Manual*

Growth monitoring

Growth during infancy and childhood is an important indicator of nutritional and health status and remains the best method of assessment at the primary care level^{81,244}. Weight gain and increase in size of the child occurs as body systems mature. Physical growth is best assessed by measuring weight, length or height and head circumference and comparing these measures with a growth reference^{58,81,244}.

Accuracy is crucial in obtaining all physical measurements. There are three components of accurate measuring:

- technique that is standardised, e.g., bare weigh children less than two years old
- equipment that is calibrated and accurate
- measurers that are trained so they are accurate and reliable.

In addition:

- ensure scales and stadiometers are regularly calibrated to manufacturer's instructions and checked each day of use
- use the same scales whenever possible
- follow manufacturer's instructions on transportation of portable scales.

Growth charts^{58,81,82,244}

- Growth charts are used as a reference to critically analyse growth measurements of weight, length or height and head circumference by comparing these against recommended populations
- There are currently a number of growth charts available for use. Current recommendations use the WHO growth standard up to 2 years of age, followed by the CDC growth charts
- Regular and consistent growth monitoring enables the health professional to critically analyse the pattern or trend of growth when plotted on a growth chart by observing the shape of the curve and compare it to percentile curve
- Factors that influence a child's growth can include gender, genetics, health, environmental facts. (e.g. nutrition)
- Children who are not following the shape of the curve over a number of readings are referred for further assessment according to recognised referral guidelines
- Always ensure the correct chart is being used. (e.g. gender)
- Health professionals may need to ensure parents understand the importance of the pattern of growth following a trajectory along the percentiles, more so than the position on the percentile charts.



Growth charts

Centre for Disease and Prevention | www.cdc.gov/growthcharts

Royal Children's Hospital, Melbourne | Top 10 things you you need to know about growth charts:
www.rch.org.au/childgrowth/about_child_growth/Top_10_things_you_need_to_know_about_growth_charts/



Queensland Health Guideline: Assessment of infant/child nutrition, growth and development within the primary health care setting. http://qheps.health.qld.gov.au/patientflow/docs/scycn_nutrit_guide.pdf

Allowance for gestational age

- Allowance for gestational age for growth and development is made for children born under 37 weeks and according to their gestational age at birth:
 - Infants less than 37 weeks gestation and after the 32nd completed week should have their age corrected until one year
 - Infants less than 32 completed weeks gestation should have their age corrected up until two years
 - Correction beyond two years may be required as directed by a tertiary specialist^[79].
- For example, If an infant is born at 34 weeks gestation visits a child health centre at eight weeks of age, the weight will be plotted at the age of two weeks. (eight weeks chronological age less six weeks preterm = two weeks).



See page 160 for further information about prematurity.



Children's Health Queensland Hospital and Health Service
 Procedure: Corrected Age for Assessment of Preterm Infants
http://qheps.health.qld.gov.au/childrenshealth/resources/proc/docs/proc_00199.pdf

Weight

- Weight (or mass) is an overall measure of body size and is of interest because it indicates changing health status and growth and development. Knowing the weight of an individual also enables the calculation of the body mass index (BMI)⁵⁸.
- Weighing activities of an infant is valued by parents and often an incentive for visiting a health professional. This raises an opportunity for other concerns to be raised and anticipatory guidance to be offered¹.
- In general, weight variations for infants follow the pattern of:
 - An initial weight loss (up to 10% of the birth weight) followed by the infant gaining weight by four to six days of age and returning to birth weight by two weeks of age
 - Gains of 150-200 g/wk up to 3 months
 - Gains of 100-150 g/wk from 3-6 months
 - Gains of 70-90 g/wk up to 12 months⁴¹.
- Families should be given accurate information about their infant's growth and informed when there are any concerns regarding poor growth or high rates of growth. This is particularly important with rising rates of obesity in children and teens in Australia and in high risk groups such as Aboriginal and Torres Strait Islander families who have a higher prevalence of:
 - small for gestational age,
 - obesity,
 - early onset type 2 diabetes and
 - other chronic diseases^{1, 84}.
- Documentation should include the child health professional's assessment of the weight measurement.

Length/height⁵⁸

- Changes in the height of an individual over a period of 3-12 months (height velocity) reflect changes in the nutritional and health status of that individual. Height is important in the calculation of BMI
- Length is measured in the recumbent (lying) position as this is the correct linear measurement for infants younger than 24 months of age or children aged 24-36 months who cannot stand unassisted

- A calibrated length board is recommended for length measures and it must have:
 - a fixed headpiece
 - a moveable foot-piece, perpendicular to the surface that the length board is on.
- Height measurement requires a vertical metric rule, a horizontal headboard and a non-compressible flat, even surface, on which the subject stands. A rigid stadiometer is best (portable measures are available for situations where the screener moves from site to site; while well-calibrated wall mounted stadiometers are ideal for centre-based screening).
- The graduations on the metric rule should be at 0.1 cm intervals and have the capacity to measure up to at least 210cm. Measurement graduations need to be easily readable.
- Children who are not following the shape of the curve over a number of readings are referred for further assessment according to recognised referral guidelines.
- Documentation should include the child health professional's assessment of the measurement.

Head circumference ^{58,60,85}

- It is recommended that the infant's head circumference recorded after birth and before discharge. Any excessive oedema or moulding of the scalp should be recorded. Head measurement should subsequently be undertaken at universal child health checks during the first 12 months of age.
- A routine measurement of head circumference is intended to aid the detection of two groups of disorders: those characterised by a large head (macrocephaly) and those indicated by a small head (microcephaly). These conditions cannot be diagnosed by measurement of the head circumference alone. A head circumference above the 97th percentile or below the 3rd percentile at any stage is an indication for more detailed assessment. In the primary care setting the infant is referred to the General Practitioner.
- If the head circumference growth line crosses the percentiles upwards and the child shows symptoms or signs of hydrocephalus, or downwards associated with other abnormality, (e.g. weight loss) referral to GP/MO is essential. Where the measurement crosses the percentile lines and there are no accompanying signs or symptoms, the measurement can be repeated in four weeks. If this measurement confirms the change in percentiles then refer to GP/MO.
- Documentation should include the child health professional's assessment of the measurement.



Growth charts

Centre for Disease and Prevention | www.cdc.gov/growthcharts ⁸²

Royal Children's Hospital, Melbourne

www.rch.org.au/childgrowth/about_child_growth/Top_10_things_you_need_to_know_about_growth_charts/

Clinical Practice Guidelines for the Management of Overweight and Obesity in adults, adolescents and children in Australia | **National Health and Medical Research Council**

www.nhmrc.gov.au/guidelines/publications/n57



Queensland Health Guideline: Assessment of infant/child nutrition, growth and development within the primary health care setting. http://qheps.health.qld.gov.au/patientflow/docs/scync_nutrit_guide.pdf



Refer to *Chronic Conditions Manual*



Practice tips: Weighing and measuring an infant

Weight

Weighing infants with too much clothing is one of the most frequent sources of error in infant weight measurements. Weighing an infant/child under two years naked gives the most accurate measurement.

1. Check the accuracy of the scales daily prior to weighing any infants.
2. Infant is placed on the scales so that the weight is distributed equally.
3. When the infant is lying quietly, weight is recorded to the nearest 10grams.
4. Record in client record / PHR and plot on the appropriate percentile chart ^{82-84,86-88}.

Referral

For infants under 12 months of age referral to a Medical Officer will be required if:

- any sudden deviation in weight, where the weight has crossed two percentiles
- weight below the 10th percentile or greater than the 90th percentile ^{82-84,86-88}.

Length

Length/height is a mandatory component of the growth assessment, weight is meaningless unless a corresponding length/height is done simultaneously.

1. Infant should be measured wearing a clean disposable nappy and singlet. Remove shoes and any hair ornaments from the top of the head.
2. Two observers are required – one observer (carer) positions the head correctly while the other ensures the remaining position is correct and brings the measuring board in contact with the feet.
3. The crown of the head must touch the stationary, vertical headboard and the child's head is held with the line of vision aligned perpendicular to the plane of the measuring surface.
4. The shoulders and buttocks must be flat against the table top, with the shoulders and hips aligned at right angles to the long axis of the body.
5. The legs are gently extended at the hips; knees and lie flat against the table top; arms rest against the sides of the trunk.
6. The measurer must ensure that the legs remain flat on the table and must shift the movable board against the heels.
7. The length is recorded to the nearest 0.1cm.
8. Record in client record, PHR and plot on appropriate percentile chart ^{41,58}.

Referral

Generally weight and height should follow the same percentiles with variations among children from different cultural backgrounds. Refer to general practitioner/medical officer if length has crossed two percentile lines or if it is above 90th percentile or below 10th percentile ^{41,58}.

Head circumference

1. Observe the overall shape of the head noting any abnormal shape and the size of the anterior and/or posterior fontanelles if present.
2. Head circumference can be measured with the infant lying supine.
3. Remove objects such as hairpins from the hair, if necessary.
4. Head circumference or OFC (occipital frontal circumference) is measured over the most prominent part on the back of the head (occiput), just above the eyebrows (supraorbital ridges), and above the ears. The goal is to locate the largest circumference of the head. It should be sufficiently tight to compress hair.
5. The measurement is recorded to the nearest 0.1cm.
6. Take a repeat measurement after taking off the tape and replacing it again. If the two measurements disagree by equal to or more the 0.3cm, then take a third measurement. The child's measured head circumference is subsequently calculated as the mean of the two observations or the mean of the two closest measurements if a third is taken.
7. Record in client record, PHR and plot on appropriate percentile chart ^{58,85}.

Referral

A head circumference above the 97th percentile or below the 3rd percentile at any stage is an indication for more detailed assessment. In the primary care setting the infant is referred to the GP ¹⁵⁷.

If the head circumference growth line crosses the percentiles upwards and the child shows symptoms or signs of hydrocephalus or other abnormality referral to GP/MO is essential. If there are no accompanying signs or symptoms, repeat the measurement in four weeks and reassess ^{58,85}.



Refer to *Chronic Conditions Manual*



Refer to the Pathways to Rural and Remote Orientation and Training
www.health.qld.gov.au/parrot/default.asp

Developmental assessment

The first year of life for an infant incorporates growing at an amazing rate in physical size and in the ability to perform tasks and develop social relationships⁵⁸. (Further information on promoting normal infant development is available within the health promotion section of this manual.)

- Development refers to the increased ability of the body to function within the environment and can be categorised into a number of domains, for example
 - Physical development – gross motor and fine motor skills
 - Socio-emotional and cognitive development
 - Language and literacy.

Whilst development proceeds at different rates in different individuals, an average systematic, predictable sequence occurs, which we can use to assess the developmental progress of each infant^{4,58}.

Validated screening tools

- There are a number of tools that are available for developmental assessment in the primary care setting. Health professionals should check which developmental assessment tools are recommended to be used in their particular setting and be trained to administer and interpret the outcomes of the tools correctly. Some screening tools include⁴:
 - **Ages and stages questionnaire (ASQ)** <http://agesandstages.com/>
Age: 3 months – 5 years
Why it is used: to identify developmental delays
Completed by: Parents/carers at home. Any concerns can be discussed with a child health professional.
 - **Parents Evaluation of Developmental Status (PEDS)**
www.pedstest.com/Home.aspx
Age: 0–8 years
Why is it used:
 To detect developmental and behavioural issues.
 Used in conjunction with ASQ for screening purposes.
 ASQ:SE Questionnaire can be used in addition to screen the personal and social skill domain
Completed by: Parents and incorporated into a child health monitoring program.
 Further information: www.rch.org.au/ccch/resources_and_publications/Monitoring_Child_Development/
 - **Brigance Screens** (Brigance Early Childhood Screen II)
www.casamples.com/downloads/11968s.pdf
Age: 0– 7 years
When it is used: Secondary screening, tests to identify developmental delay or advanced development.
Completed by: Trained health care professional.
- Developmental assessment of any child must have a holistic focus. This means that the domains of development are considered in an ecological framework that considers the physical, social, emotional and environmental factors involved⁸⁹.
- Developmental delay often describes a lag in the acquisition of a skill/developmental milestone. In less common cases the typical developmental trajectory is significantly impacted and the term disorder or impairment is commonly used. Early and accurate identification of infants with developmental delays or disorders facilitates early intervention. Early intervention has been shown to result in improved developmental, educational and social outcomes with the earlier the intervention taking place the better the outcome⁸⁹.

Communication and interaction

Communication development commences from the first interaction between the parent and child. Communication is about more than just talking and encompasses:

- Verbal and non-verbal interactions between parent and infant. Language is a cognitive process that develops in a social context. It is acquired through interaction with caring and responsive adults and is influenced by biological, cognitive, psycho-social and environmental factors ⁶⁹.
- Children who show signs of communication delay or difficulty, should be referred for further assessment and intervention as early as possible. Research shows that the best long term outcomes arise from children who are given help before the child enters school – as early as 0-3 years. The approach recommended is early intervention rather than ‘wait and see’ ⁸⁹.
- Some factors are known to increase the probability of a child experiencing a communication difficulty. These risk factors include:
 - hearing loss, including both sensorineural and early fluctuating conductive hearing loss,
 - a family history (including parents and siblings) of speech and/or language delays,
 - limited babble, limited different types of babble, or a small amount of consonants used in babble a small number of verbs (action words) in their early sentences,
 - a child’s receptive language behind their expressive language by at least 6 months,
 - delays in other areas of development (eg. fine motor and gross motor)¹⁹⁶.
 - The development of communication and interaction may also be impacted by the parent/carer’s reactions ⁸⁹, such as:
 - › The parent/carer does not respond to the child’s communication, e.g. does not respond consistently to the child’s cues, does not soothe the child when distressed, does not pay attention to the child’s reactions, is not in tune with the child.
 - › The parent/carer has limited communication with the child or may use a harsh or negative communication style with the child ⁶⁸.

Referral

When concerns are raised following a thorough developmental assessment a referral is recommended ⁸⁹. Depending on the nature of the concern and the services available, this may include referral to the families’ GP / Medical Officer / Paediatrician / EIPS/EIC/Child Health Developmental Service/Infant-Mental Health Service. The “Red Flag” Early Intervention Referral Guide for children 0-5 years can be used as a guide ⁹⁰.



See appendix 1, 2 and 8.



Monitoring Child Development | **The Royal Children’s Hospital Melbourne**
www.rch.org.au/ccch/resources_and_publications/Monitoring_Child_Development/

The Red Flag Early Intervention Referral Guide for children 0-5 years (Queensland Health)
www.health.qld.gov.au/rch/professionals/brochures/red_flag.pdf



Queensland Health Guideline: Assessment of infant/child nutrition, growth and development within the primary health care setting. http://qheps.health.qld.gov.au/patientflow/docs/scync_nutrit_guide.pdf



Refer to *Chronic Conditions Manual*

Age-appropriate interaction, speech and language skills (birth to one year) ^{69,90,96}

Age	Interaction	Speech	Understanding	Expression	When to refer
0–3 mths	<ul style="list-style-type: none"> ■ makes eye contact with you and you will smile at each other ■ becomes easily over stimulated, take care - when infant has had too much excitement - will start to cry and need to be calmed down ■ quiets to familiar voices 	<ul style="list-style-type: none"> ■ vowel sounds produced 	<ul style="list-style-type: none"> ■ infant will 'read' some of your expressions and will look worried if you look worried ■ sounds as well as sights are becoming familiar and defined - will recognise voices and turn head towards them ■ babies can start showing interest in books 	<ul style="list-style-type: none"> ■ coos and gurgles with pleasure ■ begins babbling and then listening at around 3-4 months ■ different cries indicate what needs are 	<ul style="list-style-type: none"> ■ not startling to loud noises ■ not seeking sounds with eyes ■ no vocalisations
4–6 mths	<ul style="list-style-type: none"> ■ smiles lots ■ laughs out loud, squeals with delight ■ likes being around people ■ is interested in surroundings and activities ■ is often happy to be with strangers 	<ul style="list-style-type: none"> ■ starts to make sounds when you talk 	<ul style="list-style-type: none"> ■ infant will have 'conversations' ■ will be getting excited at the feeling of a parent responding to them, shown by kicking their legs and waving their arms 	<ul style="list-style-type: none"> ■ experiments with sounds (vocal play) ■ blows raspberries, squeals and growls ■ 'talks' to toys at around 5-6 months 	<ul style="list-style-type: none"> ■ not smiling ■ not showing interest in interacting with people ■ no vocalisations or no variety in the sounds being produced

Age	Interaction	Speech	Understanding	Expression	When to refer
7–9 mths	<ul style="list-style-type: none"> ■ begins to have desires of own, simple things they know they want, like wanting to hold an object or to be picked up immediately ■ recognises the important, familiar people in their world and become sensitive to strangers ■ by 9 months may be shy with strangers, may not want to be too close to people they know, such as grandparents. However, it is a very sociable age and they will love to be talked to and played with (e.g. ‘peek-a-boo’) 	<ul style="list-style-type: none"> ■ enjoys making sounds they know and that they have made them ■ experiments and copies different sounds like clicks and lip bubbles ■ starts putting a vowel and a consonant together in long chains of babble (e.g., dadadad, mumumum, babababa) 	<ul style="list-style-type: none"> ■ infant will listen carefully when spoken to, and will try to talk back to you using babbling sounds ■ recognises familiar names or words 	<ul style="list-style-type: none"> ■ infant will use different sounds to express different emotions; such as frustrated grunts, squeals and chortles of delight ■ might say ‘ma-ma-ma’ because they can, rather than because they understand that this sound is a word they can use when they want their mother 	<ul style="list-style-type: none"> ■ does not babble or make other sounds when someone talks to them ■ does not recognise mother ■ does not show interest in surroundings
10–12 mths	<ul style="list-style-type: none"> ■ smiles and babbles and tries to engage you in a conversation ■ uses gestures and copies simple hand games like ‘clap hands’ or ‘bye bye’ ■ is frightened when parents leave and will cling and cry ■ wary of strangers ■ looks at objects and people 	<ul style="list-style-type: none"> ■ lots of babble and jargon ■ long chains of babble ■ real words may emerge 	<ul style="list-style-type: none"> ■ recognises several words ■ can identify two body parts by 12 months ■ understands no and will pause momentarily when ‘no’ is said in a stern voice 	<ul style="list-style-type: none"> ■ points and grunts ■ uses gesture ■ shakes head ■ ‘no’ by about ten months ■ some words may emerge ■ uses babble in interactions 	<ul style="list-style-type: none"> ■ babbling has not become more complex (i.e. only occasionally or not at all; babble structures do not vary) ■ does not show pleasure when with main caregiver ■ does not show anxiety with strangers

**Practice tips: Conducting a developmental assessment** ^{1,58,59,60,90}

- Developmental assessment involves:
 - eliciting and discussing parents' concerns
 - making accurate and informative observations of a child
 - obtaining relevant developmental history
 - promoting development.
- Aboriginal and Torres Strait Islander Health Workers will refer to the child health professional (as necessary) to discuss developmental assessment.
- The PHR book has specific questions about development for the parent to consider prior to attending for routine health checks. Use these questions as discussion points with parents.
- Using a systematic approach (often this is done in combination with the head to toe assessment) assess the infant against the expected milestones.
- As topics are discussed anticipatory guidance can be offered on promoting development (a variety of information about promoting normal development is included in the Health Promotion sections of this manual).
- Access the approved tool from your local hospital and health service district to document your findings.

Referral

When concerns are raised following a thorough developmental assessment a referral to the family's GP / medical officer / paediatrician / multidisciplinary team according to local referral pathways.



See appendix 7.



Refer to the Pathways to Rural and Remote Orientation and Training
www.health.qld.gov.au/parrot/default.asp



Refer to *Chronic Conditions Manual*

Assessing infant nutrition

Nutritional assessment is an opportune time for discussion and anticipatory guidance around healthy eating within the family. Considerations of cultural and environmental factors are important during these discussions.

Stages of feeding development ^{58,92,93}

Oro-motor development involves both structural development and neural development and can be used as a guide to indicate readiness to progress through each stage of feeding development. At birth the mouth is fully filled by the tongue, which is in close proximity to the cheeks, hard palate, and soft palate. The tongue protrudes past the alveolar ridge to maintain contact with the lower lip. This close proximity of structures and the infant's subcutaneous fat provides positional stability. As the infant matures, structures move further apart and postural stability is provided. The infant's oro-motor structures should be symmetrical and have a symmetrical range of movement .

Neural development impacts on feeding development. The cranial nerves primarily involved in sucking, chewing, drinking and swallowing are: CN V, VII, IX, X and XII. Initially, the infant's feeding is predominantly reflex based. It is important to understand and utilise the reflexes. For example, it is important to elicit the rooting reflex to support cue based feeding.

Development of oral feeding skills

For feeding to be optimal there must be co-ordination of the infant's ability to suck, swallow and breathe to transfer food from the mouth to the stomach ⁹³.

Sucking can be **nutritive** or **non-nutritive**. Non-nutritive sucking matures earlier than nutritive sucking ⁹³. Both behaviours seen in infants vary in a number of ways ⁹³:

	Nutritive sucking	Non-nutritive sucking
Purpose	<ul style="list-style-type: none"> Obtain nourishment 	<ul style="list-style-type: none"> Satisfy sucking desire, exploration, infant regulation
Rhythm	<ul style="list-style-type: none"> Initial continuous sucking burst, moving to intermittent sucking bursts with bursts becoming shorter and pauses longer over the course of the feed 	<ul style="list-style-type: none"> Repetitive pattern of bursts and pauses; stable number of sucks per burst and duration of pauses.
Rate	<ul style="list-style-type: none"> One suck per second, constant over course of feeding 	<ul style="list-style-type: none"> Two sucks per second
Suck: Swallow ratio	<ul style="list-style-type: none"> Young infant – 1:1 may be higher at end of feed Older infant - 2 or 3:1 	<ul style="list-style-type: none"> Very high ratio, 6:1 or 8:1

During breastfeeding, nutritive sucking comprises to two components:

Suction: the infant generates negative intra-oral pressure by closure of the nasal passages with the soft palate and a tight seal of the lips around the breast and a lowering of the mandible

Expression: by the infant moving the tongue toward the hard palate fluid is expressed by a stripping or compression process and the creation of positive pressure ⁹³.

Both rhythm components play an important role in infant feeding. When an infant has an immature suck or the rhythm is uncoordinated the feeding will not be effective. Variations within this process are created by infant factors and varied shapes, sizes and functions of the breast and nipple⁹³.

The characteristics and feeding development stages are listed in the following table. When assessing an infant, the ages are a guide only. It is important to assess the infant's skills to decide their readiness to progress through each stage of feeding development and that development of feeding skills should also be considered with the infant's development of gross and fine motor control, and their exposure to feeding experiences.

Birth ^{24,41,58,93}	
Reflexes	<ul style="list-style-type: none"> ■ Rooting reflex Reflex is stimulated by touch at the corner of the mouth Response: turn the head toward the touch ■ Suck-swallow reflex and gag reflex Reflex is triggered when the posterior tongue or pharynx is touched Response: contraction of the palate and pharynx ■ Tongue protrusion and transverse reflex Reflex is triggered by touch to lips or tongue Response: tongue protrudes and moves laterally ■ Phasic bite reflex Reflex is triggered by pressure on gums Response: rhythmic open and closing of jaw
Oro-motor skills	<ul style="list-style-type: none"> ■ respond to primitive reflexes ■ tongue occupies large proportion of the mouth ■ lips and tongue function as a total unit when feeding
Sucking	<ul style="list-style-type: none"> ■ 1:1 suck to swallow ratio ■ 2 or 3 sucks per swallow by the end of the feed ■ bursts of sucking followed by pauses ■ in-out tongue movements ■ support required to achieve midline orientation
Cup drinking	Not a main method of feeding
Solids	Not introduced

Three months ^{24,41,58,93}	
Reflexes	<ul style="list-style-type: none"> ■ gag and suck-swallow reflexes may still be present ■ rooting reflex is diminishing ■ tongue protrusion reflex present ■ phasic bite present
Oro-motor skills	<ul style="list-style-type: none"> ■ head and neck control improve along with oro-motor skills ■ increased oral and facial movement and control occurs, e.g., eye-contact, cooing, smiling, tongue poking ■ active lip movement with sucking
Sucking	<ul style="list-style-type: none"> ■ rhythmic sucking ■ 2 or 3 sucks per swallow ■ bursts of sucking followed by pauses ■ midline orientation with less support required ■ may lose some fluid from mouth during feeding
Cup drinking	Not main method of feeding
Solids	Not introduced

Four months ^{24,41,58,93}	
Reflexes	<ul style="list-style-type: none"> ■ Reflexes diminishing <ul style="list-style-type: none"> ○ gag ○ rooting ○ tongue protrusion and lateral reflex ○ phasic bite
Oro-motor skills	<ul style="list-style-type: none"> ■ lip pursing ■ blowing bubbles in saliva ■ voluntary control of mouth ■ opens mouth wide to presentation of breast/teat. ■ increased sound imitation ■ observe for signs of readiness for solids
Sucking	<ul style="list-style-type: none"> ■ in-out sucking changes to include up-down tongue movements ■ may lose some fluid from the mouth during feeding
Cup drinking	Not main method of feeding
Solids	World Health Organisation guidelines recommend introducing solids around six months

Six months 24,41,58,93

Reflexes	<ul style="list-style-type: none"> ■ reflexes diminishing <ul style="list-style-type: none"> ○ gag ○ rooting ○ tongue protrusion and lateral reflex ○ phasic bite
Oro-motor skills	<ul style="list-style-type: none"> ■ graded opening of mouth at presentation of breast/teat or spoon ■ able to hold mouth open in a quiet, stable position ■ increased active oral exploration with toys, other objects and fingers ■ gag reflex reduces as more experience of solids is gained ■ tongue movements include protrusion and lateral movements ■ longer lip closure ■ can be fed in an upright posture with some support from high chair or carer
Sucking	<ul style="list-style-type: none"> ■ no fluid is lost during sucking ■ some fluid may be lost at insertion or removal of breast/teat ■ infant can hold a bottle independently and throw it to the floor when they have finished
Cup drinking	<ul style="list-style-type: none"> ■ introduce cup drinking ■ loss of liquid may be observed ■ some coughing may be observed due to poor regulation of fluid flow while learning to coordinate ■ some parent use a spout cup to minimise loss and regulate flow ■ a wide lipped cup can help with lip closure and provide greater stability resulting in less fluid loss
Solids	<ul style="list-style-type: none"> ■ All nutritional needs are met with breast milk or formula up to around 6 months old; for good health, infant needs to start eating solids ■ introduce purees, smooth, soft, mashed solids ■ sucking pattern occurs on the spoon to remove solids ■ bolus manipulation involves sucking motions, jaw moves in an up-down motion ■ some food is pushed out of the mouth as the swallow is attempted ■ swallow is usually a suck swallow or a tongue thrust swallow ■ enjoys exploring food with fingers

Seven to nine months <small>24,41,58,93</small>	
Reflexes	<ul style="list-style-type: none"> ■ rooting reflex disappears ■ gag reflex diminishes ■ tongue protrusion and lateral reflex diminish ■ phasic bite may still be present
Oro-motor skills	<ul style="list-style-type: none"> ■ hand to mouth control improves ■ lip and jaw movement begin to separate for early chewing ■ greater range of babbling ■ coordinated lip, tongue and jaw movements in all positions ■ infants can sit in a high chair unsupported
Sucking	<ul style="list-style-type: none"> ■ up-down tongue movements more common ■ mature rhythmical sucking ■ drinks via teat/nipple or cup ■ no fluid is lost during breastfeeding/bottlefeeding
Cup drinking	<ul style="list-style-type: none"> ■ large jaw excursions with open cup ■ fluid loss continues ■ With open cup experience: <ul style="list-style-type: none"> ○ cup drinking with lower lip as stabiliser ○ mouth closure around cup rim
Solids	<ul style="list-style-type: none"> ■ solid foods are progressed from purees to smooth, soft, mashed solids according to infant cues ■ transferring foods from the centre to the sides of the mouth for chewing begins ■ begins using the upper lip to clear solids off spoon ■ enjoys exploring food with fingers, some self finger feeding

28, 41, 57, 90

10 to 12 months ^{24,41,58,93}

Reflexes	<ul style="list-style-type: none"> ■ Gag reflex diminished ■ Phasic bite reflex disappears by approximately 12 months
Oro-motor skills	<ul style="list-style-type: none"> ■ increasing coordination of jaw, tongue and lip movements, in all positions ■ can sit independently in high chair or booster seat ■ new sequences of sounds in babble ■ real words may emerge
Sucking	<ul style="list-style-type: none"> ■ Breastfeeding continues ■ if formula fed, wean from bottle as cup drinking increases
Cup drinking	<ul style="list-style-type: none"> ■ As cup-drinking experience is gained: <ul style="list-style-type: none"> ○ cup drinking becomes prominent ○ mature up-down tongue movement occurs during drinking ○ occasional loss of fluid occurs especially when the cup is removed ○ infant may sequence three or more suck swallow movements continuously ■ the tongue may protrude to make contact with the cup ■ may have some initial difficulty coordinating lip closure and sucking with a straw and may chew down on the straw
Solids	<ul style="list-style-type: none"> ■ self finger feeding ■ variety of mashed and chopped textures managed ■ can eat sandwiches and biscuits by twelve months ■ controlled sustained bite - Biting through food such as cheese and biscuits improves ■ lips active during chewing ■ easily closes lips on spoon to clear food ■ top teeth clean the lower lips ■ chewing with up-down and diagonal rotary movements ■ solid food is moved by the tongue to each side of the mouth and back to the centre of the mouth ■ holds spoon in either hand and transfers from hand to hand ■ uses utensils ■ turns spoon over in mouth

Assessment of breastfeeding

- Breastfeeding is the physiological normal way for an infant to be fed and is unequalled at providing optimal nutrition and healthy growth for around the first 6 months of life. Thereafter, appropriate complementary foods are added with continued breastfeeding up to 2 years of age or beyond, for as long as the mother and child desire ^{41, 94}.
- Timely access to child health services in the community ensure families are provided with professional support, encouragement and promotion of breastfeeding. Services can be provided in a range of modes, e.g. telephone support, clinic visits, home visiting, group sessions¹.
- Health professionals support breastfeeding by:
 - Informing families of the benefits of breastfeeding and the risks of not breastfeeding
 - supporting partners and family in the support role for breastfeeding
 - promoting maternal self-care
 - providing evidence based information, education and support on breastfeeding, e.g. correct positioning of the infant at the breast, expression and storage of breast milk
 - encouraging the family to use expressed breast milk when the mother and infant are separated
 - encouraging the family to avoid the use of teats and pacifiers until breastfeeding is well established
 - normalise and discuss newborn and infant behaviours
 - supporting families if they have specific breastfeeding concerns, e.g. perceived inadequate milk supply, painful breasts, inverted nipples
 - exploring with families strategies to overcome difficulties
 - provide information on the range of support services available, e.g. Australian Breastfeeding Association, Raising Children website
 - supporting the principles of the Baby Friendly Health Initiative⁴¹.
- Whilst exclusive breastfeeding is the best option for infants, not all families are able to do this and it is important the family be reassured that any breastfeeding is better than none ⁴¹.
- Some women will make an informed decision not to breastfeed, others may stop breastfeeding. In the absence of breastfeeding, Queensland Health recommends the use of a breast milk substitute that conforms to the recommendations of NHMRC and meet the Food Standards of Australia New Zealand ⁹⁵.
- Be culturally sensitive and where possible utilise culturally specific resources to discuss breastfeeding with parents (e.g. Growing Strong)⁴².
- Identify community partnerships and opportunities for services to work together to support optimal infant nutrition including:
 - local hospital/s
 - general practitioners
 - birthing units and postnatal services
 - breastfeeding support organisations (e.g. ABA, LANCZ - Lactation Consultants)
 - nutritionists and dieticians
 - speech pathologists
 - local pharmacies
 - oral health services ¹.

Initiation and establishment of lactation

- The initiation of lactation is hormonally driven following a drop in progesterone levels with the delivery of the placenta. However, effective removal of milk from the breasts is necessary to establish and maintain lactation. The hormone prolactin is necessary for milk production, and oxytocin initiates the milk-ejection reflex. Unrestricted breastfeeds and effective removal of milk from the breasts are the most important factors contributing to successful breast feeding ⁴¹.
- Initiation of breastfeeding occurs within the first hour or so after birth when the infant indicates readiness to feed. After the first day or so, most newborns will establish a pattern of breastfeeding between 8-12 times over 24 hours. Refer the family to Breastfeeding – Getting Started in the Child Health Information booklet ⁶².
- As lactation becomes established the hormonal influences have less influence as a process of ‘supply’ and ‘demand’ regulates milk production; that is the rate of milk production becomes regulated by the amount of milk drained from the breast ⁴¹.
- On average, a woman exclusively breast feeding will produce around 800mls a day. The storage capacity of the breast varies from person to person, women with a capacity to store a large amount of milk will have greater flexibility in their feeding frequency than women with smaller storage capacity, these women will feed more frequently to maintain a similar levels of milk production ⁴¹.
- Each mother-infant dyad will be unique in the way they feed due to individual differences, e.g. breast anatomy, anatomy of the infant’s mouth, rate of milk flow, etc. Health care professionals avoid using an arbitrary set of rules for frequency and length of feeds, as this can compromise the unique balance set up by the individual infant – mother feeding dyad ⁴¹.
- The colour of milk is irrelevant to the quality of the milk. The colour of colostrum varies from clear to pale yellow to bright orange and mature breast milk varies from creamy to opalescent. The composition of breast milk is complex, containing essential compounds and fluids that meet all the infants requirements for at least the first six months of life ⁴¹. No additional fluids are required even in hot climates.
- The changing content of the breast milk is complex and changes from feed to feed to meet with the child’s need, whether nutritional, thirst quenching or for comfort. In general however, at the start of a breastfeed the fat content is lower with an increasing rise as the breast becomes drained (noting that the breast is never fully drained) ⁴¹.
- Babies are generally offered both breasts at each feed ⁴¹, based on their feeding cues, however the infant may resist both breasts at all feeds. A period of cluster feeding on most days is normal where an infant cues for breastfeeds frequently within a short period of time over a period of hours.
- Signs that the infant is getting an adequate milk intake once breastfeeding is established, include:
 - at least four to six single use, or six to eight very wet cloth nappies in 24 hours
 - pale yellow, in-offensive urine
 - weight gain - averaged over a month
 - infant is reasonably content after some breastfeeds
 - good skin tone, moist mucus membranes and clear, bright eyes
 - infant is active and alert when awake
 - (in the first couple of months at least 2-3 soft, yellow, curdy bowel motions per day, offers further reassurance about adequate supply) ⁴¹.

Nipple care and management

Nipple pain is a common discomfort among breast feeding women in the early days with a peak of discomfort usually about the third day following birth. Continuing nipple pain is not expected and could be caused by both maternal and infant factors such as:

- incorrect positioning of the infant at the breast
- trauma from the use of breast pumps or nipple shields
- infection (Mother or Infant), e.g., thrush, Staphylococcus Aureus
- dermatological conditions (dermatitis, eczema, psoriasis)
- infant anatomical problems (ankyloglossia - tongue-tie, high arched palate, receding chin, large nipple and small mouth)
- vasospasm (Raynaud's Phenomenon) ⁴¹.

Tips for managing nipple pain can include:

- assess positioning at the breast to support optimal infant positioning and latch
- encourage the Mother to express a little milk at the end of the feed and gently spread it over the nipple and allow the nipples to air dry after feeds.
- if breast pads are used, encourage frequent changing of them if damp
- if infection or a dermatological condition is suspected, refer to a medical officer for review
- compresses with warm water may be helpful
- expressing breast milk may be needed to manage some breastfeeding difficulties; use as a last resort with ongoing support of the health professional
- infants may need further assessment and referral (e.g., tongue tie) if nipple trauma does not resolve ⁴¹.
- Refer family to the information - Common Breastfeeding Concerns: Common Early Problems – Tender or Cracked Nipples, in the *Child Health Information* booklet ⁶².



Practice tips: Promoting optimal positioning of the infant at the breast

There are many different positions that mothers can use such as side-lying, football hold, cross arm hold, and cradle hold.



1. Whatever the position, it is important the mother is comfortable with adequate support for her back, arms and feet and her clothing non-restrictive.
2. The infant is unwrapped to enable easy handling and promote skin to skin contact.
3. The infant is held facing the mother (chest to chest) and close to the mother's body.
4. The infant's body can be supported by the mother's forearm to stabilize the infant's body.
5. The infant's mouth is level with or slightly below the mother's nipple
6. By touching and stroking the nipple on the infant's nose and upper lip, the infant should tilt his head back slightly and open his mouth wide. The tongue should come down and forward.
7. Bring the infant to the breast, not the breast to the infant ⁴¹.

Indicators of correct latch

- infant's mouth is wide open with lips flanged outwards
- lips form a complete seal around the areola
- a 'suck, swallow, breathe' pattern is observed
- no dimpling or drawing in of infant's cheeks occurs during suckling
- no 'clicking' sounds
- infant's tongue over bottom gum
- infant's jaw moves rhythmically and ears may move slightly
- mother should have no pain with feeding, although nipples may be tender
- nipples should be elongated with no signs of trauma at the end of the feed ⁴¹.



See information about tongue tie, page 70.

- Refer family to the information - Breastfeeding: How do I start breastfeeding? in the *Child Health Information* booklet ⁶².

Expressing breast milk

A mother may need to express breast milk for a number of reasons, for example: premature birth. It is important the mother knows how to express and store the breast milk, this may support her feeling of breast feeding competence and increase her achieving maximum time breast feeding ⁴¹.

Preparation

- wash hands with soap and warm water and dry thoroughly (this cleans and warms the hands)
- express in a comfortable, private place where you can relax and not be interrupted (e.g. phone off, nice music)
- collect breast milk in a clean container
- encourage the milk ejection reflex (eg gently massage the breast)
- if more milk is needed try again later.

Hand expressing

- place thumb and fingers on opposite sides of the breast just behind the areola
- rhythmically squeeze the breast with a rolling movement between the thumb and fingers and an inward direction (try about twice per second).
- drops of milk form on the nipple, after the letdown reflex milk may spray.
- when the flow stops, move thumb and fingers around the areola so that all the milk ducts are emptied.

Using a pump (hand or electric)

- follow the directions that come with the pump
- follow the steps above, it is often helpful to get the flow going by hand then applying the pump
- ensure the breast cup is centred on the nipple and the flange is the correct size
- start the electric suction at a low strength and increase according to comfort ⁴¹.



<http://hi.bns.health.qld.gov.au/nursing/ccn/documents/hand-express.pdf>

Storing expressed breast milk

Pour the collected milk into a sterile storage container (glass, plastic, sealable plastic bag) and put it in the refrigerator or into the freezer in a sterilised container.

Breast milk can be:

- refrigerated for three to four days at 5° Celsius or lower. Store in the back of the refrigerator, not in the door.
- stored without refrigeration (if needed) for six to eight hours if the temperature is under 26° C. If refrigeration is available, store milk there.
- kept for two weeks only in a freezer compartment of a refrigerator.
- frozen in the freezer section of a refrigerator with separate freezer door for up to three months.
- frozen in the deep freeze (-20° Celsius or lower) for 6-12 months.
- transported in a cooler with an ice brick and place it in the refrigerator immediately when you arrive.

Other tips for managing expressed breast milk include:

- label with date and time before freezing
- use oldest milk first
- freshly expressed milk should be stored in a new container rather than added to previously refrigerated or frozen milk
- thaw frozen milk slowly by standing in the refrigerator, or if necessary for rapid defrost by standing in a container of luke-warm water and mix thoroughly - use within 24 hours.
- never refreeze or reheat breast milk
- leftover expressed milk from feeding should be discarded
- **Do not** thaw or heat breast milk in a microwave oven.
- Refer families to ‘Common Breastfeeding Concerns: Common Early Problems – Breastfeeding when you are working or away from your infant’ in the *Child Health Information* booklet ⁶².

Management of milk supply

Breast compression

When baby is only suckling at the breast and not drinking effectively, breast compressions help with the flow of milk to encourage baby to continue with nutritive suckling.

The technique may be useful for:

- poor weight gain in the infant
- colic in the breastfed infant
- frequent feedings and/or long feedings
- sore nipples in the mother
- recurrent blocked ducts and/or mastitis
- encouraging the infant who falls asleep quickly to continue drinking not just sucking ⁹⁶.



Practice tips: Supporting a mother with breast compression

Instruct the mother to:

- Hold the infant with one arm.
- Hold your breast with the other, thumb on one side of the breast (thumb on the upper side of the breast is easiest), your other fingers on the other, fairly far back from the nipple.
- **Watch for the infant's drinking.** The infant gets substantial amounts of milk when he is drinking with an “open mouth wide... pause... then close mouth” type of suck.
- Use compression while the infant is sucking but not drinking! When the infant is ‘nibbling’ at the breast and no longer drinking, compress the breast by applying gentle pressure with the flat of your hand against the breast. Do not roll your fingers along the breast toward the infant, just squeeze. This should not be painful and try not to change the shape of the areola. With the compression, the infant should start drinking again with the “open mouth wide.... pause... then close mouth” type of suck.
- Keep the pressure up until the infant no longer drinks even with the compression, and then release the pressure. Often the infant will stop sucking altogether when the pressure is released, but will start again shortly as milk starts to flow again. If the infant does not stop sucking with the release of pressure, wait a short time before compressing again.
- When the infant starts sucking again, he may drink (“open mouth wide—pause—then close mouth” type of suck). If not, compress again as above.
- Continue on the first side until the infant does not drink even with the compression. You should allow the infant to stay on the side for a short time longer, as you may occasionally get another letdown reflex (milk ejection reflex) and the infant will start drinking again, on his own. If the infant no longer drinks, however, take him off the breast.
- If the infant wants more, offer the other side and repeat the process.
- You may wish, unless you have sore nipples, to switch sides back and forth in this way several times.
- **Remember, compress as the infant sucks but does not drink** ⁹⁶.

Management of inadequate milk supply

Many women (approximately 25-35%) reduce the duration or level of breast feeding due to a perceived lack of milk supply, therefore thorough assessment is imperative ^[41]. The following conditions indicate **adequate** milk intake:

- at least 4-6 disposable, or 6-8 very wet cloth nappies in 24 hours
- pale yellow, in-offensive urine
- 3 or more bowel movements of seedy yellow stools a day by Day 3 for at least up to 6 weeks
- in the first couple of months, at least 2-3 soft, yellow, curdy bowel motions per day (absence of this does not necessarily indicate inadequate supply)
- weight gain, averaged over a month
- infant is reasonably content for some time between some breast feeds
- good skin tone, moist mucus membranes and clear, bright eyes ⁴¹.

In the case where these conditions are met over the course of breast feeding, the health professional can provide reassurance and education to families, such as normal infant behaviour and normal physiological changes within the breast.

If however these conditions are not met the health care professional will observe for other signs of insufficient milks intake such as:

- Infant lethargy,
- infrequent stools,
- scant urine,
- failure to gain weight or
- weight loss, e.g. over a period of 4 weeks

If there appears to be a low milk supply the following management is appropriate:

- Check positioning and latch
- Check the number of feeds in 24 hours
- ensure the Mother is offering both breasts at each feed
- suggest frequent skin-to-skin contact, breast massage and nipple stimulation ⁹⁷
- ensure infant is draining the first breast well
- allow the infant to finish the first breast before offering the second breast
- allow retries by offering both breasts again at each feed
- Increase frequency of feeds, e.g., unrestricted frequency and duration, offer the breast between usual feeds, wake the infant and offer an extra feed before going to bed
- Swap breasts when the infant stops suckling effectively and use both breasts twice at each feed.
- Breast compression may also increase the amount of milk available to the infant.
- If the infant is requiring supplements, consider the use of a 'supplementer system' so baby can continue to feed at the breast.
- Express between breastfeeds

- Apply a warm compress to the breast prior to feeding and during expression – this may encourage the letdown reflex
- Review use of supplementation
- Encourage woman to rest and relax and drink according to thirst
- Discourage smoking and alcohol intake; limit caffeine intake ⁴¹.



Galactogogues

Consideration may be given to informing the mother about the use of galactogogues – a medication or other substance that may increase maternal milk synthesis ⁹⁷. Due to the inconclusive research findings specific to pharmaceutical galactogogues (such as domperidone), and the lack of regulation around herbal galactogogues (e.g. fenugreek), the health care professional should use caution in delivering this information ⁹⁷.

The health care professional should be guided by their scope of practice framework and local Hospital and Health Service protocols.

Supplementary feeds

Supplementary feeding are feeds given in addition to a breast feed. There is evidence that offering supplementary feeds, i.e. water/glucose/infant formula, when there is no medical reason, adversely affects the establishment and maintenance of lactation ⁹⁸.

Indications

- Supplements should always be used **in addition to** strategies for increasing milk supply. It is preferable that strategies to increase milk supply be used before the addition of supplementary feeds, but, depending on the condition of the infant, this is sometimes not possible
- Evidence of inadequate intake
- infant malnutrition
- medical orders.

Management

- Supplements can be given via a nursing supplementer, bottle, spoon or cup. The action of feeding from a bottle is different from feeding at the breast and it is difficult for some babies to switch from one to the other.
- Expressed breast milk should be used if possible.
- Supplements should be offered after the infant has had an opportunity to drain the breasts and, if possible, only after some, not all feeds.
- Allow the infant to determine when he has had enough complement.
- Gradually reduce the complement as the milk supply increases.
- Increase the number of breast feeds per day.
- Express after breastfeeds to increase milk supply and to use as a complement when available.
- Clients should be informed of the potential outcomes for supplementary feeding and this needs to be documented in the clients record. The infant may begin to prefer the bottle and milk supply may decrease if measures aren't taken to maintain or increase supply ^{41,98}.



Practice tips: Supporting a mother to use a nursing supplementer ⁹⁸

Nursing supplementer / supply line

A temporary device used to provide additional nourishment to an infant during breast feeding when the mother's supply is inadequate or infant is ill or too lethargic to suck effectively. It is used to meet the infant's nutritional needs. Either expressed breast milk or formula may be used. The nursing supplementer may not suit all mothers. Mothers must be individually counselled so that they can make an informed decision regarding the options available ⁹⁸

Reasons for use

- to provide nutritional requirement
- increases breast stimulation
- promotes continued nutritive sucking when breast milk supply may be inadequate
- avoids nipple confusion
- adoptive mothers
- a medical reason that results in a decrease in milk secreting tissues
- time-efficient alternative to complementing with a bottle.

Management

- Avoid overfeeding (it is preferable to ensure the infant is alert and hungry and ready for the next feed).
- Educate the mother on assessment, management and instruction in the utilisation and sanitisation of the apparatus.
- As mother's lactation increases it will be necessary to reduce the volume offered in the nursing supplementer and gradually reduce the reliance on the supplementer.

Disadvantages

- Mother may find it awkward to use especially if they are having difficulties with basic breast feeding techniques.
- Mothers may find it difficult to breast feed discreetly.
- Some babies become use to the constant flow of milk and are disinclined to feed without the supplementer.
- Cleaning and sanitising is extra work.
- Mother may feel it forms a barrier between herself and infant.

Because of these disadvantages it is recommended that the mother be guided in the use of the supplementer and it's cleaning. When commencing the use of a supplementer a mother should be supervised for a minimum of three consecutive feeds so that she feels confident in using the device. The health professional must follow up the mother and infant's progress in the following days.

Oversupply

Oversupply is often a temporary difficulty during the early stage of breastfeeding prior to the 'supply-demand' process becoming established through the body's local autocrine controls⁴¹. Fast milk ejection reflex / fast flow may occur in response to the letdown reflex causing difficulty for the infant to maintain a comfortable suck-swallow pattern. Health care professionals need to distinguish between oversupply and fast milk ejection reflex/fast flow when discussing this issue with parents.

Symptoms of oversupply

- uncomfortably full breasts
- unsettled, colicky infant, frothy stools
- feeding frequently.

Symptoms of fast flow

- fussing
- choking
- gulping during feeds
- pulling off breast.

Management

The health professionals can provide reassurance to the family that this will resolve over time. However if the oversupply continues the following can be recommended:

- express a little milk until the milk ejection reflex commences and the areola softens
- temporarily feed one breast at each feed until the supply settles, i.e. put the baby back on the first breast instead of offering the second breast
- express for comfort on the second side if required
- comfort measures (cold packs, breast support, simple analgesia)
- Women with oversupply are at greater risk of mastitis due to incomplete drainage of the breasts⁴¹
- Refer client to 'Breastfeeding: Is My Infant Getting Enough Milk?' in the *Child Health Information* booklet⁶².

Mastitis

Ten to 25% of breastfeeding women will experience at least one episode of mastitis and occurs most commonly in the first month of breast feeding⁴¹.

Causes

- inadequate breast drainage
 - blocked ducts
 - poor infant latch
 - sudden changes in feeding pattern (ie infant sleeping through the night).
- nipple trauma and infection.

Signs and symptoms

- flu-like symptoms
- fever and rigors
- painful/tender/red/firm area in the breast.

Complications

Untreated and unresolved mastitis may develop into a breast abscess.

Management

- Apply a warm cloth to the affected area before / during the feed
- Feed infant frequently starting with the affected side until the acute breast symptoms begin to resolve.
- If it is too painful to start the infant on the affected side, start on the unaffected side until the milk ejection reflex and then swap breasts.
- Position the infant so that the chin is against or pointing to the affected area to enhance emptying of that area.
- Gently massage the affected area of the breast during the feed, towards the nipple during the feed
- If symptoms persist, refer to a medical officer for antibiotics, if severe, hospitalisation may be required
- Encourage rest, nutritious diet and adequate fluids ⁴¹.
- Refer client to ‘Common Breastfeeding Concerns: Common Early Problems – Swollen Breasts, Blocked Ducts, Mastitis’ in *Child Health Information* booklet ⁶².

Drugs and breastfeeding

- Many prescription drugs and medicines are compatible for a mother breast feeding, but each medication should be specifically assessed by a health professional.
- Families can also refer to the information: ‘Common Breastfeeding Concerns: Drugs and Breastfeeding’ in the *Child Health Information* booklet ⁶².



Drugs and Lactation Database | <http://toxnet.nlm.nih.gov/newtoxnet/lactmed.htm>

For health professionals:

Queensland Drug Information Centre | Royal Brisbane & Women’s Hospital | Tel: 3636 7098 / 36367599

National Prescribing Service: Therapeutic Advice and Information Service | Tel: 1300 138 677

For general public:

National Prescribing Service: Medicines Line | Tel: 1300 888 763 (weekdays 9am–6pm)

After hours and on weekends advise client to contact their local public hospital, GP or local pharmacy.

Multiple births

- Twins can be fed together or separately.
- Either alternate the breast offered for each infant or use one breast for one particular infant at each feed.
- If feeding together:
 - use underarm hold for both babies, or
 - use underarm hold for one infant and cradle hold for the second, or
 - use cradle hold for both babies (crisscross or V hold).
- Boomerang pillows and or other pillows can be used to support the babies.
- Feed on a bed, couch or floor so one infant can easily be put down without disturbing the other ⁹⁸.

Feeding through pregnancy and tandem feeding

It is not detrimental for a healthy woman to continue to breastfeed her toddler during a subsequent uncomplicated pregnancy and then breastfeed both the infant and toddler.

Considerations of breast feeding during a subsequent pregnancy

- nipple tenderness
- milk may revert to colostrum
- some women feel nauseous
- maternal fatigue
- risk of uterine contractions
- need for adequate nutrition for the mother

When breastfeeding a infant and toddler it is important that the infant has priority at the breast ⁹⁸.

Tongue tie (ankyloglossia)

Tongue tie or ankyloglossia is a developmental variant, in which the tongue has limited mobility caused by congenital thickening, tightening or shortening of the frenulum ^{99,100}. In ultrasound studies tongue movements have been observed during breastfeeding whereby the infant places their tongue over the lower gumline and cups the tongue around the breast to form a seal. This demonstrates that intra-oral negative pressure is largely responsible for milk removal. In another study examining sucking in tongue-tied infants pre and post frenotomy, the imaging confirmed suspicion that tongue-tied infants used a different sucking action and that action then converted to a normal suck post frenotomy. It is important that during an assessment of breastfeeding and lactation that the oral examination of the infant includes assessment of both tongue function and also any restriction in the upper lip to explore potential impact of a restricted labial frenulum of breastfeeding or artificial feeding ^{294,295}.

If the child health professional suspects an oral anomaly or tongue or upper lip restriction that is impacting on breastfeeding (e.g. poor latch, clicking noises, milk leakage during attempted attachment, poor tongue function including elevation and lateralisation, tongue tip may appear heart or square shaped instead of being pointed, weight loss) the child health professional is recommended to refer the family to their GP/ Medical Officer with experience in this area to facilitate diagnosis and options for families to consider, such as frenotomy ^{99, 100}.

Some child health professionals with additional training may undertake additional observation using tools to assess the function of the tongue, such as the Hazelbaker Assessment Tool for Lingual Frenulum Function ²⁹⁴.



Sometimes tongue tie may be present without having an impact on the breastfeeding diad, whereby no action is required. It is only when feeding difficulties are combined with the functioning of the infant's oral anatomy that referral is required.

- Conduct a comprehensive family health assessment including a comprehensive assessment of breastfeeding to identify specific needs of the individual infant/family.
- Consider offering referral to: Feeding Clinic, Early Parenting Service, LCA NZ, GP,/MO, Ellen Barron Family Centre.
- Provide ongoing support and review of progress through follow up visits.

Factsheet: Tongue tie: information for families



The Royal Women's Hospital (Victoria) | *Tongue tie: Information for families* (fact sheet)
https://thewomens.r.worldssl.net/images/uploads/fact-sheets/Breastfeeding_and_tongue-tie.pdf

Weaning

Weaning may be infant-led, mother-led, mutual weaning, sudden or planned weaning ⁹⁸.

All options should be discussed with the mother to allow her to make an informed decision regarding how and when she will wean and care for her breasts. The degree and duration of breast refilling depends on the amount of milk being produced before weaning commences. Ideally all babies should be weaned slowly, this way the breast milk supply decreases slowly and there is time for the infant to adjust to the change. Breastfeeds should gradually be replaced with other milk feeds (depending on the age of the infant) over time, e.g., start dropping the feed the infant is least interested in, then reduce another feed every few days depending on the individual situation ⁹⁸.

Some situations may result in a mother weaning suddenly, e.g. maternal illness, medications incompatible with breastfeeding. Breast care is important to minimise discomfort during this time and to reduce the risk of blocked ducts and/or mastitis ⁹⁸. Expressing for comfort only until lactation diminishes is the most common way of weaning, however some women with a large milk supply may find additional support by their child health professional or support service is required during this time ⁹⁸.

It is important to discuss contraceptive methods with the mother during and after weaning as the contraceptive effect of breastfeeding will cease once weaning begins.

- Refer client to ‘Common Breastfeeding Concerns: When Do I Stop Breastfeeding?’ in the *Child Health Information* booklet ⁶².



Queensland Health Healthier You – Breastfeeding | www.health.qld.gov.au/breastfeeding/default.asp

Australian Breastfeeding Association | www.breastfeeding.asn.au/bfinfo/index.html

Safe use of infant formula

When women are unable to, or have made an informed decision not to breastfeed, providing individual education around the safe use of formula is indicated. It is important to promote a responsive feeding pattern for infants whether breast or formula fed. Inappropriate bottle feeding practices can have implications for the health of the child, for example:

- putting babies to bed with a bottle can impact on a child’s oral health;
- focusing on the amount of formula consumed, rather than the infant’s feeding cues (e.g., no longer interested in sucking, pushing the teat out of the mouth) may disrupt the development of the infant’s appetite regulation;
- chronic use of formula feeding to soothe an unsettled infant may result in overfeeding and impact on appetite regulation which has been linked to increased adiposity and obesity in later life ¹⁰¹.



Practice tips: Supporting a mother to formula feed her infant

Infant formula requirements

Bottle-fed babies should be fed according to need, i.e., fed in response to their hunger cues and the feed stopped in response to cues of satiety¹⁰¹. Each infant is different and needs vary from day to day. Refer to the “Is my infant getting enough” section of the Child Health Information booklet if concerned about how much your infant is drinking. As a guide:

- Day 5- 3 months: 150ml/kg body weight/ day
- 3 – 6 months: 120ml/kg bodyweight/ day
- 6- 12 months: 100ml/kg bodyweight/ day.

It is important that infant formula is made up according to the directions and is not too diluted or over concentrated. It is recommended that infant formula, where possible be reconstituted with fluoridated water. It may take a while to settle into a feeding routine. A young infant may want to be fed as often as every three hours during the day. Feeding time may last 20 to 30 minutes.

Choosing infant formula

There are many different infant formulas available in Australia. Despite being marketed differently, there is minimal difference between the composition of most infant formulae and all must comply with regulations defined by Food Standards Australia New Zealand (FSANZ)⁹⁵. Specialised formulae should only be used where there is a diagnosed, indicated use and should be done so in consultation with a dietician or medical officer.

Standard infant artificial formula – labelled ‘suitable from birth’, this is for babies up to 12 months of age. Standard cow’s milk based infant artificial formula is the recommended choice.

Follow-on infant artificial formula – labelled ‘suitable only for babies over six months’, this is for babies aged six to 12 months. There is no research to show these preparations are any better than standard artificial formula, and they are not considered nutritionally necessary.

Thickened artificial formula – thickened formula is available and often recommended for the treatment of GORD, however, there is inconsistent support and due to the paucity of evidence it is not recommended^{41, 111}.

Premature infant artificial formula – is specifically designed for the nutritional needs of a premature infant. This is not suitable for healthy term babies.



Raising Children Network How to bottle feed your infant | <http://raisingchildren.net.au>

Making the formula



Although no identified contamination has been identified in Australia, powdered infant formula is not a sterile product and occasionally infections can occur e.g. *Cronobacter sakazakii*⁴¹. If formula is prepared with water at 70°C this will destroy bacteria, however vitamins and nutrients are also lost. In addition there is a greater risk of serious burns. It is therefore recommended to use previously boiled water that has been cooled to body temperature when preparing infant formula⁴¹.

- Check the expiry date on the can of formula and the date opened – discard after one month of opening.

- Encourage hygiene and safety practices. For example:
 - washing hands before making up the formula,
 - all the bottles, teats and utensils used for bottle feeding are both cleaned and sterilised
 - Rinse bottles, teats, screw caps and teat covers well in cold running water immediately after use.
 - Wash bottles, teats, screw caps and teat covers thoroughly with hot soapy water, rub teats inside and outside (turning inside out) and then squirt water through holes. Use a bottle/teat brush to assist cleaning.
 - Bottles can be sterilised using boiling, steam or chemical methods according to manufacturer's instructions.
 - Encourage families to use the information in the booklet *'Child Health Information: Your guide to the first 12 months'*, this includes information on sterilising and cleaning equipment.
- Care should be taken to ensure formula is made up according to manufacturer's instructions, including:
 - Measure the formula carefully using the scoop from the container
 - Level scoops with a knife
 - Take care not to mix up scoops from other containers.
 - Using the wrong strength of formula (ie too much or too little powder) may harm the infant.
- Refrigerate made up milk if not using immediately (store the bottles in the back of the fridge – not the door). Made up formula can be stored in the fridge for 24 hours. Discard any made up formula after 24 hours.
- Inform families to only put formula and water in the bottle. Do not add cereal, sugar, cordial or anything else.⁴¹

How to bottle feed

- Hold infant close when feeding. Do not leave the infant alone to drink the bottle.
- Seat yourself comfortably and hold the infant in your arms while giving the bottle, swap sides that the baby is fed on to reduce the risk of Positional Plagiocephaly.
- If families choose to heat the milk, encourage standing the bottle in a jug of hot water out of reach of children, to bring it to room temperature and then test the temperature before giving it to the infant. Dropping a small amount onto the inside of their wrist to check the temperature is a common practice to test the temperature.
- Microwave heating is not recommended as the bottle can feel cool on the outside but be hot in the middle causing scalding.
- Check the bottle flow – when bottle is upside down, the milk should drop at a steady flow from the teat. Sometimes the teat gets clogged when a powdered formula is used. Check teats often.
- Hold the bottle tilted with neck and teat filled with formula to prevent the infant from swallowing air. Even when fed properly, an infant swallows some air. Encourage giving the infant an opportunity to burp to help them to get rid of the air if necessary. If the infant is feeding happily, don't stop until they are ready, then hold the infant upright over your shoulder or upright on your lap with your hand supporting their head under the chin.
- Let the infant decide when they have finished. The amount taken will vary from feed to feed. Most feeds take around 30 minutes. Watch for signs that your infant has had enough, i.e., lack of interest in the feed, easily distracted, stops sucking, pushes the teat out of the mouth, turns the head away).
- Throw out any leftover milk.

Introduction of solid foods

- **How and when** families introduce foods to their infants will be influenced by a range of issues including culture and interest level of the child. Encouraging a range of nutritious food options and flavours establishes an infant's sense of taste and an acceptance of variety, instilling habits that can inform lifelong healthy eating patterns ⁴¹.
- Parents should be advised to introduce solids to their infant from around 6 months according to their infant's developmental signs of readiness, including:
 - The infant's head and neck control has developed enough that he/she is able to sit with support
 - Infants explores toys and other objects by putting them in his/her mouth
 - Infant watches with interest when others are eating
 - Seems hungry between milk feeds ¹⁰².
 - Delaying the introduction of solids beyond around 6 months may increase the risk of developing allergies ⁴¹.
 - First foods should be high in iron and zinc as infant stores are believed to be declining at this time ⁴¹.
 - Foods can be introduced at a rate that suits the infant progressing from pureed to lumpy to normal textures during the 6-12 month period ⁴¹.
 - By twelve months of age infants should be enjoying a variety of nutritious family foods in addition to breastmilk where possible ⁴¹.
 - Sweetened fluids, e.g. juice are not recommended and are associated with increased dental caries
 - Encourage a cup from 6 months of milk / water
 - Avoid nutrient poor foods with high levels of fat, sugar, salt. ⁴¹
- **Foods to avoid**
 - whole nuts or similar hard foods under three years to reduce the risk of choking
 - honey
 - unmodified milk
 - low fat or reduced fat milk products are not recommended for infants
 - teas, herbal teas, coffee, sugar sweetened drinks.

Referral

A health care professional may refer an infant for further assessment when:

- sucking and swallowing incoordination
- weak suck / poor latch despite support
- uncoordinated tongue movements
- breathing disruptions or apnoea during feeding
- excessive gagging or recurrent coughing during feeds
- new onset of feeding difficulty
- diagnosis of disorders associated with dysphagia
- weight loss, weight faltering or lack of weight gain (see weight section)
- severe irritability or behaviour problems during feeds
- history of recurrent pneumonia and feeding difficulty
- concern for possible aspiration during feeds
- lethargy or decreased arousal during feeds
- prolonged feeding periods

- unexplained food refusal
- delay in feeding developmental milestones
- children with craniofacial anomalies

Further specialised assessment should be made as early as possible when difficulties or risks are identified to reduce parent stress, reduce the chance of exacerbating difficulties due to negative experiences and to reduce long term negative effects such as: poor weight gain ^{41,58,92}.



Raising Children Network | <http://raisingchildren.net.au>



Refer to the Pathways to Rural and Remote Orientation and Training
www.health.qld.gov.au/parrot/default.asp

Health concerns

Colic

- Colic is a clinical term used when an infant cries excessively and persistently:
 - for more than three hours/day,
 - for at least three days per week,
 - for more than three weeks
 usually in the first three months, in an otherwise well infant.
- Whilst the aetiology is elusive, a common thought is that it is associated with an accumulation of gastrointestinal gas with varying behavioural and biological factors influencing the symptoms ^{24, 103}.
- All infants with excessive crying should have a complete medical assessment to rule out underlying medical conditions including: cow's milk allergy (see page 162) pyloric stenosis, otitis media, inguinal hernia, and intussusception ^{24, 104}.
- When an organic cause (including cow's milk allergy) has been excluded, behavioural management is recommended to help the parents manage the infant's crying. Whilst there are numerous suggested remedies/treatments for infant colic, there are none that assure infant safety and a current, strong evidence base ¹⁰³⁻¹⁰⁵.
- Emerging research is drawing possible links between colic and low numbers of, and less diversity in, the intestinal microbiota ¹⁰⁶. There are hopeful results being identified with the use of oral pre and probiotics with a systematic review recommending a large scale randomized trial ¹⁰⁵ and The Cochrane Collaboration publishing a protocol for such a trial ¹⁰³.
- Other strategies that have been found to be safe, such as, infant massage, use of Simethicone, modified infant-parent interactions; despite having no rigorous evidence base proving the relief of colic ¹⁰⁴.

Management

- Conduct a comprehensive family health assessment to identify specific needs of the individual infant/family, this should include assessment of infant feeding and sleep patterns and discussion regarding parent/carer skills and knowledge about settling strategies.



Full examination should include observation for non-accidental injury, e.g. bruises, petechiae due to the high rate of parental stress often associated with 'colic' and the increased rate of Shaken Baby Syndrome in relation to peak infant crying ^{104, 107}.

- Additional parental support may be required due to the ongoing stressors of parenting an unsettled infant. This may include:
 - All hours support services and phone numbers as per PHR, e.g. Parent Hotline, I3HEALTH
 - Safety plan (see page 177)
 - Self-care promotion
 - Attend parenting groups.
- Additional breast feeding support may be required with supporting the Mother to continue to breast feed during the infant's unsettled periods.
- Monitor emotional health of parents. Use EPDS / DASS / Attachment Assessment Tools when indicated.
- Consider offering **referral** to: GP, Feeding Clinic, Early Parenting Service or Ellen Barron Family Centre.
- Provide ongoing support and review of progress through follow up visits.

Gastro oesophageal reflux

- Vomiting and regurgitation of gastric contents into the oesophagus in infants (GOR) is a normal physiological process which self resolves usually during the first year of life of life ^{24, 41}. Some infants may be reported to be a 'happy spitter' with simple, recurrent 'spills' and most infants will have no relationship between GOR and disease – GORD (see below) ^{41, 108}. Often the amount posseted appears to be large and is worrying for the parents. As long as the infant is continuing to gain weight and is contented, it is of no concern. Parents may be advised re:
 - Use of bibs
 - Continue to sleep the infant on his back
 - Observe infant through regular health surveillance ¹⁰⁹.
- Vomiting may be a symptom of illness and if associated with fever, diarrhoea, pain, lethargy or poor feeding, the infant should be referred to a medical officer for assessment. Other causes of vomiting include: pyloric stenosis and bowel obstruction.



Pyloric Stenosis is an acute outlet obstruction of the stomach usually developing between two to five weeks of age, characterised by projectile non-bilious vomiting, dehydration and constant hunger. On palpation an olive-shaped mass is readily palpable just right of the umbilical. This condition requires immediate medical intervention ²⁴.

Gastro oesophageal reflux disease

- Gastro oesophageal reflux disease (GORD) occurs when GOR causes complications such as: Oesophagitis, weight faltering, aspiration, respiratory symptoms including apnoea ¹¹⁰.
- Symptoms include infant irritability, excessive crying with arching of the back and neck extension, vomiting, haematemesis ²⁴.
- Conduct a comprehensive family health assessment to identify specific needs of the individual infant / family, this should include:
 - Assessment of infant growth and development
 - Full feeding assessment (exclude a cracked and bleeding nipple if haematemesis has been reported)
 - Additional breast feeding support may be required with supporting the Mother to continue to breast feed during the infant's unsettled periods. Whilst there is no evidence, avoiding over feeding may be helpful ¹⁰⁸.

- Additional support may be required around bottle feeding for example:
 - › avoid aerophagia (swallowing of excessive air) by keeping bottle horizontal, appropriate teat
 - › avoid overfeeding
 - › avoid change of formula unless recommended by MO ¹⁰⁸.
- Whilst there is no evidence, keeping the baby upright during and immediately after a feed may be helpful ^{41, 108}.
- Discussion with family about infant cues relating to feeding and tiredness



Full examination should include observation for non-accidental injury and Shaken Baby Syndrome, e.g., bruises, petechiae due to the high rates of parental stress often associated with peak infant crying ^{104, 107}.

- Provide additional parental support due to the ongoing stressors of parenting an unsettled infant. This may include:
 - All hours support services and phone numbers as per PHR, e.g. Parent Hotline, I3HEALTH
 - Safety plan (see page 177)
 - Self-care promotion
 - Attend parenting groups
 - Monitor emotional health of parents
 - Parents may need to work through range of psychological tasks in relation to their parenting experience and expectations.
 - Observe parent-infant interaction and emotional health ²⁴
 - Use EPDS / DASS / Attachment Assessment Tools
- If symptoms of GORD are present the health care professional should refer the infant for a medical review within 1 week ¹⁰⁸.
- Medical officers may consider the following:
 - Differential diagnosis: Normal infant crying (see page 113), colic, cow's milk allergy (see page 162)
 - Other medical conditions, e.g. infection, pyloric stenosis, intussusception ¹⁰⁸.
 - Conservative management may be suggested when infant is thriving, this may include positional measures, e.g. use prone position after a feed when awake; avoid overfeeding.
 - Further investigations may be ordered, e.g. Ph study ¹¹⁰.
 - Medication: Proton pump inhibitors (PPI) e.g., Omeprazole or histamine-2 receptor antagonists, e.g., Ranitidine. PPIs are considered the superior of the two, however guidelines caution against the overuse of medication in infants ¹¹⁰. Antacid suspensions can lead to excessive ingestion of aluminium ⁴¹.
 - Thickening of infant feeds: there is inconsistent support for the thickening of feeds for the treatment of GORD, however due to the paucity of evidence it is not recommended ^{41, 111}.
- Provide ongoing support and review of progress through follow up visits.
- Inform families of specific support groups, e.g. Reflux Infants Support Association (RISA)



Reflux Infants Support Association (RISA) | www.reflux.org.au

Raising Children Network | <http://raisingchildren.net.au>



Refer to *Primary Clinical Care Manual*

Topics: pyloric stenosis, intussusception, acute gastroenteritis and dehydration

ONE TO FIVE YEARS

One to five years represents a period of incredible human development. Children in the one to three year age group experience significant progress in locomotion and communication. They learn to walk, talk and how to say 'no' as they also begin developing independence. Many children start to spend increasing amounts of time in environments outside the home such as child care, kindergartens and other settings. From three to five years, children's biological, psychosocial and cognitive development progress enough for them to move to an even greater degree of independence as they enter into schooling with long periods of separation from their home environment ²⁴.

The role of the child health professional is to continue to work in partnership with parents and families and in addition, work alongside staff in early childhood and education settings with evolving issues affecting child health and wellbeing ¹.

Well child health checks

Contact visits between families and child health professionals are recommended as part of the minimum standards for conducting evidence-based early detection. Surveillance focuses on individual children and includes gathering information from screening tests, physical examinations and discussions with parents and other caregivers ¹.

The visits recommended from one – five years are:

Age	Type of contact	Healthcare professional
1 ½ years	Health check	Doctor or child health nurse
2 ½ - 3 ½ years	Health check	Doctor or child health professional*
4 - 5 years	Health check	Doctor or child health professional*
Note: Check immunisation against NIPS at each visit		60

* The Aboriginal and Torres Strait Islander Child and Youth Health Worker may undertake the health checks as delegated by the RN or Doctor.

* Healthy Kids Check at GP is available for children over 3 and under 5 years and is often completed in association with a GP visit for immunisation.



Department of Health | www.health.gov.au

Expanded Medicare Healthy Kids Check | www.health.gov.au/internet/main/publishing.nsf/Content/healthy-kidschk

Checklist: www.health.gov.au/internet/main/publishing.nsf/Content/Healthy_Kids_Check-Checklist

Fact sheet: www.health.gov.au/internet/main/publishing.nsf/Content/Health_Kids_Check_Factsheet



Refer to *Chronic Conditions Manual*

- Some child health services may provide school entry screening to the whole of the Preparatory Year students and/or Year One students. Other services use more targeted approaches which provide screening following an initial assessment process (e.g. parental questionnaire for hearing). This assessment process will identify sub groups of children at greater risk of hearing difficulties and thus indicate where targeted screening is most needed. Parental concerns regarding children may also be addressed within this targeted process.
- For staff working in school settings work in partnership with DETE, parochial and/or independent schools, should follow agreed protocols for entry to the school, including preparation ahead of time and for screening activities. For further information, see page 182.

Other health checks

As part of the ‘*Chronic Conditions Manual*’ population screening through health checks are offered to all children when they present at primary health care centres in rural and remote areas. These health checks form the early detection component of the chronic disease strategy to identify risk factors and early markers which lead to the development of chronic diseases ¹⁴¹.



Refer to *Chronic Conditions Manual*

Parents may wish to access additional services to complement well child health checks, such as:

- self-weigh facilities (e.g. at child health clinics)
- information on the world wide web
- telephone support
- information and support groups – child health clinic and parent groups e.g. Young Parents Program, Triple P Parenting; playgroups, ABA ³.

As well as working with child and their parent/s, marketing positive health messages to the whole family and the wider community strengthens support for parents and can positively impact on the health of a child ¹.

Engaging families

Family structures are varied including:

- Extended families e.g. grandparents, aunts, Elders
- Foster families
- Single parent, step and blended families
- Gay, lesbian, bisexual and transgender parents ²⁵.

It is important for child health professionals to recognise each member of the family and acknowledge the significance of their role in the child’s life. For example, research shows the importance of recognising a fathers’ unique contribution to a child’s development and the family system as a whole ²⁶.

Family members are encouraged to attend appointments with the child and attendance at group based parenting programs is also recommended e.g. Triple P. Parenting groups have been found to result in positive outcomes for parents / carers with less depression, anxiety, stress, anger, guilt and more confidence and partner satisfaction reported in short term ⁶¹.



Government of Western Australia | www.communities.wa.gov.au/ | *Father Inclusive Practice*

Queensland Health | www.health.gov.au

Strong Fathers Strong Families Program , Growing Strong Resources

Raising Children Network | <http://raisingchildren.net.au/>

Videos and fact sheets on a variety of topics including Parenting in pictures, Positive parenting, Families that work well, Sole parenting, Becoming a dad, Being a grandparent, Being a grandparent carer, Teenage parents, Parenting in a same-sex relationship and Step-parents.

Family health assessment and monitoring

The health of the family, in particular a parent / primary care giver and their ability to fulfil the role of ‘parent’ is crucial in optimising child development ¹. Nurturing a child in the early years has a decisive and long-lasting impact on how children develop, their capacity to learn, their behaviour and ability to regulate their emotions, and their risks for disease in later life ¹.

- While there is no universal standard of what ‘good’ parenting is, there are characteristics that appear to enrich the parenting role such as:
 - An ability to parent in a sensitive and responsive way
 - Knowledge of the basic needs of a child (both physically and emotionally) and the ability to be available and provide for those needs
 - An ability to prioritise their child’s needs over their own e.g. a child’s safety and protection
 - The ability to be consistent yet flexible when necessary, in response to the changing demands within family life ^{63,64,69}.
- Social circumstances and family functioning also impact on the health outcomes of children. Populations that are associated with higher rates of child morbidity and mortality in Australia include:
 - Aboriginal and Torres Strait Islander
 - CALD backgrounds
 - Families with low incomes; unstable housing
 - Family make up e.g. Single parents, parents with multiple re-partnering experiences, step families, blended families
 - Children living in non-parental or out-of-home care environments
 - Low parental education levels often when other factors are present e.g. financial stress, ethnicity
 - Families with chronic illnesses and/or disability ²⁵.
- A complete family health assessment is commenced the first time a family visits a child health professional. The full family assessment may take a number of visits to complete. Once this is complete updates can be made to the assessment or the complete assessment should be redone at the discretion of the child health care professional (Refer to your local guidelines) ²⁵.
- Family health assessment is about
 - identifying bio-psychosocial risk factors relating to the health and wellbeing of the child
 - engaging with the family using a partnership approach to develop a therapeutic relationship followed by a strength based approach to build parent capacities and skills ^{1,65}.
 - formulating an individualised care plan with the family according to their level of need ^{25,66}.



When risk factors are identified additional care may be required.

See ‘Responding to need’, page 158.

See ‘How to do a family health assessment’, page 29.

See appendix 3 for a sample of a family health assessment



Family Health Assessment – A guide for child health nurses and other child health clinicians ²⁵

<http://qheps.health.qld.gov.au/ccyfh/docs/fam-health.pdf>

Nursing - AIDET and SBAR toolkit | <http://qheps.health.gov.au>

Child health assessment

Physical assessment



Healthy Hearing Program | www.health.qld.gov.au/healthyhearing | Resources ⁷²



Queensland Health Guideline: Assessment of child/child nutrition, growth and development within the primary health care setting ⁶⁵





Primary Clinical Care Manual
Topics: Patient presentation and assessment – adult/ child, and DRS ABCD resuscitation.



See page 37 for how to perform a head-to-toe physical assessment.

- Any contact with a child gives the child health professional an opportunity to gain valuable information about their developmental progress and health status. The child can be observed when:
 - speaking or interacting
 - at play
 - conducting routine health screening and surveillance in different settings.
- A physical assessment is conducted and combined with history taking and interviewing to enable the health professional to develop a holistic view of the individual health status of a child. The extent of examination varies depending on the circumstances of each health contact ⁵⁸. Follow on physical assessments are undertaken by the child health professional as per the well child checks and at other contacts at the discretion of the child health care professional.
- Ensure that universal hearing screens have been completed in the child's first year and if any follow up is required ⁵⁰.
- Vision screening in children 18 months to 5 years aims to detect visual problems early and intervene to improve overall eyesight. Common visual disorders in children include:
 - Amblyopia or 'lazy' eye (1.4 – 3.6%)
 - Strabismus or 'cross-eyed' (0.3 – 7.3%)
 - Refractive error – short or far sightedness or astigmatism (1 – 14.7%) ¹¹².
- School entry vision assessment requires the selection of the most sophisticated method of testing that the child can accurately perform. Non-vision health professionals should be trained to complete visual screening and refer to an Optometrist or Medical Officer if any concerns are identified ¹¹².
- See 'Practice tips: Conducting visual screening' on page 83.

Physical assessment specifics (one to five years)

Age	Physical characteristics ^{24, 112,141}
1.5 years	<ul style="list-style-type: none"> ■ Physical growth slows during toddlerhood. ■ Growth predominately occurs in the limbs with an average length increase of 7.5 cm/year. ■ The head circumference usually increases by 2.5 cm in the second year of life. ■ The anterior fontanelle closing between 12 – 18 months. ■ Complete a visual screen including fixation on an object, red eye reflex and corneal light reflex. <p> Aboriginal and Torres Strait Islander children: Complete hearing screen: Otoscopy and Tympanometry</p>
2.5 to 3.5 years	<ul style="list-style-type: none"> ■ Usually the birth weight has quadrupled by the second birthday. ■ In general the child's adult height will be about twice the height they are at two years old. The head circumference usually increases by 2.5 cm in the second year of life and then the rate slows to approximately 1.25cm/year up to 5 years. ■ Calculate a BMI (see page 91). ■ Complete a visual screen including a near cover test. <p> Aboriginal and Torres Strait Islander children: Complete hearing screen: Otoscopy and Tympanometry</p>
4 to 5 years	<ul style="list-style-type: none"> ■ Growth on average: length increase of 7.5 cm/year, head circumference increases approximately 1.25cm/year up to 5 years. ■ Complete a visual screen including a near cover test (see below) ■ Vision acuity screen ■ Hearing and ear health screen ■ Immunisation – is the child immunised as per recommendations?



Practice tips: Completing a vision screening ¹⁴¹

- Ask the parent if they have any concerns about their child's vision or how their eyes look e.g. in photographs particularly when a flash is used
- Children with glasses should be tested as some children may not be wearing correct glasses. It is important for parents to be aware of the need for follow-up with their eye specialist.
- **Fixation and following objects**, see page 39.
- **Red eye reflex**, see page 39.
- **Corneal light reflex**, see page 39.
- **Cover test**
 - Near cover test – vision tested to approximately 30cm
 - Far cover test – vision tested to 6 metres
 - The cover for the eye not being tested can be a simple piece of card or an occluder.
 - The far cover test is completed first and then the near cover test.
 - Ask the child to look at an object whilst keeping their eyes still. e.g. toy, finger puppet.



Do not use a lit torch as the child may be required to focus on the object for a good length of time – a light shining in their eyes may be uncomfortable.

- Cover one eye and then test the other eye by moving the object in a smooth pendulum like manner. Smooth and slow movements allow the eye time to adjust.
- Repeat the process until satisfied the test has been performed adequately.
- Any involuntary corrective movement of the eye could indicate a squint.
- Some children may have difficulty keeping their eyes focussed on the object due to age.
- Document findings such as:
 - Record any unequal movement of eyes according to the direction of movement:
 - › Outwards movement to take up fixation = convergent squint
 - › Inwards movement to take up fixation = divergent squint.
- Refer to optometrist / GP when any abnormalities are detected according to local processes.

Visual acuity screen (4-5 years)

- Full size charts should be at a distance of six meters
- Tools that may be used for vision testing include:
 - › Linear STYCAR 5 letter chart with key-card for preparatory year students
 - › Linear STYCAR 7 letter chart with/without key-card for year one students
- Establish a routine of testing the right eye first as the results of the right eye are usually recorded first.
- Children do not have to be literate to have their vision assessed with Linear Staycar 5 vision chart and keycard. Reassure parents that this is a 'matching game' and not unlike asking a child to match a square or circle when asked.
- At close distance, ask the child to point to the same 'shape' on their keycard that the assessor is pointing to on their card. When the child is able to match a number of 'shapes' correctly then the assessor can commence assessment at the six metre distance.

- An well fitting eye patch may be used to occlude the eye not being tested.
- Point clearly to letters being tested (e.g. use a red coloured pencil/pen or pointer). Make sure not to obliterate any part of a letter. If child is uncertain as to which letter requires a response, circle the letter with the pointer.
- When using the Linear STYCAR chart begin testing above the 6/9 (normal vision) line of the chart (e.g., start at 6/36) and quickly move down the chart. It is not necessary for them to read the whole chart but the whole of the lowest line reached must be tested. Do not jump along a line being tested, but proceed along the line either forwards or backwards. Allow child adequate time to respond. Allow two attempts at any one failure.
- Observe child's behaviour during testing (e.g. holding head forward, frowning, blinking, and turning head to side and/or attempting to look over occlusive eye cover). This may indicate that they are experiencing difficulty reading the letters on the chart. If child actively resists the covering of one eye, the uncovered eye may have a vision defect. In such cases, cover the other eye first and repeat procedure.
- At no time is a child to be forced to cooperate.
- Document which eye chart has been used and the reading using a fraction format.
 - › The first figure (numerator) being the distance and the second figure (denominator) being the lowest line read successfully. e.g. normal vision = 6/6.
 - › Acceptable visual acuity for the 4-6 year old child is 6/9.
 - › Acceptable visual acuity for the child younger than four years is 6/12.
- Cleaning and infection control measures are used between children.

Referral

- Refer any abnormalities detected to Optometrist/GP/Medical Officer, this will include:
 - if any clinical concerns
 - less than acceptable visual acuity for age i.e. visual acuity of 6/12 or worse in either eye
 - unequal visual acuity is outside normal parameters if there is a difference of one line or more between the eyes.



For young children do not test single letters on a bland background because you may miss some amblyopes. Instead test single letters in a line of letters or single letters with confusion bars. The crowding phenomenon (caused by the so-called abnormal contour interaction of amblyopic eyes) refers to the behaviour of amblyopic eyes – they will easily distinguish a single letter on a bland background but the true acuity of the eye is discovered when the child tries to read a single letter in a line of letters or a single letter surrounded by confusion bars.

**Practice tips: Completing a hearing and ear health screen** ¹⁴¹

- A Registered Nurse or an appropriately trained Health Worker / Practitioner may undertake an ear and hearing health screen for children less than four (4) years of age by Otoscopy and tympanometry.
- All equipment should be handled with care and maintained according to the manufacturer's instructions, this may include regular calibration.
- Maintain strict infection control recommendations to reduce contamination and spread of disease.



Do not proceed with ear health and hearing screening if there is ear pain, notable discharge or the skin is broken or inflamed. These children are referred to MO/GP/Nurse Practitioner or refer to the *Primary Clinical Care Manual*

- Hearing screening aims to identify those children most likely to have hearing loss that may interfere with their speech and language, education, health and development. Screening is aimed at detecting previously undiagnosed unilateral, bilateral and progressive hearing loss whether sensorineural, conductive or mixed in nature. Hearing loss may be temporary or permanent e.g. fluctuating conductive hearing loss.
- Ask the parent if they have any concerns about their child's hearing, ear health, speech and language development and developmental/academic progress.
- Determine if the child requires otoscopy and/or tympanometry and/or audiometry according to recommendations and clinical judgement. Recommendations are as follows:

Hearing and ear health screening recommendations between 1 – 5 years

Age*	Questions to ask	Procedure
12 months 18 months 2 years 3 years	<ul style="list-style-type: none"> ■ Has your child been free of ear infections or discharge? ■ Are you happy about your child's ears and hearing? ■ Are you happy with your child's speech and language development? 	Otoscopy Tympanometry
4 years 5 years	<ul style="list-style-type: none"> ■ Has your child been free of ear infections or discharge? ■ Are you happy about your child's ears and hearing? ■ Are you happy with your child's speech and language development? 	Otoscopy Tympanometry Audiometry

* Refer to other sections for recommendations less than 12 months (page 40) and over 5 years (page 186).

- A hearing screen for the child with grommets should be within normal limits.
- Encourage and acknowledge the child's efforts during the procedures in an age-appropriate manner.
- Always start with the right ear as a point of reference.

- Visually observe and gently palpate the area around the ear, i.e. area over the mastoid bone behind the ear, under and around the front of the ear for swelling, inflammation or tenderness.
- If using screening audiometry with otoscopy and tympanometry then the sequencing of tests will be:
 - otoscopy
 - tympanometry
 - audiometry.

Otoscopy

- The otoscopy assessment is used to check for obvious signs of ear disease.
- Three parts of the ear can be checked with an otoscope:
 - pinna – check for swelling, inflammation and/or discharge;
 - ear canal – check for inflammation, discharge, wax, fungal infections, colour and/or foreign body;
 - tympanic membrane (eardrum).
- When checking the tympanic membrane observe the following:
 - colour (normal is transparent and shiny),
 - landmarks, i.e. a reflection or ‘cone of light’ can be seen at 5 o’clock in the right ear and 7 o’clock in the left ear; other reflections may indicate bulging of the membrane.
 - the handle of malleus can be seen at 1 o’clock in the right ear and 11 o’clock in the left ear.
 - perforation or grommets may also be observed.



Do not proceed with ear health and hearing screening if there is ear pain, notable discharge or the skin is broken or inflamed. These children are referred to MO/GP/Nurse Practitioner or refer to the *Primary Clinical Care Manual*

- Position yourself in a comfortable position at the level of the child’s ear and ask the child to hold their head still. For an infant, it may be suitable for them to be on their parent/care-givers lap in a gentle brace with the child’s head against their chest.
- The examiner will use their fingers against the child’s head to anchor the otoscope if the child suddenly moves.
- Follow procedure and document findings, e.g. Otoscopy: eardrums intact and free of bulging; ear canals clean and free of debris.
- Ensure the child is placed onto a follow up and recall hearing register.

Referral / follow up



Refer to *Chronic Conditions Manual*

- Refer children to GP/MO/Nurse Practitioner
- This may include:
 - ear pain
 - ear discharge

- abnormal otoscopy findings, i.e. structural defect of the ear, wax occlusion of the ear canal, inflamed ear tissue, tympanic membrane is bulging or perforated, appearance of fluid or pus behind the tympanic membrane
- Clinician is concerned about hearing or ear health
- If referral is necessary, review in 3 months.
- When there is a history of otitis media and the screening results are within normal ranges a 6 month follow up screen is recommended
- If there are no concerns or referral place the child on a recall register and schedule the next appointment according to screening recommendations (as above).

Tympanometry

- Tympanometry is a measurement of middle ear function. It is not a test for hearing impairment.

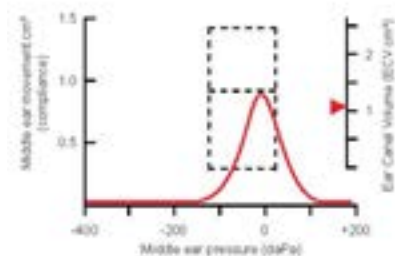


Do not proceed with ear health and hearing screening if there is ear pain, notable discharge or the skin is broken or inflamed. These children are referred to MO/GP/Nurse Practitioner or refer to the *Primary Clinical Care Manual*

- The tympanometer creates a graph – a tympanogram which should be saved, printed and stored according to local HHS protocols.
- Tympanometry measures movement of the tympanic membrane in response to pressure changes in the external ear canal, as follows:

- **Type A normal peak**

- › Ear canal volume (ECV) = 1 (0.2 to 2.0 is normal)
- › Middle ear movement (compliance) = 0.9 (0.2 to 1.4 is normal)
- › Middle ear pressure = 0 (-150 to +100 is normal)

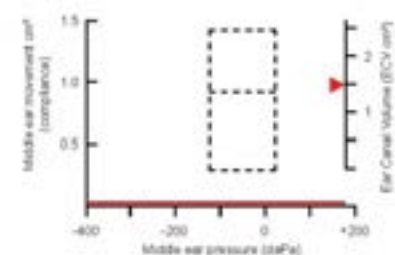


- **Type B**

- › No middle ear movement
- › No middle ear pressure

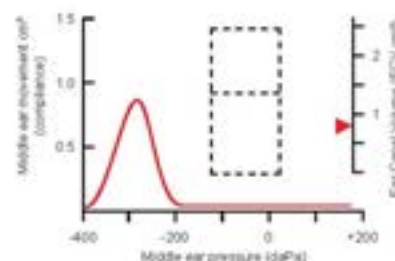
Possible causes:

- › Usually Otitis Media
- › Badly scarred eardrum
- › Eardrum perforation (hole)
- › Grommet
- › Ear canal blockage



- **Type C peak to left**

- › Normal ear canal volume
 - › Normal middle ear movement
 - › Negative middle ear pressure
- Possible causes:
- › Eustachian tube not working properly
 - › URTI
 - › Fluid moving into middle ear



- If a leak or blockage occurs during the tympanometry, try a different sized probe tip, cleaning the probe tip or repositioning it in the ear canal.
- Document results in the clinical record under the classifications of type A, B or C.

Referral / follow up



Refer to *Chronic Conditions Manual*

- Refer children to GP/MO/Nurse Practitioner
- This may include:
 - ear pain
 - ear discharge
 - Tympanogram results Type B or Type C – excepting when Tympanometry is follow by Audiometry - see Referral and follow up section following Audiometry.
 - Clinician is concerned about hearing or ear health
- If referral is necessary, review in 3 months.
- If there is a history of otitis media, review in 6 months.
- If there are no concerns or referral, place the child on a recall register and schedule the next appointment according to screening recommendations (as above).

Audiometry

- Audiometry measures the ability of the ear to detect sound by the pitch, measured in hertz (Hz) and loudness, measured in decibels (dB). It involves a simple, quick test to identify those children ‘at risk’ of hearing problems requiring further assessment.
- It is essential that testing occurs in a quiet room.
- Explain the procedure to the child and agree on an appropriate response for the developmental level of the child, e.g., pushing a response button, raising their hand, placing a coin in a container (in response to hearing the sound).
- Play tone and demonstrate the procedure to the child, i.e. “now I want you to listen to some soft sounds. I will place the earphones over your ears. When you hear the noise/beep...”
- Repeat demonstration to child at softer volumes, e.g. “Your turn now... Listen for the sound... Push the button.”
- When child can demonstrate an understanding of the procedure – perform testing.
- Not all children can or will cooperate with the procedure. If unsuccessful after further demonstration, refer the child for further assessment. Local service policies and procedures will determine available options.
- Ensure the child is comfortable, e.g. remove firm headbands, take care with earrings and adjust headphones as needed.
- Seat the child so that they cannot see the displays on the audiometer but the tester can observe child for responses and visual cues.
- Advise the child that sounds will get softer and softer.
- Remember to place the ear muffs over the correct ear and test one ear at a time, i.e. Red = Right Ear (always first) then, Blue = Left Ear.

- Ensure sounds are presented at irregular intervals so that the child is not anticipating the sounds.
- Set the audiometer to 4000Hz and 50dB.
- If the child responds to hearing the sound at 50dB, then reduce to 35dB and repeat, then if heard, reduce to 25dB and repeat.
- Record the result that the child responds to twice at the lowest perceived measurement (dB).
- Where child has failed to respond to a particular level of frequency, increase the intensity in 5 dB stages (do not going above 80dB) until two responses are obtained and record results accordingly.
- Repeat the procedure for 2000Hz and 1000Hz.
- Do the same for the other ear.
- To **pass** the child needs to respond twice at 25dB at 1000Hz, 2000Hz and 4000Hz in both ears.
- Discussion regarding a **fail** audiometry with parents will be centred around follow-up and possible referral for further investigation, rather than a finding of a hearing impairment as this may be a temporary condition and a hearing impairment cannot be determined by a screening test alone'.

Referral / follow up

- If there are no concerns and screening tests normal / pass, place the child on a recall register and schedule the next appointment according to screening recommendations (as above).
- When a scheduled screen results in:
 - Tympanogram: Type B or C and Audiometry: **fail**
 - Follow up at 3 months.
- When a follow up screen results in:
 - Tympanogram: Type A in both ears and Audiometry: **pass**
 - Follow up in 6 months.
- When there is a history of otitis media and the screening results are within normal ranges,
 - Follow up in 6 months.
- Refer children to GP/MO/nurse practitioner/audiologist when:
 - findings at a three month follow-up screen results in Tympanogram: Type B or C and audiometry: fail
 - there is ear pain or discharge
 - Audiometry: > 40 dB at any frequency in either ear
 - any child in whom a satisfactory testing has not been obtained or where doubt exists as to the validity of the results obtained or the clinician is concerned.



Refer to *Chronic Conditions Manual*

Growth monitoring

Growth during childhood is an important indicator of nutritional and health status and remains the best method of assessment at the primary care level⁸¹. Weight gain and increase in size of the child occurs as body systems mature. Physical growth is best assessed by measuring weight, length or height and head circumference and comparing these measures with a growth reference⁵⁸.

Accuracy is crucial in obtaining all physical measurements. There are three components of accurate measuring:

- technique that is standardised
- equipment that is calibrated and accurate
- measurers that are trained so they are accurate and reliable.

In addition:

- ensure scales and stadiometers are regularly calibrated to manufacturer's instructions and checked each day of use
- use the same scales whenever possible
- follow manufacturer's instructions on transportation of portable scales.

Growth charts

- Growth charts are used as a reference to critically analyse growth measurements of weight, length or height and head circumference by comparing these against recommended populations. WHO charts are recommended up to two years of age, followed by the use of the CDC growth charts^{58,81}.
- Regular and consistent growth monitoring enables the health professional to critically analyse the pattern or trend of growth when plotted on a growth chart by observing the shape of the curve and compare it to percentile curve¹⁴¹. Factors that influence a child's growth can include gender, genetics, health, environmental facts, e.g. nutrition²⁴.



Children who are not following the shape of the curve over a number of readings or are above the 95th centile or below the 10th centile are referred for further assessment according to recognised referral guidelines²⁴

- Health professionals may need to ensure parents understand the importance of the pattern of growth following a trajectory along the percentiles more so than the position on the percentile charts^{58,81}.

Allowance for gestational age

- Allowance for gestational age for growth and development is made for children born premature. Children born less than 37 weeks gestation only have their age corrected up until one year, however for children born prior to the 32nd completed week of pregnancy, their age should be corrected up until two years. Correction beyond two years may be required as directed by a tertiary specialist⁸³.
 - An example of allowing for gestation age: If a child born at 30 weeks gestation visits the Child Health Centre at 18 months of age, the weight will be plotted at the age of 15.5 months.



See page 160 for more information on prematurity



Centre for Disease and Prevention | www.cdc.gov

Growth charts – www.cdc.gov/growthcharts/who_charts.htm

The Royal Children's Hospital, Melbourne | www.rch.org.au

Top 10 things you need to know about growth charts

www.rch.org.au/childgrowth/about_child_growth/Top_10_things_you_need_to_know_about_growth_charts/



Queensland Health Guideline: Assessment of child/child nutrition, growth and development within the primary health care setting http://qheps.health.qld.gov.au/patientflow/docs/scycn_nutrit_guide.pdf

Weight

- Weight (or mass) is an overall measure of body size and is of interest because it indicates changing health status and growth and development. Knowing the weight of an individual also enables the calculation of the Body Mass Index (BMI) ⁵⁸.
- Weighing activities of a child is valued by parents and often an incentive for visiting a health professional. This raises an opportunity for other concerns to be raised and anticipatory guidance to be offered ¹.
- Families should be given accurate information about their child's growth and informed when there are any concerns regarding poor growth or high rates of growth. This is particularly important with rising rates of obesity in children and teens in Australia and in high risk groups such as Aboriginal and Torres Strait Islander families who have a higher prevalence of:
 - small for gestational age,
 - obesity,
 - early onset type 2 diabetes and
 - other chronic diseases ^{1, 84}.

Length/height

- Changes in the height of an individual over a period of 3-12 months (height velocity) reflect changes in the nutritional and health status of that individual. Height is important in the calculation of BMI ²⁴
- Length is measured in the recumbent (lying) position as this is the correct linear measurement for children younger than 2 years of age or children aged 2 – 3 years who cannot stand unassisted
- A calibrated length board is recommended for length measures and it must have:
 - a fixed headpiece
 - a moveable foot-piece, perpendicular to the surface that the length board is on.
- Height measurement requires a vertical metric rule, a horizontal headboard and a non-compressible flat, even surface, on which the subject stands. A rigid stadiometer is best (portable measures are available for situations where the screener moves from site to site; while well-calibrated wall mounted stadiometers are ideal for centre-based screening).
- The graduations on the metric rule should be at 0.1 cm intervals and have the capacity to measure up to at least 210cm. Measurement graduations need to be easily readable.

Head circumference

- Head measurement should be undertaken at universal child health checks. A routine measurement of head circumference is intended to aid the detection of two groups of disorders: those characterised by a large head (macrocephaly) and those indicated by a small head (microcephaly). These conditions cannot be diagnosed by measurement of the head circumference alone. A head circumference above the 97th percentile or below the 3rd percentile at any stage is an indication for more detailed assessment. In the primary care setting the child is referred to the General Practitioner ⁵⁸.

Body Mass Index (BMI)

- BMI is a useful screening tool to identify when a child is underweight, overweight or obese.
- It is recommended that the BMI is plotted from 2 years of age on CDC growth charts.
- An elevated BMI in childhood is associated with obesity in adulthood.
- CDC BMI charts classify overweight as being between 85 – 95th percentile and obese the 95th or above

Referral for concerns around body measurements

When a child health professional is concerned about a child's body measurements a referral to a GP/MO is advised. This includes:

- any sudden deviation in weight, where the weight has crossed two percentiles
- Weight below the 10th percentile or greater than the 90th percentile
- weight differs by two centile lines or greater compared to the length ¹⁴¹.



Refer to *Chronic Conditions Manual*



Refer to the Pathways to Rural and Remote Orientation and Training
www.health.qld.gov.au/parrot/default.asp

Developmental assessment



See Practice tip: Conducting a developmental assessment, page 51.

- Development refers to the increased ability of the body to function within the environment and can be categorised into a number of domains, for example:
 - physical development – gross motor and fine motor skills
 - socio-emotional and cognitive development
 - language and literacy ¹.
- Gathering information from the child's parent/carer reliably informs the clinician about the child's development ¹¹³.
- Developmental assessment of any child must have a holistic focus. This means that the domains of development are considered in an ecological framework that considers the physical, social, emotional and environmental factors involved ⁸⁹ and informs the development of a care plan linked to the child's needs and risk factors ^{113,114}.
- Whilst development proceeds at different rates in different individuals, most children reach sub-stages of their developmental growth in a similar order ¹¹³. A child may be considered to have a **developmental delay** when they have not met a particular milestone by a particular time and when there is delay in meeting all of their milestones at a health check they are considered to have **global developmental delay** ¹¹⁴. These symptoms may be related to underlying health issues and the child health professional will refer the child for further assessment to a MO / GP.
- Early and accurate identification of children with developmental delays or disorders allows early intervention. Early intervention has been shown to result in improved developmental, educational and social outcomes with the earlier the intervention taking place the better these outcomes ⁸⁹.

Physical development

- Children can be observed for the following patterns of gross motor development during the one – five year period. Referral will be made by the child health professional to the GP/MO with any emerging/obvious delays.

Age	Typical developmental pattern	Signs for referral
12 months	Postural control and stability develops with pre-walking activities e.g., stands well with support / walks around furniture	Unable to crawl Not pulling to stand and standing holding onto furniture items
18 months	Characteristic gait - arms and legs rigid, arms held out to support balance; flat footed	Not standing, attempting to walk without support Asymmetry or abnormal tone, posture or movements
2 years	Gait characterised by arms moving reciprocally with legs and heel-toe pattern emerging. Running usually progresses about 6 months after walking is attained	Unable to run, use stairs
3 years	Hopping usually attained about two years after walking. Children can usually walk in a straight line	Cannot jump two feet together Unable to throw a ball
4 years	Arms held by child's side and move reciprocally when they walk	Can't balance well on one leg Can't catch, throw or kick a ball
5 years	Children can usually stand on one foot	Unable to hop five times ^{90, 113,}

Cognitive development

- By the time most children have reached two years old their cognitive and fine motor skill development means they are able to manage simple self-care activities such as feeding and dressing themselves ¹¹³. If these activities are not established by three years then referral is recommended ⁹⁰. Self-care activities will also include toileting as further development occurs. If a child is not toilet trained (by day) by the age of four years, referral is recommended ⁹⁰.
- Cognitive and fine motor development will also be evident by the child's ability to build block towers, shape sort, colour match items, thread beads, hold pencils, scribble and draw. The child health professional will refer to the GP/MO when any concerns around these developmental milestones are not met – for example:
 - 3 years: unable to manipulate small objects e.g. thread a bead onto a string
 - 4 years: unable to draw a line or circle
 - 5 years: unable to draw a stick person ^{90,113}.
- Length of sleep is one of the most common topics discussed by parents at well child checks ¹¹⁵. Whilst enormous variation exists from one individual to the next, most children's brain architecture has developed to the degree that is compatible with parental expectations, for example: the child is able to drop off to sleep on their own, sleeping longer periods at night with lessening interruptions ¹¹⁶.
- The following table ^{24,59,115} offers a guide only to an average child's sleep patterns and behaviours and identifies some common conditions whereby referral is recommended:

Age	Total hours of sleep / day	Common behaviours	Considerations for referral
1-3 years	10-16 hours	<p>One nap a day in most infants 18 months of age, transitioning to no naps.</p> <p>50% of 3 year olds no longer nap in the day.</p> <p>Often attached to objects, e.g. a 'blankie'.</p>	<p>Behavioural insomnia of childhood occurs in 10 – 30% of children and is characterised by the child's inability to fall asleep or return to sleep without specific conditions such as: rocking, feeding to sleep, being in parent's bed. The child health professional advises parents to work towards prevention of this by encouraging techniques supporting self-settling and regular sleep routines (see pages 112, 122) and are offered sleep and settling support.</p> <p>When ongoing sleep issues create sleep dysfunction or/and a risk of impaired parenting, refer to: In-home parenting support with sleep and settling; day stay parenting support facilities or Ellen Barron Family Centre.</p> <p>1 – 5% of children develop obstructive sleep apnoea, commonly caused by enlarged tonsils and adenoids, often between 2 – 8 years; symptoms: snoring; unusual sleep positions e.g., hyperextended head; nighttime diaphoresis / enuresis; cognitive/ behavioural issues. Refer to GP / MO.</p> <p>Possibility of nocturnal seizures should be considered when parents discuss abnormal postures involved with sleep disturbances and behaviours. Refer to GP / MO if concerned.</p>
3-5 years	11 – 15 hours	<p>Gradual transition to no naps in the day.</p> <p>Increase of fears during sleep e.g., monsters.</p> <p>Nightmares occur in 10- 50% of children, with children remembering the event; usually occurs in the second half of sleep.</p> <p>Confusional arousals are common ('sleep drunkenness'), where the child has slurred speech and inappropriate behaviours with no memory of the event.</p> <p>Sleep terrors may occur, usually during the first half of the night. Child awakes with intense fear, but has no memory of the event.</p>	

24, 59, 115

Socio-emotional development, language and literacy

- Most parents can tell you when their child has said their first word/s clearly, however, communication is about more than just talking. It encompasses verbal and non-verbal interactions between parent and child. The language process develops in a social context. It is acquired through interaction with caring and responsive adults and is influenced by biological, cognitive, psycho-social and environmental factors⁶⁹. Social skill development involves the child gaining understanding and value of feelings and the impact of those feelings on behaviours - their own and those around them¹¹³.
- A child health professional can conduct a developmental assessment by setting up a play activity including the parent/carer, the child and the child health professional with specific toys e.g., tea set, action figures, dolls. The child health professional can observe the child's communication, interaction, role playing, turn taking during play¹¹³. The concept of attention can also be observed with children being able to sustain greater levels of attention as they develop and being able to pay less attention to external stimuli when they are focused on a task¹¹³. Parent-child interaction may also be observed.

Examples of observations may include:

Age	Typical developmental pattern	Signs for referral ^{90,113}
3 years	Follows simple game rules Takes turns	No interest in 'pretend' play Lack of social interaction Disinterested in feelings of others during play
4-5 years	Asks for more when playing with tea set Ignores external stimuli during play they are interested in	Difficulty cooperating Preference for solitary play Limited imagination Jumps from one activity to another after a short time

- Parent – child interaction will also be observed during appointments. Concerns such as parental negativity toward the child such as apportioning blame to the child for their own feelings. e.g. 'He just does that to annoy me' ¹¹³. Further information, see 'Examples of positive and problem indicators of parent-child interaction', page 30.
- Children are more likely to experience **speech delay** when they have:
 - Hearing impairment
 - Family history of speech delay
 - Low income and/or minimal parental education
 - Large family size
 - Single parenthood
 - Low birth weight, birth asphyxia, prematurity
 - Impaired parenting e.g. lack of social stimulation
 - Experienced child abuse
 - Developmental disorders e.g., autism ^{114, 117}
 - When a child has multiple risk factors there is an increased risk of developmental delay ¹¹⁷.
- While most speech and language issues resolve spontaneously in under 3 year olds, there is no clear way of identifying in which children this will be, so a 'wait and see' approach is not recommended. Research shows that the best long term outcomes arise from children who are given help before the child enter school and as early as 3 years of age ¹¹⁸.
- Children who show signs of communication delay or difficulty such as:

Age	Signs for immediate referral
12 months	Not babbling in phrases
18 months	No clear words, not saying 'mama' or 'dada', unable to follow a simple command
2 years	Not putting words together, developing a vocabulary of words e.g. 50 words
3 years	Not using simple sentences developing a vocabulary of words e.g. 50 words
4 years	Speech is difficult to understand. Unable to follow a direction including two-steps.
5 years	Has difficulty expressing 'what is wrong' to their parent. Unable to answer simple questions within a conversation. ^{87, 109}

Given that speech and communication have a significant impact on cognitive and social skills it is important that referrals for further assessment and intervention are made as early as possible ^{90, 114, 118}.

Screening tools

There are a number of tools that are available for developmental assessment in the primary care setting. Health care professionals should check which developmental assessment tools are recommended to be used in their particular setting and be trained to administer and interpret the outcomes of the tools correctly. Some screening tools include ¹:

- **Ages and Stages Questionnaires (ASQ)**
<http://agesandstages.com>
Age: 3 months – 5 years
When is it used: For identifying developmental delays
Completed by: Parent at home with a discussion of any concerns with a child health professional.
- **Parents Evaluation of Developmental Status (PEDS)**
www.pedstest.com/Home.aspx
www.rch.org.au/ccch/resources_and_publications/Monitoring_Child_Development/
Age: 0– 8 years
When is it used: Detecting developmental and behavioural issues. Used in conjunction with ASQ for screening purposes. ASQ:SE Questionnaire can be used in addition to screen the personal and social skill domain
Completed by: Parents and incorporated into a child health monitoring program.
- **Brigance Screens (e.g. Brigance Early Childhood Screen II)**
www.casamples.com/downloads/11968s.pdf
Age: 0– 7 years
When is it used: Secondary screening tests to identify developmental delay or advanced development.
Completed by: Trained health care professional

Referral

Any time a child health professional is concerned following a thorough developmental assessment a referral to the families' GP / Medical Officer is appropriate for further assessment. The "Red Flag" Early Intervention Referral Guide for children 0-5 years can be used as a guide ⁹⁰.



The Royal Children's Hospital Melbourne: Centre for Community Child Health
Monitoring Child Development

The "Red Flag" Early Intervention Referral Guide for children 0-5 years (Children's Health Queensland)
www.health.qld.gov.au/rch/professionals/brochures/red_flag.pdf



Refer to *Chronic Conditions Manual*

Assessment of nutrition

Nutritional assessment is an opportune time for discussion and anticipatory guidance around healthy eating within the family. Considerations include:

- Cultural influences
- Environmental factors
- The child's gross and fine motor development
- The child's opportunity to experience a wide variety of healthy foods ⁸¹.

Specific food preferences develop as children integrate a number of senses such as texture, smell and sight into eating, rather than taste alone. Digestive processes become established and their stomach capacity enables the child to have 3 meals per day ²⁴.

Breastfeeding

- Breastfeeding is the physiological normal way for an child to be fed and is unequalled at providing optimal nutrition and healthy growth for the first 2 years of age or beyond, for as long as the mother and child desire ^{41, 94}.
- Timely access to child health services in the community ensure families are provided with professional support, encouragement and promotion of breastfeeding. Services can be provided in a range of modes e.g., telephone support, clinic visits, home visiting, group sessions ¹.
- Be culturally sensitive and where possible utilise culturally specific resources to discuss breastfeeding with parents (e.g. Growing Strong) ⁴².
- Health professionals support breastfeeding by:
 - Informing families of the benefits of breastfeeding and the risks of not breastfeeding
 - supporting partners and family in the support role for breastfeeding
 - promoting maternal self-care
 - providing evidence based information, education and support on breastfeeding
 - exploring with families strategies to overcome feeding difficulties
 - provide information on the range of support services available e.g. Australian Breastfeeding Association, Raising Children website
 - supporting the principles of the Child Friendly Health Initiative ⁴¹.
- **Feeding through pregnancy and tandem feeding** – It is not detrimental for a healthy woman to continue to breastfeed her child during a subsequent uncomplicated pregnancy and then breastfeed both the infant and child ¹¹⁹. Considerations include:
 - nipples may become tender and sore
 - the child may notice a change of taste in the breast milk taste
 - milk supply may decrease as pregnancy progresses
 - adequate nutrition for the mother is important
 - greater risk for maternal fatigue
 - advise the woman to discuss the need for mineral / vitamin supplements with the pregnancy care provider.



Women experiencing symptoms of pre-term labour should seek medical attention ¹¹⁹

- When tandem breastfeeding:
 - It may be helpful to initially feed infant and child separately whilst the infant is establishing feeding
 - Switch sides and positions for both the infant and child
 - Tandem feeding will reduce nursing time when this is suitable for the family ¹¹⁹.

Weaning

- Weaning may be child-led, mother-led, mutual weaning, sudden or planned weaning ⁹⁸. All options should be discussed with the mother to allow her to make an informed decision regarding how and when she will wean and care for her breasts.
- Ideally all children should be weaned slowly, this way the breast milk supply decreases slowly and there is time for the child to adjust to the change. Breastfeeds should gradually be replaced over time, for example: start dropping the feed your child is least interested in, then reduce another feed every few days depending on the individual situation ^{98,120}.

- Some situations may result in a mother weaning suddenly e.g. maternal illness, medications incompatible with breastfeeding. The degree and duration of breast refilling depends on the amount of milk being produced before weaning commences. Proper care of the breasts is important to minimise discomfort and to reduce the risk of blocked ducts and/or mastitis ^{98,120}.
- Expressing sometimes for comfort until lactation diminishes will be helpful ¹²⁰.
- It is important to discuss contraceptive methods with the mother during and after weaning as the contraceptive effect of breastfeeding will cease once weaning begins ¹²⁰.



Eat for Health – Australian Dietary Guidelines | www.eatforhealth.gov.au

Raising Children Network | <http://raisingchildren.net.au>

Australian Breastfeeding Association | www.breastfeeding.asn.au



Refer to *Chronic Conditions Manual*

Health promotion

Health promotion strategies are designed to improve child and family health by enabling parents to increase health awareness, build onto their parenting skills and enhance the capacity of the family. This includes a focus on addressing the social determinants of health and building protective factors as part of everyday child health practice ¹²¹. A best practice health care model for parents with children is one that aims to ensure universal access to health promotion services ^{1,122}. Structured universal health services aims to arm parents with practical information and knowledge by:

- offering anticipatory guidance
- supporting parental skill development
- providing quality information on illness and safety prevention

to increase the opportunity for positive family experiences and improved family wellbeing ^{1,122}. Health promotion is a core element of child and family health services and in conjunction with antenatal services, is the first stage of a universal service platform that aims to support optimal health and wellbeing for parents and children ¹.

There are many resources widely available for families that focus on health promotion, illness and safety prevention (e.g. web pages, DVDs, brochures, fact sheets, booklets). Face to face consultation specific to health promotion is often provided in various settings (e.g., community centres, workplaces), commonly in the form of group education and support ^{1,122}. It is imperative that child health professionals ensure all information offered to families is:

- accurate
- current
- evidence-based
- in a format and manner that meets policy and guidelines, for example,
 - presented in a non-judgemental, culturally respectful manner
 - content meets the International Code of Marketing of Breast Milk Substitutes and the Marketing in Australia of Infant Formula (MAIF) agreement.

Child health professionals encourage families to be discriminating with information, especially information they are accessing on websites. There are numerous websites that offer reliable information for parents on a range of topics. One such site is the Raising Children Network.



Raising Children Network | <http://raisingchildren.net.au>

The personal health record and child health information booklet

All infants born in Queensland will be given a Personal Health Record (PHR) and Child Health Information Booklet which includes up to date, evidence based health promotion information (ADD image of PHR pls)

The PHR provides a guide for information sharing between parents and health care professionals by providing: 'Questions for parents' and 'Suggested topics for discussion'. This framework helps to ensure the most appropriate information is offered to families at the most appropriate time. Families are encouraged to bring the PHR to all appointments for completion by the health care professional. Inserted in the cover of the PHR is a booklet "Child Health Information – Your guide to the first 12 months" (ADD image of pls) offering information on a range of topics⁶². Health care professionals are recommended to encourage families to use this resource.

Engaging families

- Health professionals recognise family structures are varied including:
 - extended families, e.g. grandparents, aunts
 - foster families
 - single parent, step and blended families
 - gay, lesbian, bisexual and transgender parents,
- each member of the family is acknowledged for the significant role in the infant's life²⁷. It is recommended that services encourage greater involvement of significant others, particularly fathers, by considering a range of strategies including:
- Change service environments to account for possible barriers that prohibit partners/extended family attending services, e.g. vary program times and formats to improve access, include 'neutral' messages for 'parents', attract male staff, use male inclusive literature and magazines in the waiting room²⁸.
- Discuss transition to parenthood issues, parenting roles, lifestyle and relationships changes²⁷.



Government of Western Australia | www.communities.wa.gov.au

Father Inclusive Practice - Download from www.communities.wa.gov.au/Documents/About%20us/CF106%20Father%20Inclusive%20Practice%20Policy%20Paper%202012.docx

Queensland Health | www.health.gov.au

Strong Fathers Strong Families Program

Growing Strong Resources – www.health.qld.gov.au/ph/documents/hpu/how_dads_help.pdf

Raising Children Network | <http://raisingchildren.net.au>

Resources (video and fact sheets) on a variety of topics including Parenting in pictures, Positive parenting, Families that work well, Sole parenting, Becoming a dad, Being a grandparent, Being a grandparent carer, Teenage parents, Parenting in a same-sex relationship and Step parents.

At all contacts with families, child health care professionals are recommended to opportunistically educate and provide anticipatory guidance and parenting support to promote optimal family health^{1,122}. There is an endless range of topics that may be discussed with families, this section discusses topics recommended specific to health promotion and illness/injury prevention within the National Framework for Universal Child and Family Health Services¹.

Topics covered in this section include:

1. Needs of the infant (0 to 12 months)
2. Normal infant behaviour and activities to support development (0 to 12 months)
3. Needs of the child (One to five years)
4. Normal child behaviour and activities to support development (One to five years)
5. Immunisation
6. Safety, illness and injury prevention

Group parenting sessions

Family members are encouraged to attend group based parenting programs, e.g. Triple P. Parenting groups have been found to result in positive outcomes for parents / carers with less depression, anxiety, stress, anger, guilt and more confidence and partner satisfaction reported in short term ⁶¹.



Practice tips: Facilitating a group parenting session

- Group work is not suitable for every parent/child. Child health professionals should consider the needs of the family and whether or not the group setting would be suitable. Some groups will involve screening (e.g. a pre-group interview) in the preparation phase.
- Consider the following:
 - What is the clinical objective of the group program?
 - Does this person fall within the criteria of the group program? e.g., age of their children.
 - Would this group program assist the client with their presenting issues?
 - Would the client be able to function and learn in the group environment?
 - Would the group's objectives be met if we include this client in the program?
 - What other assistance does this client need at the moment?
 - Are there other presenting needs that should be prioritised?
 - If the group is not the best fit for the client, can the client be offered an individual appointment?
- Being prepared for group work is important; this includes having all the equipment and having back-up plans if required e.g., know your content, participate in adequate planning between staff if there is co-facilitation, have a back-up hard copy of session outline and notes in case computer technology fails.
- As facilitator it is important that you take the role of maintaining boundaries within the group. These boundaries are preferably designed and agreed by the group itself. 'Group rules' may include keeping to time, one person speaking at a time and a group culture that is 'constructive' rather than a 'critical'.
- It is a good idea to 'set the scene' as the facilitator of the group, for example:
 - Your role in facilitating the group, e.g., providing evidence based information, promoting the group participants to interact to build strategies and share experiences that may be helpful to one another. Using "What does anyone else think of that?" can help facilitate group interaction.
 - It will be your 'job' to maintain the agreed group rules.
 - Describe the nature of the session – didactic, interactive.
 - Also explain how you will redirect group discussions back to the agreed topic when necessary, and at times (if the conversation is not beneficial to the whole group) you may need to stop a conversation by an attendee and direct them to talk to you in more detail at the end of the group session.
- As a professional facilitator it is important to have the ability to listen and take on a broad perspectives, this may also be useful within group, facilitated by encouraging the group to view the situation through different 'eyes', e.g. How would this look if you were the child? How would this look if you were the teenager? How would this be for you or your partner?
- Having two facilitators is ideal. Co-facilitation between professional groups may bring additional expertise to the topic, for example: A Child Health Nurse and a Psychologist. This also enables one staff member to be available if a participant needs individual support whilst the other staff member can continue with the group. Co-facilitation enables an opportunity for staff to debrief about how the group went, improvements and plan future needs for the group.
- Groups should be evaluated according to the local HHS protocols. ¹²³

0 TO 12 MONTHS

Needs of the infant

Physical changes and development during the first year of life is dramatic. As body systems establish and mature there is a simultaneous development of skills, sequencing from head to toe and the body's centre to the peripherals (cephalocaudal – proximodistal) that enable the infant to respond to and grow within their environment²⁴.

The needs of an infant during this time are expansive and will be discussed under the following headings:

- a. Promotion of optimal infant nutrition
- b. Growth
- c. Cognitive Development
- d. Parent-child interaction

Promotion of optimal infant nutrition

Mothers, fathers and their support networks need appropriate and consistent information to enable them to make an informed decision about infant nutrition. The following information provides practice points to guide child health care professionals offering health promotion advice:

- Encourage families to create an environment whereby mealtime is a pleasurable time spent with other family members¹¹⁶.
- Encourage parents to offer a range of nutritious food options and flavours to establish an infant's sense of taste and acceptance of variety⁴¹.
- Encourage families to demonstrate healthy eating habits and choices to their infants that can inform lifelong healthy eating patterns⁴¹.
- Encourage families to reflect on their family and cultural eating patterns and how this may impact on their infant. For example factors that may be contributing to the rising rates of obesity include:
 - regularly consuming large meal sizes
 - a family culture of admonishing children for leaving food on their plates²⁴.
- Use culturally appropriate tools for education on breastfeeding and infant nutrition such as 'Growing Strong : Feeding You and Your Baby⁴²'. This is a resource developed to assist health staff talk with Aboriginal and Torres Strait Islander families about nutrition for mother, babies and young children. There are a range of resources available⁴². Additionally, a range of multicultural breastfeeding factsheets are available in a number of different languages⁴³.
- Identify community partnerships and opportunities for services to work together on promoting optimal nutrition including local hospitals, GPS, general practitioners, birthing units and postnatal services, local support organisations (e.g. ABA, Australian Lactation Consultant Association), nutritionists and dieticians, speech pathologists, pharmacies and oral health services¹.

Breastfeeding

Breastfeeding is the physiological normal way for an infant to feed and is unequalled at providing optimal nutrition and healthy growth for the first six months of life, thereafter, appropriate complementary foods are added with continued breastfeeding up to two years of age or for as long as the mother and child desire^{41, 94}. Forming an intention to breastfeed during the antenatal period, a woman's sense of self efficacy and the support of her partner / family are known to improve breastfeeding outcomes²⁸.

- The **Baby Friendly Health Initiative (BHFI) seven-point plan for community health centres**⁴⁴ is the global standard by which health services are assessed and accredited as 'baby friendly'. A baby friendly health service is one where mothers' informed choice of feeding is encouraged, respected and supported. To achieve the standard, health care professionals and other carers must possess:
 - training and education around supporting breastfeeding

- a sound knowledge of infant feeding
- sound skills in assisting women with breastfeeding
- a commitment and positive attitude to facilitate breastfeeding ⁴⁴.

The BHFI seven-point plan for community health centres

1. Have a written breastfeeding policy that is routinely communicated to all health care staff.
2. Educate all health care staff in the knowledge and skills necessary to implement the breastfeeding policy.
3. Inform women and their families about breastfeeding being the biologically normal way to feed a baby, and about the risks associated with not breastfeeding.
4. Inform women and their families about the management of breastfeeding and support them to establish and maintain exclusive breastfeeding to six months
5. Encourage sustained breastfeeding beyond six months with appropriate introduction of complementary foods.
6. Provide a welcoming atmosphere for breastfeeding families
7. Promote collaboration between health care staff and volunteers, breastfeeding support groups and the local community in order to promote, protect and support breastfeeding..

Source: <https://www.breastfeeding.asn.au/breastfeeding-friendly-health-services>

- The **Marketing in Australia of Infant Formula (MAIF) Agreement** is Australia's response to the *WHO International Code of Marketing Breast Milk Substitutes* (WHO Code). The MAIF Agreement contributes to the provision of safe and adequate nutrition for infants by the protection and promotion of breastfeeding and by ensuring the proper use of infant breastmilk substitutes on the basis of adequate information and through the appropriate marketing and distribution of breastmilk substitutes ¹²⁴.
- Promotion of optimal maternal nutrition during breastfeeding is important to maintain maternal health and enhance the micronutrient and fatty acid make up of breast milk. The child health care professional should encourage the Mother to consume a healthy diet during the course of breastfeeding ²⁴.
- Breastfeeding mothers are recommended to have iodine supplements as it is difficult to obtain enough dietary iodine daily. Generally it is recommended to take 100 – 150µg of iodine per day ¹²⁵. Women from specific population groups may require other supplements when breastfeeding for example: vegan breastfeeding women. These women should consult their health care professionals for individual advice.
- During the 0-12 month period discussion with families about breastfeeding may include:
 - the benefits of breastfeeding and the risks of not breastfeeding
 - the importance of exclusive breastfeeding for the first six months
 - basic breastfeeding management, e.g. how to position the baby at the breast, frequency of feeding
 - normal newborn behaviour including feeding cues
 - support networks
 - information sources and support agencies specific to feeding, e.g. local child health services, Australian Breastfeeding Association
 - returning to work and breastfeeding ³⁹.

Returning to work and breastfeeding

- Returning to work has a significant impact on breastfeeding rates in Australia. An Australian study found a higher proportion of mothers working part time were able to continue breastfeeding, than those working full time. In addition, when women returned to work by six months post-partum, formula was introduced and breastfeeding ceased, on average two months earlier than if not working¹²⁶. Women reported having a supportive workplace culture as being important in continuing breastfeeding, this included: having lactation breaks with suitable facilities to express and store EBM and flexible working hours¹²⁶.
- The child health professional should encourage mothers to discuss options with their employer regarding supporting breastfeeding
- Discuss preparation for returning to work, e.g. expressing and storing breastmilk; options to support ongoing breastfeeding¹²⁶.



National Health and Medical Research Council | www.nhmrc.gov.au
Iodine supplementation for pregnant and breastfeeding women

Formula feeding

- Information and education to families who make an informed choice to feed their baby with infant formula can be provided one-to-one, in a non-judgemental way (Detailed information is outlined in the previous section). These one-to-one sessions may include:
 - safe use of infant formula and responsive feeding practices, e.g., offering feeds according to an infant's hunger cues, stopping the feed according to infant cues, not giving the infant a bottle as part of their bed time routine
 - choosing a formula
 - correct preparation of infant formula
 - infant formula requirements
 - normal newborn behaviour including feeding cues
 - how to bottle feed your baby
 - cleaning and sterilising of equipment
 - transporting formula feeds
 - families are encouraged to wean from the bottle feeds by 12 months, following the introduction of cup feeding
 - information sources and support networks and agencies specific to feeding⁸¹.

Supplementation: fluoride

- Infants less than six months do not require fluoride supplements⁸¹.
- Most water supply is fortified with fluoride and this water should be used in preparing infant formula⁸¹.
- In remote and regional areas fluoride levels may vary and discussion is recommended with your local health care professional in relation to supplementation requirements for infants over 6 months of age⁸¹.
- Certain 'at risk' groups of infants may require supplementation (e.g., premature infants are often prescribed iron and vitamin supplements)⁸¹.

Introducing a feeding cup

- Once the infant is over six months of age a cup can be introduced regularly for the infant to develop the skill of sipping drinks from a cup. If the cup is being used for formula or EBM the cup can be sterilised as per feeding equipment.

- Cooled boiled tap water, EBM or formula can be offered in the cup with other drinks avoided until the infant is 12 months old ⁸¹.

Introducing solids

- Parents are advised to introduce solids to their infant from around six months. It is important that iron and zinc containing foods are introduced at this time as infant stores are declining.
- The parent can observe for their infant's developmental signs of readiness, including:
 - The infant's head and neck control has developed enough that he/she is able to sit with support
 - Infants explores toys and other objects by putting them in his/her mouth
 - Infant watches with interest when others are eating
 - Seems hungry between milk feeds ¹⁰².
- Texture and consistency should be appropriate to the infant's developmental stage for example:
 - Initially offer purees then progress to mashed food, then minced and chopped foods
 - 'finger foods' can be managed at around eight months, e.g. pieces of avocado, banana, toast fingers, cooked pasta shapes or pieces of cooked vegetables, soft cooked meats such as fish
 - By 12 months the infant should be having a wide variety of foods and be eating what the rest of the family are having ⁸¹.
- Introducing to a range of food flavours and textures between six to nine months reduces the risk of later feeding difficulties ³. For example: infants kept on pureed foods and not offered lumpy foods prior to 10 months were found to be more fussy at eating at three years of age ¹⁰².
- New foods may need to be offered repeatedly before the infant gets accustomed to the taste ¹⁰².
- Parents can be guided during feeding by their infant feeding cues such as:

Interest	Disinterest
<ul style="list-style-type: none"> ■ Open their mouth to accept food ■ Pick up food ■ Feel food ■ Put food into their mouth 	<ul style="list-style-type: none"> ■ Close their mouth when food presented ■ Turn their head the other way ■ Push the food away ■ Spit food out repeatedly ■ Try to get out of their highchair ¹⁰²

- Infants should not be coerced or force fed ¹⁰².
- Refer families to their booklet *Child Health Information – Your guide to the first 12 months* for further information including tips, recipes and a sample menu ⁶².

Foods to avoid or offer with caution

- Honey should not be given to infants less than one year as it can contain *Clostridium botulinum* and cause illness in the infant.
- Avoid foods poor in nutrient value or high in salt, fat or sugar, e.g., ice cream, industrialised custards, chips, potato chips, lollies, processed meat (sausage, ham, salami).
- Hard foods, e.g. whole nuts, seeds, raw carrot, celery, apple should be avoided for the first three years due to the risk of choking. All of these foods can be given to an infant in a suitable consistency (e.g. nuts in a paste form, cooked carrot) ⁸¹.

Beverages to avoid or offer with caution

- Unmodified animal and plant based milks should not be used as the main source of drink for an infant less than 12 months, because of the unsuitability of the nutritional and electrolyte composition.

- Unpasteurised milks are to be avoided altogether as they may cause the infant illness due to possible infective molecules.
- Low fat and reduced fat milks are not recommended as they are nutritionally unsuitable for children for the first two years.
- Juice drinks, sweet beverages, tea or caffeinated drinks are to be avoided ⁴¹.

Infants with a family history of allergy

- Breastfeed
- Follow normal introduction of foods process, there is insufficient evidence to support limiting foods and delaying food introduction may actually increase the risk of some allergies ⁴¹.

Vegetarian or vegan diets

- Vegetarian diets do not provide enough iron and vegan diets are also low in vitamin B12.
- Parents are advised to:
 - continue breastfeeding for as long as possible, e.g. > 2 years
 - seek dietetic advice (this may include use of soy-based formula in the not breastfeeding)
 - nutritional supplements may be required ⁸¹.



Baby feeding cues and 10 ways we support mothers and babies to breastfeed (2012):
www.health.qld.gov.au/breastfeeding/documents/feeding_cues.pdf

Growing Strong : Feeding You and Your Baby (2014)
www.health.qld.gov.au/ph/documents/hpu/growing_strong.asp

Baby Friendly Health Initiative | www.health.qld.gov.au/breastfeeding/bfhi.asp

Multicultural fact sheets in a range of languages:
www.health.qld.gov.au/multicultural/public/child_hlth.asp#Breast%20feeding

National Health and Medical Research Council | www.nhmrc.gov.au
Eat for Health - Infant feeding guidelines – Information for health workers (2012)

Growth

- Parents are encouraged to engage with health services to monitor their infant's growth and can be given some broad guidelines to use to benchmark against, regarding their infant's weight gain, such as:
 - Back to birth weight by two weeks of age
 - Double their birth weight by six months with an average gain of 150 grams/week
 - Triple their birth weight by the first birthday with weight gain on average of approximately 80 grams/week ^{24,41}.
- Child health professionals can inform parents about the use of growth charts and the influencing factors over growth e.g., genetic and environmental factors and the importance of their infant tracking to the infant tracking to their individual pattern ²⁴.
- Parents can be informed that in general that:
 - height increases by 2.5cm per month during the first six months
 - growth 'spurts' occur. The infant is generally almost one and half times their birth length by the time they are one year old - with the majority of growth occurring in the infant's trunk ²⁴.
- Parents can be informed that the growth of the head and closing over of the fontanelles reflects growth and development of the brain and nervous system, general guidelines can be offered, such as:
 - The brain weight increased by 2.5 times during the first year of life

- The posterior fontanelles closes between 6 – 8 weeks
- The anterior fontanelles closes between 12 – 18 months ²⁴.

Cognitive development

- Child health professionals offer information to families about:
 - how the infant brain grows faster in the first five years of life than at any other time
 - how brain development is influenced by life experiences
 - life experiences help form neural pathways
 - neural pathways mould the brain and an individual's behaviour and functioning
 - the brain needs stimulation to grow
 - critical periods during human develop mean the brain is more sensitive to certain environmental stimuli at particular times ¹²⁷.
- Child health professionals inform parents about their infant's movements and how the infant's motor skill development is linked to key milestones during the first 12 months. 'The Child Health Information – You guide to the first 12 months' is recommended to support families with specific information ⁶⁰.
- During the period of birth to one year the infant progresses cognitively from
 - reflexive behaviours to
 - simple repetition to
 - imitating activities ²⁴.
- As cognitive pathways develop, infants apply their learning to their environment ²⁴.
- The child health professional can use practical examples to demonstrate to parents how cognitive development can impact on different behaviours during the infant's first year and how they can support their infant's cognitive development.

The following are examples of how the child health professional may do this:

Example 1: Primary circular reactions

Explain to parents how consistent behaviours can impact on an infant's behaviour of his/her environment ²⁴:

- At birth the infant will cry in response to hunger
 - › the mother talks to the infant while preparing for the feed
 - › a nipple is put in their mouth
 - › they suck reflexively
 - › the infant feels satisfied.
- At one to four months when the infant has experienced repetition of their hunger needs being met, the infant may cry in response to hunger but now stop crying when the caregiver's voice is heard because the infant anticipates that hearing the voice also means that their hunger need will be satisfied.
- This example demonstrates the sensorimotor development of primary circular reactions, whereby a reflex behaviour is replaced with a voluntary act, indicating the infant has incorporated learning and adaptation to their environment ²⁴.

Example Two: Object permanence

The concept that objects still exist beyond the visual field can also be explained to parents with an example such as: 'Separation anxiety'.

- At 6-8 months of age the infant cries in response to their parent leaving their sight because they don't know that the parent still exists beyond their visual field.

- By experiences of the parent leaving and returning to the infant’s visual field by around 9 – 10 months, the separation anxiety usually resolves, as the infant gains a sense that the parent still exists outside of their visual field – object permanence ²⁴.
- Sharing this type of information with parents may assist in parents understanding why their infant behaves in a certain way and how their parenting may influence these behaviours.
- Effects of parenting on the infants’ developing brain has been a source of much research and even though this research is at an embryonic stage, it has significantly influenced policy development with the incorporation of services that promote parent-infant relationships and parenting skill development ^{128, 129}.
- Parents are encouraged to discuss any concerns about their infant’s development with their child health professionals and/or GP.
- Refer families to resources to raise their awareness of delays in development such as the: *The “Red Flag” Early Intervention Referral Guide for Children 0 – 5 years* ⁹⁰.



Raising Children Network | <http://raisingchildren.net.au>
Growth and development fact sheets

Parent-infant interaction

The normal social development of an infant begins primarily with reflex behaviours, such as the grasp reflex and transitions to social communications, such as smiling. These interactions generally have a profound effect on care givers and offer a stimulus for evoking continued interactions ²⁴. Ongoing interactions whereby the infant develops an expectation that their needs are met by a sensitive care giver, usually results in the formation of a secure attachment between the infant and their primary care giver ^{24, 130}. Promoting the development of healthy parent-infant relationships is seen as one of the best ways to promote infant emotional wellbeing and positive mental health ⁶⁸.

- Attachment may be enhanced by a number of different strategies promoting physical contact and face-to-face contact time during everyday activities that the parent and infant enjoy, for example:
 - using the ‘en face’ position
 - skin to skin contact with baby
 - talking to the infant
 - baby massage
 - going for a walk with use of a parent facing pram
 - spending time playing games, e.g. ‘peek a boo’ ^{24, 68}.
- The child health professional can share information to increase the parent’s awareness and sensitivity to the infant’s attachment behaviours, such as:
 - Differential crying, smiling and vocalisation to the primary care giver more than anyone else
 - Looking more at the primary care giver
 - Clinging to the primary care giver
 - Crying if they leave the room
 - Looking back at the primary care giver for reassurance when exploring ²⁴.
- The child health professional can share information to increase the parent’s awareness and sensitivity of their own behaviours that may influence attachment, such as:
 - opportunity for visual contact with baby
 - talking, smiling, stroking, kissing,

- rocking, using soothing measures
- how they are expressing their feelings and emotions toward their infant ^{24, 131}.

Parents are informed that an infant's brain development is enhanced when the infant feels nurtured, loved and secure and when their care-givers respond to their needs ¹²⁷.

An infant's ability to develop self-regulation, i.e. regulate his/her own emotions and behaviours, are enhanced by positive parent-infant interactions ¹²⁷.

Parents are encouraged to discuss any concerns about their infant's development with their child health professionals and/or GP.

Refer families to resources to raise their awareness of delays in development such as the: The "Red Flag" Early Intervention Referral Guide for Children 0 – 5 years ⁸⁹.



The development of communication and interaction may also be impacted by the parent/carer's reactions, such as:

- The parent/carer does not respond to the child's communication, e.g., does not respond consistently to the child's cues, does not soothe the child when distressed, does not pay attention to the child's reactions, is not in tune with the child.
- The parent/carer has limited communication with the child or may be harsh or negative communication with the child ⁶⁸.

Referral

When concerns about the health of parent / carer following a thorough family and developmental assessment a referral to the families' GP / Medical Officer / Infant-Mental Health Nurse / Early Intervention Specialist is appropriate for further assessment ⁸⁹.



See Practice tips: Conducting a Family Health Assessment on page 29 for further indicators.
See appendix 1 and 2.



Monitoring Child Development | **The Royal Children's Hospital Melbourne**
www.rch.org.au/ccch/resources_and_publications/Monitoring_Child_Development

The "Red Flag" Early Intervention Referral Guide for children 0-5 years | **Queensland Health**
www.health.qld.gov.au/rch/professionals/brochures/red_flag.pdf



Queensland Health Guideline: Assessment of infant/child nutrition, growth and development within the primary health care setting ⁶⁶
http://qheps.health.qld.gov.au/patientflow/docs/scycn_nutrit_guide.pdf

Normal infant behaviour (birth to one year)

Patterns of sleep

Newborn infants begin life with sleeping a lot over the first few days whilst they recover from the birth process and adjust to the extra-uterine environment. Following this, the infant responds to their internal and external environment by controlling sensory input and regulating sleep-wake states. It is important for parents and health care professionals to have a basic understanding of these concepts to assist in understanding an infant's behaviour ²⁴.

Behavioural state	Description	Implications
Deep sleep (quiet)	Closed eye lids Eye balls still Regular breathing Body still, with occasional twitch	Baby sound asleep, limited response to external environmental factors
Light sleep (active)	Eye balls rapidly moving (REM) under closed eye lids Irregular breathing Slight body movements (e.g. twitching, smile) Noises – groans, moans, short cries while still asleep REM sleep constitutes approximately 50% of total sleep time in newborns	External sounds / disturbances may arouse the infant Noises can be interpreted as pain or discomfort by parents, however this is normal behaviour
Drowsy	Eyes may open and close Irregular breathing Some active movements with occasional mild startles	External stimuli arouse the infant May be enjoying non-nutritive sucking
Quiet alert	Eyes wide open and bright Active body movements in response to the environment Stares at close range objects Focuses attention on stimuli Regular breathing	Seeks to satisfy hunger and enjoys non-nutritive sucking Best time to position baby at the breast for feeding Displays cues to communicate with care giver Ideal time to interact with infant and be in close view of infant Plays with developmentally appropriate toys
Active alert	Eyes open Irregular breathing May whimper / whine Restless body movements	Infant sensitive to an external or internal stimuli Parent can adjust environment, anticipate infant needs Soothe the infant
Crying	Eyes open or tightly closed Irregular breathing Grimaces Strong cry Uncoordinated movements of the extremities	Intervene to provide comfort / relieve hunger Soothing measures used in active alert state usually no longer work – try rocking, swaddling, sushing, warm bath. Crying is part of normal infant development. The average crying time for an infant at 6 weeks of age is around 3 hours/day and often the crying is in the afternoon or evening. Constant inconsolable crying requires further investigation

24, 41

The newborn baby does not distinguish day from night; however as the infant experiences more activity, sound, and interaction with carers during day time hours and less at night the infant develops a diurnal clock, sometimes referred to as a circadian rhythm. Usually by 3-4 months of age the infant has developed a nocturnal pattern of sleep. Total daily sleep again is variable

There is an enormous variation in the amount of sleep and activity among infants depending on their individuality including: temperament, behavioural characteristics such as: irritability, consolability. These individual differences are normal and should be anticipated by parents ²⁴. The following offers a guide to an average infant's sleep-wake pattern:

Age	Average hours of total sleep per day	General pattern
Newborn	16-18 hours/day	2-4 hours of sleep at a time Usually sleep, feed, short play, then back to sleep Commonly wake between 2-3 times for a night feed Gradually develop nocturnal pattern of sleep
Three months	14-15 hours/day	usually by 3-4 months, some babies start sleeping for a six-hour stretch at night usually one to two night feeds 3-4 day time naps
Six months	14 hours/day	At six months around 60% of babies can sleep 6-8 hours at night, with one feed during the night Three day time naps
Nine months	14 hours/day	May sleep up between 10-12 hours overnight Two day time naps
12 months	12-14 hours/day	May sleep up between 10-12 hours overnight Two day time naps

115,120,132

How should infants 0-12 months behave when they are awake?

Most infants are naturally active when awake and their innate behaviours draw attention of their primary care givers, this interplay of interactions and experiences generally enables infants to progress through normal milestone development ^{24, 116}. This process is influenced by a range of variables including individuality of both infants and care givers, quality of the relationship between them, the care giving environment, family system, cultural and social factors ¹¹². Families need to be guided about their infant's expected developmental milestones and activities that may enhance their development. The following table outlines some strategies around this. Child health professionals can refer families to the 'How your baby develops' in the 'The Child Health Information – You guide to the first 12 months' ⁶².

Parents are encouraged to discuss any concerns about their infant's development with their child health professionals and/or GP.

Refer families to resources to raise their awareness of delays in development such as the: The "Red Flag" Early Intervention Referral Guide for Children 0 – 5 years ⁹⁰.

Activities to support development

Sleep ^{24,120,132}

Infant behaviour

- An infant's behaviour changes as they become tired. Tired signs include:
 - Newborns – Closed fists, fluttering eye lids, grimace, glazed stare, jerky limb movements, whinging, yawning, seeking comfort by sucking, crying, screaming.
 - 3-12 mths – Loss of interest in activity, whining, irritable, glazed stare, sucking on things, pulling ears/hair, rubbing nose or eyes, yawning, clinginess, clumsiness, crying, screaming. Infants generally become tired when they're awake for more than:
 - Newborns: 60-90 minutes
 - 3-6mths: 1.5 – 3 hours
 - 6-12mths: 2-3 hours
- Infants can become overtired quickly

Parenting tips / Skills to support infant development

- Parents learn to observe for the baby's tired signs and react in a timely manner to settle the infant to sleep, delaying things until the infant is overtired may make it harder to get the infant to sleep.
- Parents can anticipate tiredness by being aware of how long their baby has been awake
- Develop a regular routine prior to the putting the infant into their sleep space e.g. reduce stimulation, wrap your infant (under 4 months of age)/use a correctly sized sleeping bag, read a quiet story, tell your infant it is 'sleep time'
- For infants less than six months establish a night time bed time and wake-up time
- Encourage the infant to go off to sleep on his/her own by putting him/her down just before he goes to sleep
- Sometimes infants need to be comforted off to sleep by: patting, shushing, rocking

Cautions and things to avoid

- Avoid overstimulation e.g., screen time
- Using the same soothing technique every time to settle the infant provides consistency, however using it until the infant is asleep each time may result in some infants becoming dependent on this activity to go off to sleep.
- See SIDS prevention in safety and injury section



Raising Children Network | <http://raisingchildren.net.au>

Resources in both video and fact sheets: Baby sleep: in a nutshell, Understanding sleep, Patting baby to sleep, Guide to solving sleep problems

Crying ^{24,41,90,120,127,132}

Infant behaviour

- Crying is an infant's way of communicating to their parent that they have a need. It is part of normal infant development.
- Infants cry as a result of a need for food, sleep, interaction, discomfort, e.g. too cold and often for unknown reasons.
- The average crying time for an infant at six weeks of age is around three hours/day and often the crying is in the afternoon or evening. Disease is diagnosed in less than 5% of these infants and crying often results in a cause of early cessation of breastfeeding and the diagnosis of a range of disorders such as colic, reflux, lactose intolerance ⁴¹.

Parenting tips / Skills to support infant development

- Provide information to families on normal infant behaviour – feeding, sleeping and crying etc so that they have realistic expectations and a range of strategies that may assist in soothing their infant, e.g. Change nappy, offer feed, cuddle, check clothing is of a comfortable level.
- Provide information to families on how to tell if their baby is sick, e.g., temperature, rash, decreased intake
- Provide information to families on general parenting support resources, such as 13HEALTH and Parentline.
- Encourage families to develop a personal list of their own resources if they need help e.g. neighbour, friends, family members that they may call on to support them.
- Discuss with parents early signs of frustration and what to do if they are becoming frustrated e.g., put the baby in a safe place such as their cot and take some time out until feeling calmer or seeking help
- Some families choose to use a pacifier to soothe their infant and some infants suck their thumb or finger to comfort themselves. Discussion with families should include the pros and cons of using a pacifier vs infant sucking their thumb.

Cautions and things to avoid

- Inconsolable crying should be investigated
- Ensure that dummy-sucking doesn't interfere with feeding by using only when baby isn't hungry, such as after or between feeds.
- Do not use a cord or chain to attach the dummy around baby's hand, neck or cot – choking hazard.



Raising Children Network | <http://raisingchildren.net.au>

Resources in both video and fact sheets: Crying baby checklist - in pictures, Crying baby, Overstimulation: babies and children, Dummies

Physical activity / play ^{24,79,90,120,127,133,134}

Infant behaviour

- Moving around is natural for infants and important for their development. Infants have an innate desire to explore their environment.
- Physical movements help the infant develop muscle strength and coordination that lay foundations for many of their developmental milestones that may be met in the first year - such as rolling, sitting up, crawling and pulling to stand and sometimes walking.
- Play promotes the healthy development of a range of emotional, social, motor and cognitive skills.

Parenting tips / Skills to support infant development

- The newborn baby needs support as he/she is developing greater coordination with their head, body and limb movements.
- Preventative measures to avoid Positional Plagiocephaly are important for all babies.
 - Alternate the sides and positions that you hold the infant to offer them a variety of movement opportunities; alternate the infant's head between right and left side when sleeping prone and use other positions when the infant is awake. When feeding the infant swap sides to alternate positions during the feed time.
 - Tummy time: When the baby is awake tummy time helps to build neck, head and upper body strength, this can be done on any safe surface, including on the parents chest, over their arm, on the carpet or on a rug.
 - To prevent positional plagiocephaly it is recommended that when awake, the infant is positioned on their side or on their tummy at least three times per day for approximately 10–15 minutes each time.
 - Demonstrate how to position their infant in varying positions as above
- Floor play: Spend time with the infant during floor play, shaking rattles, moving to music, placing toys just in reach of the infant, encouraging the infant to hold and play with toys e.g., rattle.
- As the infant develops use tunnels for fun, crawling activities, use push and pull toys

Cautions and things to avoid

- Routine baby checks should include examination for: Plagiocephaly: a misshapen skull and sometime mild facial asymmetry and Torticollis: tightening of the neck muscles – often associated with plagiocephaly.
- A recent Canadian study found a 46.6% incidence of Positional Plagiocephaly in infants between 7 – 12 weeks of age when examined in community based, well child clinics.
- Avoid use of infant walkers as these do not enhance development and increase the rates of infant injury.



Raising Children Network | <http://raisingchildren.net.au>

Resources in both video and fact sheets: Moving and play for babies, Playing with your baby

Use handouts to promote the use of preventative measures for positional plagiocephaly e.g. SIDS and Kids – Baby's head shape.

Emotional wellbeing^{24,41,68,90,120,127,132,134}

Infant behaviour

- Infants learn social skills and interaction by observing those around them and by their own experiences of social interaction.
- Cultural, social, physiological factors impact on emotional development e.g. wellness / illness of the infant or parent.
- An infant seeks to develop attachment with a primary carer. A secure attachment develops when consistent and sensitive love and care is offered to the infant. A secure attachment is important for healthy social and emotional wellbeing.

Parenting tips / Skills to support infant development

The child health professional can promote positive parenting behaviours and a parenting style that supports healthy infant-parent relationships. Parents can be encouraged to:

- Have fun interacting with their infant ‘face-to-face’ – ‘en face position’ is beneficial with newborns.
- Express emotions through facial expressions and gestures to help the infant learn about a range of expressions and emotions.
- Be aware of their tone of voice and think about whether it is in line with their facial expressions and gestures.
- Name emotions to assist the infant learning what the emotions are and what they look like.
- Respond in a caring way to their infant’s communication i.e. Comfort their infant when they cry – and talk about not being able to ‘spoil’ an infant by responding to them;
- Smile at the infant when they smile at you.
- Delight in them by spending time with them, talking and singing to them.
- Use a mirror for play as the infant develops their sense of self (around 8 mths).
- Expose the infant to a range of positive experiences and activities.

Cautions and things to avoid

- Parents can be encouraged to:
 - Reflect on their parenting style and the factors impacting on it, e.g. how they were parented?
 - Reflect on how their parenting style affects interaction with their infant
 - Avoid screen time e.g. watching TV
- A full family assessment is recommended and referral to the EIPS/EIC/ GP/Infant-Mental Health Nurse if a child health professional identifies signs of altered attachment models, e.g. limited interaction between infant-parent, negative or harsh communication from parent about or to the child, carer gives little indication that he/she is in tune with the child, infant described by the parent/carer in a negative manner⁸⁹



Raising Children Network | <http://raisingchildren.net.au>

Resources in both video and fact sheets: Connecting with your baby, What’s in a smile, Bonding for Dads, Baby massage, and Baby Cues interactive video guide

The “Red Flag” Early Intervention Referral Guide for children 0-5 years (Children’s Health Queensland) www.health.qld.gov.au/rch/professionals/brochures/red_flag.pdf

Australian Family Strengths Nursing Assessment Guide¹³¹. See appendix 1

Building Health Brains: The Eleven Key Messages. See appendix 2

Speech, hearing and vision ^{24,90,120,127,141}

Infant behaviour

- Babies startle in response to loud noises and turn their head to the direction of their parent's voice early on, a reassuring feature for parents that the infant can hear.
- The infant's vision is linked to their behaviours and parents observe their infant focusing on their face and close objects in the early weeks of life.
- Speech development in infants progresses from 'coos' to imitating and attempting their first words in their first year. Infants start putting vowel sounds together and use communications with their body e.g., pointing, 'no' with a shake of their head, as they naturally explore communicating with those around them.
- Infants learn to talk by listening and trying. Reading, talking and singing to infants helps them to develop their language skills.
- Parents are informed that there is a great variation from one infant to another in how much they communicate, just as there is with adults

Parenting tips / Skills to support infant development

- Parents can be encouraged to:
 - Use the 'en face' position in the early weeks – an optimal distance for baby to see them and interact with them
 - Understand that 'looking away' is their baby's way of saying 'I need a break'
 - From birth, read stories aloud, sing songs, recite rhymes to baby
 - Talk to baby, even if it means talking through what you are doing e.g., 'Mummy's just washing up then we will change your nappy and read a story'
 - React, praise their infant's efforts to communicate and repeat words to create a two way conversation and turn taking
 - Teach baby gestures and simple words e.g., such as waving and 'bye, bye'
 - Encourage their infant to have fun with noise e.g., baby rattles, banging pots and pans
 - Attend community activities that promote reading and interaction e.g., local libraries often hold activities for children such as 'Rhyme Time' or 'Baby Time'

Cautions and things to avoid

- Avoid screen time e.g. watching TV



Raising Children Network | <http://raisingchildren.net.au>

Resources in both video and fact sheets: Connecting and communicating videos: 0-6 months, 7-17 months; Telling stories; Babies play and learning: about playgroups; Activities to promote literacy; Reading from four months

The "Red Flag" Early Intervention Referral Guide for children 0-5 years (Children's Health Queensland) www.health.qld.gov.au/rch/professionals/brochures/red_flag.pdf

Oral health ^{24,41,120,127,256}

Infant behaviour

- Drooling: Whilst some salivary glands are active from birth, most don't begin to secrete saliva until about 2-3 months of age, as salivary production increases, drooling becomes common in infants, more so when the infant is in upright positions. Drooling gradually lessens as the infant develops full control of the musculature of the mouth
- Teething: While teeth erupt at different times from one infant to another, teething is a common challenge for parent due to the discomfort it may cause as the crown of the tooth breaks through the periodontal membranes. The first tooth appears between 6-10 months of age with all 20 baby teeth usually appearing by the time the infant is three years.

Parenting tips / Skills to support infant development

- Parents can be encouraged to:
 - Keep the infant's skin clean and dry by the use of bibs when drooling is excessive.
 - Use firm, cool items for baby to suck/chew on e.g. teething ring, sugar-free rusk.
 - Introduce cleaning for the infant's gums a couple of times a day before the teeth appear. A damp face washes can be used. This then can continue once the first teeth appear.
- A small soft toothbrush for infants can be used, but no toothpaste is required until approx. 18 months.

Cautions and things to avoid

- Avoid leaving an infant with a bottle when going to bed
- Never use honey on a pacifier



Raising Children Network | <http://raisingchildren.net.au>

Resources in both video and fact sheets: Dental care for babies, Caring for your baby's teeth (video)



Refer to *Chronic Conditions Manual*

ONE TO FIVE YEARS

Needs of the child

The needs of a child during this time are expansive and will be discussed under the following headings:

- Promotion of optimal nutrition
- Growth
- Cognitive development
- Parent-child interaction

Promotion of optimal nutrition

Mothers, fathers and their support networks need appropriate and consistent information to enable them to make an informed decision about child nutrition. The following information provides practice points to guide child health care professionals offering health promotion advice:

- Encourage families to create an environment whereby mealtime is a pleasurable time spent with other family members ¹¹⁶.
- Encourage families to demonstrate healthy eating habits and choices to their children that can inform lifelong healthy eating patterns ⁴¹.
- Encourage parents to offer a range of nutritious food options and flavours to establish a child's sense of taste and acceptance of variety ⁴¹.
- Early on, parents can be guided during feeding by their child's feeding cues such as:

Interest	Disinterest
<ul style="list-style-type: none"> ■ Pick up food ■ Feel food ■ Put food into their mouth 	<ul style="list-style-type: none"> ■ Close their mouth when food presented ■ Turn their head the other way ■ Push the food away ■ Spit food out repeatedly ■ Try to get out of their highchair

102

- Children should not be force fed ¹⁰².
- Families are encouraged to wean children from bottle feeds by 12 months, following the introduction of cup feeding. Pasteurised milks offer a rich source of protein and calcium and can be added to the child's diet from one year onwards. Offering pasteurised cow's milk should be limited to around 500mls / day however to avoid the risk of reducing the variety of food intake best for a child ⁸¹.
- Follow-on child artificial formula – labelled 'suitable only for babies over six months' are not considered nutritionally necessary ⁸¹.
- Children aged less than two years should be offered full cream milk – low and reduced fat milk products are not nutritionally suitable for this age group. After two years the child can drink the reduced-fat products with the rest of the family ⁸¹.
- Encourage families to reflect on their family and cultural eating patterns and how this may impact on their child. For example factors that may be contributing to the rising rates of obesity include:
 - regularly consuming large meal sizes
 - a family culture of admonishing children for leaving food on their plates ²⁴.

- Families should avoid
 - Foods poor in nutrient value or high in salt, fat or sugar
 - Hard foods e.g., whole nuts, seeds, raw carrot, celery, apple should be avoided for the first three years due to the risk of choking. All of these foods can be given to a child in a suitable consistency e.g. nuts in a paste form, cooked carrot
 - Unpasteurised milks are to be avoided altogether as they may cause the child illness due to possible infective molecules.
 - Juice drinks, sweet beverages, tea or caffeinated drinks ⁸¹.
- Parents using a vegetarian/vegan diet are advised:
 - That vegetarian/vegan diets generally do not provide enough iron and are also low in vitamin B12 for children
 - to continue breastfeeding for as long as possible e.g. > 2 years
 - to seek dietetic advice
 - nutritional supplements may be required ⁸¹.
- Use culturally appropriate tools for education on breastfeeding and child nutrition such as ‘Growing Strong : Feeding You and Your Baby ⁴²’. This is a resource developed to assist health staff talk with Aboriginal and Torres Strait Islander families about nutrition for mother, babies and young children. There are a range of resources available ⁴³. Additionally, a range of multicultural breastfeeding factsheets are available in a number of different languages ⁴³.
- Identify community partnerships and opportunities for services to work together on promoting optimal nutrition including local hospital/s, general practitioners, birthing units and postnatal services, local support organisations e.g. ABA, Australian Lactation Consultant Association (ALCA), nutritionists and dieticians, speech pathologists, local pharmacies and oral health services ¹.

Breastfeeding

- Breastfeeding is the physiological normal way for a child to feed and is unequalled at providing optimal nutrition and healthy growth for as long as the mother and child desire ^{41, 94}.
- Promotion of optimal maternal nutrition during breastfeeding is important to maintain maternal health and enhance the micronutrient and fatty acid make up of breast milk. Child healthcare professionals should encourage the mother to consume a healthy diet while breastfeeding ²⁴.
- Breastfeeding mothers are recommended to have iodine supplements as it is difficult to obtain enough dietary iodine daily. Other population groups may require other supplements when breastfeeding for example: vegan breastfeeding women. These women should consult their health care professionals for individual advice ⁸¹.
- During the this period discussion with families about breastfeeding may include:
 - the benefits of breastfeeding and the risks of not breastfeeding
 - information sources and support agencies specific to feeding e.g. local child health services, Australian Breastfeeding Association
 - returning to work and breastfeeding ^{39,81}.



National Health and Medical Research Council | www.nhmrc.gov.au
 - Iodine supplementation for Pregnant and Breastfeeding Women

Returning to work and breastfeeding

Returning to work has a significant impact on breastfeeding rates in Australia with a higher proportion of mothers working part time able to continue breastfeeding, than those working full time ¹²⁶. Women reported having a supportive workplace culture as being important in continuing breastfeeding, this included: having lactation breaks with suitable facilities to express and store EBM and flexible working hours ¹²⁶. The child health professional should encourage mothers to discuss options with their employer regarding support of breastfeeding. Discuss preparation for returning to work e.g., expressing and storing breastmilk ¹²⁶.

Extended breastfeeding

There is no public health recommendation of when a mother and child should cease breastfeeding ¹³⁵. Mothers who continue to breastfeed past infancy are often exposed to society constraints, with some women describing being ‘under surveillance’ by their community ¹³⁵. Women who choose to breastfeed children may need additional support from their child health professional with continuing feeding when their societal norm is infant breastfeeding ¹³⁵.

Child health professionals may advocate for breast feeding information to include pictures of children breastfeeding, rather than just babies breastfeeding to assist in addressing cultural barriers ¹³⁵.

The Marketing in Australia of Child Formula (MAIF) Agreement is Australia’s response to the WHO International Code of Marketing Breast Milk Substitutes (WHO Code). The MAIF Agreement contributes to the provision of safe and adequate nutrition for infants by the protection and promotion of breastfeeding and by ensuring the proper use of child breastmilk substitutes on the basis of adequate information and through the appropriate marketing and distribution of breastmilk substitutes ¹²⁴.



Queensland Government | www.health.qld.gov.au

‘Growing Strong : Feeding You and Your Baby’

Baby Friendly Health Initiative

Multicultural Health – ‘translated health information in your language’

National Health and Medical Research Council | www.nhmrc.gov.au

Infant Feeding Guidelines: information for health workers (2012)

Growth

Child health professionals can inform parents about the use of growth charts and the influencing factors over growth e.g. genetic and environmental factors and the importance of their child tracking to their individual pattern.

Age	Average growth	24
1 ½ years	<ul style="list-style-type: none"> ■ Physical growth slows during toddlerhood. ■ Growth predominately occurs in the limbs with an average length increase of 7.5 cm/year. ■ The head circumference usually increases by 2.5 cm in the second year of life. ■ The anterior fontanel closing between 12 – 18 months. 	
2 ½ to 3 ½ years	<ul style="list-style-type: none"> ■ Usually the birth weight has quadrupled by the 2nd birthday. ■ In general the child’s adult height will be about twice the height they are at 2 years old. The head circumference usually increases by 2.5 cm in the second year of life and then the rate slows to approximately 1.25cm/year up to 5 years. 	

Age	Average growth 24
4 to 5 years	<ul style="list-style-type: none"> ■ Growth on average: <ul style="list-style-type: none"> ○ length increase of 7.5 cm/year ○ average weight 16.5-19 kgs ○ head circumference increases approximately 1.25cm/year up to 5 years.

Cognitive development

Child health professionals inform parents about how their child's ongoing development is linked to advances in behaviours in this age group, for example:

- Myelination of the spinal cord becomes complete, resulting in an opportunity for the child to develop bladder and bowel control, with day time toilet training often being achieved around the age of 2 years ²⁴.
- The child begins to incorporate previous learning with new skills including intellectual reasoning, such as turning on a light switch ²⁴.
- A child's sense of autonomy advances along with greater understanding about object permanence, generally meaning they can tolerate longer periods of separation from parents and home ²⁴.
- As their sense of autonomy and language skills advance, power and control is explored and their self-identity is expressed through behaviours such as wilfulness, possessiveness, developing rituals ²⁴.
- By the fourth year of life a child's dramatic development of self usually means they demonstrate a capacity to separate their own feelings from others, show empathy, and integrate their behaviours into those more aligned with their society ¹¹⁶.

Parent-child interaction

Promoting the development of healthy parent-child relationships is seen as one of the best ways to promote child emotional wellbeing and positive mental health. The period of one to five years encounters incredible advances in child development and a balancing of the need of security toward the parent and the desire to explore their environment and assert themselves ¹¹⁶. This can be at times, a threat to the parent-child relationship, but at the same time offers an opportunity for the child and parent to learn and experiment with conflict and conflict resolution. When this process and experience progresses successfully (most of the time), both the child and parent learn valuable life lessons and relationship skills ¹¹⁶.

Parents are encouraged to discuss any concerns with their child health professionals and/or GP. Refer families to resources to raise their awareness of delays in development such as the: The "Red Flag" Early Intervention Referral Guide for Children 0 – 5 years ⁹⁰.



See appendix 1 and 2

Normal behaviour and activities to support development: one to five years

Child health professionals inform parents about the enormous variation of activity and sleep among children depending on their environment and individuality, including: temperament, behavioural characteristics ^{116, 128}.

The following tables offer a guide only, to a child's behaviours patterns and activities and offers

strategies and tips that may enhance their child’s development.

When parents raise concerns about their child’s behaviour, discuss these concerns with the parents and refer families to resources to raise their awareness of delays in development such as the: The “Red Flag” Early Intervention Referral Guide for Children 0 – 5 years. Referral may also be appropriate

Sleep ^{24, 58, 115,132}

Child behaviour

- A child’s behaviour changes as they become tired
- Children can become overtired quickly
- **1 - 3 years:**
 - average total sleep/day = 10-16 hrs
 - One nap a day in most infants 18 months of age, transitioning to no naps. 50% of 3 year olds no longer nap in the day.
 - Often attached to objects e.g. ‘blankie’.
- **3 – 5 years:**
 - Gradual transition to no naps in the day.
 - Increase of fears during sleep e.g. monsters.
 - Nightmares occur in 10- 50% of children, with children remembering the event; usually occurs in the second half of sleep.
 - Confusional arousals are common (‘sleep drunkenness’), where the child has slurred speech, disorientated behaviour with no memory of the event.
 - Sleep terrors may occur, usually during the first half of the night. Child awakes with intense fear, but has no memory of the event.

Parenting tips / Skills to support infant development

- Develop a regular bedtime routine (e.g quiet time, reading, no stimulation).
- Establish a bed time and wake up time.
- Encourage day time naps according to the child’s tired signs.
- Avoid scary TV shows, books etc, if your child is developing bed time fears.
- Encourage your child to eat well – being hungry or ‘too full’ before sleep can be uncomfortable.
- Encourage the child to get plenty of natural light and be active during the day

Cautions and things to avoid

- Avoid overstimulation e.g. screen time
- Try to avoid using the same soothing technique every time to settle the child to sleep as they may become dependent on this
- See SIDS prevention in safety and injury section.



Raising Children Network | <http://raisingchildren.net.au>

Resources in both video and fact sheets on a variety of topics: e.g Phasing out night feeds, Patting settling technique, Moving to a ‘big bed’. Understanding sleep: 20 frequently asked questions, Tired signs in babies and children, Sleep Issues: Calling out and getting out of bed, Night terrors

Physical activity: exercise and play ^{24,136,204}

Child behaviour

- Children should be involved in physical activity every day for at least 3 hours spread across the day.
- Children enjoy being active. They engage in various types of play, especially enjoying imitative free play without ridged rules where they can act out and make sense of their world. Play provides stimulation for physical, social and cognitive development.
- Play activities may include: jumping, running, climbing, pushing, pulling, activities with sporting equipment, tricycles, bicycles, and in wading pools or sand boxes.
- Planned activities may include working with the parents e.g., gardening, cooking.
- Playing with toys (formal or made up toys e.g., pots and pans, cooking utensils, cardboard boxes, dress up clothes) can promote gross and fine motor skills, creativity and self-expression .
- Children should have limited inactivity, with no more than one hour at a time (excepting sleep) throughout the day be spent sitting completing quiet siting activities ie: reading / drawing / older children watching TV.

Parenting tips / Skills to support infant development

- Walk to things when you can e.g., pre-school, local shops
- Promote a range of play activities for your child by providing appropriate, safe play space, toys / made up toys, play dough, etc.
- Plan time to play with their child in the back yard or take your child to the park or sporting field – play with balls, skip, teach your child to ride a bike / scooter.
- Develop limits on screen time within the family.
- Have a few ‘screen free’ days during each week
- Record the child’s favourite show so that they can watch them when they are unable to be outside playing.

Cautions and things to avoid

- Screen time is a major obstacle to physical activity in children [116].
- No screen time for children under 2 years. With children 2 – 5 years, watching and using screens e.g., DVD, TV, electronic games, smartphone; should be limited to less than one hour per day [131]
- Avoid having TV on the background within the family home.



Raising Children Network | <http://raisingchildren.net.au>

Resources in both video and fact sheets on a variety of topics: e.g Physical activity for children – how much and why?, Getting children involved, Overcoming obstacles to physical activity, Winter activities, Toddler exercise, Play and learning

Toilet training ^{24,120,137, 138,139}

Child behaviour

- Sometime after the child has accomplished walking voluntary control of the anal and urethral sphincters becomes apparent to the child. Other milestones are also necessary however to prepare the child to toilet train, including communicating this sensation to the parent and learning the process of ‘holding on’ and ‘letting go’. Psychological and cultural factors also impact.
- The average age of commencing toilet training is around 20 months with girls usually being ready a couple of months earlier than boys.
- Each family should choose the right time for them, considering the:
 - Physical readiness of the child, e.g. sphincter muscle control evident by the ability to stay dry for 2 hours, waking dry after a daytime sleep, regular bowel movements.
 - Mental readiness, e.g. recognises the urge to ‘wee’ or ‘poo’, verbal or non-verbal skills to communicate the need, ability to imitate behaviours and follow parents directions.
 - Psychological readiness of family, for the child, e.g. curiosity about family member’s toilet habits, wants soiled nappy/underwear off quickly, desire to please parent, able to sit quietly on toilet.
- For the parents: recognises the child is ready to toilet train, ready to invest time and energy into the training, available to encourages the child and provide consistency around toileting training.
- Night time dryness will not be available until the child’s sleep cycle matures and many children continue to be ‘wet’ at night. Girls often until four years of age and boys until around five years

Parenting tips / Skills to support infant development

- Encourage a child’s recognition of urges, toileting attempts and successes.
- Be consistent with instructions.
- Make it easy and simple for the child to access the toilet, e.g. potty / toilet seat and stool quickly available, clothing easy to remove.
- Using a small stool under the feet may help to facilitate defecation as well as helping the child feeling safe.
- Stay with the child when they are on the toilet.
- Remind a child when they are busy and engrossed in play activities.
- Plan ahead and encourage toileting prior to car trips.
- Expect periods of regression.
- If toilet training is causing stress for the family and progress is slow, have a break from the process and try again when child and parent are ready.

Cautions and things to avoid

- Avoid punishing a child for not getting to the toilet on time
- Avoid commencing toilet training around stressful family events eg: birth of another baby, moving house.
- If parents are worried about toilet training progress they should discuss this with the Child Health Professional / GP.



Raising Children Network | <http://raisingchildren.net.au>

Resources in both video and fact sheets on a variety of topics: e.g Toilet training: when to start?, Getting ready for toilet training, Basic steps for toilet training, Wet nights, Using training pants, Setbacks and accidents when toilet training.

Mealtimes 41,81,120,140,141

Child behaviour

- Generally by 1 year, children can be eating the same foods as the rest of the family. Children experience decreases in appetite as their growth slows and at times may develop periods of fussiness and strong taste preferences. Growth spurts can result in hunger bursts. This inconsistency can make it difficult for parents, so developing family principles around mealtimes may be helpful.
- Parents are advised to use the Australian Dietary Guidelines to monitor their child's intake is adequate to support and promote optimal growth and development.

Parenting tips / Skills to support infant development

- Parents can be encouraged to
 - Establish family routines around mealtimes e.g., hand washing before eating, modelling healthy meal time behaviours, making healthy choices for the entire family.
 - Eat together as a family when possible.
 - Create a pleasant environment for mealtime with few distractions e.g. no television.
 - Provide food that is developmentally suitable, nutritional, and fresh if possible.
 - Promote interest in food e.g., provide food predictably when child is hungry, provide appropriate variety and texture of foods; promote independent eating when developmentally appropriate.
 - Offer children new foods a number of times when they don't appear to like it – it sometimes takes 6 – 10 times before they adjust their taste to certain foods. If still unsuccessful try again in a few months.
 - Provide praise to the child when appropriate healthy eating habits and food choices are made.
 - Offer the most nutritious foods first.
- Teach children about groups of foods that are healthy, i.e., 'often' foods and 'sometimes' foods.
- Encourage children to drink water and limit cordials, soft and sports drinks.
- Encourage children to eat whole fruits and limit juices.

Cautions and things to avoid

- Avoid forcing a child to eat and using punishments specific to eating.
- Avoid using foods for reward as this may teach the child to use eating as a form of comfort.
- Avoid foods with high calories and low nutrient content; high in salt, sugar or caffeine.
- Whilst healthy snacks offer an opportunity to increase overall nutrition, avoid snacking for 60 to 90 minutes prior to meals.



Raising Children Network | <http://raisingchildren.net.au>

Resources in both video and fact sheets on a variety of topics: e.g Nutrition and fitness: the basics, Too much eating or not enough?, Seven tips for happy mealtimes, Video: Eating Strategies

Oral health

120,142-146

Child behaviour

- Whilst teeth erupt at different times from one child to another, all 20 baby teeth usually appearing by the time the child is three years with the first permanent tooth not erupting until approximately 6 years of age.
- Good oral health is associated with improved general health.
- Tooth decay is a mostly preventable disease and is associated with significant health problems. Dental and periodontal disease causes pain and discomfort and can result in personal disfigurement with 25% of all adults over the age of 15 years reporting an experience of discomfort regarding their dental appearance.
- Oral health continues to be a common problem in Australia, with only 55% of children being decay-free at age 6 years of age.

Parenting tips / Skills to support infant development

- Parents can be encouraged to:
 - Set up a routine of dental hygiene at least twice a day.
 - Use a small soft toothbrush with no toothpaste until approx. 18 months, after that a pea sized amount of fluoride toothpaste is recommended, twice / day. Encourage the child to rinse and spit out following teeth brushing.
- A dental health check is recommended at approx. 2 years and when the child commences school.
- For young children the most effective method of cleaning the teeth is cleaning by brushing and flossing by the parents.
- Make teeth brushing fun and use games to access all teeth, e.g., “Roar like a lion” gives parents access to back teeth; ‘say cheese”, the front teeth.
- Parents can support the child to learn to brush their teeth from about two years but will require help and supervision up until approximately eight years of age.

Cautions and things to avoid

- Encourage children to ‘let go’ of their dummies or sucking their thumb or fingers. This usually happens by 2 – 4 years of age.
- Avoid putting your child to sleep with a bottle, leaving the milk on your child’s teeth can increase the risk of decay.

Health promotion resources

Raising Children Network fact sheets and video resources:



Raising Children Network | <http://raisingchildren.net.au>

Resources in both video and fact sheets on a variety of topics: e.g. Teeth development, Cleaning your child’s teeth, Visiting the dentist, Caring for your child’s teeth.

Speech, hearing and vision 88,112,120,141

Child behaviour

- Parents are informed that there is a great variation from one child to another in how much they communicate, just as there is with adults.
- Speech remains predominantly egocentric, as language progresses often the child may misunderstand the meanings of some words even though they use them e.g., left and right, yesterday, tomorrow.
- Between 2 and 4 years children are learning so many words in a short space of time that dysfluency of words ie: stammering, stuttering may be common during this time.
- By four years a child will use approx. 1500 different words and make sentences that are increasingly complex.

Parenting tips / Skills to support infant development

- Parents can be encouraged to:
 - Read stories aloud, sing songs, recite rhymes
 - React, praise their child's efforts to communicate
- If stammering occurs, encourage child to 'slow and relax, resist completing sentence, take time to listen
- Attend community activities that promote reading and interaction e.g. local libraries often hold activities for children

Cautions and things to avoid

- Avoid screen time e.g. watching TV, with the exception of short interactive activities with caregivers.



Raising Children Network | <http://raisingchildren.net.au>

Resources in both video and fact sheets on a variety of topics: e.g. Connecting and communicating videos: Activities to promote literacy, Reading and Speaking two languages at home.

The "Red Flag" Early Intervention Referral Guide for children 0-5 years (Children's Health Queensland)
www.health.qld.gov.au/rch/professionals/brochures/red_flag.pdf

Emotional wellbeing ^{24,68,116,132,134,147}

Child behaviour

- Children continue to learn social skills and interaction by observing those around them and by their own experiences of social interaction.
- Cultural, social, physiological factors impact on emotional development e.g. wellness / illness of the child or parent, observing violence in the home or community.
- At around 18 months of age the toddler recognises him/herself as an individual person. Physically aggressive behaviours e.g. biting, hitting, kicking are common as toddlers react spontaneously to biological drives. Self-expression and self-assertion develop and as language development progresses, some regulation of affect and aggression emerges.
- Often word meanings are taken literally resulting in misinterpretation e.g. bad and good; wrong and right.
- Interpretation of wrong doing often evokes a feeling of guilt.
- Body image begins to develop and children are aware of societal values e.g. pretty, ugly, big, little.
- Three- to five-year-olds generally like to please their parents and conform to their expectations. They will however have periods of frustration and experiment with their own control and power e.g. wearing specific clothes, picky about food. As they develop, they become increasingly aware of social expectations and begin to develop moral judgement, a sense of justice and a conscience. Do's and Don'ts become important.
- The child's sexual awareness of basic anatomical differences and sexual stereo-types becomes evident through curiosity and play
- Common parenting issues include: eating, tantrums and bedtime problems and disobedience.

Parenting tips / Skills to support infant development

- The child health professional can promote positive parenting behaviours and a parenting style that supports healthy child-parent relationships
- Parents can be encouraged to:
 - Respond in a caring way to their child's communication
 - Be aware of their tone of voice and think about whether it is in line with their facial expressions and gestures; use consistent messages, it is much easier for a child to learn. Name emotions to assist the child learning what the emotions are and what they look like / feel like.
 - Play with their child – mutual play fosters positive interaction and may strengthen the child-parental relationship.
 - Explore what their child is thinking and meaning through non-verbal approaches such as imaginative play. Parents need to be aware that children do not always interpret these things correctly and they may need to explore a child's thinking.
 - Instil positive body image messages
 - Encourage children to ask questions and express their feelings
 - Structure quiet time/ rest time into the child's schedule
 - Prepare for changes e.g. entering school
 - Attend parenting groups and support programs to share ideas with other parents and discuss common difficulties or concerns.

Cautions and things to avoid

- Parents can be encouraged to:
 - Reflect on their parenting style and the factors impacting on it, e.g. how they were parented
 - how their parenting style affects their interaction with their child
- Limit screen time in line with recommendations
- If a child health professional identifies altered attachment models, disruptive behavioural and aggressive a full family assessment is recommended, and referral to the Early Intervention Clinician within the multidisciplinary team.



See appendix 1 and 2



Raising Children Network | <http://raisingchildren.net.au>

Resources in both video and fact sheets on a variety of topics: e.g. Toddler connecting and communicating: in a nutshell, Guide for talking to children, What's in a smile, Through a child's eyes, Preschoolers - connecting

The "Red Flag" Early Intervention Referral Guide for children 0-5 years (Children's Health Queensland) www.health.qld.gov.au/rch/professionals/brochures/red_flag.pdf

Immunisation: Birth to five years

Immunisation is one of the most cost effective and efficient means available for the maintenance of public health, with safe and effective vaccines available against a number of preventable diseases⁴⁷. Immunisation is important for everyone, adults as well as young children.

Meeting population health goals for immunisation rates involves collaborative practice with a range of service providers across government and non-government sectors. For infants aged 12-15 months, Queensland's coverage rate for full vaccination as at 31/12/2013 was 90.7%¹⁴⁸. The goal is 95%¹⁴⁹.

Best practice for the child health professional in the provision of immunisation services requires adhering to standards of practice that are articulated in documents within Australia, Queensland and individual Hospital and Health Services.

When families are visiting a Child Health Professional it provides opportunity to assess the child's immunisation record against the current National Immunisation Program Schedule (NIPS). Validate the immunisation status where possible and encourage vaccination when it is due. Other initiatives to help families keep up to date with their child's vaccination schedule may be available such as: VacciDate¹⁵⁰.

Some child health professionals have additional qualifications (i.e., have completed an Immunisation Program Nurse course for Queensland) to administer vaccines under certain conditions. These qualifications allow staff to immunise provided the organisation is an accredited immunisation program provider and they work under a Drug Therapy Protocol and a Health Management Protocol.

An Endorsed Immunisation Program Nurse, working autonomously, may only administer those vaccines outlined in the current QH Drug Therapy Protocol – Immunisation Program without doctor's prescription. A Registered Nurse may administer vaccines ordered by a medical officer. All immunisations administered are registered on the QH database - Vaccination Information and Vaccination Administration System (VIVAS) and recorded in the child's PHR⁴⁷.

VIVAS will also ensure these records are included on the national database, the Australian Childhood Immunisation Register (ACIR).

Identified population groups require additional vaccinations e.g., Aboriginal and Torres Strait Islander children, children born <28 weeks gestation⁴⁷.



Queensland Health | www.qld.gov.au/health/conditions/immunisation/index.html

Immunisation – Information for Nurses

www.health.qld.gov.au/immunisation/health_professionals/nurse.asp

Immunisation – Vaccination information and vaccination administration system (VIVAS)

www.health.qld.gov.au/immunisation/health_professionals/vivas.asp

For health professionals:

www.health.qld.gov.au/immunisation/health_professionals/default.asp

National Immunisation Program Schedule Queensland

www.health.qld.gov.au/immunisation/documents/nips_antigens.pdf

What's your date to vaccinate? Initiative | <http://vaccinate.initiatives.qld.gov.au/know-your-dates/>

The Australian Immunisation Handbook 10th Edition

www.immunise.health.gov.au/internet/immunise/publishing.nsf/Content/Handbook10-home

Immunise Australia Program | Information line: 1800 671 811

www.immunise.health.gov.au/internet/immunise/publishing.nsf/Content/home

Australian Childhood Immunisation Register (ACIR) | Tel: 1800 653 809

Australian Childhood Immunisation Register statistics

www.medicareaustralia.gov.au/provider/patients/acir/statistics.jsp VacciDate



Primary Clinical Care Manual

See immunisation program, tetanus immunisation



Refer to the Pathways to Rural and Remote Orientation and Training

www.health.qld.gov.au/parrot/default.asp

Vaccine management

Vaccines are delicate, biological substances that are very expensive and need to be stored within the temperature range of +2 to +8 degrees celsius at all times.

As health professionals we need to ensure people receive effective vaccines. All people responsible for handling vaccines must undertake education around the importance of effective vaccine management¹⁵¹.

Child health care professionals will be guided by local policies and procedures and national guidelines such as: 'National Vaccine Storage Guidelines – Strive for 5' regarding safe vaccine management.



National Vaccine Storage Guidelines – Strive for Five | Australian Government

www.immunise.health.gov.au/internet/immunise/publishing.nsf/Content/IMM77-cnt1

Safety, illness and injury prevention

This section discusses injury prevention and safety promotion to reduce the risk of SUDI and overall morbidity relating to injuries.

SUDI or sudden unexpected death in infancy is an overall term used to encompass all cases of sudden and unexpected deaths between seven and 365 completed days of life¹⁵².

In the age group of zero to five, safety and injury prevention requires more than supervision. Successful strategies to reduce injuries are often referred to as the three 'E's' which include education, enforcement and engineering¹⁵³ but these can be expanded to six 'E's' which include environmental changes, evaluation and enthusiasm. The most successful way to reduce injuries is to use a mixture of all strategies – a multi-strategic approach. The following table outlines practice related to each strategy. Strategies to reduce injuries are evidenced based and should be applied across the continuum of care. The following are some examples that may be useful:

Strategy	Action
Education- information and awareness raising helps prepare people for change	<ul style="list-style-type: none"> ■ Talk to parents/carers about the common childhood injuries to increase their awareness ■ Provide information about how to reduce hazards ■ Reinforce information with brochures, fact sheets and websites.
Enforcement – laws and legislation force people to act in a safer manner	<p>Ensure parents/carers are aware of the legal requirements:</p> <ul style="list-style-type: none"> ■ to properly restrain all children in an approved child restraint in vehicles ■ hot tap water must be delivered to bathrooms at 50°C ■ fence pools and spas ■ install an electrical safety switch and smoke alarms in the home
Engineering –products are designed to be safe.	<ul style="list-style-type: none"> ■ Ensure parents/carers consider safety issues when choosing products (e.g. avoid baby walkers, look for potential choking hazards when purchasing toys etc.) ■ Encourage parents/carers to select products that meet safe design standards, and look for the Australian Standards-approved sticker when purchasing products. ■ Encourage parents/carers to set up play areas in a safe manner (e.g. soft falls material under play equipment).
Environment	<p>Ask parents to:</p> <ul style="list-style-type: none"> ■ identify hazards in their home – encourage parents to use a home safety checklist as a guide ■ make simple environmental changes according what was identified on the checklist (e.g. Install guards at the top and bottom of stairs; move poisonous substances so they are locked up high; keep hot liquids out of reach; check infant sleeping environments) ■ use the same principles to identify hazards in homes that they may be visiting and either modify that environment or exercise a higher level of care if the environment cannot be modified. (e.g. pills on bench top at Grandma’s house)
Evaluation	<p>Follow-up parents/carers:</p> <ul style="list-style-type: none"> ■ ask if they have used a home safety checklist ■ Ask what safety measures they installed in their home and what they do for homes they visit ■ Praise parents for positive actions taken
Enthusiasm	<ul style="list-style-type: none"> ■ Be positive and supportive and encourage parents to take action in optimising child safety

Common injury groups that occur in the birth to five years age group are listed in the tables ^{18,24,45,61,120,141,144,154-157} below, along with recommendations for parents regarding injury prevention. Examples of resources that can be accessed are also provided.

Falls ^{46,120,144,248}

General information

- Falls occur commonly from prams, strollers, cots, high chairs, baby change tables, beds.
- The majority of injuries from prams, strollers and change tables occurred when the infant/child was not strapped in.
- In Australian hospitals 2010-2011:
 - An injury following a fall was the leading cause of hospitalisation for injured children
 - Of hospitalised, injured children, falls accounted for 45% of these.

Recommendations for parents

- Ensure all infant/child equipment and furniture items meets Australian Safety Standards
- Never leave an infant unattended on a change table, lounge, bench, beds, in a high chair or in a bath.
- Always use an in-built five-point harness to buckle a child in a car. Do not wrap an infant under a harness
- Use the wrist strap attached to pram/stroller to avoid roll away injuries and use the brake, avoid overbalancing equipment by overloading baskets under prams, hanging bags on handles.
- Provide secure area for play away from hazards, such as stairs
- Avoid baby walkers.
- Ensure furniture items are secured to avoid it toppling over on to a child e.g. televisions, water coolers
- Actively supervise children in playgrounds and on play equipment – encourage children less than three years to play on equipment under one metre in height, and under 1.5 metres for children between three and five years.
- Discourage the use of trampolines in this age group
- Parents are advised to learn basic first aid and resuscitation.



Kidsafe (Child Accident Prevention Foundation of Australia) | www.kidsafe.com.au
Resource: Babies from birth to crawling

Raising Children Network | <http://raisingchildren.net.au>
Resources: Baby safety in a nutshell, Playground Safety – Fun without tears, Preventing falls for babies and toddlers, Rough and tumble play, Prevention and first aid

Drowning / near drowning ^{48,120,155}

General information

- Drowning accounted for the death of 31 children aged 0-4 years in Australia (July 2012 - June 2013) with falls into water causing the majority of deaths, followed by bathing accidents.
- Drowning on farms accounts for around 40% of child farm deaths, with dams being responsible.

Recommendations for parents

- Never leave infant / child unattended in a bath
- Always supervise a swimming child
- Remove water hazards e.g. buckets of water, water features.
- Ensure fencing around pools and spas meets council safety requirements
- Secure a safe outdoor play area that prevents unintended access to pools/dams/wells/unfenced water
- Parents are advised to teach their children water skills and to learn resuscitation.



Kidsafe (Child Accident Prevention Foundation of Australia) | www.kidsafe.com.au
Resource: Childhood drowning, Farm safety checklist, Bathing your baby

Raising Children Network | <http://raisingchildren.net.au>
Resources: Baby safety in a nutshell, Playground Safety – Fun without tears, Preventing falls for babies and toddlers, Rough and tumble play, Prevention and first aid

Farmsafe Australia | www.farmsafe.org.au

Motor vehicle accidents including driveway accidents 48,120,156

General information

- Incorrect installation and use of infant car restraints and low speed vehicle run-over injuries cause a high rate of morbidity and mortality in this age group.
- Many low-speed accidents occur at or near a child's home with the driver of the vehicle often their parent.

Recommendations for parents

- Never leave children unattended in the car.
- Secure safe play area that prevents unintended access to driveways/roads
- Develop a safety routine before starting motor vehicles, e.g. ensure children are clearly visible and with an adult (when not travelling with them in the car), and ensure children are safely harnessed and securely fastened in the car prior to turning on the ignition.
- Ensure infant restraint meets the Australian/New Zealand Standard and are correctly fitted.
- Children less than six months of age should be in a rear-facing car restraint in the back seat of the car with an inbuilt harness.
- Parents are advised to learn basic first aid and resuscitation



Kidsafe Queensland (Child Accident Prevention Foundation of Australia) | www.kidsafeqld.com.au

Raising Children Network | <http://raisingchildren.net.au>
Resources: Child car restraints and booster seats

The **Royal Automobile Club Queensland** (RACQ) (www.racq.com.au), **Queensland Ambulance Service** (<https://ambulance.qld.gov.au/index.html>) and **Kidsafe** can assist parents/carers with hiring baby capsules and installation advice for child restraints.

Choking / asphyxiation / poisoning

48,120, 248

General information

- Infants explore their environment by using all their senses, commonly putting things in their mouth. This poses a risk for choking on small items with a common cause of injury being hard food items, buttons, small batteries.
- Each year in Queensland almost 850 children aged 4 and under present at hospitals as a result of poisoning.
- Poisoning often occurs as a result of incorrect use of medication, herbal remedies.

Recommendations for parents

- Never prop feed your baby
- Supervise your infant/child when feeding/eating
- Commence feeding solids with pureed /soft, finely mashed foods
- Avoid foods that are hard and small e.g., nuts, seeds, whole grapes, popcorn, lollies
- Do not dress infant in baby clothes with long drawstrings, ribbons or cords
- Ensure curtain / blind cords are out of reach and secured safely out of children's reach
- Keep your infant's play area free from small items that may be a choking hazard
- Ensure children's toy items meet the Australian Safety Standard
- Ensure toys are free from small parts that could be swallowed.
- Keep small objects out of the infant's reach
- Keep a check on the floor for small objects where your baby is playing
- Use child safety latches to keep children out of cupboards
- Store medications and dangerous substances e.g., detergents, alcohols, chemicals out of reach of children – preferably in a cupboard located at least 1.5m off the ground and with a child-resistant lock.
- Mothers should keep their hand bag out of reach
- Encourage parents to seek advice on correct use of medications e.g. Paracetamol, herbal preparations
- Parents are advised to learn basic first aid and resuscitation.
- Advise parents of poisons information centre phone number – providing support seven days a week / 24hrs a day.



Kidsafe Queensland (Child Accident Prevention Foundation of Australia) | www.kidsafeqld.com.au
Resources: Choking and suffocation, Toys, Poisoning, Choking first aid (in pictures and for Aboriginal children), CPR for babies (in pictures and for Aboriginal children), Preventing strangulation and suffocation

Raising Children Network | <http://raisingchildren.net.au>
Resources: Child car restraints and booster seats

The **Royal Automobile Club Queensland** (RACQ) (www.racq.com.au), **Queensland Ambulance Service** (<https://ambulance.qld.gov.au/index.html>) and **Kidsafe** can assist parents/carers with hiring baby capsules and installation advice for child restraints.

Burns 46,120,296

General information

- Infants can be burned in an instant with the majority of infant burns occurring in the home and often as a result of hot drinks and food.

Recommendations for parents

- Avoid consuming hot drinks / hot foods while holding infants
- Do not leave hot items in reach of child
- Microwave ovens heat fluid / foods unevenly – avoid heating bottles in the microwave, stir food thoroughly and test the temperature
- Keep children away from hot objects (e.g. heater, BBQ, candles)
- Use safety plugs in power sockets
- Bath temperature should be around 36°C (adults usually have their baths around 41°C)
- Use caution around hot taps
- Use safety gates to keep children out of high-risk areas (e.g. out of the kitchen when the family are cooking.)
- Choose clothing labelled ‘low-fire danger’
- Parents are also advised to learn basic first aid for burns ensure their home has smoke detectors.
- ‘Slip, Slop, Slap & Wrap’ – avoid sunburn by dressing infant in light-weight long sleeved clothing and a hat, find shade when possible and use baby sunscreen.



Kidsafe Queensland (Child Accident Prevention Foundation of Australia) | www.kidsafeqld.com.au

Raising Children Network | <http://raisingchildren.net.au>

Resources: Bathing your baby, Scalds prevention and first aid

The **Royal Automobile Club Queensland (RACQ)** (www.racq.com.au), **Queensland Ambulance Service** (<https://ambulance.qld.gov.au/index.html>) and **Kidsafe** can assist parents/carers with hiring baby capsules and installation advice for child restraints.

SIDS 45, 46, 120**General information**

- SIDS has reduced significantly since the introduction of public health campaigns over the past 20 years; however SIDS still rates at 0.2 per 1000 births (2012). Queensland had the highest number of SIDS deaths in Australia in 2012 with 21 of the 50 deaths [46].
- Many parents relapse into smoking again during early parenting, citing 'stress reduction, 'good feelings and a social activity' as reasons for the relapse.

Recommendations for parents

Health professionals continue to promote the SIDS guidelines, such as:

- Maintain a smoke-free environment for the infant
- Breastfeed
- Sleep the infant in their own safe sleeping place in the same room as an adult caregiver for the first six to 12 months
- Sleep the infant on the back from birth (not on their side or tummy). Wrapping the infant firmly (but not tightly) may help them stay on their back. Discontinue wrapping once infant can roll over
- Use a light, cotton fabric e.g. muslin
- Ensure the infant isn't overdressed under the wrap
- An appropriately fitting sleeping bag may be used as an alternative or when you can no longer use a wrap
- Keep the head and face uncovered when asleep
- Remove bibs
- Position the infant so that the feet are at the bottom of the cot
- Provide a safe sleeping environment night and day
- Ensure mattress and cot meet Australian Safety Standards
- Ensure mattress is a snug fit in the cot and ensure bedding is tucked securely
- Do not use bumpers, pillows, soft toys, pacifier cords

Co-sleeping

If parents are considering sharing the same bed with their infant, offer the following information:

- Bed sharing should be avoided when:
 - an infant is less than three months, premature or small for age
 - parent is a smoker or under the influence of alcohol or any medication causing sedation or the caregiver is overtired
 - the sleep environment is not consistent with SIDS recommendations e.g., Doonas, waterbed
 - bed is shared with other children, pets.
- Use a sleeping bag for the infant so that there is no sharing of adult bedding with the infant
- Discuss with parents support strategies and alternative stress reduction activities other than smoking e.g. parenting groups, play groups, ABA groups.
- Learn basic first aid and resuscitation.



SIDS and Kids | www.sidsandkids.org

Includes resources specific to Aboriginal and Torres Strait Islander families and in other languages.

Kidsafe Queensland | www.kidsafeqld.com.au Fact sheet: Tobacco smoke exposure

Raising Children Network | <http://raisingchildren.net.au> Resources: Bathing your baby

Assault / witnessing violence 18-21, 120

General information

- Children are acutely aware of their environment and are able to react either outwardly or inwardly, when those around them experience tension, fear, anxiety, depression and aggression.
- Relationship issues and / or domestic violence, may impact on the child in numerous ways including children being injured by their care givers e.g. shaken baby syndrome.
- Child health professionals should be alert to families expressing stress / relationship difficulties and maintain a child protection focus considering physical and psychological risks of harm.
- Discuss with all parents / care givers what to do if they are finding parenting challenging, this may be developed into a 'safety plan' for the parents to keep with them.

Recommendations for parents

- Refer parents to the Contacts page in the Personal Health Record with a range of supports including 24- hour hotlines.
- Discuss common challenges for parents and strategies to manage stress and reduce fatigue.
- Encourage parents to create a loving and calm environment.
- Encourage families to reflect on their parenting styles and own behaviours as a parent and how this may be impacting on the infant/child.
- Parents are encouraged to attend parenting programs to improve psychosocial health and parental functioning.



See child protection, page 173.

See appendix 1



Raising Children Network | <http://raisingchildren.net.au>

Resources: Services and Support in a nutshell, When you feel like you might hurt your child, Feeling angry as a parent

Babies and toddlers – Keeping them safe (fact sheet)

Queensland Centre for Domestic and Family Violence Research

www.noviolence.com.au/public/factsheets/babies.pdf

Illness prevention 48,120

General information

- Whilst prevention of communicable diseases is managed primarily through immunisation, raising the awareness of families and children of how to prevent the spread of illnesses is an important strategy around illness prevention.

Recommendations for parents

- Model positive hygiene behaviours by washing own hands regularly
- Teach children how to wash their hands and when to wash their hands ie: before eating, after toileting
- When children have symptoms of illness, teach them to reduce droplet spread by using a tissue when coughing or sneezing and discarding them;
- Discourage sharing of eating and drinking utensils
- Encourage families to limit the exposure of their child to others when ill. Some illnesses will have a recommended minimum exclusion periods from school, pre-schools and child care centres .



Raising Children Network | <http://raisingchildren.net.au>
Resources: Daily personal hygiene, Health concerns



Refer to *Chronic Conditions Manual*

Early identification

An important role of child health professionals is identifying factors that may impact on the health outcomes of children and providing support, early intervention and referral when necessary ¹.

This section:

- Identifies factors that increase the risk of a child experiencing sub-optimal health outcomes and
- Provides guidelines on how child health professionals can work with families where these factors exist, including additional targeted services and referral and care coordination with other service providers. Services will depend on the local community, resources and context of health care.

The healthcare context

Targeted services may be provided within a variety of settings to promote engagement of families into the service ¹. Depending on local resources, this may include extended home visiting, group programs (e.g. cultural specific parenting groups), outreach services (e.g. supported playgroups, young parents support groups, early years centres) and specific population group services (e.g. CALD clinic).

Priority groups include:

- Aboriginal and Torres Strait Islander families
- Families from a culturally and linguistically diverse (CALD) background
- Socioeconomically disadvantaged children and families

- Single parents, parents with multiple re-partnering experiences, step families and blended families
- Children living in non-parental or out-of-home care environments
- Parents with low parental education levels, often when other factors are present e.g. financial stress
- Families with chronic illnesses and / or disability
- Isolated families e.g., living in remote areas ²⁵.

A comprehensive family health assessment will provide a foundation for engaging families and providing ongoing services. The use of additional resources and tools may facilitate a comprehensive family health assessment, including:

- interpreter services
- parental mental health screening e.g. Edinburgh Postnatal Depression Scale (EPDS), Depression Anxiety Stress Scale (DASS)
- infant-maternal/paternal attachment tools.

When screening identifies additional risks or family needs, care options can be explored with families and the child health multidisciplinary team. Services will be tailored in partnership with families and guided by the local Hospital and Health Service protocol and models of care. This may include, for example:

- universal service provision with brief structured interventions and/or
- referral to additional support services within or external to the service ¹.

The child health professional uses a strength based, partnership approach to build parent capacities and skills, focusing on:

- providing evidence based, culturally sensitive, parenting information
- offering periodic anticipatory guidance according to the predictable stages of growth and development
- promoting, establishing and maintaining positive social supports
- enabling parents to solve problems for themselves and practicing personal coping strategies ^{1,65}.

Vulnerability factors

Whilst there are a wide range of factors that may indicate a family will have additional needs, for the purpose of this manual the following are grouped together for discussion:

- Aboriginal and Torres Strait Islander Families
- Culturally and linguistically diverse (CALD) people and people from Refugee backgrounds
- Families with low income, unstable housing, low parental education level
- Family Structure: Young, single, same sex attracted and re-partnering parents, step and blended families
- Children living in non-parental care environments
- Infants of parents with a disability, physical illness
- Isolated families e.g., living in rural and remote areas
- Families experiencing substance use issues: smoking, alcohol and other substance misuse
- Family with current violence, past abuse, or where a parent has experienced abuse as a child
- Families where there is parental mental health and wellbeing concerns ^{25,144}.



Refer to *Chronic Conditions Manual*

Aboriginal and Torres Strait Islander families

It is important to invite a family to identify their child as Aboriginal and Torres Strait Islander to ensure their cultural needs can be considered. Health in the context of an Aboriginal and Torres Strait Islander is a holistic concept, encompassing physical, social, emotional, spiritual and the cultural wellbeing of the child as well as their community. Each individual family will have their own beliefs and needs, influenced by differing cultural practices between clans across urban, rural and remote areas of Australia.

Generally however, men's and women's business remains a fundamental cultural practice within Aboriginal and Torres Strait Islander families, and kinship and family responsibilities hold a higher priority than personal health needs. These concepts, along with communication difficulties and cultural differences, often create a barrier to accessing and staying engaged with health care agencies¹⁵⁸. Additional factors for health care professionals to consider when working with Aboriginal and Torres Strait Islander families are outlined below.

Cultural needs ^{25,51,158-165}

Why there may be additional need

- Aboriginal and Torres Strait Islander clans differ in their belief systems across Australia; stereotyping cultural needs and cultural misunderstanding continues to exist. Considering the individual families' belief system and the impact it may have on parenting and their child will improve culturally responsive health care and work towards improving health outcomes.
- Aboriginal and Torres Strait Islanders may feel fearful and mistrusting of health care services due to the history of mistreatment and disadvantage that has occurred in Australia.
- Establishing and maintaining a therapeutic relationship over time using appropriate communication strategies has resulted in improved service engagement
- Families may have had to travel to access health care and be isolated from their community and networks. This may induce feelings of disconnection and being overwhelmed, and fear of the unknown or of being judged.

Recommendations specific to Aboriginal and Torres Strait Islander families

- Involve Aboriginal and Torres Strait Islander Health workers / practitioners in the assessment and planning of health care, where available.
- Use colours, art work, toys and equipment within the health care setting that may be aligned with the local culture.
- Invest time into establishing a therapeutic relationship with families; this is thought to increase ongoing engagement of the family. Use strategies such as:
- Spread assessment over a number of sessions to enable rapport to be built when possible.
- Use a suitable environment for the family whereby naturalistic observation may be used to gather information e.g., playground, home.
- Use a soft voice, a non-judgemental, respectful tone and avoid jargon.
- Use a casual discussion process to illicit information rather than a formal interview process.
- Invite discussion about the individual families' cultural views and document how these may impact on parenting as part of the Family Health Assessment. This may include the families' cultural beliefs and gender specific practices e.g. men's and women's business and how that will impact on their parenting
- Extended family support - Aunties may be a strong support to the Mother and a child carer

- Their baby may be integrated into community life from birth
- Child development may be viewed more broadly than physical milestone development and include increasing in autonomy and independence and social maturity of the infant/child
- Their child may be shown and told about dangers and then allowed to experiment and learn caution and consequences through participation, rather than being given directives to obey or using distraction techniques.
- Work with the family to strengthen supports and develop strategies that align with their own belief system.



Aboriginal and Torres Strait Islander patient care guideline (Queensland Government, 2014)
www.health.qld.gov.au/atsihealth/documents/patient_care_guideline.pdf

Australian Indigenous HealthInfo Net | www.healthinfonet.ecu.edu.au

Mortality and morbidity ^{25,51,158-165}

Why there may be additional need

- When compared to the general Australian population, Aboriginal and Torres Strait Islander children are two-three times more likely to die in infancy.
- Most deaths were related to conditions originating in the perinatal period e.g., birth trauma, complications of foetal growth.
- Ill-defined conditions including SIDS were the second-leading causes of death and the third most common cause was congenital malformations.
- Many Aboriginal and Torres Strait Islander families live in overcrowded conditions, increasing the risk of co-sleeping and SIDS. In non-remote areas in Australia 66% of Aboriginal and Torres Strait Islander infants < 1 year usually sleep on their backs, whilst only 43% of infants in remote areas sleep this way.
- Aboriginal and Torres Strait Islander peoples in Australia have an overwhelming burden of chronic disease and policy strategies are focusing on improving the health of the Aboriginal child to break the ongoing cycle of poor health [156].
- Infancy is an ideal period to commence healthy food preferences and eating habits which are firmly established during this crucial period.
- When compared to the general Australian population, Aboriginal and Torres Strait Islander children are 2-3 times more likely to:
 - be of low birth weight
 - have dental caries.
- 3% of Australian children aged 0-14yrs live in remote and very remote areas, 38% of these children were of Aboriginal and Torres Strait Islander. Obesity in these areas is a greater risk with 27% of children living outside a major city aged 5-14 years being overweight or obese compared to 21%

Recommendations specific to Aboriginal and Torres Strait Islander families

- Involve Aboriginal and Torres Strait Islander Health workers / practitioners in the discussions where ever possible.
- Complete a comprehensive family health assessment (see page 29), in particular:

- discuss safe sleep practices with the family and plan how they might use SIDS prevention strategies (See SIDS prevention on page 135)
- demonstrate how to set up safe bedding and how to dress baby for bed
- Talk about the importance of nutrition and promote and support breast feeding and explain how it will result in improved health outcomes as well as lessening the financial burden. Ensure families have information for after-hours breast feeding support services / help lines. See previous section
- Chat about health impacts of alcohol and other drugs and refer to appropriate support services / help lines.
- Explain the importance of providing a smoke free environment for the child. Refer to appropriate support services / help lines.
- Highlight the importance of immunisation and keeping up with the planned schedule – see previous section
- Demonstrate how their child is growing and how they are progressing on the percentile charts, particularly considering high rates of low birth weight infants and also high rates of obesity in the Aboriginal and Torres Strait Islander population.
- Promote oral health, e.g., brushing teeth at least twice per day, regular dental checks see....
- Catch up well child health checks can be facilitated by working in partnership with community members to consider a variety of ways for families to access services eg: community picnics with child health professionals clinics.
- Use local referral pathways for families suffering loss of a child to ensure they can access grief and loss support.



Queensland Health resources for health professionals:

[www.health.qld.gov.au/Aboriginal and Torres Strait Islander health/health_professionals.asp](http://www.health.qld.gov.au/Aboriginal%20and%20Torres%20Strait%20Islander%20health/health_professionals.asp)

Smokecheck training program | www.health.qld.gov.au/atod/prevention/smokecheck.asp

Growing Strong – Feeding you and your baby | www.health.qld.gov.au/ph/documents/hpu/growing_strong.asp

Looking after young mouths (flipchart) | <http://health.qld.gov.au/oralhealth/documents/30708.pdf>

SIDS and Kids Indigenous brochure

www.sidsandkids.org/wp-content/uploads/indigenousbrochure_001.pdf

Raising Children Network | <http://raisingchildren.net.au>

Videos for Indigenous parents: Watching your kids, Routines and Nutrition

Playgroup Queensland | www.playgroupqueensland.com.au

To find a supported playgroup - www.playgroupqueensland.com.au/find-a-playgroup-in-queensland/

Lifeline | www.lifeline.org.au

Tool kit: Coping with sorrow, loss and grief

www.lifeline.org.au/Get-Help/Facts---Information/Loss-and-Grief

Australian Indigenous HealthInfo Net | www.healthinonet.ecu.edu.au

Ear health, literacy and learning ^{25,51,158-165}

Why there may be additional need

- Aboriginal and Torres Strait Islander children have the world's highest recorded rates of middle ear disease. Middle ear infection is common and has been diagnosed in infants as young as two weeks of age.
- The associated conductive hearing loss can have a profound impact on their development.
- Aboriginal and Torres Strait Islander children have 30% more likely to require assistance with learning or communicating.

Recommendations specific to Aboriginal and Torres Strait Islander families

- Health professionals are recommended to include an ear health assessment at every child check.
- Otoscopy is a visual examination of the pinna, ear canal and ear drum with an otoscope, and should be undertaken at all ages.
- Tympanometry is a test of middle ear function, and should be used from 6 mths following otoscope examination showing no abnormality. Always perform otoscopy before tympanometry. If you see discharge or a perforation during otoscopy do not proceed with tympanometry. See page 184.
- Referral will be made for further assessment if concerns are identified.
- Audiometry is a measurement of hearing and should be conducted from 4 years of age.
- Aboriginal and Torres Strait Islander Mothers are encouraged to breast feed their children as long as possible.
- Inform Aboriginal and Torres Strait Islander families that:
 - their children have a greater risk of ear and hearing problems
 - children need to hear well to be able to talk well
 - 'runny ears' and ear pain is not normal and that the children should be seen immediately at a health centre
 - frequent ear checks are important even when the child appears well
 - their child is more likely to have an ear infection when they have a runny nose or cold
- Encourage good hygiene practices, such as regular hand washing, nose blowing and eating fresh fruit and vegetables.
- Promote 'On time' vaccinations
- Healthy living conditions are important for a child's development, eg. A smoke free environment and breastfeeding if possible.
- Post-diagnostic medical guidelines have been developed for the medical assessment of children diagnosed with a hearing loss.



Refer to *Chronic Conditions Manual*



Refer to the Pathways to Rural and Remote Orientation and Training
www.health.qld.gov.au/parrot/default.asp



Recommendations for Clinical Care Guidelines on the Management of Otitis Media in Aboriginal and Torres Strait Islander Populations (Australian Government)

www.health.gov.au/internet/publications/publishing.nsf/Content/CA2578620005D57ACA25792800821BE8?OpenDocument

A range of culturally appropriate health promotion resources and tools are available from:

Care for Kids Ears | www.careforkidsears.health.gov.au

Deadly Ears program | www.health.qld.gov.au/deadly_ears/

Deadly Ears also provides a number of training and development resources for healthcare professionals. See www.health.qld.gov.au/deadly_ears/html/train-dev.asp

Yarning Together – It's about yarning with bub (2011)

www.health.wa.gov.au/docreg/education/population/child_health/growth_and_development/HP11287_yarning_together.pdf

Families as First Teachers program | www.faft.net.au

A program for families with infants 0-4 yrs.

Raising Children Network | <http://raisingchildren.net.au/>

Video: Play and learning: designed for Aboriginal & Torres Strait Islander parents

Queensland Hearing Loss Family Support Service | Tel: 1800 352 075

www.health.qld.gov.au/healthyhearing/pages/family.asp

A statewide service providing support and counselling for families of children diagnosed with a permanent hearing loss. Support available from birth through to completion of Year 1. General information and translated brochures about the program are available at www.health.qld.gov.au/healthyhearing

Family wellbeing^{25,51,158-165}

Why there may be additional need

- Aboriginal and Torres Strait Islander children are 8-9 times more likely to be in the child protection system and they are over-represented in 'out of home' care services.
- Many Aboriginal and Torres Strait Islander children are growing up in an environment with poverty, family dysfunction and violence with a greater risk of maltreatment and with high levels of distress. For example:
 - In a report on social and emotional wellbeing, over one third of Torres Strait Islander people reported high to very high levels of psychological distress and had experienced at least one life stressor (death of a family member / close friend, serious illness, inability to get work) in the previous 12 months of their life.
 - Higher rates of psychological distress were associated with poor health outcomes

Recommendations specific to Aboriginal and Torres Strait Islander families

- Promote parental wellbeing by offering psychosocial support strategies including:
 - Discussion around parental post-natal feelings e.g. adjusting to parenthood
 - Promoting peer support e.g. attend culturally specific parent groups / playgroup, telephone conversations with family / friends
- Provide non-directive counselling in partnership with the parent ie: empathetic parent centred discussion with a focus on listening and summarising and supporting the parent to develop understanding of their own circumstances and a way to move forward
- Psycho-education appropriate to the education level and specific culture of the family promoting
 - Self-care e.g. lifestyle, sleep and exercise, safe use of alcohol
 - Discussion around vulnerabilities specific to the families' situation.
- If assessment identifies acute mental health concerns the health care professional should stay engaged with the client and seek further support from their acute mental health service provider.
- The child health professional may identify child safety concerns and be required to complete a 'Report of Suspected Child in Need of Protection'. See page 172.



See appendix 1



Centre for excellence in Indigenous tobacco control | www.ceitc.org.au/ceitc-publications-and-resources

Raising Children Network | <http://raisingchildren.net.au>

Videos for Indigenous parents: Watching your kids, Routines

Lifeline | www.lifeline.org.au

Tool kit: Help when you are feeling down – www.lifeline.org.au/Get-Help/Facts---Information/Depression
A self-help resource for Aboriginal and Torres Strait Islander people who are feeling down

Yarning about mental health (flip chart)

www.healthinfont.net.edu.au/key-resources/promotion-resources?lid=19702

Playgroup Queensland | www.playgroupqueensland.com.au

To find a supported playgroup - www.playgroupqueensland.com.au/find-a-playgroup-in-queensland

Children from culturally and linguistically diverse (CALD) or refugee backgrounds ^{24,163,166,167}

Identified risks / additional needs

- One in five people in Queensland were born overseas.
- Cultural factors and belief systems will vary according to the family's background.
- Queenslanders speak more than 220 languages from more than 220 countries.
- Common issues to CALD families include:
 - some family members will have limited understanding of English
 - Overcrowded housing, transient housing arrangements – this leads to an increase of environmental safety risks for children
 - Older children may have the responsibility of caring for their younger siblings due to cultural norms
 - Unemployment rates are high in migrants- 10.6% compared to 5.9% for those born in Australia.
- Refugees are a highly vulnerable population with common health issues including incomplete immunisation coverage, nutritional deficiencies (e.g. iron, vitamin D), growth and developmental issues, poor dental health, interrupted language development, sometimes communicable diseases such as tuberculosis, Hepatitis B and parasitic infections, mental health conditions such as: post-traumatic stress disorder, anxiety and depression. These issues may be present in the child or the parents / carers.
- Child health professionals need to be alert for the use of the cultural practice of Female Genital Mutilation (FGM). While it is illegal in Australia it may still be practiced in some cultural groups. Families are more likely to follow this practice when:
 - The family are from African or Middle Eastern countries
 - No-one talks to the mother about FGM
 - The mother has limited access to information about FGM
 - The child's mother or sisters have been 'cut'
 - The paternal grandmother has an influence over the family
 - The mother has limited contact with other people outside of her own family.
 - FGM may be carried out anytime between 7 days of age, up to teenage years, marriage or first pregnancy but is most common between the ages of 5 – 8 years. It is often commonly associated with a cultural celebration or leaving the country for a period of time.

Principles to underpin good clinical practice

- Welcoming cultural diversity as a strength helps eliminate discrimination and strengthens community cohesion.
- Arrange an interpreter and information in the families' own language when possible.
- Avoid using family members as interpreters as this may breach confidentiality and information may be inaccurate.
- Research general customs, values and beliefs of particular cultures to prepare for an appointment with a CALD family. This may enhance your ability to gain information and develop a rapport.
- If the general customs include FGM and the child is female, explain that FGM is illegal and that the law in Australia helps families to protect their daughters from FGM. When talking to the mother use language that the mother can understand and avoid indicating any judgement to the practice. For example: Have you been closed? or Were you circumcised / cut down there?

- Offer the mother assurance that she can talk to you again about this if she wishes.
- It may be necessary to complete a 'Report of Suspected Child in Need of Protection'. See page 172.
- Conduct a comprehensive family health assessment to identify specific needs of the individual family.
- Work in partnership with the family to develop an ongoing plan of care, this may include:
 - Extra support through home visiting to assess the family's living arrangements and support the family to identify safety hazards may be effective in reducing rates of injuries.
 - Review immunisation and promote a catch up schedule if necessary, encourage ongoing immunisations on time.
 - Promoting and supporting breast feeding will result in improved health outcomes as well as lessening the financial burden. Ensure families have information for after hours breast feeding support services / help lines. see previous section
 - Coordinate referrals for any identified concerns e.g. disruptive behavioural and aggressive in children. Refer to additional specialty services e.g. EIPS, Refugee health clinic, support groups.
- Collaborate with GPs, local government and non-government care providers to advocate for appropriate services for CALD / Refugee families.
- Promote parental wellbeing by offering psychosocial support strategies including:
 - Discussion around parental post-natal feelings e.g. adjusting to parenthood
 - Promoting peer support e.g. attend parent groups / playgroup, telephone conversations with family / friends
 - Provide non-directive counselling in partnership with the parent ie: empathetic parent centred discussion with a focus on listening and summarising and supporting the parent to develop understanding of their own circumstances and a way to move forward
 - Psycho-education appropriate to the education level and specific culture of the family to promoting self care e.g. lifestyle, sleep and exercise demonstrate unfamiliar activities and use picture pamphlets where possible.



Queensland Transcultural Mental Health Centre

www.health.qld.gov.au/metrosouthmentalhealth/qtmhc/default.asp
Multilingual resources relating to mental health issues.

Raising Children Network | <http://raisingchildren.net.au>

Fact sheet: Professionals working with interpreters

Video resources are available for Australian parents from different cultures - Titles include: Play and learning, Connecting and communicating, Adjusting to a new country, Being parents from different cultures, Speaking languages at home.

General parenting resources are available in English and in 12 other languages plus Auslan, e.g. Services and support, Safe sleep, Safe bathing, Wrapping, Dressing a newborn, Baby massage, Bottle and formula preparation.

Good Food for New Arrivals | <http://goodfood.asetts.org.au/>

A range of pamphlets and relevant information specific to refugee and asylum seekers especially around food and nutrition.

Queensland Program of Assistance to Survivors of Torture and Trauma | www.qpastt.org.au

Offers a range of culturally sensitive resources for those who have suffered trauma prior to arriving in Australia.



Family Health Assessment – A guide for child health nurses and other child health clinicians ²⁵

<http://qheps.health.qld.gov.au/ccyfh/docs/fam-health.pdf>

Low family income / unstable housing / low parental education level ^{1,24,25,65,144,149,168}

Identified risks / additional needs

- Children from families with low income, unstable housing and/or low level of education are known to have poorer health outcomes.
- A lack of resources often correlates with a risk of poor nutrition, insufficient clothing, poor sanitation. When multiple risk factors are present, there is a higher risk of child abuse and neglect. Infant mortality rates are 1.2 times higher in families with low income than with infants in higher income families; with the children having twice the number of decayed teeth by the time they were six years old.
- Often children have a lack of opportunity to access activities outside of the home due to lack of transportation, this may result in lack of opportunities for socialisation and health care needs; vaccination schedules may not be maintained.
- Growth retardation and obesity are risks when nutritional requirements are not met and illness more common. Overcrowded living circumstances results in higher incidence of communicable illnesses.

Principles to underpin good clinical practice

- Home visiting programs for these families have proven effective in improving health outcomes.
- For low income families promoting and supporting breast feeding will result in improved health outcomes as well as lessening the financial burden e.g. formula feeding, less health costs due to reduced rate of illness
- Ensure families have information for after hours breast feeding support services / help lines.
- Conduct a comprehensive family health assessment to identify specific needs of family.
- Work in partnership with the family to develop an ongoing plan for care
- Review immunisation history and promote a catch-up schedule if necessary, as soon as possible. Encourage ongoing immunisations on time.
- Provide psycho-education appropriate to the education level of the parent, demonstrate unfamiliar activities and use picture pamphlets where possible.
- Inform the family of free / low-cost, local activities and resources e.g. playgroups, library activities, soup kitchens, community gardens.
- Coordinate referrals for any identified concerns e.g. poor growth.
- Promote oral health care in children. See previous section.
- Promote parental wellbeing by offering psychosocial support strategies including:
 - Discussion around parental post-natal feelings e.g. adjusting to parenthood
 - Promoting peer support e.g. attend parent groups / playgroups, phone conversations with family/friends
- Provide non-directive counselling in partnership with the parent ie: empathetic parent centred discussion with a focus on listening and summarising and supporting the parent to develop understanding of their own circumstances and a way to move forward
- Psycho-education specific to promoting self-care e.g. lifestyle, sleep and exercise.



Raising Children Network | <http://raisingchildren.net.au>

'Parenting in Pictures' resources include: Baby massage, Bathing a newborn, Hygiene and daily care for babies, How to breastfeed, Breastfeeding positions,



Family Health Assessment – A guide for child health nurses and other child health clinicians ²⁵
<http://qheps.health.qld.gov.au/ccyfhs/docs/fam-health.pdf>

Family structure: young, single, same sex attracted, re-partnering parents, step and blended families ^{11,25,65,168,169,170-172}

Identified risks / additional needs

- The prevalence of family forms other than two biological parents and only their mutual children, has risen dramatically and includes single parenthood, multi-partnered fertility (a parent with children from multiple partners), step families, blended families and families with same-sex parents.
- A range of vulnerabilities exist for children of these families – the more disruption to family life, the more the likelihood of a detrimental impact on the child’s emotional and physical wellbeing.
- Young parents have significantly higher levels of antenatal and postnatal depression and an increased risk of performing unresponsive parenting practices, having higher levels of parenting stress, having repeat pregnancies and poor parental educational outcomes. Their children are also at greater risk of maltreatment, child abuse and being developmentally delayed.
- Children may have an increased risk of alcohol related harm when their parent/s are young adults when heavy drinking is common at this life stage. Older parents also have greater intake of alcohol.
- Single parent families may be at greater risk of alcohol related harm to children.
- Non-nuclear families with step-parents or defacto partners are over-represented in child safety statistics.
- Children of same-sex parent families are prone to stigma related to parental sexual orientation which may result in negative impacts on the child’s mental and emotional wellbeing.

Principles to underpin good clinical practice

- Welcoming diversity of family forms as a strength will reduce discrimination and enhance community cohesion, ultimately reducing the risk of negative stigma impacting on the child.
- Social support for parents has been shown to improved emotional wellbeing for the family, therefore linking parents into suitable networks is important e.g. Young Parents Program.
- Often young parenthood, single parenthood is associated with a low income, so promoting and supporting breast feeding will result in improved health outcomes as well as lessening the financial burden e.g. formula feeding, less health costs due to reduced rate of illness. Ensure families have information for after-hours breast feeding support services / help lines.
- Extra support may be indicated through home visiting to assess the family’s living arrangements and to identify unmet health needs to improve health outcomes for the child.
- Discuss child care and behaviours, particularly safety - use an education level suitable to the parent, demonstrate unfamiliar activities and use picture pamphlets where appropriate.
- Promote parental wellbeing by offering psychosocial support strategies including:
 - Discussion around parental feelings e.g. adjusting to new situations
 - Provide non-directive counselling in partnership with the parent ie: empathetic parent centred discussion with a focus on listening and summarising and supporting the parent to develop understanding of their own circumstances and a way to move forward
 - Psycho-education specific to promoting self-care
 - Discussion around vulnerabilities specific to the families’ situation.



Raising Children Network | <http://raisingchildren.net.au> | Video and fact sheets on a variety of topics.

ReachOut.com | <http://au.reachout.com>

A non-government organisation for youth providing information about mental fitness, alcohol and drugs.



Family Health Assessment – A guide for child health nurses and other child health clinicians ²⁵
<http://qheps.health.qld.gov.au/ccyfh/docs/fam-health.pdf>

Children living in non-parental or out-of-home care environments

11,65,144,149

Identified risks / additional needs

- The majority of children in Australia live with at least one of their biological parents, however of those infants less than one year living in non-parental care, 33% live with relatives/kin and 64% in foster care with stability of placement of key importance.
- These group of children have many vulnerabilities including a higher incidence of:
 - acute and chronic illness
 - emotional and behavioural issues
 - e.g. poor social relationships with parents and peers.

Principles to underpin good clinical practice

- Providing support for the foster parents is key in promoting the ongoing placement of the foster child which will provide greater stability and improved health outcomes.
- Conduct a comprehensive family health assessment to identify specific needs of the foster family and the foster child.
- Work in partnership with the family to develop an ongoing plan for care
- Review immunisation history and promote a catch up schedule if necessary, as soon as possible. Encourage ongoing immunisations on time.
- Coordinate referrals for any identified concerns e.g. Early Intervention Clinician for behavioural issues.
- Collaborate with local government and non-government services to advocate for appropriate support services and training for foster families.
- Promote foster family wellbeing by offering psychosocial support strategies including:
 - Discussion around feelings e.g. adjusting to caring for the foster child
 - Promoting peer support e.g. attend parent groups / playgroup, telephone conversations with family / friends
 - Provide non-directive counselling in partnership with the parent ie: empathetic parent centred discussion with a focus on listening and summarising and supporting the parent to develop understanding of their own circumstances and a way to move forward
 - Psycho-education specific to promoting self-care e.g. lifestyle, sleep and exercise



Raising Children Network | <http://raisingchildren.net.au>

Resources in both video and fact sheets on a variety of topics, including Raising foster children and Being a grandparent carer



Family Health Assessment – A guide for child health nurses and other child health clinicians ²⁵
<http://qheps.health.qld.gov.au/ccyfhs/docs/fam-health.pdf>

Children of parents with a disability / physical illness

11,65,144,168,173

Identified risks / additional needs

- About one in six children live with a parent with a disability. The key factor for children of parents with a disability is whether the parent can provide adequate care for the child. This will depend on the type and severity of their disability and the level of support they have. Evidence suggests that parents with intellectual disability can provide adequate parenting when appropriate supports are in place and the child is likely to develop in line with their peers from similar socio-demographic backgrounds.
- Parents with chronic illness such as: Diabetes, Epilepsy, may encounter a number of factors that impact on family life including: hospitalisations, loss of income, dependency on others, social stigmatisation. Under these conditions children may be emotionally or physically compromised with some children developing a carer role to the parent, or developing behavioural problems.

Principles to underpin good clinical practice

- Families with disability often have an associated low income. Promoting and supporting breast feeding will result in improved health outcomes as well as lessening the financial burden, e.g. formula feeding, less health costs due to reduced rate of illness. Ensure families have appropriate information for after-hours breast feeding support, services / help lines.
- Provide psycho-education appropriate to the education level of the parent, demonstrate unfamiliar activities and use picture pamphlets where possible.
- Plan with the parent how to work with their disability / illness and parenting, e.g. epileptics may need to change nappies on the floor, await a family member's support for bathing their infant/child.
 - Promote parental wellbeing by offering psychosocial support strategies including:
 - Discussion around parental post-natal feelings, e.g. adjusting to parenthood
 - Promoting peer support, e.g. attend parent groups / supported playgroups, support from family / friends.
 - Provide non-directive counselling in partnership with the parent ie: empathetic parent centred discussion with a focus on listening and summarising and supporting the parent to develop understanding of their own circumstances and develop strategies to overcome barriers specific to disability.
 - Psycho-education specific to promoting the child's safety and managing the disability whilst parenting, e.g. lifestyle changes, ways to enhance safety, e.g. assistance at bath times.



Raising Children Network | <http://raisingchildren.net.au>

Resources in both video and fact sheets on a variety of topics: e.g Parenting with physical disability

Epilepsy Australia | www.epilepsyaustralia.net



*Family Health Assessment – A guide for child health nurses and other child health clinicians*²⁵

<http://qheps.health.qld.gov.au/ccyfh/docs/fam-health.pdf>

Identified risks / additional needs

- About one in six children live with a parent with a disability. The key factor for children of parents with a disability is whether the parent can provide adequate care for the child. This will depend on the type and severity of their disability and the level of support they have. Evidence suggests that parents with intellectual disability can provide adequate parenting when appropriate supports are in place and the child is likely to develop in line with their peers from similar socio-demographic backgrounds.
- Parents with chronic illness such as: Diabetes, Epilepsy, may encounter a number of factors that impact on family life including: hospitalisations, loss of income, dependency on others, social stigmatisation. Under these conditions children may be emotionally or physically compromised with some children developing a carer role to the parent, or developing behavioural problems.

Principles to underpin good clinical practice

- Families with disability often have an associated low income. Promoting and supporting breast feeding will result in improved health outcomes as well as lessening the financial burden, e.g. formula feeding, less health costs due to reduced rate of illness. Ensure families have appropriate information for after-hours breast feeding support, services / help lines.
- Provide psycho-education appropriate to the education level of the parent, demonstrate unfamiliar activities and use picture pamphlets where possible.
- Plan with the parent how to work with their disability / illness and parenting, e.g. epileptics may need to change nappies on the floor, await a family member's support for bathing their infant/child.
 - Promote parental wellbeing by offering psychosocial support strategies including:
 - Discussion around parental post-natal feelings, e.g. adjusting to parenthood
 - Promoting peer support, e.g. attend parent groups / supported playgroups, support from family / friends.
 - Provide non-directive counselling in partnership with the parent ie: empathetic parent centred discussion with a focus on listening and summarising and supporting the parent to develop understanding of their own circumstances and develop strategies to overcome barriers specific to disability.
 - Psycho-education specific to promoting the child's safety and managing the disability whilst parenting, e.g. lifestyle changes, ways to enhance safety, e.g. assistance at bath times.



Raising Children Network | <http://raisingchildren.net.au>

Resources in both video and fact sheets on a variety of topics: e.g Parenting with physical disability

Epilepsy Australia | www.epilepsyaustralia.net



Family Health Assessment – A guide for child health nurses and other child health clinicians ²⁵

<http://qheps.health.qld.gov.au/ccyfhs/docs/fam-health.pdf>

Isolated families (e.g. living in remote areas) 11,65,149

Identified risks / additional needs

- Three per cent of Australian children aged 0-14yrs live in remote and very remote areas, 38% of these children were of Aboriginal and Torres Strait Islander families.
- Infant mortality rates were almost double in the remote areas compared to city areas.
- Children living in remote areas have more than twice the number of decayed teeth as those in major cities.
- Many Aboriginal and Torres Strait Islander people live in remote and rural areas. Obesity in these areas is a greater risk with 27% of children living outside a major city aged 5-14 years being overweight or obese compared to 21%.

Principles to underpin good clinical practice

- Review immunisation history and promote a catch up schedule if necessary, as soon as possible. Encourage ongoing immunisations on time.
- Promote parental wellbeing by offering psychosocial support strategies including:
 - Discussion around parental post-natal feelings e.g., adjusting to parenthood
 - Promoting peer support e.g. attend parent groups/playgroups, conversations with family and friends
 - Provide non-directive counselling in partnership with the parent ie: empathetic parent centred discussion with a focus on listening and summarising and supporting the parent to develop understanding of their own circumstances and a way to move forward
 - Psycho-education specific to promoting self-care e.g. lifestyle, sleep and exercise.



Raising Children Network | <http://raisingchildren.net.au>

Factsheet: How to make new friends and keep old ones

Also offers online discussion forums where parents can chat to other parents.

Epilepsy Australia | www.epilepsyaustralia.net



Family Health Assessment – A guide for child health nurses and other child health clinicians ²⁵

<http://qheps.health.qld.gov.au/ccyfh/docs/fam-health.pdf>

Smoking, alcohol and substance misuse ^{11,23-25,65,168}

Identified risks / additional needs

- Environmental tobacco smoke is one of the most hazardous toxins to infants. Exposing an infant/child to tobacco smoke puts them at risk of a range of serious health issues such as SIDS, respiratory illness, including asthma. Tobacco use is the risk factor associated with the highest disease burden in Australia.
- Whilst smoking inside the family home has decreased, 6% of Australian households with children 0 – 14 yrs had someone who smoked at least once inside the home daily.
- Misuse of substances, including alcohol, cannabis, stimulants, opioids, inhalants and un-prescribed benzodiazepines, is known to increase the risk of a range of poor health outcomes including injury, illness, mental health issues, family violence.
- Consideration of the impact of misuse of substances during foetal development is also important e.g., risk of Neonatal Abstinence Syndrome.
- Drug exposed infants may suffer withdrawal reactions and symptoms of a varying nature. These may include poor feeding, vomiting, frantic / uncoordinated sucking, tremors, irritability, high pitched cry, temperature instability, and disrupted sleep patterns.

Principles to underpin good clinical practice

- Build a professional, trusting and empathetic relationship that encourages a continuation of health care.
- Assessment of the child's environment is important during the family health assessment. The health care professional should obtain information about family smoking, alcohol consumption and use of other substances (cannabis, stimulants, opioids, inhalants and un-prescribed benzodiazepines) during pregnancy and any current use. Both the pattern and frequency of use are important e.g. occasional use, regular recreational or non-dependent use, habitual, regular or dependent use, binge use.
- These practices are often more common in low risk families, therefore promoting and supporting breast feeding to improve health outcomes as well as lessening the financial burden is important. Ensure families have information for after-hours breastfeeding support services / help lines. See previous section.
- Working in partnership with the family, offer a brief intervention based on the **5 'A's'**:
 - **Ask:** Ask all families about smoking as part of this assessment. Does anyone living or visiting at home smoke?
 - **Assess:** How might you keep your baby in a smoke free environment when you smoke?
 - **Advise:** Did you know that there is no safe level of environmental tobacco smoke - smoking in the car, even with windows down still exposes children to harmful levels of tobacco smoke.
 - **Assist:** Have you thought of contacting the Quit line again, it usually takes a few attempts at quitting before people give up completely.
 - **Ask again:** Remember to enquire how they are going, e.g. How did you go contacting the Quitline?
- Promote parental wellbeing by offering psychosocial support strategies including:
 - Discussion around parental feelings e.g. adjusting to parenthood
 - Psycho-education specific to promoting self-care:
 - › discuss services that can support the woman to stop or reduce substance use
 - › provide the woman with evidence based information designed to minimise the harm associated with the use of substances e.g. smoke outside the home; safe use of alcohol,

- Promote peer support e.g. attend parent groups/playgroup, phone conversations with family/friends
- Provide non-directive counselling ie: empathetic parent-centred discussion with a focus on listening and summarising and supporting the parent to develop understanding of their own circumstances and a way to move forward
- Coordinate referrals for any identified concerns e.g., Alcohol, Tobacco and Other Drugs Services.
- Consider risk to infant /child (see page 172.)



Alcohol, Tobacco and Other Drugs Services (ATODS) | www.health.qld.gov.au/atod

Quitline | www.health.qld.gov.au/quitsmoking/

Raising Children Network | <http://raisingchildren.net.au>

Resources in both video and fact sheets on a variety of topics: e.g. Second-hand smoke and your child, New mums and dads: healthy lifestyle choices.

Drug and alcohol use | <http://australia.gov.au/topics/health-and-safety/drug-and-alcohol-use>



Family Health Assessment – A guide for child health nurses and other child health clinicians ²⁵

<http://qheps.health.qld.gov.au/ccyfh/docs/fam-health.pdf>

Family violence / past abuse / parent abused as a child ^{11,18,25,59,65,175}

Identified risks / additional needs

- While some children are subjects of physical violence, many children living in a home where there is family violence are ‘silent’ victims of domestic violence. Experiencing, hearing or seeing the impact of family violence can impact on infants and children in a broad range of physical, emotional and behavioural ways.
- Parents who were abused as children may carry with them residual, multidimensional effects which can impact on parenting and family functioning.
- Whilst routine screening has been widely introduced in health care setting for intimate partner violence, actual screening rates remain low – with barriers identified, such as:
 - lack of privacy,
 - limited confidentiality,
 - health professionals frustration about women remaining in abusive relationships.
- Despite challenges, health workers reported benefiting from brief, scripted questions embedded into established screening programs. In Queensland, it is recommended that a domestic violence screen is undertaken at the first visit as part of the family health assessment.
- See appendix 4.

Principles to underpin good clinical practice

- Home-visiting programs for these families has proven to be effective in improving health outcomes.
- Work in partnership with the family to establish a professional, trusting and empathetic relationship that encourages an ongoing plan for health care.
- Conduct a comprehensive family health assessment to identify specific needs of the individual family.

Principles to underpin good clinical practice

- Discuss a safety plan with the parent and provide crisis service information. Encourage the parent to access local support groups specific to her need.
- Sensitively promoting and supporting breast feeding will result in improved health outcomes. Ensure families have information for after-hours breast feeding support services / help lines. See previous section
- Promote parental wellbeing by offering psychosocial support strategies including:
 - Discussion around parental post-natal feelings e.g. adjusting to parenthood
 - Promoting peer support e.g. attend parent groups / playgroup, telephone conversations with family/friends
 - Provide non-directive counselling in partnership with the parent ie: empathetic parent-centred discussion with a focus on listening and summarising and supporting the parent to develop understanding of their own circumstances and a way to move forward
- Psycho-education specific to promoting self-care e.g., lifestyle, sleep and exercise.
- If assessment identifies immediate safety issues the health care professional will support the family to seek support from Police and/or local crisis services.



The child health professional may identify child safety concerns and be required to complete a 'Report of Suspected Child in Need of Protection'. See page 172.



Access to support for health care professionals after dealing with complex situations will reduce the risk of staff 'burn out'.



Raising Children Network | <http://raisingchildren.net.au>

Resources in both video and fact sheets on a variety of topics: e.g More than arguments: domestic violence' and 'Handling conflict with your ex-partner'

Lifeline provides free, accredited training for health professionals. See www.dvalert.org.au/



Family Health Assessment – A guide for child health nurses and other child health clinicians ²⁵
<http://qheps.health.qld.gov.au/ccyfhs/docs/fam-health.pdf>

Parental mental health and wellbeing ^{11,25,61,65,69,169,174}

Identified risks / additional needs

- Parental mental health and wellbeing in the child's early years of life is known to have a significant health impact on their health as well as the overall health of the family unit.
- The development of secure attachment relies on the child's attachment figure to be 'a safe haven'; when the parent is able to provide consistent comfort and a secure base for the child, he/she feels able to explore the world. This optimises the child's chance of developing social skills that will assist him/her in successfully navigating life.
- Parental functioning e.g. inter-parental conflict, is also a significant predictor of psychological health of children – the more disruption to family life, the more the likelihood of a detrimental impact on the child's emotional and physical wellbeing.

- If a parent is suffering a mental illness this may impact on their availability to their child as well as their consistency in parenting behaviours that support child-parental attachment. Children with parents suffering from a mental illness are more likely to have an altered attachment, socio-emotional and behavioural problems.

Principles to underpin good clinical practice

- Work in partnership with the family to establish a professional, trusting and empathetic relationship that encourages an ongoing plan for health care.
- Conduct a family health assessment to identify specific needs of the family particularly around mental and emotional health. This will include family history of mental illness, current emotional health issues, relationship between parents and how these factors are impacting on the child.
- Promote parental wellbeing by offering psychosocial support strategies including:
 - Discussion around parental post-natal feelings e.g. adjusting to parenthood
 - Promoting peer support e.g., parent groups/targeted groups for PND/playgroups, telephone conversations with family and friends, online forums with other parents
 - Promote reflection on parental relationships and encourage parents to seek support if they are feeling distressed about their relationship
 - Provide non-directive counselling in partnership with the parent ie: empathetic parent centred discussion with a focus on listening and summarising and supporting the parent to reflect on their own behaviours, develop insight and understanding of their own circumstances and a plan a way forward
 - Psycho-education specific to promoting self-care e.g. maintain appointments with counsellors, continue to link with health professionals, promote healthy lifestyle.
 - Discussion around local support services e.g. support for relationship counselling.
- Discuss a safety plan with the parent and provide crisis service information. See page 175.
- Encourage the parent to access local support groups specific to their need. This may include group-based parenting groups. These have proven benefits on depression, anxiety, stress, confidence and satisfaction with the partner relationship e.g. Triple P.
- Ongoing home visiting programs for families experiencing mental illness has proven effective in improving health outcomes through the development of a connected relationship with a health professional as well as an opportunity to continue to monitor child development.
- Sensitively promoting and supporting breastfeeding with consideration of maternal medication treatments and transmission rates to the child via breast milk. Ensure families have information for after-hours breast feeding support services / help lines. see previous section



If assessment identifies altered attachment models, refer to early intervention clinician.



If assessment identifies acute mental health concerns the health care professional should stay engaged with the client and seek further support from their acute mental health service provider.



The child health professional may identify child safety concerns and be required to complete a 'Report of Suspected Child in Need of Protection'.



Raising Children Network | <http://raisingchildren.net.au>

Resources in both video and fact sheets on a variety of topics including Looking after yourself, Your wellbeing, Anxiety, Stress, Sleep, Coping toolkit, Your relationship, Relationship toolkit, Family management

Lifeline provides free, accredited training for health professionals. See www.dvalert.org.au

ReachOut.com | <http://au.reachout.com>

A non-government organisation for youth, offering resources and information about mental fitness appropriate for young parents.

Beyond Blue | www.beyondblue.org.au

Resources for women, men, young people and carers, as well as resources for professionals (clinical practice guidelines, perinatal mental health training)



*Family Health Assessment – A guide for child health nurses and other child health clinicians*²⁵

<http://qheps.health.qld.gov.au/ccyfh/docs/fam-health.pdf>

Responding to need

The therapeutic relationship between child health professionals and families often results in families sharing information with child health professionals, which may identify a greater level of need¹⁷⁶. This enables the child health professional to partner with the family and additional higher level services specific to the needs of the child and family¹.

This section identifies higher level and specialty services that are available to families who have additional needs and some of the needs whereby children and families may require a higher level of intervention. This includes prematurity, cow's milk protein allergy, weight faltering/malnutrition, childhood obesity, infant/child sleep dysrhythmia, post-natal depression, parental grief and loss. This section also outlines how child health professionals work with families with identified needs.

The healthcare context

A comprehensive family health assessment will provide the foundation for ongoing care. When additional needs are identified by the child health professional one of two processes will be undertaken according to clinical judgement and the clinical context:

1. Referral by the child health professional to another service and/or
2. Engagement in a case management approach.

Immediate action will be required in the event that an acute health issue is identified by the child health professional, for example:

- concerns for the immediate safety of the child/family, e.g. domestic violence, child abuse or neglect
- impaired parenting capacity, e.g. parent exhibiting signs of psychosis or acute mental health concern
- concerns about a child having been physically abused e.g. shaken baby syndrome
- child having difficulty breathing, change of level of consciousness.

In situations such as these, the child health professional will take immediate action to alert the relevant emergency services (ambulance, police, acute mental health services, etc.).

Ongoing care planning will continue during the course of intervention by the specialty services and in consultation with other primary care providers such as the GP.



Refer to *Primary Clinical Care Manual*

Topics: Patient assessment, Emergencies

Home visiting

Evidence-based home visiting programs provide the opportunity for families with identified needs to access tailored services within their home. Families are more likely to actively engage in service provision over a number of visits when it is delivered in their home^{52,55,56}. Sustained home visiting programs have shown trends of improved health outcomes specific to breastfeeding, the woman's experience of motherhood and the children's mental development⁵⁵. Aboriginal and Torres Strait Islander families are offered a culturally appropriate model of home visiting.

Case management

- To manage and coordinate service provision for families with identified needs where a number of health care providers are involved, a case manager may be assigned to the family to coordinate the overall care. This model of care has demonstrated a more effective approach with a greater chance of the needs of the family being met¹⁷⁷.
- Key elements of case management include:
 - family partnership
 - comprehensive and ongoing family assessment
 - cultural safety
 - working with and utilising community resources (it is important for the case manager to be aware of local services available to meet additional needs of families)
 - participating in interdisciplinary consultation and collaboration
 - monitoring and evaluating client and service delivery outcomes
 - advocating on behalf of family with identified need
 - documenting client encounters and case manager activities with a focus on family centred practice
 - scheduling of follow-up and review outlined in the families' care plan.
- During transitions between services families are particularly vulnerable to experiencing 'care fragmentation'¹⁷⁶. This includes:
 - from the community to hospital and back to community after birth or inpatient events
 - between general practitioners, agencies and other services
 - for children placed with different carers
 - between health care professionals in the same organisation
 - during other events, such as an admission to parenting centres
- Ideally a care plan will be developed in partnership with the family across the continuum of care¹⁷⁶.
- All health professionals should work together, particularly at the point of transition between services, with a commitment to collaborating to improve outcomes for the child and family¹⁷⁶.
- Good communication is integral to all these processes¹⁷⁶.
- Families accessing a range of services can use the PHR to record significant health events / problems, notes and appointments. Families are encouraged to bring the PHR to all health care appointments for completion by the health care professional.

Ellen Barron Family Centre

- The Ellen Barron Family Centre (EBFC) is a tertiary-level, statewide residential service, providing early parenting support through parenting education programs for families with children aged birth to three years.
- Families are referred to EBFC by a primary carer or primary care agency, for example: a child health professional or GP.

- The service is a Nurse Lead Service that works within a multidisciplinary team framework. The team views the child as the centre of care but utilises a partnership and family focussed approach to engage and work with families.
- Utilising selected referral criteria, families may be triaged into one of three parenting programs:
 - The Sleep Education Program (SEP) – a short-stay program (usually two days) for families experiencing parenting difficulties specific to infant sleep that has not been able to be managed in the community of origin;
 - The Parenting Education Program (PEP) – a medium-stay program for families (usually 5 days) experiencing complex parenting difficulties such as: dysfunctional sleep, feeding difficulties, weight faltering and often associated with a risk for impaired parenting.
 - Extended Parenting Education Program (EPEP). A long-stay program (usually 11 days) for families with highly complex needs, for example: parents with mental illness, disability or engagement with child protection services.
- There are a range of resources available for families being referred to the centre including access to Responsive Settling techniques for parents to gain skills for managing child sleep issues, e.g., Responsive Settling Video Series.
- Discharge planning endeavours to link families back into primary health care providers and local resources within their own community.
- See Ellen Barron Family Centre | www.health.qld.gov.au/ellenbarronfamilycentre/default.asp

Brief practice intervention

There are a range of situations where additional need may be identified in the birth-to-five-years age group. These are outlined below.

Premature infant 24,47,59,81,83,92,93,178

General information

- Annual premature birth rates specific to Queensland is approximately 8.6%.
- Additional considerations in premature babies beyond the initial neonatal period include:
 - Lowered resistance to infections.
 - Premature babies are generally discharged once oral feeding has been established, however some babies may be discharged earlier. These babies may be receiving compensatory feeds via an alternate method.
 - The longer the period of non-oral feeding the greater risk for feeding resistance, particularly if early feeding isn't aligned with the infant's reflexive behaviours.
 - Greater patience is required with feeding as they are often slower feeders and tire easily. Shorter, more frequent feeds may be needed until the baby gains weight and matures.
 - Suck-swallow-breath incoordination may occur when the infant is tired or not ready for feeding which may result in coughing, choking, apnoea and /or bradycardia.
- It is important to observe for infant feeding readiness e.g. mouthing, hand-to-mouth actions, sucking on the hand, wakeful.
- Observe the infant for signs of tiring during feeding e.g. behavioural state change, increase duration of sucking pauses, increased milk leakage, reduced tone.

Clinical practice points

- Breast feeding is especially important for premature infants in supporting gut development and reducing rates of infection.
- Education for parents should include:
 - Infant cues for readiness for feeding
 - Signs of tiring
 - The infant shouldn't be 'encouraged' to continue feeding if they have tired, rather given smaller, more frequent feeds
 - Good stabilising position to ensure comfort of infant and parent.
- Allowance for gestational age for growth and development is made for children born under 37 weeks and according to their gestational age at birth:
 - Infants born between 32 weeks and the 37th completed week should be corrected up until 12 months
 - Children born less than 32 completed weeks gestation should have their age corrected up until two years
 - Correction beyond two years may be required as directed by a tertiary specialist.
- A formula fed premature infant may be initially prescribed a formula specific for the additional nutritional needs of a premature infant.
- Premature infants are at greater risk of SIDS - health promotion strategies are important for parents.
- Premature infants may require supplementation e.g. iron and vitamin supplements
- The immunisation schedule aligns with the infants actual birth date. Additional vaccination may be prescribed depending on the degree of prematurity e.g. children born <28 weeks gestation.

Higher level services

- Case management strategies may include:
 - Additional breast feeding support may be required with supporting the mother and infant to transition to fully breast feeding.
 - For infants signalling feeding resistance e.g. turning the head away from the nipple, gagging:
 - Referral to allied health professional for specialist feeding support.
 - Parent can engage infant in pleasurable activities during play e.g. stroking the face from the cheeks to the lips, touching the lips, tongue
- Consider risk of impaired parenting:
 - Parents of premature infants may need to work through range of psychological tasks in relation to early birth and parenting experiences relating to prematurity e.g., initial separation of infant from parents, risk of infant loss, adaptation to the intensive care nursery environment, fear of bringing their infant into the home environment.
 - Observe parent-infant interaction and emotional health.
- Use EPDS / DASS / Attachment assessment tools
- Targeted parenting groups e.g. Post-natal wellbeing group, Circle of Security group.
- Targeted home visiting according to need/risk.

Referral options

- Specialist clinics/services e.g. feeding clinic, Early Parenting Service
- GP
- Early Intervention Clinician
- Speech / Occupational Therapist
- Ellen Barron Family Centre
- Specific support groups e.g. PIPA (Preterm Infants Parents Association – www.pipa.org.au)



Raising Children Network | <http://raisingchildren.net.au>

Cow's milk protein allergy (CMPA) ^{24,104,179}

General information

- CMPA is a common food allergy (approximately 2.5%), 50% of these infants grow out of this by three to four years of age.
- CMPA is diagnosed by: comprehensive history, careful physical examination and allergy testing e.g. stool analysis, serum IgE levels, skin prick, radioallergosorbent test (RAST)
- Over diagnosis may result in unnecessary impacts on quality of life for the parents and the child.
- Symptoms include:
 - Gastro-intestinal: Diarrhoea (may include mucous, blood), vomiting, abdominal pain,
 - Respiratory: Rhinitis, conjunctivitis, bronchitis
 - Skin: urticarial rash, atopic dermatitis, excessive crying, pallor from anaemia
- Confirmed CMPA is treated with diet (excluding cow's milk).
- 50% of children sensitive to cow's milk are also sensitive to soy.
- Goats milk is unsuitable for infants
- Use of probiotics in the prevention and treatment of CMPA is promising but more research is required.

Clinical practice points

- Additional parental support may be required due to the ongoing stressors of parenting an unsettled infant.
- Additional breast feeding support may be required with supporting the mother to continue to breast feed:
 - during the infant's unsettled periods prior to diagnosis
 - follow diagnosis with altering the Mother's diet to eliminate cow's milk.
- Education for parents should include:
 - Exclusive breastfeeding for the first 4-6 months minimises severe allergic reactions during early childhood
 - Elimination of cow's milk from maternal diet when breastfeeding
 - Reading food labels

- Use of prescribed formulas if not breast feeding e.g., hydrolysed (partially or fully depending on symptoms [100]) or amino acid-based formula
- Care of the infant's skin
- Gradual re-introduction of cow's milk protein may be re-introduced after approx. 12 months as advised by GP/Dietician.
- Cost factors are a consideration as a result of increased costs of medical appointments and formula costs if not breast feeding.

Higher level services

- Case management strategies may include:
 - Consider risk of impaired parenting
 - Parents may need to work through range of psychological tasks in relation to their parenting experience and expectations.
 - Use EPDS / DASS / Attachment Assessment Tools
 - Targeted parenting groups e.g., Post-natal wellbeing group, Circle of Security group.

Referral options

- GP
- Specialist Clinics / Services e.g., Allergy Clinic
- Dietician
- Early Intervention Clinician
- Ellen Barron Family Centre
- Specific support groups
 - ABA
 - Allergy & Anaphylaxis Australia, www.allergyfacts.org.au



Raising Children Network | <http://raisingchildren.net.au>



Refer to *Primary Clinical Care Manual*

Weight faltering / malnutrition ^{24,86,88,140,180,181}

General information

- Child health professionals refer to a medical officer when the child's weight for age decelerates over two percentile lines or falls below the 10th percentile for further investigation.
- Weight faltering describes a pattern of growth rather than a diagnosis and may include normal variations of growth.
- Malnutrition is diagnosed by a medical officer by looking at a number of criteria and occurs when a child is under nourished to the degree that it results in failed growth occurring due to inadequate caloric intake, inadequate absorption or excessive caloric expenditure.
- Out of infants diagnosed with acute malnutrition, 80% develop it by the age of 18 months.
- Catch up growth may take time e.g., 4-8 weeks of a successful intervention e.g., dietary changes.
- Prolonged, severe malnutrition can result in poor physical and cognitive development.

Clinical practice points

- Conduct a comprehensive family health assessment to identify specific needs of the individual child/ family, this should include:
 - Oral intake, what and how much, how often
 - Food preferences, texture preferences, swallowing, drooling, chewing issues
 - Cultural and social context of meal times
 - Impact of family budget on foods
 - Impact of rural environment on food choices
 - Sleep patterns (poor sleep can disturb metabolic processes and disrupt appetite control)
 - Activity assessment e.g. use of pacifier, feeding environment, play activities
 - Parental-child interaction particularly during feeding.
- Parental psycho-education in particular:
 - Demonstrate how their child is progressing on the percentile charts and explain the need for intervention.
 - Promote and support ongoing breast feeding – complete a breast feeding assessment to ensure child is being fed according to the child's feeding cues; assess breast milk supply; ensure families have information for after-hours breast feeding support services / help lines. see previous section
 - Talk about the importance of nutrition and promote oral intake of solids from around six months based on the Australian Dietary Guidelines. See previous section

Higher level services

Case management strategies may include:

- Work in partnership with other health care professionals (e.g. GP and dietician), to implement a feeding plan.
- Targeted home visiting according to need/risk.
- Consider risk of impaired parenting
- Many parents do not notice weight faltering/malnutrition due to its insidious and gradual presentation. Additional parental support may be required to work this through with parents. Observe parent-child interaction and emotional health
- Use EPDS / DASS / Attachment Assessment Tools
- Targeted parenting groups e.g. Post-natal wellbeing group, Circle of Security group.

Referral options

- GP
- Specialist clinics or services (e.g., Speech pathologist, feeding clinic, early parenting service)
- Dietician
- EIC/EIPS
- Ellen Barron Family Centre



Raising Children Network | <http://raisingchildren.net.au>

Eat for Health – Australian Dietary Guidelines | www.eatforhealth.gov.au

Obesity in childhood 4,84,87,140,141

General information

- Child health professionals refer to a medical officer when the child's weight for age accelerates over two percentile lines or is above the 95th / 97th percentile for further investigation.
- One of Australia's leading health concerns is the effects of overweight and obesity, with risks including type 2 diabetes, cardiovascular disease, mental illness and eating disorders.
- Other possible consequences of overweight and obesity for children's health and wellbeing may include:
 - Social discrimination and associated poor self-esteem, depression, teasing or bullying
 - Increased risk of developing negative body image and eating disorders.
- The causes of obesity are multidimensional e.g., inheritability, lifestyle factors (sedentary activities, screen time), early life experience (poor maternal nutrition), environmental factors (availability of cheap processed foods with high levels of saturated fats, salt, sugar).
- Evidence suggests that excess weight gain in infancy can predict later obesity.
- Exclusive breastfeeding for the first 6 months is known to reduce the risk of obesity.
- Weight maintenance during childhood growth will usually result in a gradual decline of the BMI.
- Aboriginal and Torres Strait Islander children are at greater risk of obesity and type 2 diabetes.
- Children are more at risk of becoming obese if their family is:
 - from the Pacific Islands, Middle East or Arabic regions
 - experiencing socio-economic disadvantage
 - living in rural and regional areas.

Clinical practice points

- Conduct a comprehensive family health assessment to identify specific needs of the individual child / family, this should include:
 - Dietary intake, what and how much
 - Cultural and social context of meal times
 - Impact of family budget on foods
 - Impact of rural environment on food choices

- Child sleep patterns (poor sleep can disturb metabolic processes and disrupt appetite control)
- Child activity assessment e.g. play time activities, screen time
- Parental- child interaction particularly during feeding.
- Parental education in particular:
 - Demonstrate how their child is progressing on the percentile charts and explain high rates of obesity in the Australian population.
 - Promote and support breast feeding and explain improved health outcomes including lessening the risk of obesity. Ensure families have information for after-hours breast feeding support services / help lines (see previous section).
 - Talk about the importance of nutrition and promote food intake based on the Australian Dietary Guidelines (see previous section)
 - Describe the concept of ‘often’ foods and ‘sometimes’ foods
 - Discourage habits such as: using foods for reward; giving foods as a form of comfort to a child.
 - Encourage drinking plain water rather than other sweetened drinks e.g. cordial, juices, soft drinks, sports drinks.
 - Promote an increase in physical activity and reduction in sedentary activities.
- Work in partnership with the family to develop an ongoing plan of care to promote responsive feeding practices and sustainable family lifestyle habits, i.e., child ideally seated with the family at meal times, in a comfortable and safe high chair / chair;
- Pleasant environment with few distractions e.g. no television
- Provide food that is developmentally suitable, nutritional, and fresh when possible
- Avoid foods with added salt and sugar, high in saturated fats.
- Promote child’s interest in food e.g. provide food predictably when child is hungry, cease feeding when child is showing signs of disinterest; avoid coercion or forcing of foods; provide appropriate variety and texture of foods; promote independent eating when developmentally appropriate
- Provide ongoing support and review of progress through follow up visits.
- Establish family routines around mealtimes e.g. hand washing before eating, modelling healthy meal time behaviours, making healthy choices for the entire family.
- Early weight management awareness gives children the opportunity learn positive lifestyle behaviours.

Higher level services

Case management strategies may include:

- Additional breast feeding support may be required
- Consider risk of impaired parenting
- Observe parent-child interaction and emotional health - EPDS / DASS / Attachment Assessment Tools
- Targeted parenting groups (e.g. Post-natal wellbeing group, Circle of Security group)

Referral options

- GP
- Ellen Barron Family Centre
- Specialist clinics or services (e.g. a feeding clinic)
- Early Intervention Clinician
- Dietician

Sleep dysrhythmia ^{24,59,182-185}

- Loss of sleep causes known temporary changes in behaviours and difficulties in cognition, with emerging evidence suggesting chronic sleep loss can result in neuronal damage and cognitive loss in children. When the child doesn't sleep well this increases risk of parenting exhaustion and fatigue which has its own consequences - impacting on parenting stress levels, optimal parenting behaviours and collectively the child-parent relationship.

Clinical practice points

- Conduct a comprehensive family health assessment to identify specific needs of the individual child / family, this should include:
 - Child's feeding history ie: child feeding and dietary intake, what, how, how much.
 - Assess growth to ensure there is not an underlying feeding issue
 - Cultural and social context of the family and sleep environment
 - Child sleep patterns, including activities and objects that may be associated with sleep
 - Child activity assessment e.g., play time activities, screen time
 - Parental- child interaction.
- Parental psycho-education, in particular:
 - Child tired signs and cues
 - Provide information about evidence based techniques that may enhance child settling and sleep e.g., Responsive Settling.
 - Provide information on strategies that may reduce parenting fatigue e.g., planning and prioritising child and self care; 'normal' for developmental sleep patterns, the importance of social supports, ways to maximise parental support and manage their workloads.
- Work in partnership with the family to develop an ongoing plan of care to promote child sleep suited to the individual child and family. This may include:
 - Establishing a family routine around sleep,
 - ensuring the child's needs for nutrition and hygiene have been met,
 - ensuring a safe sleep environment.
- Use EPDS / DASS / Attachment assessment tools
- Provide ongoing support and review of progress through follow up visits.

Higher level services

- Case management strategies may include:
 - Parenting support – in home e.g., brief intervention within the home to support sleep and settling and developing routines.
 - Consider risk of impaired parenting and observe parent-child interaction and emotional health.
 - Parents of children who have sleep dysrhythmia may need to work through range of psychological tasks in relation to their parenting experiences when they are likely to be sleep deprived themselves e.g. parental expectations and perceptions vs reality of parenting

Referral options

- Ellen Barron Family Centre (www.health.qld.gov.au/ellenbarronfamilycentre)



Raising Children Network | <http://raisingchildren.net.au>

Ellen Barron Family Centre | www.health.qld.gov.au/ellenbarronfamilycentre

Post natal depression (PND) ^{11,51, 186}

General information

- Postnatal depression is a common disorder with approximately 16% of women experiencing PND within the first 3 months after birth. For those women with a past history of PND, 20-40% will have a relapse in subsequent perinatal periods.
- PND is known to have impact on the woman, child and significant others, including a greater risk of:
 - Parenting difficulties
 - Relationship difficulties
 - Loss of social networks and greater risk of social isolation
 - Breastfeeding difficulties
 - Poor child growth and developmental delay
 - Child mental health issues such as insecure attachment
 - deprivation of the needs being met of other children in the family.

Clinical practice points

- Conduct a comprehensive family health assessment to identify specific needs of the individual child / family.
- Administer EPDS / DASS / Attachment assessment tools following an informed consent process. See appendix 5 and 6.
- For women with:
 - a high EPDS score (over 13 may indicate major depression) ensure timely access to mental health assessment and management;
 - A score of 1, 2 or 3 to Question 10 on the EPDS assess their current safety plan and according to clinical judgement seek immediate advice and mental health assessment;



A 'Report of Suspected Child in Need of Protection' may be required. See section

- Assess the health of other parent / care givers for the child/other children when possible
- Gain a full understanding of the situation including availability of extended family supports
- Full examination should include observation for non-accidental injury e.g. bruises, petechiae due to the high rate of parental stress.
- Puerperal psychoses whilst uncommon usually occurs within 2-3 weeks of birth. Families suffering complex perinatal mental health issues commonly have associated histories of childhood abuse, alcohol / substance abuse and / or domestic violence.
- Maintain a therapeutic relationship by:
 - Encourage expression of feelings
 - Effective listening
 - Maintaining a non-judgemental, family-centred approach.
- Self-care promotion

Clinical practice points

- Information about perinatal mental health:
 - Beyond Blue has a range of resources for families including information specific to Aboriginal and Torres Strait Islander families, multicultural people (information translated to other languages), lesbian, gay bisexual and transgender (LGBTI) parents.
- Additional parental support may be required. This may include:
 - Targeted parenting groups e.g. Post-natal wellbeing group, Circle of Security group.
 - a safety plan. See page 175.
 - Additional breast feeding support may be required with supporting the Mother to continue to breast feed. Consideration should be given to medications and breastfeeding.
- Provide ongoing support and review of progress through follow-up visits.

Higher level services

- Case management strategies may include:
 - Targeted home visiting according to need/risk
 - Early Intervention Clinician / Parenting Specialist
 - Targeted parenting groups e.g. postnatal depression support groups
 - Consider risk of impaired parenting

Referral options

- GP
- Acute mental health facility
- Infant mental health worker
- Drug and alcohol support services
- EBFC – (for parenting support)



Beyond Blue | www.beyondblue.org.au *Including free online training available for health professionals

Raising Children Network | <http://raisingchildren.net.au>



Child Safety | <http://qheps.health.qld.gov.au/csu/Home.htm>



Refer to *Chronic Conditions Manual*

Disruptive behaviour / aggression / regulatory disorders ^{24, 116}

General information

- During the preschool years, most children learn how to demonstrate their sense of autonomy in a socially acceptable manner. Tantrums that are common in the 2 – 3 years slowly lessen with children being more able to communicate their concerns and needs to their care givers.
- Some children however will display ongoing disruptive behaviours, aggression and regulatory disorders. Parents may be raise concerns such as their child being:
 - Overly sensitive, fearful, anxious
 - Intolerant to change
 - Slow to engage or react
 - Difficult to control with prolonged tantrums and aggressive outbursts
 - Poor impulse control and overactivity
 - Commonly these issues are associated with poor feeding, sleeping behaviours.

Clinical practice points

- Conduct a comprehensive family health assessment to identify specific needs of the individual child / family, this should include:
 - Child's feeding and sleeping history
 - Assess growth and development to ensure there is not an underlying medical issue
 - Cultural and social context of the family environment
 - Child activity assessment e.g., play time activities, screen time
 - Type of behaviours and circumstances around the behaviours
 - Parental- child interaction.
- Explore parental responses to the child's behaviours.
- Parental psycho-education, in particular:
 - Discuss developmentally appropriate behaviours and normal attachment
 - Discuss the tendency of boys to have more aggressive behaviours than girls.
 - Provide information during the appointment about parenting techniques that may enhance child behaviours and provide information and resources e.g., parenting tip sheets on discipline, tantrums.
 - Promote parental reflection on their current strategies and how they may be able to alter their own behaviours / reactions and try different parenting strategies.
 - Provide information on strategies that may reduce parenting fatigue e.g., ways to maximise parental support and manage the additional needs of the child.
- Work in partnership with the family to develop an ongoing plan of care to promote positive childhood behaviours. This may include: Establishing a family routine around sleep, mealtimes, hygiene needs, exercise and playing, using reward charts for positive behaviours.
- Encourage parents to enrol in a group parenting program e.g., Triple P.
- Use DASS / Parenting Attachment Assessment Tools
- Provide ongoing support and review of progress through follow up visits.

Higher level services

- Case management strategies may include:
 - Targeted parenting groups e.g., Triple P Parenting Program
 - Early Intervention Clinician / Parenting Specialist
 - Consider risk of impaired parenting

Referral options

- GP/MO
- Infant – mental health worker
- Ellen Barrom Family Centre (for parenting support with children up to three). See page 158.



Raising Children Network | <http://raisingchildren.net.au>

Parental grief and loss ^{24,59,73,144,187}

General information

- Supporting parents through grief and loss of varying degrees is an important aspect of the child health professional's role.
- In Queensland, the infant mortality rate (ie: death rates in the first year of life) is 5.4 infant deaths to every 1000 births. The overall infant mortality rate in Australia is 4.1:1000 .
- Around 7% of Australian children aged 0-14 have a level of disability.

Clinical practice points

- When facing unexpected events, parents generally want:
 - a clear simple explanation regarding
 - the diagnosis
 - what the future may look like for the child
 - advice on what to do now
 - advice on what to do next
 - a warm, sympathetic listener
 - time to ask questions at the time and as they come to terms with the situation.
- Use a strengths-based approach, for example:
 - Presenting the child's appealing features and potential for development
 - Available options / rehabilitative treatment
 - Ask parents to identify their own strengths and abilities in coping with difficult situations
 - Provide written information about support networks and agencies specific to the condition.

- Parents of a special needs child may need to work through range of psychological tasks in relation to:
 - hospitalisation of their child, adaptation to the health care environment, fear of bringing their child into the home environment, and fear of their child dying.
 - Grief and loss feelings around expectations of having a 'normal' child
 - Possible preparation for child loss when prognosis is poor.
 - Observe parent-child interaction and emotional health
- Provide ongoing support and review of progress through follow up visits.

Higher level services

- Case management strategies may include:
 - Targeted home visiting according to need/risk .
 - EIC / EIPS

Referral options

- GP
- Specialty agencies specific to special need, such as:
 - Down Syndrome Association of Queensland, www.dsaq.org.au/information-about-down-syndrome.htm
 - SANDS Queensland (miscarriage, stillbirth and newborn death support), www.sandsqld.com
 - Cleftpals Queensland, www.cleftpalsqld.org.au



Queensland Government Department of Communities, Child Safety and Disability Services
www.communities.qld.gov.au/disability/support-and-services

SANDS Queensland | www.sandsqld.com

Cleftpals Queensland | www.cleftpalsqld.org.au

Protecting children

The role of child health professionals encompasses a range of broad multifaceted practice strategies from health education and promotion, growth and development monitoring, early intervention for health issues through to complex assessment of the safety of a child¹⁸⁸. The Child Safety QHEPS site provides information for Queensland Health staff, Child Protection Liaison Officers (CPLO) and Child Protection Advisors (CPA) provide support to local HHS staff when managing child protection issues. While recognising and responding to child abuse and neglect remains a focus for all health workers, it is a mandated process for nurses, midwives and medical officers.

All health professionals have a responsibility in recognising, reporting and responding to child abuse and neglect (children that have suffered, may be suffering, or at risk of suffering significant harm). Department of Health guidelines clearly articulate these responsibilities, including:

- Health Professional Child Safety Capability Requirements
- Reporting and responding to a reasonable suspicion of child abuse and neglect
- Responding to an unborn child health risk alert
- Information sharing in child protection

Initial orientation to local child protection processes and key contacts should be part of the onboarding of all

child health staff along with annual updates.

The following are some factors in the first year of life that may increase the risk of child abuse or neglect:

Child factors	Family characteristics
<ul style="list-style-type: none"> ■ Intrauterine exposure to toxins ■ Prematurity ■ Low Birth Weight ■ Feeding difficulties ■ Sleep difficulties ■ Developmental delay ■ Difficult temperament ■ Disruptive behaviour ■ Insecure attachment 	<ul style="list-style-type: none"> ■ First time parent ■ Maternal / Paternal depression ■ Maternal / Paternal mental illness ■ Maternal / Paternal criminality ■ Isolated, single parent ■ Isolated, disadvantaged parents ■ Interparental conflict ■ Financial stress ■ Coercive family practices / domestic violence ■ Alcohol consumption particularly in single parent households ■ Substance abuse ■ Poor parental role modelling including past abuse as a child

24, 171, 189

- Clinical findings that may indicate harm may include:
 - Any injury noted on an infant who is not yet mobile
 - Bruises on any part of a baby
 - Pinch marks
 - Human bite marks
 - Burns (e.g. cigarette burns, scalds on feet and buttocks from immersion in hot water)
 - Fractures of any type
 - Behavioural factors e.g. unsettled baby, altered attachment ¹⁸⁹.
- These findings should be viewed with suspicion and a report completed, notify your CPLO/ Child Protection Advisor and arrange for a medical assessment to be conducted.

- **Shaken baby syndrome** occurs most commonly in infants under 12 months correlating with the normal peaks of infant crying¹⁰⁷. Aboriginal and Torres Strait Islander infants are at greater risk¹⁰⁷. It is likely that many cases are not reported or identified. Abusive head trauma (inclusive of shaken baby syndrome) is the most common cause of infant morbidity and mortality in physically abused infants with 20% of these infants dying as a direct result of injuries sustained during such an incident. Those that survive often suffer enduring cognitive limitations¹⁰⁷.
- **Factitious disorder imposed on another** (previously known as factitious disorder by proxy / Münchausen syndrome by proxy) is a rare form of child abuse whereby:
 - a caregiver (most commonly the child's mother)
 - fabricates history (commonly allergy, fever, asthma, seizures),
 - exaggerates the child's behaviours, and/or
 - induces signs of illness (e.g., use of laxatives, starving)
 - to the extent that unnecessary medical procedures and treatments are implemented. The child may have a past or current medical condition.
- Considering the following factors may assist the child health professional during comprehensive assessment:
 1. Does the caregiver have a diagnosis of mental illness (50% of perpetrators have a factitious disorder themselves and 75% have a co-existing personality disorder)
 2. Does the child health professional's physical examination and observations match the caregiver's concerns?
 3. Do other family members confirm reported history?
 4. Is there diagnostic evidence?
 5. Have treatments been commenced due to caregiver's insistence?^{24, 190}
- There are numerous factors to consider when determining a suspicion of child abuse or neglect. At times, a single factor e.g., cigarette burn mark, may clearly indicate the need for a 'Report of Suspected Child in Need of Protection'. At other times a broader view of the circumstances may be needed. Working within a risk and protective factor framework may assist the clinician in making this judgement. Within this framework, risk factors are those that have the potential to increase the risk of harm and protective factors are those that have the potential to provide additional safety for the child or lessen the risk¹⁸⁹.

Sample framework of protective and risk factors

0-12 mths	Protective factors	Risk factors
Infant/child factors	<ul style="list-style-type: none"> ■ Settled infant/child ■ Sleep patterns developmentally appropriate ■ Feeding well for age ■ Easy to soothe ■ Calm temperament ■ Positive and warm child-parent interaction 	<ul style="list-style-type: none"> ■ Unsettled infant/child ■ Poor infant/child sleep, e.g. short sleeps, frequent waking in the night ■ Feeding difficulties ■ Difficult to soothe ■ Congenital abnormalities, disability ■ Altered child-parent interaction e.g. exaggerated separation anxiety ■ Lacks interest in playing and interacting with others ■ Not sharing enjoyment with others using eye contact or facial expression
Family factors	<ul style="list-style-type: none"> ■ Good physical and emotional health of parents ■ Positive and warm parent-child interaction ■ Positive parent-child attachment ■ Harmonious parental relationships ■ Stable family structure ■ Past positive family attachments 	<ul style="list-style-type: none"> ■ Parental mental illness, depression, anxiety ■ Parental chronic illness ■ Parental substance abuse ■ Poor parent-child interaction e.g. limited responses to the child's cues ■ Altered parent-child attachment ■ Parental conflict ■ Parental history of poor impulse control ■ At risk family structure e.g. single parent, recent separation of parents ■ Past history of altered attachment
Social / environmental factors	<ul style="list-style-type: none"> ■ Financially stable ■ Consistent parental employment ■ Stable housing ■ Supportive family and friends who serve as positive role models and/or mentors 	<ul style="list-style-type: none"> ■ Financially stressed / poverty ■ Unemployment, intergenerational family unemployment. ■ Poor housing / unstable housing / overcrowded living circumstances / violent neighbourhood ■ Isolated / estranged from family and friends ■ History of abuse as a child, abusive relationships, intergenerational family violence

- To fulfil their responsibilities as mandatory reporters, doctors and registered nurses are required to immediately report to Department of Communities, Child Safety and Disability Services of a reasonable suspicion that a child has suffered, is suffering or is at risk of suffering significant harm caused by physical and sexual abuse and may not have a parent able and willing to protect them from harm. This does not preclude reporting of significant harm caused by emotional/psychological abuse and neglect.
- Any other health professionals have a duty of care to report a reasonable suspicion of child abuse and neglect which meets the same threshold.
- Child health professionals need to be aware that their report provides a snapshot of circumstances from their own professional perspective, at the time of the report. Circumstances may change quickly, e.g. when their report is added to other information held in relation to the family such as Police reports,



Practice tips: Developing a safety plan

191

- Developing the plan requires careful consideration and is built on the child and parent's needs, capacity and expressed concerns.
- Encouraging parent/s to reflect on strategies that have worked for them in stressful circumstances in the past may guide them in identifying their strengths and useful strategies for the future.
- If the child health professional doesn't agree that the parent's strategies align with ensuring safety of the child, the child health professional will work in partnership with the parent, using an open and transparent process to challenge these strategies and develop appropriate ones.
- Family members (or what the parent considers to be family) often form a key resource for providing child safety. Explore these resources with the Mother / Father and encourage the parent to assume an active role within the plan.
- Address the specific concerns / risks around child safety and individual trigger points using the words of the parent.
 - For example: Risk and trigger identified from parent saying: "I get so frustrated and can't think what to do when the baby is crying constantly."
 - In this example the **risk** is: I get so frustrated and can't think what to do; and the **trigger** is: when the baby is crying constantly.
 - These words can be used to formulate a strategy within the plan, such as:
I am more likely to get frustrated when the baby is crying constantly
 - *Strategies that I can put into place to reduce this occurring may include – taking the baby for a walk in the pram*
 - *When I feel frustrated and can't think, I will:*
 - › *place the baby safely in the cot,*
 - › *put the cot side up*
 - › *ring Tracey for support on _____*
 - › *If Tracey doesn't answer I will ring the Parent Hotline on 1300 30 1300*
- Include external agencies that are available for 24 hour support e.g. Lifeline, Parentline, 13Health.
- When reviewing the plan with families reflect on how they have used the plan and congratulate them for using strategies and for successes in managing difficult situations and accessing support. This will build parental empowerment and self-efficacy.
- See sample safety plan in resource section.

Section 3

Five to twelve years



The ‘middle’ childhood years are characterised by more gradual physical growth and social and emotional development ²⁴. This age range begins with most children experiencing the entrance to a school environment which has a significant impact on individuals and ends with preadolescence; so whilst growth and development progress at a steadier pace, this age stage remains a significant time in a person’s life ²⁴.



Please note: Some children in this stage of the continuum may also experience issues discussed in the Twelve to Eighteen Years section of this manual.

Developmental surveillance and health monitoring

Developmental surveillance, health monitoring and assessment aims to ensure early and accurate identification of children who have health issues and/or developmental delays, and facilitate access to early intervention services.

This section includes:

- the context of healthcare,
- child health surveillance and monitoring
- common health concerns including:
 - speech and communication concerns
 - daytime and bed wetting
 - soiling and constipation
 - Pediculus Capitis (head lice).

The healthcare context

- In Queensland during this age stage, universal child and family health services are commonly focused more on parenting support and skill development through group parenting programs; provision of additional services is available to those families at risk or in greater need, such as Aboriginal and Torres Strait Islander families ^{4,59}.
- Consultations with child health professionals may be in a number of settings, such as: community-based clinics, community locations, family homes, early childhood settings, schools and by a variety of modes e.g., face to face, phone, group work according to local HHS guidelines ^{1,59}.
- In Queensland, school health nursing has been identified as an important innovation in public health nursing, particularly in rural and remote areas; however, the context of health care for children in their primary school years has changed over time¹⁹². A shortage of funding particularly in recent times with global economic constraints has meant many school nursing services have been cutback to align with service redesign¹⁹³.
- School nursing has been impeded by other barriers also, such as, limited knowledge of the function of the school nurse, lack of standardised position descriptions, unmanageable nurse-to-student ratios and limited research¹⁹³.
- In some settings in Queensland, Child Health Nurses continue to provide a service to primary schools where an arrangement is agreed between the local school and HHS. At a health service level, schools offer an efficient point to access a large proportion of the younger age group and established links between health and educational departments fosters opportunities around service delivery in the school setting¹⁹². Many services in this age group are on an ad-hoc basis, commonly at a targeted service level.

- Child health services may also be provided at a targeted level by early intervention parenting specialists/early intervention clinicians/child health psychologists/social workers. These services aim to enhance parents' skills to meet the needs of the children and support parents in dealing effectively with family challenges.
- Working within a school setting may allow the child health professional to build capacity in the setting and thus support health. The Health Promoting Schools (HPS) Framework adapted from the NHMRC (1996) is an approach designed to incorporate a holistic way of working and is underpinned by principles encompassing individual physical, mental, social, emotional and spiritual wellbeing and broader wellbeing for the community. Outcomes have demonstrated improved resilience in children ¹⁹⁰. For more information about the HPS, see page 236.



Practice tips: Working within school settings

- Staff working in school settings work in partnership with DETE, parochial and independent schools.
- It is important to follow agreed protocols for entry to the school, including workplace health and safety considerations, for example: always sign in and out of the visitors book when attending the school.
- Once an agreement has been reached between a HHS and a local school to provide services within a school setting, follow-up arrangements may need to be negotiated. For example:
 - Advise school children, parents and school staff of the services available to school-aged children. A proforma article may be written for insertion into the school newsletter, with details of the screening program/s, role of the child health professional, screening date/s and contact details.
 - Book facilities required for screening activities/appointments e.g., a suitable room.
 - Ensure valid written parental/caregiver consent is obtained prior to the commencement of any screening/appointment at the school.
 - Develop appropriate links with other health care providers (e.g. the School Based Oral Health team).



Department of Education, Training and Employment (DETE) staff are primarily responsible for the administration of first aid services on the school campus. If the health care professional is the first on an accident scene, a duty of care exists to provide first aid intervention to prevent further injury or death (providing this is administered in accordance with HHS policy and within the nurse's scope of practice). The health care professional should notify their line manager of any incident and follow processes in accordance with local HHS policy, e.g., obtaining a copy of any records of the incident referring to the actions of the child health professional or completing an incident report.

Well child health checks

- In rural and remote areas as part of the ‘Chronic Disease Guidelines’ population screening through health checks are offered to all children when they present at a primary health care centre. These health checks form the early detection component of the chronic disease strategy to identify risk factors and early markers which lead to the development of chronic diseases¹⁴¹.
- The final recommended well child health check is the 4 – 5 year check. This check is often undertaken by a GP/MO under the expanded Medicare ‘Healthy Kids Check’ in association with immunisation.
- Child Health Nurses and Aboriginal and Torres Strait Islander Health Practitioners may also conduct this assessment. An Aboriginal and Torres Strait Islander Child Health Worker may conduct this assessment under the delegation of an RN/MO⁶⁰.



Queensland Health | www.health.gov.au

Expanded Medicare Healthy Kids Check. Resources: Healthy Kids Check checklist and fact sheet



Chronic Conditions Manual

Child health assessment

Physical assessment

- A physical assessment is conducted and combined with history taking and interviewing to enable the health professional to develop a holistic view of the individual health status of a child.



Primary Clinical Care Manual

Topics: Patient presentation and assessment – adult/ child, DRS ABCD resuscitation.

Accuracy is crucial in obtaining all physical measurements. There are three components of accurate measuring:

- technique that is standardised
- equipment that is calibrated and accurate
- measurers that are trained so they are accurate and reliable.

In addition:

- ensure scales and stadiometers are regularly calibrated to manufacturer’s instructions and checked each day of use
- use the same scales whenever possible
- follow manufacturer’s instructions on transportation of portable scales.



See practice tips, page 45

- Growth during childhood is an important indicator of nutritional and health status and remains the best method of assessment at the primary care level⁸¹. Weight gain and increase in the size of the child occurs as body systems mature. During this age range, the average growth for children is approximately 5 cm/year with a weight increase of approximately 2 – 3 kg/year²⁴.
- Factors that influence a child’s growth can include gender, genetics, health, environmental facts, e.g., nutrition⁵⁸. Towards the end of this age range the rapid growth in height and weight, especially for girls signals prepubescence. The development of secondary sexual characteristics often creates concerns for children in this age group²⁴. Puberty represents a key developmental milestone that is ideally addressed within the school curriculum, health care professionals may partner with schools to address this topic through the HPS.

- Physical growth is best assessed by measuring weight, height and BMI and comparing these measures with a growth reference ⁵⁸. The CDC growth charts are used for this age range. Always ensure the correct chart is being used, e.g., gender.
- **Referral:** When concerns are raised referral to GP / Medical Officer is recommended for further assessment, i.e. measurements have crossed two percentile lines or if measurements are above the 90th percentile or below the 10th percentile ⁸⁶⁻⁸⁸.



Centre for Disease and Prevention | www.cdc.gov
Growth charts www.cdc.gov/growthcharts and www.cdc.gov/growthcharts/who_charts.htm

The Royal Children's Hospital, Melbourne | www.rch.org.au
www.rch.org.au/childgrowth/about_child_growth/Top_10_things_you_need_to_know_about_growth_charts/



Queensland Health Guideline: Assessment of infant/child nutrition, growth and development within the primary health care setting | http://qheps.health.qld.gov.au/patientflow/docs/scycn_nutrit_guide.pdf

- Ensure that universal and any additional hearing screens have been completed and enquire if any follow up appointments are required ¹⁰.
- Vision screening in children is recommended (Non-vision health professionals should be trained to complete visual screening) at 5 years to detect visual problems early and intervene to improve overall eyesight. Other screening may be indicated to detect common visual disorders in children, such as:
 - Amblyopia or 'lazy' eye (1.4 – 3.6%)
 - Strabismus or 'cross-eyed' (0.3 – 7.3%)
 - Refractive error – short or far sightedness or astigmatism (1 – 14.7%) ¹¹².
- Referral to a Optometrist /GP/MO is recommended if any concerns are identified ¹¹².



Practice tips: Visual acuity screening (5 to 12 years)

- Full size charts should be at a distance of six meters
- Tools that may be used for vision testing include:
 - Linear STYCAR 5 letter chart with key-card for Preparatory Year students
 - Linear STYCAR 7 letter chart with/without key-card for Year One students
 - Snellen Chart for older children.
- For young children do not test single letters on a bland background because you may miss some amblyopes. Instead test single letters in a line of letters or single letters with confusion bars. The crowding phenomenon (caused by the so-called abnormal contour interaction of amblyopic eyes) refers to the behaviour of amblyopic eyes – they will easily distinguish a single letter on a bland background but the true acuity of the eye is discovered when the child tries to read a single letter in a line of letters or a single letter surrounded by confusion bars
- Children do not have to be literate to have their vision assessed with Linear Stycar 5 vision chart and keycard. Reassure parents that this is a 'matching game' and not unlike asking a child to match a square or circle when asked.
- Explain the procedure accurately and at an appropriate level for the individual child, e.g., at close distance, ask the child to point to the same 'shape' on their keycard that the



Practice tips: Visual acuity screening (5 to 12 years)

assessor is pointing to on their card. When the child is able to match a number of 'shapes' correctly then the assessor can commence assessment at the six metre distance.

- Establish a routine of testing the right eye first as the results of the right eye are usually recorded first.
- Use a cover such as an eye patch to occlude the eye not being tested.
- Point clearly to letters being tested, (e.g., use a red coloured pencil/pen or pointer). Make sure not to obliterate any part of a letter. If the child is uncertain as to which letter requires a response, circle the letter with the pointer.
- When using the Linear STYCAR chart begin testing above the 6/9 (normal vision) line of the chart (e.g., start at 6/36) and quickly move down the chart. It is not necessary for them to read the whole chart but the whole of the lowest line reached must be tested. Do not jump along a line being tested, but proceed along the line either forwards or backwards. Allow the child adequate time to respond. Allow two attempts at any one failure.
- Observe the child's behaviour during testing (e.g. holding head forward, frowning, blinking, and turning head to side and/or attempting to look over occlusive eye cover). This may indicate that they are experiencing difficulty reading the letters on the chart. If the child actively resists the covering of one eye, the uncovered eye may have a vision defect. In such cases, cover the other eye first and repeat procedure.
- At no time is a child to be forced to cooperate.
- Document which eye chart has been used and the reading using a fraction format.
- The first figure (numerator) being the distance and the second figure (denominator) being the lowest line read successfully
 - Normal visual acuity is considered 6/6.
 - Acceptable visual acuity for the 4-6 year old child is 6/9.
- Use cleaning and infection control measures for equipment, e.g., eye patches/glasses, between children.
- **Referral:** Refer any abnormalities detected according to local HHS protocols. e.g. to Optometrist/GP/Medical Officer, this will include:
 - less than acceptable visual acuity for age i.e. visual acuity of 6/12 or worse in either eye
 - unequal visual acuity is outside normal parameters if there is a difference of one line or more between the eyes
 - Use clinical judgement regarding the above referral parameters if any concerns, e.g., if the child is tested late in the day and there are concerns regarding his/her ability to concentrate effectively, repeat the vision screening test in the morning to see if a different result is obtained prior to referral.

**Practice tips: Ears and hearing screen: 5 to 12 years**

- A Registered Nurse or an appropriately trained Health Worker/Practitioner may undertake an ear and hearing health screen ¹⁴¹.
- Do not proceed with ear health and hearing screening if there is ear pain, notable discharge or the skin is broken or inflamed. These children are referred to MO/GP/Nurse Practitioner or managed in accordance with the *Primary Clinical Care Manual*.
- Ask the parent/carer how their child is going at school and who has referred them for assessment to gain any additional context behind their visit.
- Ask the child/parent/carer if they have any concerns about the child's hearing, ear health, speech and language development and developmental progress using the questions outlined below. It may be appropriate to ask these verbally or incorporate these questions into the written history/consent form.

Ear and hearing health screening recommendations (5 – 12 years) ¹⁴¹

Age	Questions to ask	Procedure
5 years 12 years	<ul style="list-style-type: none"> ■ Has your child been free of ear infections or discharge? ■ Are you happy about your child's ears and hearing? ■ Are you happy with your child's speech and language development? 	<ul style="list-style-type: none"> ■ Otoscopy ■ Tympanometry ■ Audiometry
6 – 11 years	<ul style="list-style-type: none"> ■ Aboriginal and Torres Strait Islander descent? ■ Family history of genetic hearing loss? ■ Speaks in a loud or monotone voice? ■ Does not respond to name? ■ Watches others continuously? ■ Asks for statements to be repeated? ■ Withdraws in a group? ■ Has disruptive and impulsive behaviour? ■ Teacher reports hearing difficulty? ■ Parent/carer reports hearing difficulty? 	<p>If 'YES' to any of these questions, perform:</p> <ul style="list-style-type: none"> ■ Otoscopy ■ Tympanometry ■ Audiometry



Refer to page 85 for practice tips on otoscopy, tympanometry, audiometry and referral.



Refer to *Chronic Conditions Manual*

Developmental assessment

- Development refers to the increased ability of the body to function within the environment and can be categorised into a number of domains, for example:
 - Physical development – gross motor and fine motor skills
 - Socio-emotional and cognitive development
 - Language and literacy ¹.
- The child’s development is significantly affected by the family environment, with the parent/carer-child attachment relationship being a pivotal factor influencing child development ¹⁹⁵.
- Developmental assessment of any child must have a holistic focus. This means that the domains of development are considered in an ecological framework that considers the physical, social, emotional and environmental factors involved ⁸⁹ and informs the development of a care plan linked to the child’s needs and specific risk factors ¹¹³.
- Whilst development proceeds at different rates in different individuals, most children reach sub-stages of their developmental growth in a similar order ¹¹³. A child may be considered to have a developmental delay when they have not met a particular milestone by a particular time [110]. When there is delay across many areas of development at a health check they are considered to have global developmental delay ¹¹⁴. These symptoms may be related to underlying health issues and the child health professional will refer the child for further assessment to a MO/GP.
- Developmental surveillance is designed to detect early delay and risk factors for child developmental delay, to enable the implementation of early intervention strategies. Concerns raised by parents, teachers and other school staff, once the child is integrated into the school setting will also impact on developmental surveillance ¹⁹⁶.
- The 5 – 12 year age range encompasses significant psycho-social developmental phases which impact on development, including:
 - **Cognitive development.** A key change occurs as children move from an egocentric view to being able to view things more broadly and consider things from another’s perspective. This impacts on the development of relationships and a child’s understanding of such relationships. As cognitive development progresses, perceptual thinking (based on what can be seen) and conceptual thinking (unseen factors) combine to enable the child to make judgements based on their own reasoning. The child learns to incorporate their previous experiences, observations and memories into anticipation and how they experience and understand current situations ²⁴.
 - **Moral development.** As a child’s brain develops the ability to incorporate conceptual thinking and logic, enables the child to consider moral standards around them, such as learning what is acceptable in the family and in the classroom. A child learns to act according to these standards and develops feelings relating to their own behaviour. These behaviours can be guided by others by positive reinforcement and children develop feelings such as guilt when behaviours do not meet with expected standards. For younger children they usually judge using ‘right’ and ‘wrong’ but as further moral development occurs, the older child incorporates a broader context of the situation ²⁴.
 - **Spiritual development.** School aged children begin to consider what is natural and supernatural and are fascinated with learning about spirituality and religious views of their family. Children develop a sense of conscience and are guided by family ideals and beliefs more so than those of their peers at this stage. Children may expect punishment for misbehaviours and find comfort in religious rituals depending on their spiritual beliefs ²⁴.
 - **Social development.** Fitting in within a peer group becomes increasingly important as a child develops during the school years. As a child develops individuality and begins to gain independence from their parents/carers, they experience dealing with leadership, dominance, authority, etc. and experiment with relationship development within their peer group. Sex roles between boys and girls seem insignificant early on, but in the later school years differences become more apparent. The peer group becomes an increasing influence, however, parents/carers remain

significant in their child's life in supporting and shaping their personalities, setting standards for behaviour and establishing value systems for the child ²⁴.

- **Developing a self-concept.** As children grow and mature, a conscious awareness of themselves forms, e.g., their physical appearance, abilities, own values. Self-concept encompasses a child's body image, sexuality and self-esteem and is influenced by their family, peers and important others during this stage. Many children in this age group become highly sensitive about their appearance and any physical deviations from the 'norm'. Negative feelings may lead to self-doubt and positive feelings develop self-respect and self-confidence ²⁴.

Screening tools

There are a number of validated tools available for health care professionals to complete a developmental assessment during this age range. Health care professionals should check which developmental assessment tools are recommended to be used in their particular setting and be trained to administer and interpret the outcomes of the tools correctly. Commonly, screening tools include ¹:

- **Parents Evaluation of Developmental Status (PEDS)**

www.pedstest.com/Home.aspx

Age: 0– 8 years

When it is used:

Detecting developmental and behavioural issues needing further evaluation

May be useful as a surveillance tool ¹⁹⁶.

Completed by: Parents and incorporated into a child health monitoring program.

Additional resource: www.rch.org.au/ccch/resources_and_publications/Monitoring_Child_Development/

- **Brigance Screens** (Brigance Early Childhood Screen II)

www.casamples.com/downloads/11968s.pdf

Age: 0– 7 years

When it is used: Screening tool consisting of nine forms, screens articulation, language, fine and gross motor, personal skills and general knowledge ¹⁹⁶.

Completed by: Trained health care professionals use as a secondary screening tool when indicated.

- Referral: When concerns are raised following a thorough child health assessment a referral to the families' GP / Medical Officer is recommended for further assessment ⁸⁹.



Refer to page 51 for practice tips on developmental assessment.

Common health concerns

Child health professionals are frequently asked for information on a broad range of topics. The following common health concerns will be covered in this section:

- speech and communication concerns,
- daytime and bed wetting
- Soiling and constipation
- Pediculus capitis (head lice).

(Other common concerns for this age stage, for example, 'picky / fussy' eaters, may be covered in other areas of this manual, e.g., fussy eating is incorporated under developing healthy eating in the health promotion section.)

The following tables outline information, parenting tips, cautions, referral recommendations and further resources specific to these topics.

Speech and communication concerns 24,88 196

- Most fundamental speech and language skills are achieved by the time a child is four years old.
- Speech sound disorders can impact on a child's ability to interact socially with those around them and engage fully in education, which may reduce a child's overall quality of life.
- Children with identified mild to severe speech sound disorders have reduced risk of educational and social impacts when early intervention is implemented by a speech-language pathologist.
- The early years are a crucial time for identifying disorders and implementing early intervention.

Parenting tips / Skills to support child development

- Stuttering, stammering and various speech dysfluencies relating to sensorimotor integration where the child is thinking quicker than the word is formed by the body, are common up to approximately five years.
- Encourage the child to relax and speak slowly.
- Take the time to listen attentively to the child.
- Share interest in reading together by discussing what the child is reading; use the local library to borrow books and attend activities promoting healthy reading habits.
- Encourage the child to ask questions, reflect and explore ideas through chatting together.
- Encourage parents to meet with their child's teacher informally and discuss expectations, goals and individual needs of the child.
- Encourage parents to meet with their child's teacher when there appears to be problems.
- When the child is completing homework, provide an area that is well lit and promotes concentration, i.e., is free from interruption or distractions.
- An educational app, developed by the DETE, is available as a free download. 'SPEAK' (Speaking Promotes Education And Knowledge) oral language app, is designed for children from birth to six years. Download from <http://deta.qld.gov.au/about/app/index.html>

Cautions and things to avoid

- Avoid finishing words/sentences for children.
- Avoid pressuring a child to produce a particular sound.
- Do not criticise the child for speaking differently.
- Limit screentime.

Referral

- Children with speech and language difficulties should be referred to GP/MO/Speech Therapist for review. For example, children who are having difficulties:
 - Expressing themselves to their parent, e.g., telling them what is wrong
 - Answering simple questions within a conversation
 - Following directions with a number of steps
 - Being understood when speaking
- The "Red Flag" Early Intervention Referral Guide for children 0-5 years can be used as a guide ⁸⁷

Bedwetting / daytime wetting ^{24,120,137-139,196,197}

- Night time dryness will not be available until the child's sleep cycle matures and many children continue to be 'wet' at night.
- Approximately 1 in 5 children experience wet beds at 5 years of age and 5% of children at 10 years.
- Nocturnal enuresis is defined as involuntary urination on at least 2 nights/week for at least 3 consecutive weeks beyond the age of 5 years.
- Approximately 6% of Australian children in the age group 5 – 12 years are affected by nocturnal enuresis.
- 'Wetting the bed' may result in increased anxiety within the family and can interfere with child's normal psychosocial development.
- Most (75 – 85%) of nocturnal enuresis occurs at a primary level, i.e., later age of becoming dry at night. The remainder of children become dry at night (for a period of > 6 months) and then start bed wetting again.
- Children are more likely to experience 'wet beds' if they:
 - have psychological problems,
 - have behavioural problems,
 - are from lower socioeconomic groups,
 - live in overcrowded or out-of-home care, environments.
- Sometimes children experience daytime symptoms as well, these children should be referred to their GP/MO. ²⁸

Parenting tips / Skills to support child development

All children with urinary symptoms should be referred for review. The following parenting tips may be offered to families whilst awaiting referral appointment and/or following the GP/MO excluding any secondary causes of symptomology.

- Behavioural management with appropriate support, education and follow up has been found to be successful in 18% of children with nocturnal enuresis, after eight weeks.
- Provide reassurance to the child and care-givers about the condition, e.g. not the child's fault, skills will develop in time.
- Provide encouragement and appropriate rewards specific to behaviours that the child can control, e.g. regular toileting through the day, toilet attempt prior to bed time and first thing in the morning, participating in changing clothing and wet linen.
- A diary may be kept about times bed wetting occurs and parents may try to wake and toilet the child around that time.
- Be consistent with information about bed wetting and any instructions. For example, avoid excessive food or drink for several hours prior to bed time.
- Make it easy and simple for the child to access the toilet at night, e.g. a lit pathway to toilet, clothing that is easy to remove.
- Ensure constipation is treated if necessary
- Enuresis alarms have been found to be successful in approximately 63% of children with nocturnal enuresis after six months of use. A follow-up appointment between two and three weeks after an enuresis alarm is commenced, facilitates support with any initial difficulties and continued use. If no positive response is evident after two to three months of use, stop use and re-try again at later date.

Cautions and things to avoid

- Avoid punishing a child for not getting to the toilet on time.

Referral

- Children with nocturnal enuresis, day time wetting or urinary symptoms should be referred to their GP/MO for review to exclude secondary causes of symptomology.
- Refer to a Continence Nurse/Clinic.
- Consider referral to EIPS/EIC if emotional or behavioural issues are observed or parenting difficulties are noticed.



Continence Foundation of Australia | www.continence.org.au | Free helpline: 1800 33 00 66
Factsheets: Bedwetting, Day wetting, Soiling
Toilet Tactics Kit – www.continence.org.au/pages/-toilet-tactics-kit-411.html

Raising Children Network | <http://raisingchildren.net.au>
Assorted fact sheets and video resources



Queensland Health Guideline: Assessment of infant/child nutrition, growth and development within the primary health care setting | http://qheps.health.qld.gov.au/patientflow/docs/scycn_nutrit_guide.pdf



Refer to *Chronic Conditions Manual*

Soiling and constipation ^{24,120,190}

- Normally children have 1 – 2 soft formed stools per day, however there is great variation from one child to the next.
- Constipation is a common issue in children with estimated prevalence rates as high as 29% of the paediatric population. It has also been reported as a diagnosis in 20% of children attending emergency departments for abdominal pain and the second most common reason for referral to a paediatric gastroenterologist.
- The Rome III symptom-base defines constipation as follows,
 - When the child is under four years old, and there are more than two or the following symptoms present for a period of one month, or
 - When the child is over four years old and there are more than two of the following symptoms present for a period of two months:
 - › less than two (2) defecations/week
 - › more than one episode of faecal incontinence/week
 - › stool retentive posture
 - › painful, hard stools
 - › large diameter stools
 - › large faecal mass on abdominal palpation or in the rectum.
- Constipation often causes painful defecation which may in turn result in a child fearing this and setting up a cyclical pattern (e.g., painful defecation › stool holding › stool accumulation › stool loses water › harder, larger stool › more painful defecation). Over time, overflow incontinence may occur and/or a stretched rectal vault and a decreased urge to defecate.
- Encopresis is voluntary/involuntary defecation in inappropriate settings (according to the child's own environment), occurring in a child over 4 years, at least once per month for at least 3 months
- Primary encopresis occurs when faecal continence is not achieved by four years of age.
- Secondary encopresis occurs after four years of age.

Parenting tips / skills to support child development

All children meeting the criteria for constipation should be referred for review to a GP/MO. The following parenting tips may be offered to families whilst awaiting referral appointment and/or following the GP/MO excluding any secondary causes of symptomology.

- Child health professionals should provide information, reassurance and education to families at a level appropriate to the individual, e.g. normal physiology of bowel functioning.
- Dispel myths around causation and promote a non-threatening and no-blame approach to the issue.
- Review the child's diet and encourage a daily food intake according to the Australian dietary guidelines, particularly ensuring adequate intake of high fibre foods, e.g. cereals, fruits and vegetables, balanced with adequate fluid intake, preferably water. In addition reducing highly refined foods and those high in sugar may be helpful. See page 195.
- Encourage a toilet ritual. This may include:
 - providing an appropriate and safe toileting area
 - ensuring the child is positioned well and comfortably on the toilet - providing a foot stool may help,
 - encouraging the child to sit on the toilet 10-15 mins after meals for intervals of 10–15 min,

- providing a quiet enjoyable activity for the child to participate in during this time to encourage this behaviour,
- providing encouragement and rewards e.g. sticker chart for sitting on the toilet, special game for defecating on the toilet.
- Encourage physical activity according to recommendations e.g., Australia's Physical Activity and Sedentary Behaviour Guidelines for Children (5 - 12 years).
- Stool softeners may be necessary or medications as prescribed by the GP/MO.

Cautions and things to avoid

- Avoid punishing a child for not getting to the toilet on time.

Referral

- Children with constipation or encopresis should be referred to their GP/MO for review to exclude secondary causes of symptomology.
- Consider referral to EIPS/EIC if emotional or behavioural issues are observed or parenting difficulties are noted.



Raising Children Network | <http://raisingchildren.net.au>

Fact sheets and video resources, including Constipation and Soiling (encopresis)

Australian Dietary Guidelines

www.eatforhealth.gov.au/sites/default/files/files/the_guidelines/n55_australian_dietary_guidelines.pdf

Australia's Physical Activity and Sedentary Behaviour Guidelines for Children (5 - 12 years).

www.health.gov.au/internet/main/publishing.nsf/content/health-pubhlth-strateg-phys-act-guidelines#apa512



Refer to the *Chronic Conditions Manual*

Pediculus Capitis (head lice) ²⁸⁸

- Head lice live on human hair and suck blood from the scalp, they reproduce as mature adults from about 10 days of age by laying eggs (approx. 8 'nits' per day) on the shaft of the hair, approx. 1.5cm from the scalp. The eggs hatch between 7 – 10 days.
- Spread is mainly by direct head to head contact during cuddles, play or close contact. Head lice can survive off the hair for approx. 24 hours and may be transmitted from objects such as combs, bed linen, etc., to another person.
- Head lice are world-wide and affect all people from different socio-economic and ethnic groups.
- Head lice are not a sign of poor hygiene.
- Chemical head lice products should be approved by the Therapeutic Goods Administration. These products are obtainable without a prescription and contain four different types of active ingredients:
 - Pyrethrins,
 - Synthetic Pyrethroids,
 - Organophosphates,
 - Combinations of herbal and essential oils.

Pediculus Capitis (head lice) ²⁸⁸

- Some lice may become resistant to a particular active ingredient, therefore if a product fails to be effective (all head lice not dead at the end of the recommended treatment time) suggest changing to a different active ingredient for the next treatment (in 7 – 10 days).

Parenting tips / skills to support child development

- Regular examination (e.g., weekly during infestation) can enhance the opportunity for early detection. Early detection can break the cycle of lice reproduction and decrease treatment time. All members of the household should be checked.
- The presence of eggs (nits) doesn't always indicate head lice are active as they may be dead or hatched and can remain attached to the hair for a number of weeks.
- Eggs are the most difficult to kill with the most effective removal method being pulling them off the hair using fingernails.
- A simple, effective way to examine for lice is by applying white coloured hair conditioner to all dry hair, leave for 5 minutes and then completely comb out with a fine tooth comb. After each comb through, wipe the comb onto a white tissue to check for head lice. At the completion of the process used tissues should be disposed of into a rubbish bin tied in a plastic bag.
- Treatment should be undertaken when live lice are found on the child's head.
- Non-secticial treatment may be with used on all children and is as effective as insecticidal or chemical treatments. It is also cheaper, but generally requires longer treatment time. Use the same process as for 'detection' (see above) using hair conditioner, fine toothed comb and tissue. Repeat the process every two days for 10 consecutive days with no lice being found.
- Synthetic or natural insecticides or a chemical based treatment may be used on children over 2 years. Strictly follow the manufacturer's directions which will include re-treating in 7 days to kill any lice that have hatched from eggs that were not removed. No chemical treatments kill the eggs.
- Pillow cases of people with infestation should be washed daily on a hot cycle or put in the clothes dryer for 15 minutes.
- Wash hair combs and brushes after use for 30 seconds under hot water (60 °C).

Cautions and things to avoid

- Do not share brushes, combs or pillows.
- Strictly follow manufacturer's directions when using chemical/insecticidal products.
- Avoid use of chemical/insecticidal products on children less than 2 years.
- If a chemical / insecticidal product is used and doesn't kill the lice, revert to the non-secticial treatment option for 7 – 10 days before re-treating with a different active ingredient.
- Do not apply chemical/insecticidal products more than once per week as this may cause skin irritation.

Referral

- Children should be referred to a MO/GP/Nurse Practitioner for review if there is swelling of the lymph nodes or fever. This can indicate a secondary bacterial infection of the scalp.



Head lice fact sheet (Queensland Health) ²⁸⁸ | http://access.health.qld.gov.au/hid/infectionsandparasites/parasites/headlice_fs.asp

Health promotion

Health promotion strategies are designed to improve child and family health by enabling parents and children to increase health awareness, build onto their skills and enhance their capacity. This includes a focus on addressing the social determinants of health and building protective factors as part of everyday child health practice ¹²¹.

The health promotion framework for 5 – 12 year olds is commonly built on a collaborative partnership between the school community and local government and non-government agencies working together. Many Queensland schools adopt the Health Promoting Schools Framework, based on the Ottawa Charter for Health Promotion (1986). This framework incorporates three interconnected domains of:

- curriculum, teaching and learning;
- school, organisation, ethos and environment; and
- partnerships and services ¹⁹⁸.

By using a comprehensive approach and working in partnership with schools, it is possible to build the capacity of communities through enhanced knowledge, skills, resources and management support for health promotion in the school setting. In this way, communities are better equipped to identify and address issues of concern in the future ¹⁹⁸.



For further information about the Health Promoting Schools Framework, see page 236.

In some settings in Queensland, child health nurses continue to provide a service to primary schools where an arrangement is agreed between the local school and HHS. At a health service level, schools offer an efficient point to access a large proportion of the younger age group and established links between health and educational departments fosters opportunities around service delivery in the school setting ¹⁹².

For child health services not directly providing services within the school setting, working with government and non-government organisations is important to build community capacity. Collaborative planning for community events, activities or health services helps to ensure there is adequate time, funds, and resources to provide a sustainable service or activity ¹⁹⁹.

Consultations with child health professionals at a universal service level for this age group are commonly provided to parents using interactive group sessions, according to local HHS models of care ¹⁵⁹. These groups may be co-facilitated by a child health nurse and an early intervention parenting specialist.

Group information sessions, provided to parents in groups, effectively encourages networking building possible supportive contacts for the longer term and improves parental psychosocial wellbeing ¹⁷⁴.



For further information about practice tips on facilitating group parenting programs, see page 100.
For the youth health section, see page 227.

Engaging families

Marketing positive health messages to the child's whole family and the wider community strengthens support for parenthood and can positively impact on the health of a child ¹.

Family structures are varied and include:

- Extended families, e.g. grandparents, aunts, elders
- Single parent, step and blended families
- Foster families
- Gay, lesbian, bisexual and transgender parents ²⁵.

Health professionals recognise each member of the family and acknowledge the significance of their role. For example, research shows the importance of recognising a fathers' unique contribution to a child's development and the family system as a whole ²⁶. It is recommended that services facilitate the involvement of fathers and significant others by considering a range of strategies including:

- Create a physical and attitudinal environment that welcomes the father/ partner/extended family. This may include having relevant visual materials and resources ²⁸.
- Discuss parenthood roles and the impact on family lifestyle and relationships ²⁷.
- Change service environments to address potential barriers to partners/extended family attending services, e.g., vary program times and formats to improve access, include 'neutral' messages for 'parents', attract male staff, use male inclusive literature and magazines in the waiting room ²⁸.
- Having Aboriginal and Torres Strait Islander male staff available facilitates inclusiveness of Aboriginal and Torres Strait Islander fathers/partners ²⁹.



Strong Fathers, Strong Families Program (Queensland Health)
www.health.gov.au/internet/main/publishing.nsf/Content/oatsih-sfsf

Growing Strong Resources | www.health.qld.gov.au/ph/documents/hpu/how_dads_help.pdf

Father Inclusive Practice (Government of Western Australia)
www.communities.wa.gov.au/Documents/About%20ous/CF1o6%2oFather%2oInclusive%2oPractice%2oPolicy%2oPaper%2o2o12.docx

Quality information and education

It is recommended that at every contact with children and families, child healthcare professional should educate and provide anticipatory guidance and parenting support to promote optimal family health ^{1, 122}.

Parenting groups may form part of a child health service's model of care. Providing parenting education in groups enables normalisation of many common developmental issues which supports parents in their role and also can be a more efficient way to deliver information to a greater number of people at the one time ¹⁷⁴. Parents are encouraged to reflect about their child, their feelings and needs, and the child-parent relationship within the sessions. Parents/carers commonly ask about discipline, chores, homework, lying and fears. Parenting Tip Sheets (e.g., Triple P) can be used to provide information to parents individually and in groups.

There is an endless range of topics that may be discussed with children and families, this section discusses topics recommended specific to health promotion and illness/injury prevention within the National Framework for Universal Child and Family Health Services ¹ as follows:

Nutrition and healthy eating patterns ^{84,197,200}

- 25% of Australian children between 2 and 17 years are overweight or obese and 5% are underweight. There is no significant differences in males and females.
- 92% of Australian adults do not eat five serves of vegetables and 52% don't consume two serves of fruit daily.
- 'Treat' foods (high energy and low nutrient foods) are known to contribute to health issues such as obesity. Australian children's energy intake was on average made up of 41% of 'treat' foods.
- Many parents report concern about their child's eating habits and describe their child's eating as 'picky, fussy or irregular'.
- One study (McDermott, et.al., 2010) found an association between infant feeding difficulties at 6 months and 'irregular' eaters at 5 years of age, with 40% of these still being 'irregular' eaters at 14 years of age. Dysregulated mood and sleep patterns were noted as significant for these children and a significant level of maternal anxiety in the child's first 5 years was also found.
- There is a lack of research evidence on the intricacies of how inadequate micronutrient intakes are impacting on children in wealthier nations, however emerging evidence suggests:
 - sub-optimal performers in cognitive functioning,
 - greater risks of attention deficit hyperactivity disorder and
 - insulin resistance.
- Establishing a pattern of good dietary habits are known to decrease health risks such as obesity and long term chronic conditions heart disease and cancers.

Parenting tips / skills to support child development

- Ensure children receive all the nutrients they need to grow and develop normally by including a wide variety of nutritious foods from these core food groups every day:
 - Plenty of vegetables, legumes and fruits of different types and colours.
 - Grain (cereal) foods, mostly wholegrain and/or high cereal fibre varieties, such as breads, cereals, rice, pasta, noodles, polenta, couscous, oats, quinoa and barley.
 - Lean meats and poultry, oily fish, eggs, tofu, nuts and seeds, and beans.
 - Milk and dairy products such as yoghurt and cheese.
 - Encourage reduced fat options.
- Replace foods high in saturated fat (butter, cream, cooking margarine, coconut and palm oil) with foods which contain predominately polyunsaturated and monounsaturated (olive oil, spreads, nut butters/pastes and avocado).
- Read labels to choose lower sodium options ('reduced-salt' or 'low-salt' foods).
- Promote responsive feeding practices including:
 - Provide a pleasant environment with few distractions e.g., calm environment, no television, avoid family conflicts
 - Promote the child's interest in food e.g., provide food predictably when the child is hungry, cease providing low nutrient snacks inbetween mealtimes; avoid forcing of foods; provide appropriate variety and texture of foods; reward independent eating e.g., star chart.

Nutrition and healthy eating patterns ^{84,197,200}

Parenting tips / skills to support child development cont.

- Establish family routines around mealtimes e.g., hand washing before eating, model healthy meal time behaviours, make healthy choices for the entire family.
- Limit mealtimes to approx. 30 minutes or when the child is no longer interested.
- Consider the use of a feeding diary.
- A full family diet consists of three meals and two snacks each day.

Cautions and things to avoid

- Limit intake of foods containing saturated fat.
- Avoid food and drinks containing added sugar such as confectionary, sugar-sweetened soft drinks and cordials, fruit drinks, vitamin waters, energy and sports drinks.
- Do not add salt to foods in cooking or at the table.
- Avoid food and drinks containing added salt.



Australian Dietary Guidelines

www.eatforhealth.gov.au/sites/default/files/files/the_guidelines/n55_australian_dietary_guidelines.pdf

Healthy Schools | www.health.qld.gov.au/healthyschools/nut_default.asp#young

Fun not fuss with food | **Queensland Health**

www.health.qld.gov.au/health_professionals/food/funnotfusswithfood.asp



Refer to *Chronic Conditions Manual*

Physical activity ²⁰⁴

- 25% of Australian children between 2 and 17 years are overweight or obese. There is no significant differences in males and females.
- In 2011-2012 children between 5 – 17 years did approx. 90 minutes of physical activity per day with 60% doing one hour per day.
- Sedentary behaviour is considered as sitting or lying down without sleeping.
- Physical activity has numerous benefits including:
 - Social development opportunities – learning to play in a team can develop communication and co-operation skills.
 - Reduces anxiety and stress levels
 - Improves concentration
 - Improves physical fitness, coordination and body movement
 - Reduces unhealthy weigh gain
 - Improves bone and muscle health.
- Reduces risk of cardiovascular disease and type 2 diabetes.

Parenting tips / skills to support child development

- Motivate children to engage in at least 60 minutes every day on moderate to vigorous physical activity (accumulated across the day). Additional physical activity up to several hours per day may have additional health benefits.
- Children should participate in muscle and bone strengthening activities (running, skipping, dancing, gymnastics, etc) at least three times a week.
- Encourage free play activities in a safe environment daily.
- Encourage helping around the home with active tasks such as, washing the car, gardening.
- Limit screen-based activities (e.g. watching TV, using a computer) to less than 2 hours per day.
- Other family members can be a role model for children by adhering to recommended activity guidelines in other age groups.
- Encourage your child to join a sporting group or activity eg: dancing, martial arts, soccer etc.
- Engage the family in activities, such as, walk to the park, go for a family bike ride, day at the beach.

Cautions and things to avoid

- Discourage computers and televisions in the bedroom.
- Avoid driving children on short trips if walking is possible – encourage parents to walk children to school or form a walk to school group e.g. ‘The Walking Bus’.
- Avoid sunburn – always encourage sun protective behaviours



Australia's Physical Activity and Sedentary Behaviour Guidelines for Children (5 - 12 years)
www.health.gov.au/internet/main/publishing.nsf/content/health-pubhlth-strateg-phys-act-guidelines#apa512 ²⁰⁴

Nature Play QLD: Getting Our Kids Outdoors | Queensland Government | www.natureplayqld.org.au

Green Time vs Screen Time tool | www.natureplayqld.org.au/resources/21/green-time-vs-screen-time

Oral health 24,120,142,201,257

- Australian children visiting public dental health clinics from six states and territories in 2010 were identified as having:
 - Decay in baby teeth in more than 50% of 6 year olds
 - Decay in permanent teeth in almost 50% of 12 year olds.
- Dental caries (decay) is one of the most prevalent health issues in Australia across all age groups.
- Children and young people living in rural and remote areas or in low socio-economic status areas have significantly worse oral health than those living in metropolitan areas.
- Poor oral health can not only impact on a young person's psychosocial wellbeing, but can also lead to long-term health problems due to the association of periodontitis with heart disease.
- Dental caries are highly preventable, with most being related to dietary issues.
- Dental caries are caused by excessive plaque build-up through infrequent, substandard tooth cleaning.

Parenting tips / skills to support child development

- Permanent teeth will begin to erupt from around 6 years age; some permanent teeth will replace baby teeth and others such as the permanent molars will come through behind the last baby molars.
- Most children in this age group should be sharing the responsibility of caring for their teeth with their parents as the skill to use a toothbrush properly develops, supervision may still be necessary.
- Children should brush their teeth for at least 2 minutes in the morning before breakfast and last thing before bed at night.
- Regular flossing at least daily may reduce gum disease and build-up of plaque.
- Alcohol free mouthwash can be used after brushing to remove bacteria.
- Parents and children are encouraged to eat a healthy, balanced diet that includes calcium rich foods and healthy snack choices with limited sugary or acidic foods and drinks.
- Children should be having regular dental check-ups.
- Oral health services are provided to students from four years until the end of year ten. For further information, see www.health.qld.gov.au/oralhealth/services/school.asp

Cautions and things to avoid

- Avoid brushing teeth within one hour after a meal (acid-containing foods may soften the tooth enamel making it possible to damage it with brushing).
- Avoid carbonated beverages, diet drinks and sports drinks which are high in sugar / citric and phosphoric acid which may contribute to teeth decay
- Avoid sipping sweet drinks over a prolonged period
- Involvement in contact and accident prone sports leads to an increased risk of trauma and damage to the teeth and soft tissues of the mouth. A professionally made mouth guards is recommended.



Healthdirect | www.healthdirect.gov.au/teeth-cleaning
Contains an A-Z listing of topics, e.g., Teeth cleaning, Dental caries

Queensland Health Oral Health Services | www.health.qld.gov.au/oralhealth/services/school.asp

Use culturally specific resources for oral health education where possible:

The Indigenous Oral Health Flipcharts are a health education tool aimed to prevent oral disease in Aboriginal and Torres Strait Islander communities. The resource 'Building Strong Teeth' is aimed at school children and can be used by teachers.

Emotional wellbeing 24,202,-205

- Middle childhood may be complicated by child behavioural problems, many of these do not meet a criteria for clinical diagnoses.
- Mental health problems affect psychological growth and development, health-care needs, educational and occupational attainment, and are often associated with truancy and later involvement within the justice system.
- Exposure to adverse childhood events may impact on emotional wellbeing, the more events the more likelihood there will be an impact.
- Child/youth health professionals use a strengths based approach to build positive behaviours and skills to enhance a child's coping skills and self-regulation.
- Protective factors that enhance emotional wellbeing include a secure child-parent attachment, family cohesion and social support, effective resource management, engagement with others in the community.
- Regular physical activity may improve self-esteem and confidence levels, and reduce anxiety and stress.

Parenting tips / skills to support child development

- Parents are encouraged to:
 - Spend quality time with their child and provide a safe physical and emotional environment - The child health professional may use the Australian Family Strengths Nursing Assessment Guide (See Appendix 1) as a tool to explore family strengths and encourage activities to enhance effective family functioning and build resilience [131].
 - Provide limit setting and clear boundaries for children to guide a child's behaviour and reduce undesired behaviours.
 - Provide rewards and encouragement for desired behaviours, e.g. a child displays effective self-regulation by persisting at a difficult task.
 - For children in their middle years encourage parents to explore options and use problem solving techniques with their child when they are faced with a challenge rather than problem solving for them.
 - Role model positive behaviours, e.g., by reflecting on how they express their own emotions, enhance cooperation with others, demonstrate a positive self-concept.
- Parents can support children to build their self-confidence by working together with the child using strategies such as:
 - Recognise their strengths and achievements (learnt to ride a bike, good mark in a subject)
 - Develop positive self-talk and gain awareness of possible negative self-talk .
- Encourage a regular bed time to promote sleep periods of approximately 11 hours per night at 5 years reducing to around 9 hours by 12 years of age.



Child health professionals may use the Australian Family Strengths Nursing Assessment Guide, see appendix 1.



The Safe Schools Hub Toolkit | www.safeschoolshub.edu.au/safe-schools-toolkit/overview
A whole-of-school approach to addressing safety and wellbeing, including bullying and responsible use of ICT.

Reachout | <http://au.reachout.com> | Useful information for young people regarding wellbeing:

Friends for Life - an anxiety prevention and resilience building program

Kids Matter | www.kidsmatter.edu.au/primary/programs/friends-life

Immunisation ^{242,243}

- 89% of Australian children at 5 years old were fully immunised.
- The prevention of communicable diseases is managed primarily through immunisation.
- Children attending schools are at greater risk for the transmission of vaccine preventable diseases particularly if they are not up to date with their immunisations.
- School environments, where children come in close contact with one another, are a common source of many infectious illnesses.
- School Immunisation Programs (SIP) will offer students immunisation in accordance with the Queensland immunisation schedule.

Recommendations

- Promote families to immunise their children and when necessary work with families to update their child's immunisation schedule.
- Provide information and support for teachers on immunisation where this fits within local models of care.
- Encourage the school to provide regular information in the school newsletter (especially at the beginning of the school year) on specific health issues.
- Targeted work can be undertaken with sub groups within the school community where there is a greater risk for children to be overdue for immunisations including children who have been in out-of-home care, CALD families and refugee entry families.
- Child health professionals should maintain an awareness of negative messages propagated by anti-vaccine movements so that they may answer questions accurately and counter concerns as necessary (Paul & Fabio, 2014).



Immunise Australia | www.immunise.health.gov.au/

Provides comprehensive information regarding immunisation including strategies to address myths and misconceptions surrounding vaccination.

Illness prevention ^{24, 120,144}

Whilst prevention of communicable diseases is managed primarily through immunisation, raising the awareness of families and children of how to prevent the spread of illnesses is an important strategy around illness prevention.

- Although **cancer** is rare in childhood, it is a leading cause of death, accounting for about 19% of deaths among 1–14 year olds in 2009–11. Since 2001, the most common cancer types in these cases have been lymphoid leukaemias, neuroblastoma and ganglioneuroblastoma, and acute myeloid leukaemias (4.1, 1.1 and 0.8 per 100,000 children respectively during 2006–2010). The proportion of 0–14 year olds who survived cancer five years after diagnosis improved from 68% in 1983–1989 to 81% in 2004–2010.
- In 2011 there were 983 new cases of **type 1 diabetes** among children (23 per 100,000 children) with little difference between boys and girls (AIHW 2014a). The rate of new cases of type 1 diabetes in children did not change significantly from 2000 to 2011, with between 21 and 26 per 100,000 children each year.
- **Asthma** is the most prevalent chronic illness in Australia in children less than 15 years with an incidence of 10% , boys 12% and girls 8%.

Recommendations

- Hand washing is the single best method of reducing the spread of pathogens and nosocomial infections. Model positive hygiene behaviours by washing own hands regularly; teach children how to wash their hands and when to wash their hands ie: before eating, after toileting.
- Encourage families to limit the exposure of their child to others when ill.
- When children have symptoms of illness, teach them to reduce droplet spread by using a tissue when coughing or sneezing and discarding them.
- Discourage sharing of eating and drinking utensils.
- Families should have a written asthma action plan developed in conjunction with the GP/MO and a copy should be provided to the child's school
- Encourage self-management of Asthma and provide support and education appropriate to the individual's stage of psychosocial development (National Asthma Council, 2014). This may include:
 - Carrying relievers at all times
 - Learning to recognise and avoid triggers
 - Avoiding smoking environments



Staying Healthy in Child Care | www.nhmrc.gov.au/_files_nhmrc/publications/attachments/ch43.pdf
The recommended reference for health professionals, covering a wide range of topics for preventing infectious diseases and fact sheets for many common respiratory, gastrointestinal and skin conditions.

The Germ Busters Primary Schools Program is a hygiene improvement program that includes resources for children, parents and staff. The program is easily incorporated into the daily routine of schools.

Asthma Friendly Schools Program | Asthma Foundation Queensland's
www.asthmaaustralia.org.au/Asthma-Friendly-Schools.aspx

Raising Children Network | <http://raisingchildren.net.au/>
Fact sheets: Daily personal hygiene, Health concerns

Sun safety and skin cancer prevention ^{120,296}

- Exposure to ultraviolet radiation (UVR) during outdoor activity and inadequate sun protection increases the risk of developing skin cancer. Melanoma is the most dangerous type of skin cancer with a strong causative link to sunlight exposure. Eye damage and premature ageing are also effects of exposure to UVR.
- Sunburn can be defined as any reddening of the skin lasting for at least 12 hours after sun exposure.

Recommendations

- Parents and children are encouraged to prevent skin cancer in five ways:
 1. Seek shade;
 2. Wear sun protective clothing that covers as much of their body as possible;
 3. Put on a broad-brimmed hat that shades their face, neck and ears;
 4. Wear wrap-around sunglasses;
 5. Apply SPF₃₀₊ or higher broad spectrum water resistant sunscreen liberally to clean, dry skin, at least 20 minutes before being exposed to the sun, and reapply at least every two hours when outdoors.
- Encourage protection from ultraviolet rays (UVR) even when going outdoors for a short time and especially during periods when the UVR levels are highest (between 10am – 2pm).
- Avoid using sun screen which has passed its use by date.
- Parents and children are encouraged to check their skin regularly for melanoma, with the first sign usually being the appearance of a new spot, or a change in an existing freckle or mole. They should be taught the **ABCDE** guidelines for the early detection of melanoma:
 - **A** is for **ASYMMETRY**: One-half of a mole or birthmark does not match the other.
 - **B** is for **BORDER** irregularity: The edges are irregular, ragged, notched, or blurred.
 - **C** is for **COLOUR** variation: The colour is not the same all over, but may have differing shades of brown or black, sometimes with patches of red, white, or blue.
 - **D** is for **DIAMETER**: The area is larger than 6 mm or is growing larger.
 - **E** is for **EVOLVING**. Changes in size, shape, colour, elevation, or another trait (such as itching, bleeding or crusting).



Sun Safety Queensland | www.sunsafety.qld.gov.au

Cancer Council Queensland | QUEST website | <https://quest.org.au/quest/schools/>

Provides a library of tools and resources to assist schools to promote and support healthy choices, including sun safe behaviours. Schools need to register to access these resources.

Melanoma Institute Australia

www.melanoma.org.au/about-melanoma/detection-and-screening/checking-your-skin.html

Information to support health education with young people surrounding skin checks for melanoma.

Injury prevention ^{46,120,144,156}

- Injuries in children aged 5 – 14 years occur in a range of settings including schools, sporting environments and their neighbourhoods.
- Children gain additional knowledge and ability during this age range to keep themselves safe.
- The leading causes of death in children between ages 5 – 9 years in Queensland during 2010-2011, were drowning and transport related injuries. Drowning accounts for about 40% of child farm deaths, with dams responsible for 21% of these.
- Across population age groups, the rates of Australian hospitalisations (2010-2011) for 5-14 year-olds as a result of injury were as follows: Drowning and submersion – 11.3%, Burns – 11%, Falls – 10.4%, Transport injury – 9.7%, and Poisoning – 3.9%
 - Intentional self-harm was reported in the age group of 10-14 years old, more commonly in girls. See page 244 for further information.

Recommendations

Child health professionals are advised to research the most common injury risks in their local area to include community focused safety messages.

Parents are advised to learn basic first aid and resuscitation as well as the following:

- Always supervise a swimming child and teach children water and basic resuscitation skills.
- Ensure fencing around pools and spas meets council safety requirements.
- Microwave ovens heat fluid / foods unevenly, many burns occur from foods heated in microwaves, e.g. hot noddles spilled on a child's lap. Encourage children to be cautious about removing food from microwaves and to stir food thoroughly and test the temperature prior to eating.
- Use caution around hot taps.
- Choose clothing labelled 'low fire danger'.
- Parents are also advised to learn basic first aid for burns ensure their home has smoke detectors.
- Actively supervise children in playgrounds and on play equipment.
- Never leave children unattended in the car.
- Develop a safety routine before starting motor vehicles, e.g. child in an appropriate restraint and has seat belt fastened.
- Encourage parents to seek advice on correct use of medications e.g., paracetamol, herbal preparations.
- Advise parents of **Queensland Poisons Information Centre**, Tel: **13 11 256** – which provides support and advice, seven days a week, 24 hours a day.



Kidsafe Qld | <http://www.kidsafeqld.com.au>

Fact sheets: Childhood drowning, Farm-related injury, Home safety checklist.
Download from www.kidsafeqld.com.au/publications/fact-sheets

Raising Children Network | <http://raisingchildren.net.au/>

Fact sheets - Scalds prevention and first aid

Hot water burns like fire (brochure) | www.health.qld.gov.au/ph/documents/hpu/28207.pdf

Queensland Poisons Information Centre | www.health.qld.gov.au/PoisonsInformationCentre | T: 13 11 26

Early identification

An important role of child health professionals is identifying factors that may impact on the health outcomes of children and providing support, early intervention and referral when necessary ¹.

This section:

- Identifies factors that increase the risk of a child five to twelve years experiencing sub-optimal health outcomes, and
- Provides guidelines on how child health professionals can work with children and their families where these factors exist, including additional targeted services and referral and care coordination with other service providers. Services will depend on the local community, resources and context of health care.

The healthcare context

- The Primary Health Care (PHC) model promotes positive health outcomes for children, young people and their families through the delivery of accessible, acceptable, appropriate and culturally respectful PHC services. Targeted services aim to increase parenting skills, support parents to respond effectively to their child's needs and decrease risk factors impacting on family functioning. These services may be provided within a variety of settings to promote engagement of families, e.g. schools, community centres [6]. Depending on the local model of care, this may include:
 - Appointments for short term individual structured intervention
 - Group programs, e.g. Circle of Security parenting groups
 - Outreach services e.g. enuresis clinic within a school setting
 - Specific population group services e.g. Stepping Stones Triple P for parents of a child with a disability.

Social determinants of health and wellbeing

- **Priority groups include:**
 - Aboriginal and Torres Strait Islander families
 - Families from a culturally and linguistically diverse (CALD) background
 - Socioeconomically disadvantaged children and families
 - Parents with low parental education levels, often when other factors are present e.g. financial stress
 - Single parents, parents with multiple re-partnering experiences, step families and blended families
 - Children living in non-parental or out-of-home care environments
 - Families with chronic illnesses and/or disability
 - Isolated families e.g. living in remote areas ²⁵.
- When multiple risk factors are present, there is a higher risk of child abuse and neglect ²⁵.
- Children from families with a low income have poorer health outcomes. For example, they have twice the number of decayed teeth by the time they are six years old, compared to families with higher incomes ¹⁴⁴. These families often experience a lack of basic resources (e.g. insufficient clothing, unsuitable food, unstable housing), resulting in poor nutrition and unsuitable living circumstances ²⁴. Growth retardation and obesity are risks when nutritional requirements are not met and illness more common. Overcrowded living circumstances results in higher incidence of communicable illnesses ²⁴. Vaccination schedules may not be maintained ²⁵.
- The prevalence of family structures other than two biological parents and only their mutual children, has risen dramatically and includes single parenthood, multi-partnered fertility (a parent having children to more than one partner), step families, blended families and families with same sex parents ¹⁶⁹. A range of vulnerabilities exist for children of these families – the more disruption to family life, the more the likelihood of a detrimental impact on the child's emotional and physical wellbeing ¹⁶⁹.
- Young parents have significantly higher levels of antenatal and postnatal depression and an increased risk of performing unresponsive parenting practices, higher levels of parenting stress and repeat

pregnancies, and poor parental educational outcomes¹⁷⁰. Their children are also at greater risk of maltreatment, child abuse and being developmentally delayed¹⁷⁰.

- Children may have an increased risk of alcohol related harm when their parent/s are young adults when heavy drinking is common at this life stage¹⁷¹. Older parents also have greater intake of alcohol²⁵. Single parent families may be at greater risk of alcohol-related harm to children¹⁷¹.
- Non-nuclear families with step parents or defacto partners are over represented in child safety statistics²⁵.
- Children of same-sex parent families are prone to stigma related to parental sexual orientation which may result in negative impacts on the child's mental and emotional wellbeing¹⁷².
- The majority of children in Australia live with at least one of their biological parents, however of those infants less than one year living in non-parental care, 33% live with relatives/kin and 64% in foster care with stability of placement of key importance¹³⁹.
- Children living in non-parental or out-of-home care environments have many vulnerabilities including a higher incidence of acute and chronic illness, emotional and behavioural issues, e.g., poor social relationships with parents and peers¹³⁹.
- About 1 in 6 children live with a parent with a disability¹⁴⁴. The key factor for children of parents with a disability is whether the parent can provide adequate care for the child. This will depend on the type and severity of their disability and the level of support they have. Evidence suggests that parents with intellectual disability can provide adequate parenting when appropriate supports are in place and the child is likely to develop in line with their peers from similar socio-demographic backgrounds^{144,173}.
- Parents with chronic illness, such as diabetes or epilepsy, may encounter a number of factors that impact on family life including hospitalisations, loss of income, and dependency on others¹⁷³. Under these conditions children may be emotionally or physically compromised with some children developing a carer role to the parent, or developing behavioural problems¹⁷³.
- Parental mental health and wellbeing in the child's early years of life is known to have a significant health impact on their health as well as the overall health of the family unit^{25,174}. The development of secure attachment relies on the child's attachment figure to be 'a safe haven'; when the parent is able to provide consistent comfort and a secure base for the child, he/she feels able to explore the world. This optimises the child's chance of developing social skills that will assist him/her in successfully navigating life⁶⁹. If a parent is suffering a mental illness this may impact on their availability to their child as well as their consistency in parenting behaviours that support child-parental attachment. Children with parents suffering from a mental illness are more likely to have an altered attachment, socio-emotional and behavioural problems⁶⁹.
- Parental functioning e.g. inter-parental conflict, is also a significant predictor of psychological health of children¹⁷⁴; the more disruption to family life, the more the likelihood of a detrimental impact on the child's emotional and physical wellbeing¹⁶⁹.
- Approximately 3% of Australian children aged 0-14yrs live in remote and very remote areas, 38% of these children were of Aboriginal and Torres Strait Islander families. Children living in remote areas encounter more than twice the number of decayed teeth as children in major cities. Obesity in these areas is a greater risk with 27% of children aged 5-14 years, being overweight or obese compared to 21% in city areas.



Raising Children Network | <http://raisingchildren.net.au>

Video and fact sheets on a variety of topics, including: Parenting after separation, Handling conflict with your ex-partner, Working with parents, Positive parenting, Sole parenting, Teenage parents.

Epilepsy Australia | www.epilepsyaustralia.net

ReachOut.com | <http://au.reachout.com/>

Resources and information about mental fitness.

Referral for Active Intervention services

www.communities.qld.gov.au/childsafety/child-safety-practice-manual/chapters/10-general/10-14-referral-for-active-intervention-services/key-steps/1-determine-eligibility-for-a-rai-referral



Practice tips: Working with a school aged child and a family at risk to provide additional support

- Welcoming diversity of family forms as a strength will reduce discrimination and enhance community cohesion, ultimately reducing the risk of negative stigma impacting on the child ¹⁶⁸.
- A comprehensive health assessment will provide a foundation for engaging children and their families and providing ongoing services. The use of additional resources may be required to facilitate a comprehensive family health assessment, such as an interpreter.
- When screening identifies additional risks or family needs, care options can be explored with families and the child health multidisciplinary team. Services will be tailored in partnership with families and guided by the local Hospital and Health Service protocol and models of care. This may include, for example:
 - universal service provision with brief structured interventions and/or
 - referral to additional support services within or external to the service ¹.
- The child health professional uses a strength based, partnership approach to build the child's capacities and skills, focusing on:
 - providing evidence based, culturally sensitive information
 - promoting the establishment and maintenance of positive social supports
 - facilitating and supporting children and parents to solve problems for themselves and practicing personal coping strategies ^{1, 65}.
- Social support for parents has been shown to improve emotional wellbeing for the family with additional needs, therefore linking parents into suitable networks is important [168].
- Coordinate referrals for any identified concerns e.g. EIC/EIPS for behavioural issues.
- Psycho-education specific to promoting self-care e.g., lifestyle activities, sleep and exercise ^{11, 65}

Additional factors are to be considered when working with families with specific cultural needs. These are now outlined.

Aboriginal and Torres Strait Islander families

It is important to invite a child and their family members to identify as Aboriginal and Torres Strait Islanders, to ensure their cultural needs can be considered. Health in the context of an Aboriginal and Torres Strait Islander is a holistic concept, encompassing physical, social, emotional, spiritual and cultural wellbeing of the individual as well as their community. Each individual family will have their own beliefs and needs, influenced by differing cultural practices between clans across urban, rural and remote areas of Australia. Men's and Women's Business remains a fundamental cultural practice within Aboriginal and Torres Strait Islander families and kinship and family responsibilities hold a higher priority than personal health needs. These concepts, along with communication difficulties and cultural differences, often create a barrier to accessing and staying engaged with health care agencies ¹⁵⁸. Additional factors that the health care professional can consider when working with Aboriginal and Torres Strait Islander families are outlined in the following tables:

Cultural needs 25, 158-160

Why there may be additional need

- Aboriginal and Torres Strait Islander clans differ in their belief systems across Australia; stereotyping cultural needs and cultural misunderstanding continues to exist. Considering the individual families' belief system and the impact it may have on parenting and their child will improve culturally responsive health care and work towards improving health outcomes.
- Aboriginal and Torres Strait Islanders may feel fearful and mistrusting of health care services due to the history of mistreatment and disadvantage that has occurred in Australia.
- Establishing and maintaining a therapeutic relationship over time using appropriate communication strategies has resulted in improved service engagement.
- Families may have had to travel to access health care and be isolated from their community and networks. This may induce feelings of disconnection and being overwhelmed, and fear of the unknown or of being judged.

Recommendations

- Invest time into establishing a therapeutic relationship with children and their families; this is thought to increase ongoing engagement of the family.
- Involve Aboriginal and Torres Strait Islander Health workers / practitioners in the assessment and planning of health care, where available.
- Use colours, art work, games and equipment aligned with the local culture.
- Spread assessment over a number of sessions to enable rapport to be built when possible.
- Use a suitable environment for the family whereby naturalistic observation may be used to gather information e.g., playground, home.
- Use a soft voice, a non-judgemental, respectful tone and avoid jargon.
- Use a casual discussion process to illicit information rather than a formal interview process.
- Consider cultural issues and discuss how this may impact on their child's health, for example:
 - Their child may be integrated into community life from birth with child development may be viewed more broadly than physical milestones and include increasing in autonomy and independence and social maturity of the child.
 - Their child may be shown and told about dangers and then allowed to experiment and learn caution and consequences through participation, rather than being given directives to obey.
 - Gender specific services for appropriate 'men' or 'women' issues.
- Work with the family to strengthen supports and develop strategies that align preventative strategies with their own belief system.
- Consider providing service delivery linked with additional supports to facilitate transport to appointments e.g., transport provided by Elders. This not only provides transport but also support and camaraderie.
- Provide services where people can easily access them e.g. shopping centre, school.
- Provide a variety of styles of appointments such as: 'walk-in', appointments released on the day, to enable better access for families who need it.
- Invite discussion about the individual families' cultural views and document how these may impact on parenting as part of the Family Health Assessment, e.g., Men's and Women's Business and how that will impact on their parenting; Extended family support - Aunties may be a strong support to the Mother and the child.



For health professionals

Aboriginal and Torres Strait Islander patient care guideline (Queensland Government, 2014)
www.health.qld.gov.au/atsihealth/documents/patient_care_guideline.pdf

Healthy Jarjums' is a program designed for Aboriginal and Torres Strait Islander children. It supports classroom activities by raising cultural awareness of Indigenous values, customs, language and food-related practices. Available from Inala Community Health Centre.

Common health concerns 159, 162-164

Why there may be additional need

- Aboriginal Australians use emergency health care services more often than other Australians
- Aboriginal and Torres Strait Islander children have the world's highest recorded rates of middle ear disease. Middle ear infection is common and has been diagnosed in infants as young as 2 weeks of age. The associated conductive hearing loss may have a profound impact on their development, e.g., communication.
- An Australian study on Aboriginal children attending emergency departments identified the six most common reasons as: respiratory problems (30%) with a common diagnosis of asthma; injuries (21%); digestive (12%) with a common diagnosis of gastroenteritis; skin infections (11%); infectious illness (8%); ear, nose and throat disorders (4%).

Of these presentations, 44% were found to be potentially preventable either by the nature of the concern or that a primary care provider could have treated the presenting concern.

Recommendations

- It is recommended that preventative measures and targeted health promotion programs are offered to reduce these common health concerns, as well as appropriate access to primary health care facilities in non-emergency settings.
- Health professionals are recommended to include an ear health assessment at every child check. This should include Otoscopy, Tympanometry and Audiometry as the clinician deems appropriate to the specific situation. See page 85.
- Inform Aboriginal and Torres Strait Islander families about local health services and when to seek support.
- Inform Aboriginal and Torres Strait Islander families about ear health, for example:
 - their children have a greater risk of ear and hearing problems
 - children need to hear well to be able to talk well
 - 'runny ears' and ear pain is not normal and that the children should be seen immediately at a health centre when this occurs
 - frequent ear checks are important even when the child appears well
 - their child is more likely to have an ear infection when they have a runny nose, cold or other upper respiratory infections
 - some children have symptoms of ear disease, others none; common symptoms include: Pulling their ears, ear pain, fever, can't hear properly, sore throat, runny fluid or pus from the ear, not eating, diarrhoea, vomiting
 - how to prevent ear disease e.g. regular checks, don't smoke around your children, don't stick anything in your child's ear

Recommendations / cont.

- encourage good hygiene practices, such as regular hand washing, nose blowing, face wiping
- encourage on time vaccinations
- healthy living conditions are important for a child's development, e.g. a smoke free environment, healthy food intake



For health professionals

SmokeCheck Indigenous Smoking Program | www.health.qld.gov.au/atod/prevention/smokecheck.asp

Safety for Piccanninny (booklet) | www.emergency.qld.gov.au/publications/pdf/Piccanninny_booklet.pdf

Deadly Ears program | www.health.qld.gov.au/deadly_ears

Training and development site for health care professionals
www.health.qld.gov.au/deadly_ears/html/train-dev.asp

Recommendations for Clinical Care Guidelines on the Management of Otitis Media in Aboriginal and Torres Strait Islander Populations 2010 (Australian Government)

www.health.gov.au/internet/main/publishing.nsf/Content/health-oatsih-otitismedia-clinical-guidelines2010

Care for Kids Ears | www.careforkidsears.health.gov.au

Raising Children Network | <http://raisingchildren.net.au>

Videos produced for Aboriginal & Torres Strait Islander parents. *Topics include Play and learning, Watching your kids, Routines, and Nutrition.*



Refer to *Primary Clinical Care Manual*

Topics: Acute otitis media, chronic suppurative otitis media, otitis externa



Refer to *Chronic Conditions Manual*

Family wellbeing 51, 161, 165

Why there may be additional need

- Aboriginal and Torres Strait Islander children are 8-9 times more likely to be in the child protection system and they are over-represented in 'out of home' care services.
- Many Aboriginal and Torres Strait Islander children are growing up in an environment with poverty, family dysfunction and violence with a greater risk of maltreatment and with high levels of distress. For example:
 - In a report on social and emotional wellbeing, over one third of Torres Strait Islander people reported high to very high levels of psychological distress and had experienced at least one life stressor (death of a family member / close friend, serious illness, inability to get work) in the previous 12 months of their life.
 - Higher rates of psychological distress were associated with poor health outcomes.

Recommendations

- Promote parental wellbeing by offering psychosocial support strategies including:
 - Promoting peer support e.g., attend culturally specific parent groups, telephone conversations with family / friends
 - Provide non-directive counselling in partnership with the parent ie: empathetic parent centred discussion with a focus on listening and summarising and supporting the parent to develop understanding of their own circumstances and a way to move forward
 - Psycho-education appropriate to the education level and specific culture of the family to promote self-care (e.g., lifestyle, sleep and exercise, safe use of alcohol) and discussion around vulnerabilities specific to the families' situation.
- If assessment identifies acute mental health concerns the health care professional should stay engaged with the client and seek further support from their acute mental health service provider.



The child health professional may identify child safety concerns and be required to complete a 'Report of Suspected Child in Need of Protection'. See page 222.



Centre for excellence in Indigenous tobacco control | www.ceitc.org.au/ceitc-publications-and-resources

Raising Children Network | <http://raisingchildren.net.au>

A selection of Video resources for Aboriginal and Torres Strait Islander parents

Lifeline | www.lifeline.org.au

Tool kit: 'Help when you are feeling down' – a self-help resource for Aboriginal and Torres Strait Islander people

Tool kit: 'Coping with sorrow, loss and grief' – a resource for Aboriginal & Torres Strait Islander people

Yarning about mental health: An easy guide to mental health assessment (flip chart)

(Nagel, T. and Griffin, C. 2009. Cooperative Research Centre for Aboriginal Health)

Referral for Active Intervention services

www.communities.qld.gov.au/childsafety/child-safety-practice-manual/chapters/10-general/10-14-referral-for-active-intervention-services/key-steps/1-determine-eligibility-for-a-rai-referral

Children from culturally and linguistically diverse families ^{24, 149, 163, 166, 167, 206}

Why there may be additional need

- One in five people in Queensland were born overseas.
- Cultural factors and belief systems will vary according to the families' background.
- Queenslanders speak more than 220 languages from more than 220 countries.
- Common issues to CALD families include:
 - some family members will have limited understanding of English
 - Overcrowded housing, transient housing arrangements – this leads to an increase of environmental safety risks for children
 - Older children may have the responsibility of caring for their younger siblings due to cultural norms
 - Unemployment rates are high in migrants- 10.6% compared to 5.9% for those born in Australia.
- Refugees are a highly vulnerable population with common health issues including:
 - Incomplete immunisation coverage
 - Nutritional deficiencies e.g., iron, vitamin D
 - Growth and developmental issues
 - Poor dental health
 - Interrupted language development
 - Sometimes communicable diseases such as tuberculosis, Hepatitis B and parasitic infections
 - Mental health conditions such as: post-traumatic stress disorder, anxiety and depression
- These issues may be present in the child or the parents/carers. Refugee young people are at heightened risk of developing co-morbid substance use disorders, with many using alcohol and other drugs as a means of coping with stressors relating to both pre-migration and settlement experiences.
- Child health professionals need to be alert for the use of the practice of **Female Genital Mutilation (FGM)**. Whilst it is illegal in Australia it may still be practiced in some cultural groups. Families are more likely to follow this practice when:
 - The family are from African or Middle Eastern countries
 - No-one talks to the mother about FGM
 - The mother has limited access to information about FGM
 - The child's mother or sisters have been 'cut'
 - The paternal grandmother has an influence over the family
 - The mother has limited contact with other people outside of her own family.
- FGM may be carried out anytime between seven days of age, up to teenage years, marriage or first pregnancy but is most common between the ages of 5 – 8 years[163]. It is often commonly associated with a cultural celebration or leaving the country for a period of time.

What to do

Principles to underpin good clinical practice:

- Welcoming cultural diversity as a strength helps eliminate discrimination and strengthens community cohesion.

Children from culturally and linguistically diverse families ^{24, 149, 163, 166, 167, 206}

What to do cont.

- Arrange an interpreter and information in the families' own language when possible.
- Avoid using family members as interpreters as this may breach confidentiality and information may be inaccurate.
- Research general customs, values and beliefs of particular cultures to prepare for an appointment with a CALD family. This may enhance your ability to gain information and develop rapport with the family.
- If the general customs include FGM and the child is female, explain that FGM is illegal and that the law in Australia helps families to protect their daughters from FGM. When talking to the mother use language that the mother can understand and avoid indicating any judgement to the practice. For example:
 - "Have you been closed?"
 - "Were you circumcised / cut down there?"
 - Offer the mother assurance that she can talk to you again about this if she wishes.



It may be necessary to complete a 'Report of Suspected Child in Need of Protection' See page 222.

- Conduct a comprehensive family health assessment to identify specific needs of the individual.
- Work in partnership with the child, family and school to develop an ongoing plan of care, this may include:
 - Review immunisation and promote a catch up schedule if necessary, encourage ongoing immunisations on time.
 - Coordinate referrals for any identified concerns e.g. disruptive behavioural and aggressive in children. Refer to additional specialty services e.g. EIPS, Refugee health clinic, parental support groups.
 - Collaborate with GPs, local government and non-government care providers to advocate for appropriate services for CALD / Refugee



Family Health Assessment – A guide for child health nurses and other child health clinicians (Queensland Health, 2012)

Queensland Transcultural Mental Health Centre

www.health.qld.gov.au/metrosouthmentalhealth/qtmhc/default.asp

Raising Children Network | <http://raisingchildren.net.au/>

Good Food for New Arrivals | <http://goodfood.asetts.org.au>

A range of pamphlets and relevant information specific to refugee and asylum seekers especially around food and nutrition.

The Queensland Program of Assistance to Survivors of Torture and Trauma | www.qpastt.org.au

Offers a range of culturally sensitive resources for those who have suffered trauma prior to arrival in Australia.

Responding to need

This section:

- Identifies higher level and specialty services that are available to children who have additional needs,
- Identifies some of the needs whereby children may require a higher level of intervention. For the purpose of this manual, the following three issues have been discussed:
 - weight faltering / malnutrition
 - childhood obesity
 - behavioural difficulties.
- Outlines how child health professionals work with families with identified needs.

The healthcare context

A comprehensive health assessment will provide the foundation for clinical decision making by the child health professional when additional needs are identified. The pathway for additional services and ongoing care will be guided by the local HHS model of care and the clinical context, this may include:

1. Short term individual structured intervention,
2. Engagement in a case management approach, and/or
3. Referral to another service.



Immediate action will be required in the event that an acute health issue is identified by the child health professional, for example:

- concerns for the immediate safety of the child / family, e.g. domestic violence, child abuse or neglect
- impaired parenting capacity, e.g. parent exhibiting signs of psychosis or acute mental health concern
- concerns about a child having been abused or neglected.
- the child acute symptoms, e.g. difficulty in breathing, change of level of consciousness.

In situations such as these, the child health professional will take immediate action to alert the relevant emergency services e.g. Ambulance, Police, Acute Mental Health Services, Royal Flying Doctor Service, Queensland Government Department of Communities, Child Safety and Disability Services.



Primary Clinical Care Manual
Topics: Patient assessment, emergencies

Case management

To manage and coordinate service provision for families with identified needs where a number of health care providers are involved, a case manager may be assigned to the family to coordinate the overall care. This model of care has demonstrated a more effective approach with a greater chance of the needs of the family being met ¹⁷⁷.

Key elements of case management include:

- family partnership
- comprehensive and ongoing family assessment
- cultural safety
- working with and utilising community resources (it is important for the case manager to be aware of local services available to meet additional needs of families)
- participating in interdisciplinary consultation and collaboration
- monitoring and evaluating client and service delivery outcomes
- advocating on behalf of a child with an identified need
- documenting client encounters and case manager activities with a focus on family centred practice
- scheduling of follow-up and review, outlined in the care plan.
- During transitions between services children and families are particularly vulnerable to experiencing 'care fragmentation' ¹⁷⁶. This includes:
 - from the community to hospital and back to community after inpatient events
 - between general practitioners, agencies and other services
 - for children placed with different carers
 - between health care professionals in the same organisation.
- Ideally a care plan will be developed in partnership with the family across the continuum of care ¹⁷⁶.
- All health professionals should work together, particularly at the point of transition between services, with a commitment to collaborating to improve outcomes for the child and family ¹⁷⁶.
- Good communication is integral to all these processes ¹⁷⁶.
- Families accessing a range of services can use the PHR to record significant health events / problems, notes and appointments.

Brief practice intervention

There are a range of situations where additional need may be identified in this age group, the following tables outlines some of these:

Weight faltering / malnutrition 24,59,83-86,88,140,178, 177, 180,181,207-208

- Child health professionals refer to a medical officer when the child's weight for age decelerates over two percentile lines or falls below the 10th percentile for further investigation.
- Weight faltering describes a pattern of growth rather than a diagnosis and may include normal variations of growth .
- Malnutrition is diagnosed by a medical officer by looking at a number of criteria that should include an assessment of the diet and eating behaviours, past and current medical, social, and family history, and should include a complete physical examination.
- Malnutrition occurs when a child is under nourished to the degree that it results in failed growth occurring due to inadequate caloric intake, inadequate absorption or excessive caloric expenditure.
- Prolonged, severe malnutrition can result in poor physical and cognitive development.

Clinical practice points

- Conduct a comprehensive family health assessment to identify specific needs of the individual child/ family, this should include:
 - Food intake, what and how much, how often
 - Cultural and social context of meal times
 - Impact of family budget on food availability
 - Impact of rural environment on food choices
 - Sleep patterns (poor sleep can disturb metabolic processes and disrupt appetite control)
 - Activity assessment e.g. mealtime environment, play activities
 - Parental- child interaction particularly during meal times.
 - Parental psycho-education in particular:
 - › Demonstrate how their child is progressing on the percentile charts and explain the need for intervention.
 - › Talk about the importance of nutrition and promote healthy eating habits based on the Australian Dietary Guidelines
 - › Educate parents to regard mealtimes as a period of learning and love.
- Work in partnership with the family and other health care professionals to implement a plan of care to promote responsive feeding practices including:
 - Advise caregivers/parents to recognize child's signals of hunger and satiety, and not to force the child to eat;
 - Provide consistent time and location for meals;
 - Child ideally seated with the family in a comfortable chair when having meals;
 - Provide a pleasant environment and remove distractions e.g., calm environment, no television, avoid family conflicts
 - Provide food that is developmentally suitable, nutritional, and fresh when possible

Weight faltering / malnutrition 24,59,83-86,88,140,178, 177, 180,181,207-208

Clinical practice points

- Promote child's interest in food e.g., provide food predictably when child is hungry, cease meal time when child is showing signs of disinterest; provide appropriate variety and texture of foods; promote independent eating.
- Establish family routines around mealtimes e.g., hand washing before eating, model healthy meal time behaviours, make healthy choices for the entire family.
- Consider the use of a diet diary
- Provide three meals and two snacks each day.
- Monitor emotional health of parents.
- Provide ongoing support and review of progress through follow up visits.
- It is important not to re-measure too often as this may cause high parental anxiety, usually the GP / Paediatrician / Dietician will suggest a recommended plan for reweighing.

Higher level services

Case management strategies may include:

- Have a multidisciplinary team approach with the involvement of health professionals with varied specialties. The management strategy should include:
 - A diet plan for provision of adequate calories, protein and other nutrients;
 - Nutritional counselling;
 - Monitoring of growth and nutritional status;
 - Treatment for the underlying cause of malnutrition;
 - Specific treatment of complications or deficiencies.
 - Targeted home visiting according to need/risk.
 - Consider risk of impaired parenting
- Many parents do not notice weight faltering / malnutrition due to its insidious and gradual presentation
- Additional parental support may be required to work this through with parents observe parent-child interaction and emotional health.
- Targeted parenting groups e.g. Circle of Security group.

Referral options

- GP
- Specialist clinics/services e.g. feeding clinic, early parenting service
- Dietician
- Ellen Barron Family Centre
- Early intervention clinician
- Speech pathologist



Eat for Health: Australian Dietary Guidelines | www.eatforhealth.gov.au

Raising Children Network | <http://raisingchildren.net.au>

Obesity in childhood ^{24, 84, 87, 141, 140}

- Child health professionals refer to a medical officer when the child's weight for age accelerates over two percentile lines or is above the 95th / 97th percentile for further investigation.
- One of Australia's leading health concerns is the effects of overweight and obesity, with risks including type 2 diabetes, cardiovascular disease, mental illness and eating disorders.
- Other possible consequences of overweight and obesity for children's health and wellbeing may include:
 - Social discrimination and associated poor self-esteem, depression, teasing or bullying
 - Increased risk of experiencing early onset of puberty
 - Increased risk of developing negative body image and eating disorders.
- The causes of obesity are multidimensional e.g., inheritability, lifestyle factors (sedentary activities, screen time), early life experience (poor maternal nutrition), environmental factors (availability of cheap processed foods with high levels of saturated fats, salt, sugar).
- Evidence suggests that excess weight gain in infancy can predict later obesity.
- Exclusive breastfeeding for the first 6 months is known to reduce the risk of obesity.
- Weight maintenance during childhood growth will usually result in a gradual decline of the BMI.
- Aboriginal and Torres Strait Islander children are at greater risk of obesity and type 2 diabetes in children.
- Children are more at risk of becoming obese if their family is:
 - from the Pacific Islands, Middle East or Arabic regions
 - experiencing socio-economic disadvantage
 - living in rural and regional areas.

Clinical practice points

- Conduct a comprehensive family health assessment to identify specific needs of the individual child / family, this should include:
 - Dietary intake, what and how much.
 - Cultural and social context of meal times e.g. where are meals eaten and with whom?
 - Impact of family budget on foods.
 - Impact of rural environment on food choices.
 - Child sleep patterns (poor sleep can disturb metabolic processes and disrupt appetite control [80]).
 - Child activity assessment e.g., play time activities, mealtime environment, screen time.
 - Parent- child interaction particularly during meal times.
- Parental education, in particular:
 - Demonstrate how their child is progressing on the percentile charts and explain high rates of obesity in the Australian population.
 - Talk about the importance of nutrition and promote healthy eating habits based on the Australian Dietary Guidelines.
 - Describe the concept of 'often' foods and foods to limit.

Obesity in childhood 24, 84, 87, 141, 140

- Discourage habits such as using foods for reward, and giving foods as a form of comfort.
- Encourage drinking plain water rather than other sweetened drinks e.g., cordial, juices, soft drinks, sports drinks.
- Promote an increase in physical activity and reduction in sedentary activities
- Work in partnership with the family to develop an ongoing plan of care to promote responsive feeding practices and sustainable family lifestyle habits, i.e., child ideally seated with the family at meal times, in a comfortable and safe chair;
- Provide a pleasant environment and remove distractions e.g., calm environment, no television, avoid family conflicts
- Provide food that is developmentally suitable, nutritional, and fresh when possible
- Avoid foods with added salt and sugar, high in saturated fats.
- Promote child's interest in food e.g., provide food predictably when child is hungry; provide appropriate variety and texture of foods; promote independent eating.
- Establish family routines around mealtimes e.g., hand washing before eating, modelling healthy meal time behaviours, making healthy choices for the entire family.
- Provide three meals and two snacks each day. Have set meal times and avoid food craving.
- Early weight management awareness gives children the opportunity to learn positive lifestyle behaviours.
- Provide ongoing support and review of progress through follow up visits

Higher level services

Case management strategies may include:

- Weight maintenance is an acceptable approach in most situations.
- Have a multidisciplinary team approach with the involvement of health professionals with varied specialties. The management strategy should include:
 - A diet plan for provision of adequate calories, protein and other nutrients;
 - Nutritional counselling;
 - Monitoring of growth and nutritional status;
 - Lifestyle change— including healthy eating habits, reduced sedentary behaviour, increased physical activity and measures to support behavioural change.
 - Assist children with disordered eating, poor body image, depression and anxiety and weight-related bullying where these are present.
- Consider risk of impaired parenting
- Observe parent-child interaction and emotional health
- Targeted groups e.g. Kids on Track, PEACH (Parenting, Eating and Activity for Child Health)

Referral options

- GP
- Specialist clinics/services e.g. feeding clinic
- Dietician
- Early intervention clinician
- Group programs, e.g. PEACH program, Kids on Track

Bullying / cyberbullying / cybersafety ^{205, 209, 210, 211, 212}

- Bullying / Cyberbullying is when people repeatedly and intentionally use words and actions to cause distress and may include hurtful messages (body languages, teasing, making rude gestures in person or on-line) or keeping someone out of a group (on or off-line).
- The general prevalence for 10-17 year old Australians experiencing cyberbullying in a year is around 20% with the peak age being 12-15 years.
- High rates of bullying occur in Australian primary schools with approximately 25% of students in Year 4 and 32% of students in their final primary school years report being affected by bullying (Kids Helpline – School related bullying, 2012)
- There are further threats to young people’s safety on line through cyberstalking, which can include frequent and intrusive threats, cryptic messages and sexual innuendo. Some adult predators engage in on-line grooming by creating fake profiles to befriend and gain the trust of young people on-line. The prevalence of cyberstalking in Australia is unknown.
- It is vital to include safety messages that are specific to the risks the children are exposed to in your community as well as the general risks. Research in your local area will indicate the most common injury risks.

Clinical practice points

- As there is no easy division between ‘traditional’ bullying and cyberbullying, interventions and preventions should look at strategies which deal with both of these. Health promotion messages should communicate the seriousness of the problem, including potential legal and social consequences.
- Use a coordinated approach involving children, parents and schools in the process of raising awareness of risks, and developing measures to counter inappropriate on-line behaviours.
- Encourage parents to role model appropriate behaviours in the home, e.g., no bullying, violence, healthy boundaries and assertiveness.
- Encourage children to talk to someone they know and trust, a friend or adult if they feel bullied.
- If they feel safe and confident encourage them to talk to the person who is bullying them and tell them you won’t put up with it.
- Encourage conversations around school life and difficulties such as bullying.
- Encourage your child to avoid being a silent bystander and speak up if he/she witnesses bullying, by talking to a friend / adult / teacher.
- Discourage computers and televisions in the bedroom / areas that limit adult supervision.
- Avoid ‘brushing off’ a child’s complaint of bullying.
- Tell your child bullying is not their fault.
- Children experiencing bullying may present with a range of symptoms including:
 - Unexplained bruises, cuts, pencil marks on skin,
 - Reluctance to attend school
 - Being easily distressed
- Seek professional support if the child is experiencing ongoing difficulties.
- Ensure families and kids have access to information such as Helplines, brochures etc. School related bullying (Kids Helpline, 2012)
www.kidshelp.com.au/grownups/news-research/hot-topics/bullying.php#cite-note_3

Bullying / cyberbullying / cybersafety ^{205, 209, 210, 211, 212}

Higher level services

Case management strategies may include:

- Cybersmart | www.cybersmart.gov.au/Schools.aspx
Commonwealth Government site with a variety of resources on cybersafety
- ThinkUKnow | www.thinkuknow.org.au/site/index.asp
An internet safety program – includes interactive training for parents, carers and teachers
- The Safe Schools Hub | www.safeschoolshub.edu.au/safe-schools-toolkit/overview
A toolkit for a whole-of-school approach to addressing safety and wellbeing, including bullying and safe and responsible use of ICT.
- Reachout | <http://au.reachout.com/cyberbullying>
Useful information about cyberbullying for young people

Disruptive behaviour / aggression / regulatory disorders ^{24,116}

- During the preschool years, most children learn how to demonstrate their sense of autonomy in a socially acceptable manner, i.e., self-regulation. Tantrums that are common in the 2 – 3 years slowly lessen with children being more able to communicate their concerns and needs to their care givers.
- Some children however will display ongoing disruptive behaviours, aggression and regulatory disorders. Parents may be raise concerns such as their child being:
 - Overly sensitive, fearful, anxious
 - Intolerant to change
 - Slow to engage or react
 - Difficult to control and aggressive outbursts
 - Poor impulse control and overactivity
- Commonly these issues are associated with poor eating and sleeping behaviours.

Clinical practice points

- Conduct a comprehensive family health assessment to identify specific needs of the individual child / family, this should include:
 - Child's nutritional, activity and sleeping history
 - Assess growth and development to ensure there is not an underlying medical issue
 - Cultural and social context of the family environment
 - Child activity assessment, e.g. physical activity, screen time
 - Type of behaviours and circumstances around the behaviours e.g., what settings do these behaviours occur and is it when particular people are around them?
 - Parent-child interaction.
 - Explore parental responses to the child's behaviours.

Disruptive behaviour / aggression / regulatory disorders ^{24,116}

Clinical practice points / cont.

- Parental psycho-education, in particular:
 - Discuss developmentally appropriate behaviours and the benefits of a secure child-parent attachment.
 - Discuss the tendency of boys to have more aggressive behaviours than girls.
 - Provide information during the appointment about parenting techniques that may enhance child behaviours and provide information and resources e.g., parenting tip sheets on discipline
 - Promote parental reflection on their current strategies and how they may be able to alter their own behaviours / reactions and try different parenting strategies.
 - Provide information on strategies that may reduce parenting fatigue e.g., ways to maximise parental support and manage the additional needs of the child at this time.
 - Work in partnership with the family to develop an ongoing plan of care to promote positive childhood behaviours. This may include: Establishing a family routine around sleep, mealtimes, hygiene needs, exercise and play, using reward charts for positive behaviours.
- Encourage parents to enrol in a group parenting program e.g. Triple P.
- Provide ongoing support and review of progress through follow-up visits

Higher level services

Case management strategies may include:

- Targeted parenting groups e.g. Triple P Parenting Program
- Early Intervention Clinician / Parenting Specialist
- Consider risk of impaired parenting

Higher level services

- Refer to GP/MO to rule out underlying medical condition.
- Child and Youth Mental Health Service



Raising Children Network | <http://raisingchildren.net.au>

Nature Play QLD: Getting Our Kids Outdoors | www.natureplayqld.org.au/about
Green Time vs Screen Time tool - www.natureplayqld.org.au/resources/21/green-time-vs-screen-time

Protecting children

The role of child health professionals encompasses a range of broad multifaceted practice strategies from health education and promotion, growth and development monitoring, early intervention for health issues through to complex assessment of the safety of a child [186]. The Child Safety QHEPS site provides information for Queensland Health staff. Child Protection Liaison Officers (CPLO) and Child Protection Advisors (CPA) provide support to local HHS staff when managing child protection issues. While recognising and responding to child abuse and neglect remains a focus for all health workers, it is a mandated process for nurses, midwives and medical officers.

All health professionals have a responsibility in recognising, reporting and responding to child abuse and neglect (children that have suffered, may be suffering, or at risk of suffering significant harm). Queensland Government Guidelines clearly articulate these responsibilities, including:

- Health Professional Child Safety Capability Requirements
- Reporting and responding to a reasonable suspicion of child abuse and neglect
- Responding to an unborn child health risk alert
- Information sharing in child protection.

Initial orientation to local Child Protection processes and key contacts should be part of the on-boarding of all child health professionals along with annual updates.

The following are some factors that may increase the risk of child abuse or neglect:

Child factors	Family characteristics
<ul style="list-style-type: none"> ■ Children younger than 4 years of age ■ Children with a disability, e.g., deafness ■ Poor sleep patten, e.g., frequent waking in the night ■ Altered child-parent attachment ■ Aboriginal and Torres Strait Islander descent 	<ul style="list-style-type: none"> ■ History of abuse or neglect of another child in the family ■ Absence of social supports / isolation ■ Parental mental illness, depression, anxiety ■ Parental chronic illness ■ Parental substance abuse ■ Poor parent-child interaction ■ Altered parent-child attachment ■ Parental history of poor impulse control ■ At risk family structure e.g., single parent, recent separation of parents, parental conflict ■ Children in out-of home care

24, 171, 189

- **Factitious disorder imposed on another** (previously known as factitious disorder by proxy / Münchhausen syndrome by proxy) is a rare form of child abuse whereby a caregiver (most commonly the child's mother):
 - fabricates history (commonly allergy, fever, asthma, seizures),
 - exaggerates the child's behaviours, and/or
 - induces signs of illness (e.g., use of laxatives, starving)

to the extent that unnecessary medical procedures and treatments are implemented. The child may have a past or current medical condition.

- Considering the following factors may assist the child health professional during comprehensive assessment:
 - Does the caregiver have a diagnosis of mental illness (50% of perpetrators have a factitious disorder themselves and 75% have a co-existing personality disorder)
 - Does the child health professional's physical examination and observations match the caregiver's concerns?
 - Do other family members confirm reported history?
 - Is there diagnostic evidence?
 - Have treatments been commenced due to caregiver's insistence? ^{24, 190}
- There are numerous factors to consider when determining a reasonable suspicion of child abuse or neglect. At times, a single factor e.g., cigarette burn mark, may clearly indicate the need for a report. At other times a broader view of the circumstances may be needed. Working within a risk and protective factor framework may assist the clinician in making this judgement. Within this framework, risk factors are those that have the potential to increase the risk of harm and protective factors are those that have the potential to provide additional safety for the child or lessen the risk ¹⁸⁹.



For an example of a risk and protective framework, see page 174.

- To fulfil their responsibilities as mandatory reporters, doctors and registered nurses are required to immediately report to Department of Communities Child Safety and Disability Services of a reasonable suspicion that a child has suffered, is suffering or is at risk of suffering significant harm caused by physical and sexual abuse and may not have a parent able and willing to protect them from harm. This does not preclude reporting of significant harm caused by emotional/psychological abuse and neglect.
- Any other health professional has a duty of care to report a reasonable suspicion of child abuse and neglect which meets the same threshold.
- Child health professionals need to be aware that their report provides a snapshot of circumstances from their own professional perspective, at the time of the report. Circumstances may change quickly, e.g., when their report is added to other information held in relation to the family such as Police reports, a different response may be determined by the Department of Communities, Child Safety and Disability Services, than what the child health professional may have been expecting.
- Resources that support the child health professional include the Child Safety home page resources, CPLO, CPA and Line Manager.



- When a health professional forms a reasonable suspicion they should immediately report their concerns directly to Child Safety Services using a 'Report of suspected child in need of protection form. It is recommended that you also telephone Child Safety Services and document your actions in the client's record.
- When a child health professional suspects a child has been physically harmed and fears they follow local policy and guidelines to:
 - facilitate immediate access for acute medical assessment of the child
 - Report to Department of Communities, Child Safety and Disability Services if the harm is significant and there is not be a parent able and willing to protect the child.
 - notify their supervisor/s
 - forward a copy of the report to your local CPLO / CPA.



Dealing with requests for information from Queensland Police Service

Staff may at times be approached by Queensland Police for information; be requested to provide a statement or be interviewed by police; or be approached by the Queensland Police Service to attend court to give evidence. Should any of these situations occur, it is essential to first discuss the matter with your line manager who will seek advice from HHS management/medico-legal services as required, and direct you to specific HHS policies and procedures addressing the matter.



Department of Communities, Child Safety and Disability Services | Enquiries Unit: 1800 811 810
www.communities.qld.gov.au/childsafety/child-safety-services

The Queensland Child Protection Guide

www.communities.qld.gov.au/childsafety/partners/our-government-partners/queensland-child-protection-guide/online-child-protection-guide

Referral for Active Intervention services

www.communities.qld.gov.au/childsafety/child-safety-practice-manual/chapters/10-general/10-14-referral-for-active-intervention-services/key-steps/1-determine-eligibility-for-a-rai-referral

Section 4

12 to 18 years



Adolescence is a significant transition period when many important modifiable risk factors emerge or accelerate to influence health and wellbeing in later life. Consequently, adolescence is an opportune time for health gains through both prevention and early intervention^{213, 214}. The school-based youth health nursing service targets this life-span period by providing a range of prevention and early intervention activities to support the health and wellbeing of young people in state secondary schools across Queensland. In some areas school-based adolescent health services are also supported by Aboriginal and Torres Strait Health Workers.

School-based youth health nurses (SBYHN) utilise the Health Promoting Schools Framework to work collaboratively with school communities to address contemporary health issues, while also supporting young people identified at risk through brief intervention and referral to relevant support services²¹⁵. SBYHN service provision is guided by a Memorandum of Understanding and Program Management Guidelines negotiated between individual Hospital and Health Services (HHS) and the corresponding DETE regional office. SBYHNs also practice in accordance with relevant Standards of Practice, such as the National School Nursing Professional Practice Standards³ and the Competencies for the Specialist Paediatric and Child Health Nurse (currently under review)².

The practice guidelines outlined in this manual are intended to provide clarity surrounding areas of youth health practice where guidance may not be provided in the relevant SBYHN Memorandum of Understanding and Program Management Guidelines or HHS policies/procedures. These practice guidelines constitute a general guide only and are subject to the professional judgement of the SBYHN and Aboriginal and Torres Strait Islander Health Worker and the requirements of the HHS in which they practice. They are presented in accordance with the core service elements outlined in the National Framework for Universal Child and Family Health Services (2011) which provide the structural framework for this manual, however as previously highlighted, the SBYHN role is focused on primary prevention activities aimed at promoting health and wellbeing, mediating risk and supporting early intervention for young people, as opposed to screening and surveillance activities.



Exemplar documents surrounding HHS/DETE partnership arrangements to support the SBYHN role may be accessed via the SBYH SharePoint site www.notes.health.qld.gov.au/sites/sbyh/default.aspx.

Note: Access to site restricted to SBYHNs.

Health and developmental surveillance

Social determinants of health and wellbeing

- Adolescence is a period of rapid growth and physiological changes, individuation, socialisation and emotional development marking the transition between dependence and independence. Many of these adolescent developmental changes can impact on short- and long-term health and wellbeing^{213, 216}.
- Structural determinants of health (such as access to education, health-care services and employment opportunities), intermediate determinants of health (such as connectedness to family and school) and exposure to social and environmental risks also affect health behaviours during adolescence and health outcomes^{213, 217-218}.
- Health behaviours account for a large proportion of the burden of disease in Australia. These behaviours include tobacco smoking, physical inactivity, substance use, poor diet and unsafe sexual practices. Many of these behaviours are initiated during adolescence, and consequently interventions to avert or alter young people's engagement in these behaviours may significantly influence long term health outcomes^{214, 218, 219}.
- The leading causes of injury and death for young people are falls, transport incidents, intentional self-harm, assaults and suicide.

- Males are more likely to succumb to injury from falls, transport incidents and assaults, whereas females are more likely to be hospitalised for intentional self-harm;
- Aboriginal and Torres Strait Islander young people are over-represented in deaths as a result of suicide²²⁰, and are 1.7 times more likely to suffer injury than other young people¹⁶⁵.
- The leading health concerns for young people are:
 - Mental health issues (relating to stress, depression, body image, bullying, deliberate self-harm, relationship difficulties and eating disorders);
 - Unsafe sex and sexually transmissible infections (particularly chlamydia and gonorrhoea);
 - Substance use (including tobacco smoking, alcohol consumption and illicit drug use) and violence associated with substance use;
 - Overweight and obesity increasing the risk of chronic disease;
 - Unsafe levels of sun exposure increasing the risk of skin cancer;
 - Asthma; and
 - Oral health problems such as untreated decay^{213, 220}.
- Young Aboriginal and Torres Strait Islander people experience the same health concerns as other young people however, the extent of the problem is comparatively higher. For example:
 - There is a higher prevalence of psychological distress, with a three times greater rate of hospitalisation for mental and behavioural disorders (with schizophrenia, alcohol misuse and reactions to severe stress representing the leading causes);
 - Aboriginal and Torres Strait Islander young people are more than twice as likely to smoke cigarettes on a daily basis¹⁶⁵; and
 - The rate of diagnosis of chlamydia for Aboriginal and Torres Strait Islander young people was 3.5 times that of the non-Indigenous notification rate²²¹.
- Safe and supportive families and schools, and positive peer interactions represent protective factors for young people. Supporting them with health information, skill development and access to appropriate health services also serves to minimise health risk behaviours and supports them to optimise their health in the transition to adulthood^{213,24,217}.

Service access barriers

- A range of barriers influence young people's access to health services, including:
 - limited knowledge of available services;
 - concerns regarding confidentiality;
 - attitudes, communication style and confidence of the health care provider;
 - negative perceptions of health services;
 - affordability;
 - transportation issues;
 - developmental characteristics of young people (e.g. decreased insight into their health needs and/or difficulties expressing their concerns); and
 - issues relating to gender, age and culture²²²⁻²²⁵.
- It is important to be mindful of these barriers so that SBYHNs and Aboriginal and Torres Strait Islander Health Workers may promote a youth-friendly health service in the school setting, while also working effectively with young people and their parents to overcome barriers to accessing other suitable health care services within the community.

The healthcare context: school-based

School-based youth health nursing service provision

- In line with current Department of Health Service Agreements, every Hospital and Health Service is required to provide school based youth health nursing services to state secondary schools in Queensland to support and promote adolescent health and wellbeing through a Primary Health Care (PHC) framework.
- SBYHNs maintain a preventative rather than treatment focus and work to promote positive health outcomes for young people and their families through the delivery of accessible, acceptable, appropriate and culturally respectful PHC services in the school setting. More specifically SBYHNs:
 - provide the opportunity for young people, their parents and members of the school community to access a health professional for matters relating to the health and wellbeing of young people; and
 - support school communities to adopt a whole-of-school Health Promoting School approach to address contemporary health and social issues facing young people and their families in order to help young people make a safe and healthy transition into adulthood ²⁸⁸.
- Young people in schools are provided with access to the SBYHN in a number of ways:
 - Individual, confidential consultations involving age-appropriate assessment, brief intervention and referral to appropriate health services or community agencies;
 - health information sharing in the classroom through co-facilitation of lessons with a health and wellbeing focus; and
 - targeted group work in partnership with other support personnel.
- It is recommended that the activities of the SBYHN be developed in consultation with each school community and documented in a formal business plan. It would be prudent to structure this plan in accordance with the strategic objectives of the relevant HHS in order to demonstrate support for the achievement of key performance indicators. An example business plan template is provided (see appendix 9) which outlines generic activities surrounding SBYHN service delivery in the school setting. It is recommended that business plans be contextualised to each school community with activities informed by SBYHN client data and health promotion evaluations, as well as discussions with school community members and the Local Consultative Team (LCT) (which will generally comprise the SBYHN, line manager and the school's principal or appointed proxy). The business plan should also be informed by and build upon recommendations made in the previous LCT report. An example LCT reporting template is provided (see appendix 10). This should be populated in accordance with the content of the business plan.

Specific exclusions to the SBYHN role

- In view of the intent of the SBYHN role and as a nurse is not always in attendance at a particular school, there are specific exclusions to the SBYHN role, including:
 - The SBYHN does not provide clinical or intensive nursing care (such as first aid, wound care, medication administration, stomal care, gastric feeding, or intensive long term therapeutic counselling); and
 - The SBYHN will not be given supervisory duties for any group of students or individuals other than during individual health consultations or group health interventions.
 - It is important to note that group health interventions do not extend to school-based immunisation programs, and SBYHNs should not be charged with the responsibility of supervising students during these events or be expected to participate in the running of School Based Immunisation Programs (SIP) in secondary schools as a part of their role.
 - A fully trained and qualified vaccination team will conduct the School-based Immunisation Program (SIP). The team visiting your school may be from Queensland Health, your local Council or another health provider contracted by Queensland Health (contact 13 HEALTH [13 43 25 84] for details of the

SIP Coordinator in your area). Liaison with the school and organisation of the SIP is the primary responsibility of the School Based Vaccine Providers who are also responsible for: Arrangements with the school to obtain consent forms; providing adequate staffing to meet the requirements of the SIP; documentation; planning for emergency and contingency procedures; and evaluation.

- SBYHNs can work strategically with identified partners to assist with the development of approaches that will most effectively promote and increase the uptake of eligible secondary students to receive vaccination. This is discussed in Section 2 which addresses health promotion strategies in the school setting.
- Department of Education, Training and Employment (DETE) staff are to maintain responsibility for the administration of first aid services on and off school campus, including during school camps, athletics and swimming carnivals, school dances etc.
 - However, should the nurse be the first on the scene in a first aid situation, a duty of care exists to provide first aid intervention as is required to prevent further injury or death (providing this is administered in accordance with HHS policy and within the nurse's scope of practice). The SBYHN should be mindful of maintaining an accurate record of the incident and the interventions performed and store this record in accordance with HHS policy.
 - In the event that an opinion is sought from the SBYHN in relation to a first aid event, the SBYHN must act within their scope of practice and in accordance with HHS guidelines. A professional opinion about the nature of the injury or symptoms may be provided where appropriate, and the SBYHN may suggest referral to an appropriate medical service for further management or investigation as required (such as ambulance transfer to hospital or attendance at a GP).
 - It is the responsibility of the school to notify a student's parent or caregiver regarding any injury or illness, as per DETE policy and procedures.
 - The SBYHN does not function as the provider of training to school staff for first aid, medication administration or any nursing or medical care (such as EpiPen usage, gastric feeding, BGL testing etc). DETE is responsible for sourcing this training via other avenues.

Rapport building with young people in the school setting

Establishing consent

- Prior to progressing with a consultation it is important for the SBYHN to assess whether the young person has a sufficient level of maturity and understanding with regard to the issues and the health service proposed, and determine whether the young person comprehends and can consent to the service. This is called establishing 'Gillick competence'. It is not age specific and is based on the capacity of the young person to understand the nature and extent of the service being offered. It is necessary to consider their intelligence and general attitude, personality and state of health and wellbeing, as a young person with particular needs such as learning difficulties, physical disabilities, or communication problems may still be vulnerable whatever age they are ²²⁶.
- In line with good practice, the SBYHN will explore with the student the possibility of involving a parent/caregiver. If the request is declined, the possibility for this can be revisited once rapport has been built between the SBYHN and young person. However, the application of Gillick competence places the 'best interests' of the young person above any parental right to be informed.

Explaining confidentiality

- On initial presentation the SBYHN will explain to the young person the parameters of the service and bounds of confidentiality prior to the young person disclosing personal information. Confidentiality forms the cornerstone of effective therapeutic relationships between young people and health care providers. When young people understand a service is confidential they are more willing to disclose information about behaviours that entail a health risk, to seek health care, and to return for follow up consultations ²²⁷.
- Young people seeking support from SBYHNs in the secondary school are entitled to confidentiality of

their information under Part 7 of the *Hospital and Health Boards Act 2011, Queensland* (HHB Act)²²⁸.

- There will at times be exceptions where disclosure is permitted under the HHB Act²²⁸. It is important to clarify the parameters of confidentiality and highlight specific circumstances which require disclosure at the outset of the consultation to promote trust and allow the young person to make an informed decision as to the information they discuss with the SBYHN ²²⁷.
- In particular, young people should be made aware of Child Safety legislation and Queensland Health Guidelines which mandate reporting of: Engagement in sexual activity less than 14 years of age; concerns regarding non-consensual sexual activity; and sexual activity where there is a significant age or power imbalance.
- A comprehensive confidentiality preamble is not designed to prevent the notification of young people at risk of harm, but is essential to allow young people informed choice regarding the sharing of personal information, and to develop a trusting and empowering relationship with them.

Other factors which influence rapport building

- Nurses in SBYHN positions need to reflect on their own beliefs and values in order to ensure that these do not impact on the provision of safe, non-judgemental and culturally sensitive health care to young people.
- The SBYHN is not required to wear a HHS uniform as clinical uniforms can inhibit the rapport building process. Maintaining a smart-casual age-appropriate dress standard suitable for working in the school setting can help to build trust and emotional connections with young people ²²⁹.
- Further enablers to building rapport with young people include:
 - Introducing yourself on a first name basis and describing your role in the school and your availability.
 - Taking time to promote a connection by discussing topics unrelated to their issue of concern.
 - Maintaining awareness of popular music, TV, internet and social media preferences of young people to promote understanding of cultural factors that influence young people's health and wellbeing, while providing a point of congruence to build genuineness in the therapeutic relationship.
 - Using respectful language that is not laden with professional jargon. SBYHNs should be familiar with the contemporary vocabulary of young people and seek clarification of new terms, however they should avoid using adolescent lingo when speaking with young people.
 - Engaging in active listening, being attentive to subtle messages expressed by young people, and demonstrating empathy to ensure they feel heard and their experiences are regarded seriously helps to convey respect and build trust.
 - Sharing humour where appropriate.
 - Recognising that adolescents are not a homogenous group and therefore it is important to tailor communication and care to the individual needs and preferences of the young person ^{227, 229}.

Rapport building with adolescent boys

- Gender socialisation can influence adolescent boys' willingness to engage in help-seeking behaviours. Consequently it is helpful for SBYHNs to employ gender-specific strategies to promote access and build rapport with adolescent boys in the school setting. This can include:
 - reframing SBYHN service provision to reduce the stigma associated with help-seeking;
 - maintaining visibility in the school grounds to promote familiarity;
 - having posters in the room that appeal to boys and novelty items or sports equipment they may play with during consultations to deflect the intensity of the interaction and facilitate communication;
 - ensuring the consultation room is arranged to minimise a confrontational style of interaction;
 - considering an alternative venue for consultations that still protects the confidential nature of the

interaction;

- allowing boys to set the pace of disclosure;
- using male-orientated analogies to clarify their understanding;
- normalising developmental stages and behaviours;
- recognising that anger is the most dominant and socially accepted emotion for adolescent boys to display and can often result in their real needs being overlooked;
- providing a safe and non-judgemental environment for boys to express angry feelings, and helping them to recognise the emotions and situations that may have precipitated these feelings ²²³.

Culturally competent care

- In Australia many young people are not only experiencing the challenge of adolescence, but of growing up between two cultures. Culturally competent care is paramount for the SBYHN role in order to build rapport and foster a trusting relationship.
 - Nurses need to be sensitive to the cultural influences operating in an adolescent's life, and have an appreciation of the wide range of cultural, ethnic, linguistic and social differences among adolescents by taking the time to educate themselves about the different cultural and ethnic groups comprising their school communities.
 - Nurses should identify and challenge their own cultural assumptions, values and beliefs, and adopt a respectful, open and non-judgemental approach to dealing with culturally diverse young people and their families.
 - Specific communication and interaction skills may also be necessary, and interpreters may be needed to overcome the impact of language or communication differences with young people and their family members. SBYHNs are to adhere to specific HHS policies and procedures surrounding the engagement of interpreting services in consultation with their line managers and school administrative personnel.
 - It may be helpful to display multilingual posters and provide multilingual pamphlets on different health topics.
 - Scheduling longer appointments with adolescents from culturally and linguistically different backgrounds may also be necessary in view of potential communication challenges.
 - A comprehensive psychosocial history is crucial, and should include questions that enquire into cultural and identity issues. This would include enquiring as to how they view themselves within the context of their culture and whether they follow the norms of their culture. It may also be helpful to ask about the meaning of a young person's symptoms, where relevant, within the context of their culture of origin.
 - It may be appropriate to sensitively enquire about experiences that may have adversely affected their health, development and attitudes to illness (such as refugee experience, exposure to war and trauma and racism), and also consider whether cultural differences (such as attitudes to sexuality) might affect referral and treatment options.
 - It is also important to be sensitive to gender issues and preferences for male or female health professionals when initiating referrals to other services ²³⁰.

Engaging Aboriginal and Torres Strait Islander Young People

- A variety of barriers impact on help-seeking and health service utilisation by Aboriginal and Torres Strait Islander young people ²²² and SBYHNs should be mindful of specific cultural norms when attempting to build rapport and facilitate their engagement. Suggested strategies include:
 - Initially position yourself alongside the Aboriginal and Torres Strait Islander young person looking at the ground to allay any cultural concerns regarding the maintenance of eye contact. Assess non-verbal cues to determine their comfort with this style of interaction.

- It is vital that an immediate and personal connection is made with the Aboriginal and Torres Strait Islander young person and an effective means of achieving this is through a discussion about genealogy. It is helpful to have an understanding of different language and family groups within the region in which you work, and also be willing to share of your own background to promote engagement at a therapeutic level.
- Recognise that a holistic view must be taken of an Aboriginal and Torres Strait Islander young person's presenting situation (particularly mental health concerns) which incorporates physical, mental, emotional, spiritual and cultural states of being. Resist commenting on discrete symptoms or emotional states and instead provide more broad statements when reflecting concerns that encompass this holistic perspective.
- Aboriginal and Torres Strait Islander young people may be disinclined to respond to a direct question with a direct answer, particularly questions of a personal nature which may promote a sense of shame. Utilising more narrative and open-ended questions can mediate this and promote communication.
- Recognise that gender is a subculture within Aboriginal and Torres Strait Islander culture and that gender differences between the SBYHN and young person can inhibit discussion of private topics such as family relationships and sexual activity. Comment on this gender disparity and invite the young person to express how they feel about this. It may be necessary to facilitate the young person's access to a same-gendered support worker to address these issues ^{231, 232}.

Youth health assessment

- To facilitate effective care planning, SBYHNs need to explore beyond the presenting issue to determine the young person's strengths and supports, underlying concerns, risk factors and significant issues which require intervention. A youth health assessment will generally include two components:
 1. **Demographic assessment** – country of birth, language spoken at home, Aboriginal and Torres Strait Islander status, housing and family structure, engagement with support staff in and outside of the school, health and immunisation history and completion of a genogram (which is a visual representation of the young person's family and strength of connections). (NB: SBYHNs should follow HHS protocols surrounding the information required to support their specific client registration processes.); and
 2. **A psychosocial health assessment.**
- There are a variety of psychosocial assessment instruments available for use with adolescents which facilitate engagement and provide an overall understanding of the young person and their environment ²³³.

HEEADDSSS assessment

- The HEEADDSSS adolescent psychosocial assessment is a series of open-ended questions recommended by the Royal Australasian College of Physicians for use in primary, secondary and tertiary care environments, and is ideal for use with young people in the secondary school setting. The HEEADDSSS assessment begins with less emotionally charged issues and moves to the more sensitive ones allowing the health professional to build rapport with the young person while systematically gathering information about their world, including details surrounding their family, peers, schooling and health-risk behaviours. It helps to identify areas for intervention and prevention while also eliciting the young person's strengths and protective factors ²³⁴.
- HEEADDSSS is an acronym which guides assessment of relevant domains, including:
 - home
 - education/employment
 - eating and exercise
 - activities and peer relationships
 - drug use/cigarettes/alcohol

- depression/self-harm/suicidality
- sexual activity/sexuality
- safety
- spirituality.
- A willingness and openness of the youth health professional to talk about issues such as drugs, sex, suicide and depression demonstrates concern and caring and allows the normalisation of these issues in the context of the issues affecting the lives of young people.
- Careful wording of questions and use of the HEEADDSSS assessment tool in the standard format helps to minimise the discomfort of both the professional and the young person. Be mindful to request permission to ask sensitive questions and it may be helpful to use a ‘third person’ approach when discussing some topics to increase the young person’s comfort (e.g. ‘a friend who has a problem’).
- Due to broad ranging developmental maturity across adolescence it is also important to be aware of appropriate questions to ask with the HEEADDSSS assessment tool for different ages.
- Additionally, the circumstances surrounding the young person’s visit, the time available for the consultation and the young person’s willingness to engage will influence whether or not a complete HEEADDSSS assessment is conducted during an initial consultation, and it may be necessary to undertake this over subsequent visit/s.



See appendices 11-12 for an example of an Adolescent Health Record (incorporating a genogram template) and a HEEADDSSS assessment tool. For further information on the use of the HEEADDSSS tool in your work with young people refer to the GP Resource Kit 235.

Risk and protective factors

- SBYHNs should be mindful of the balance of risk and protective factors when evaluating a young person’s situation and developing an appropriate plan of care. Risk and protective factors fall into four broad domains: the individual, family, peer group and school, and community.
 - Examples of risk factors in young people include low self-esteem, chronic illness, refugee status, family breakdown, bullying and social isolation in school, together with parental risk factors such as alcohol abuse, depression and unemployment.
 - Examples of protective factors are an intact family, strong parental engagement, good peer relationships, and participation by the young person in school and in sporting or creative activities that they enjoy and from which they gain social interaction and new skills ²³⁶.
- Where there are concerns about a young person’s mental health and wellbeing, and particularly their risk of self-harm and/or suicide, a more comprehensive mental health and risk assessment is indicated which encompasses both subjective and objective assessment data to assess their level of risk and the immediacy of intervention.
 - This may be achieved by the inclusion of specific probing questions throughout the HEEADDSSS assessment, or you may find it helpful to utilise a separate mental health and suicide assessment checklist to guide your assessment and your determination of the young person’s level of risk relative to their reported protective factors.



See appendix 13 for an example of a Mental Health Assessment Guide and Checklist for Suicide Risk Assessment.



Guidelines for Suicide Risk Assessment and Management
http://qheps.health.qld.gov.au/mentalhealth/docs/guide_suicide_risk.pdf

Recognition of child abuse and neglect

- While working with young people in the school setting there may be opportunities to identify and recognise child protection issues that are specific to the young person.
- Informing a reasonable suspicion of child abuse and neglect, health professionals are able to share information regarding a child's health, safety and wellbeing needs with other government agencies (defined as prescribed entities e.g. Queensland Health, Queensland Police Service, Department of Communities, Child Safety and Disability Services).
- It is important to have a thorough knowledge and understanding of the definitions of child abuse and neglect in order to respond consistently and appropriately.
- In recognising child abuse and neglect in children in the school setting it is important to refer to the clinical information that may assist in the formation of a reasonable suspicion of child abuse and neglect.



When a health professional forms a reasonable suspicion they should immediately report their concerns directly to Child Safety Services using a 'Report of suspected child in need of protection' form.

When a child health professional suspects a young person has been physically harmed they follow local policy and guidelines to:

- facilitate immediate access for acute medical assessment of the young person
- Report to Department of Communities, Child Safety and Disability Services if the harm is significant and there may not be a parent able and willing to protect the child.
- notify their supervisor/s
- forward a copy of the report to your local CPLO / CPA.



School staff have reporting obligations regarding reasonable suspicions of child abuse and neglect that they become aware of in their work with students and families. Should school staff approach you with concerns regarding a student's safety, remind them of their reporting obligations and refer them to the DETE policies pertaining to this responsibility.



Department of Communities, Child Safety and Disability Services

Child Safety Services' enquiries Unit: 1800 811 810
www.communities.qld.gov.au/childsafety/child-safety-services

The Queensland Child Protection Guide is an online decision-support guide available to assist professionals
www.communities.qld.gov.au/childsafety/partners/our-government-partners/queensland-child-protection-guide/online-child-protection-guide



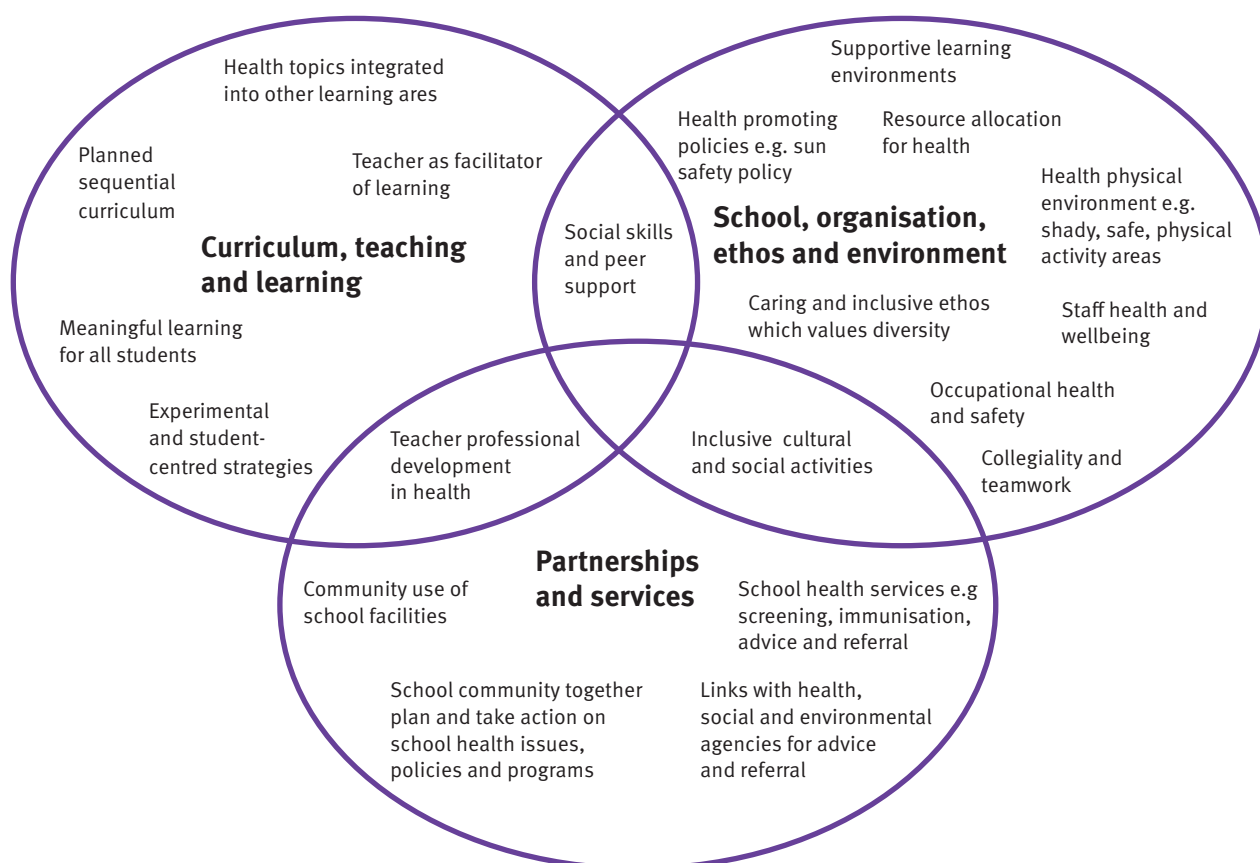
Child Safety Unit, Queensland Health | qheps.health.qld.gov.au/csu/
 Fact sheet: Clinical Risk Factors and Indicators of Harm in Children 13-18 years
 Fact sheet: Information Sharing

Health promotion

Health promoting schools approach

The SBYHN service is focused upon prevention, harm minimisation and early intervention. SBYHNs utilise the Health Promoting Schools (HPS) Framework to guide their health promotion efforts and build capacity to support health and wellbeing in the secondary school setting.

The HPS Framework is based on the Ottawa Charter for Health Promotion (1986) and incorporates the three interconnected domains of: curriculum, teaching and learning; school, organisation, ethos and environment; and partnerships and services¹⁹⁸ (see diagram below).



- The HPS framework represents the complex nature of the school environment and highlights the importance of working across each of these areas to promote a coordinated and comprehensive approach to health and wellbeing. The HPS approach is built upon collaborative partnerships between a range of disciplines within and external to the school, with health promotion strategies being tailored to meet local need and align with the socio-cultural status of the school community^{194,237}.
- To ensure the sustainability of health promotion strategies, the SBYHN is not the driver of health promotion within the school but can provide a facilitative role and act as a catalyst for change. In her seminal study of SBYHN implementation of the HPS approach, Carlsson (2005) determined that SBYHNs represented a significant enabler to schools' adoption of HPS practice and influenced positive health outcomes for individuals and school communities. However, a number of barriers were identified that influence HPS implementation. These include:
 - Lack of funding support for health promotion initiatives;
 - Time constraints;

- Inadequate understanding of the HPS approach (by the SBYHN and school personnel);
 - Inadequate skills and confidence of the SBYHN to advocate for and support HPS strategies;
 - Insufficient commitment of the school to the HPS approach, particularly at a policy level; and
 - Inadequate community connections ²¹⁵.
- To overcome these barriers it is vital that SBYHNs develop knowledge and skills surrounding the HPS approach; educate school personnel on the value of this approach; and seek champions within the school setting to advocate for and support the implementation of a multi-pronged approach to health promotion to build capacity and comprehensively address health and wellbeing issues within their school communities ²¹⁵.



More information about the HPS framework is contained in the health promoting schools 'Toolbox for Creating Healthy Places to Work, Learn and Play', see www.health.qld.gov.au/healthyschools/toolbox.asp

Capacity building

- By using a comprehensive approach and working in partnership with schools, it is possible to build the capacity of school communities through enhanced knowledge, skills, resources and management support for school health promotion. In this way, school communities are better equipped to identify and address issues of concern in the future.
- Building capacity for health within the school environment includes:
 - the development of systems and structural relationships within the school that will support health promotion;
 - the development of effective partnerships between the SBYHN and relevant stakeholders in education, health and community organisations that will support health promotion;
 - forging successful links with parents, given the crucial influence parents and caregivers have on their young person's behaviours. Parents can also facilitate links with local organisations to provide valuable resources and enhance schools' capacity to address health issues;
 - the development of processes for ongoing professional development ensure the expertise of the SBYHN is maintained, this in turn enhances the provision of ongoing quality health information and education;
 - building the skills, knowledge and commitment of school staff and student leaders to encourage an understanding and support of health promotion; and
 - Appropriate collaborative planning together with school communities, to ensure there is adequate time, funds, and resources to provide a sustainable service, activity or event ¹⁹⁹.
- Institutionalising health promotion in day-to-day school processes and management is the key to building capacity towards a health-promoting school ¹⁹⁹. The SBYHN is well placed to support this process.



The Healthy Schools website has many resources that will support health promotion efforts in the school community. www.health.qld.gov.au/healthyschools/default.asp

School health audit

- Capacity building involves the promotion of ownership and empowerment to effect sustained change, and therefore all key stakeholders must be involved in initial planning activities to foster engagement and a partnership approach to health promotion initiatives ¹⁹⁴.
- A school health audit (as outlined in the 'Toolbox for Creating Healthy Places to Work, Learn and Play') provides a structured way to approach this task which is inclusive of the perspective of a range of community stakeholders. This tool facilitates identification of processes, policies and activities that

may already be in place to address health and wellbeing issues in the school setting, and establishes baseline measures, resources and gaps for future planning.

- To support the identification of priority health issues to address within the school community it may also be useful to refer to school-specific data to establish trends in health issues prompting student presentations to the SBYHN. These data may be augmented by reference to contemporary state and national data sets regarding adolescent health issues.
- Once relevant health issues have been identified the SBYHN, in conjunction with the identified health promotion champions within the school, can develop an action plan utilising a range of health promotion initiatives to address these health issues in accordance with the HPS framework.

Health promotion strategies

In accordance with the HPS framework, promotion/prevention strategies from each of the three domains are needed to comprehensively address health issues in the school setting. Strategies to incorporate into the action plan may include the following:

Curriculum, teaching and learning

- Working with the curriculum coordinator or head teachers to facilitate the integration of health and wellbeing content surrounding identified health issues across the curriculum for all year levels (extending beyond the Health and Physical Education syllabus where appropriate).
- Supporting teachers in the planning, development and delivery of teaching and learning activities related to the identified health issues (refer to the “Alert” below).
- Promoting professional development opportunities for teachers and other school staff that will assist them in the delivery of the school curriculum surrounding the identified health issues.
- Providing teachers with contacts from key organisations/services who may be able to assist with their curriculum development surrounding key health issues (eg. provision of resources, organisation of guest presenters etc.).
- Liaising with teachers and guidance officer/s to establish and co-facilitate mentoring and/or support programs for young people at risk of identified health issues.

School organisation, ethos and environment

- Supporting development of an overarching policy outlining the school’s commitment and intended action surrounding the health and wellbeing issues.
- Promoting and/or co-facilitating professional development for school personnel to assist their understanding of how to support young people with identified health concerns.
- Collaborating on the development of protocols and procedures for identifying and supporting students at risk of specific health issues. These may incorporate a description of risk factors; reporting requirements for young people deemed to be at risk; delineation of the roles various people within the school have around the identification of the health issue; and confidentiality and duty of care surrounding provision of support for young people contending with the health issue.
- Contributing articles to the school newsletter to keep young people and parents informed about relevant health issues and supports available.
- Providing health information in student notices to raise awareness of issues and available supports.
- Displaying a range of promotional materials supporting key messages regarding the selected health issues (eg. posters, fliers, postcards, media articles etc.) in your office and around the school.
- Advocating for and collaborating on the implementation of school-wide intervention programs to address identified health issues.
- Promoting and organising ‘theme’ weeks (or months) surrounding specific health issues using multiple strategies to promote awareness and discussion (eg information displays, special events, presentations etc).

- Implementing awareness-raising activities for school staff surrounding health and wellbeing issues (including staff room displays; electronic staff notices; provision of information leaflets and case studies in their pigeon boxes; targeted wellbeing activities such as relaxation classes, health checks etc.). For greater impact these activities may coincide with nationally recognised health awareness days/weeks (see www.health.gov.au/calendar).

Partnerships and services

- Showcasing staff modelling healthy attitudes and behaviours to parents and the broader school community (eg. via the school newsletter and at school events).
- Establishing contact with key organisations that provide accurate information and resources on the health issues.
- Enlisting key organisations, community agencies and relevant education and health professionals to participate or advise on development of school health and wellbeing policies.
- Enlisting the support of community agencies with the facilitation of health and wellbeing days for specific year levels or the whole school community to promote service availability;
- Encouraging school personnel to join relevant networks supporting the identified health issue.
- Participating in professional development opportunities surrounding the identified health issues to stay abreast of evidence-based practice relevant to these areas.
- Collaborating in the development of funding applications to state and federal government, local councils, and non-government bodies to progress initiatives/activities within the school to support the promotion/prevention of selected health issues;
- Forming clusters with other likeminded schools to create a critical mass for larger projects and initiatives surrounding identified health issues.
- Supporting other SBYHNs within the local team with health promotion events/days to facilitate increased student involvement and coverage of a wider range of health topics. The school community may also benefit from the broader expertise available through the involvement of other SBYHNs, and collaborative activities such as these provide a valuable opportunity for mentoring support for nurses who are new to the SBYHN service.
- Providing opportunities for parents to come together and discuss issues related to supporting their children with identified health issues (eg. establishing a parents' meeting or hosting parent morning teas etc.).



SBYHNs may support teaching staff with curriculum guidance, provide appropriate teaching and learning resources and contribute to lesson planning as required, however, curriculum, teaching and learning are the domains of DETE personnel and SBYHNs should maintain appropriate boundaries in this regard. SBYHNs who co-facilitate classroom lessons with a health and wellbeing focus must ensure that lesson plans align with curriculum requirements, contribute to an overarching approach to addressing content areas, and are approved by relevant teaching staff and Heads of Department prior to delivery of these lessons.

- A National Health and Physical Education Curriculum has been developed and is awaiting endorsement. See www.australiancurriculum.edu.au/health-and-physical-education/content-structure

Health promotion strategies and resources

- The table below lists the main health issues that young people contend with, and provides guidance surrounding some key points to address in regard to these health issues, with links to relevant health promotion activities and/or resources. Please note that this is not intended to be an exhaustive list of resources, and there may well be other suitable programs and activities available to support your health promotion efforts in the school setting. It is important that all information provided to young people and school community members is contemporary and evidence based, and it is the SBYHN's

responsibility to ensure that resources used for health promotion and health education purposes meet these requirements.

- Printed, audio-visual and electronic materials produced by state and federal health departments, or health information which is available to the public through the Queensland Health Internet website are appropriate for use. Materials sourced from “allowed sites” (<http://qheps.health.qld.gov.au/allowed-sites/>) are also suitable, with examples including National and Medical Research Council guidelines, Beyond Blue and Raising Children’s Network.
- Materials not meeting the criteria outlined above should be subject to a systematic review process to ensure they are contemporary and evidence based and meet the needs of the intended clients. SBYHNs are advised to follow resource review processes currently in place in their HHS (or if there is no guidance in this regard, seek a copy of the Client Education Resource Group Resource Review Tool used by CHQHHS). This tool makes reference to the Suitability Assessment of Materials (SAM) Tool to aid in the determination of the appropriateness of resources, which may be accessed at: <http://aspiruslibrary.org/literacy/SAM.pdf>

Evaluation of health promotion activities

- Although evidence-based health promotion resources have already been evaluated to ensure their suitability and effectiveness, SBYHNs are encouraged to undertake localised evaluations of process and impact measures to gauge the effectiveness of program implementation in their school community, and determine how the program impacted on participants’ knowledge of the health issue and their intended health or help-seeking behaviours. These evaluation results will not only serve to support negotiations to undertake future health promotion activities within the school community, but information regarding barriers and enablers to implementation may be shared with other SBYHNs to inform their health promotion efforts.
- SBYHNs should be guided by evaluation requirements stipulated by their HHS and school. Questions to consider when designing an evaluation of a school-based health promotion program may include:

Process

- Has the program been implemented as intended?
- What proportion of the target group has received the program?
- What factors have impacted on the uptake of the program?
- Have program participants been satisfied with the program?
- How effective were arrangements to enlist personnel to support program implementation and evaluation?

Impacts

- What impact was there on students’ knowledge, intended health or help-seeking behaviours?
- What unanticipated positive and negative impacts have arisen from the program?
- Have all strategies been appropriate and effective in achieving the desired impacts?
- What have been the critical success factors and barriers to achieving the desired impacts?
- Is the cost reasonable in relation to the magnitude of the benefits?
- Have levels of partnership and collaboration increased?

Implications for future programs

- Should the program be continued or developed further?
- How can the operation of the program be improved in the future?
- What performance monitoring and continuous quality improvement arrangements should be maintained into the future?
- How will the program, or the impacts of the program, be sustained beyond the funding timeframe (if applicable)?
- Will additional resources be required to continue or further develop the program? ²³⁸.

Key adolescent health issues and suitable health promotion strategies and resources

Nutrition and physical activity / obesity prevention

Prevalence

- In 2011–12, 33% of young people age 15–24 years were overweight or obese, compared with 26% of children aged 5–14 years, indicating that excess body weight is increasing with age.
- While 30% of children aged 5–14 consumed the recommended daily intake of fruit and vegetables, this dropped dramatically to 4% of 15–24 year olds.
- Almost half (46%) of 15–24 year olds were either sedentary (9%) or reported low levels of exercise (37%)²⁸⁰.

Recommendations

- Young people need to do at least 60 minutes of moderate to vigorous physical activity every day (and for additional health benefits up to several hours per day).
- Young people should engage in activities that strengthen muscle and bone on at least three days per week.
- Young people should minimise the time they spend being sedentary every day by limiting use of electronic media for entertainment (e.g. television, electronic games and computers), and break up long periods of sitting as often as possible²⁰⁴.
- Adolescents need sufficient nutritious food to maintain a rate of growth consistent with the norms for age, gender and stage of physiological maturity.
- They should eat plenty of vegetables, legumes, fruits and cereals (preferably wholegrain).
- They should include lean meat, fish, poultry and /or alternatives, and low fat milks, yoghurts, cheeses and / or alternatives.
- Water should be their primary drink.
- Young people should be discouraged from consuming energy-dense, nutrient poor foods (such as those high in saturated fats, refined sugar and salt) which contribute to overweight and obesity and the onset of chronic disease²³⁴.

Cautions / things to avoid

- When promoting healthy weight, optimum nutrition and physical activity, it is essential to avoid inadvertently encouraging disturbed body image and disordered eating or exercise behaviour.
- Promote the positive, appealing aspects of healthy eating rather than harmful effects of unhealthy eating.
- Management of overweight and obesity is recommended to reduce risk of associated conditions, and of being overweight and developing chronic disease in later life.
- Adhering to the dietary guidelines and avoiding discretionary foods and drinks, is recommended for children and adolescents and will help to maintain their weight while they grow in height, thus normalising their body mass index. However, dietary restriction beyond this may result in nutrient deficiencies and sub-optimal growth.
- Individual assessment and clinical supervision by a registered dietician and/or medical practitioner is recommended to ensure appropriate growth and development for overweight adolescents.



Make your move – Sit less, Be active for life! Australia’s physical activity and sedentary guidelines 13-17 years (Australian Government Department of Health, 2014).

To order free copies, visit www.health.gov.au/internet/main/publishing.nsf/content/pasbr

The Dietary Guidelines for Children and Adolescents in Australia and the *Australian Guide to Healthy Eating* provide information on the nutritional and energy requirements of adolescents.

www.eatforhealth.gov.au/sites/default/files/files/the_guidelines/n55_australian_dietary_guidelines.pdf

Diabetes Queensland delivers “Need for Feed”, a hands-on cooking program for students in years 7 to 10 in public and private schools across Queensland. www.needforfeed.org.au

Healthy Schools | www.health.qld.gov.au/healthyschools/nut_default.asp#young

Mental health and wellbeing: Body image and disordered eating

Prevalence

- The ideal body image espoused by our current culture is one of thinness for females and a lean but muscular body for males.
- There is a lot of pressure from multiple sources to conform to these standards. This is associated with a very high rate of body dissatisfaction in our society, especially among adolescents who are particularly vulnerable to this pressure.
- Body dissatisfaction can influence the development of poor self-esteem and disordered eating.
- Characteristics of disordered eating, such as restrained eating, binge eating, fear of fatness, purging and distorted body image, are commonly reported in adolescents.
- The difference between disordered eating and eating disorders is the frequency and severity of the associated behaviours.
- Prevalence data on eating disorders is not routinely collected in Australia, however it is estimated that over 75,000 young girls and almost 30,000 young men aged 15–19 suffered from eating disorders in 2012.
- Comorbidity with anxiety, depression and substance use disorders is common, and rates of suicide are elevated amongst those with eating disorders ^{297, 245}.

Recommendations

- The key factors in the development of body dissatisfaction and disordered eating can be grouped into three categories:
 - **cultural messages**, generally communicated through the mass media;
 - **social messages**, such as those given by people in an individual’s immediate social environment; and
 - **personal characteristics** of the individual (including perfectionistic traits and a tendency to judge themselves according to external standards).
- Health promotion strategies which target each of these factors can help to prevent negative body image and disordered eating:
- Using a self-esteem approach can strengthen the resilience of young people and their ability to resist socio-cultural pressures regarding thinness. This can lead to improvements in body satisfaction and physical self-concept as well as reductions in the importance of peer group acceptability and physical appearance.

Recommendations cont.

- Media literacy fosters a healthy scepticism about mass media messages and encourages young people to think critically about the images that they are confronted with in their everyday lives. Consequently, media literacy programs can help to decrease the internalisation of cultural ideals and goals associated with body dissatisfaction.
- Interventions which teach critical thinking skills and encourage challenging of thought processes which promote the thin ideal can help change negative attitudes and friendship group behaviours and improve body image.
- Discussing and providing information about puberty, normal growth and development, expected and natural increase in body fat during adolescence (in females) and the influence of genetics over body shape and size have been useful in preparing adolescents for physical change²⁴⁶.

Cautions / things to avoid

- There is no evidence to suggest that talking about the causes, symptoms and detrimental effects of eating disorders or the use of case studies are effective prevention techniques.
- Further, there is some research to indicate that talking about certain aspects of eating disorders, for example symptoms, is potentially harmful as it may 'normalise' or glamorise the illness.
- Information about the causes, symptoms and detrimental effects may be useful to aid identification of eating disorders, but are more suited to presentation in professional development sessions with teaching and school staff, rather than with young people themselves²³³.

**The National Eating Disorders Collaboration** | www.nedc.com.au/for-schools

Provides details of prevention and early intervention resources suitable for use in schools.

The Butterfly Foundation for Eating Disorders | <http://thebutterflyfoundation.org.au/for-professionals/>

A variety of fact sheets on body image and eating disorders, as well as links to curriculum resources available for purchase.

The Eating Disorders Australia Inc. (QLD) | <http://eda.org.au/>

Provides information, support, referrals and support group services for all people affected by eating disorders in Queensland. This organisation also provides tailored workshops for positive body image and eating disorders to schools, health professionals and the community.

Isis, the Eating Issues Centre Inc. | <http://www.isis.org.au/iloveme/for-schools/>

The 'I Love Me – Peer Mentor, Support and Leadership Program' is a two-day interactive program that invites students to take responsibility for their own health, wellbeing and body esteem and to contribute to the creation of a safe and supportive school environment for their peers.

Mental health and wellbeing : Anxiety, depression, intentional non-suicidal self-harm, and suicide ideation

Prevalence

- Mental health problems affect young people’s psychological growth and development, health-care needs, educational and occupational attainment, and involvement with the justice system.
- In 2007, 9% of young Australians aged 16–24 years had high or very high levels of psychological distress.
- The leading specific cause of mental ill health among young people was anxiety and depression, accounting for 24% of the burden of disease in this age group.
- Females were more likely than males to have experienced mental health concerns (30% and 23% respectively) ²⁴⁷.
- During 2008-2009, there were almost 7000 hospitalisations of young Australians aged 15-24 years due to intentional self-harm ²⁴⁸ (NB: Updated prevalence data surrounding mental health concerns in young people is due for release in late 2014.)
- Suicide remains a leading cause of death in this age group, with 10.1 deaths per 100,000 young people aged 15-24 years during 2011 ²⁸⁵.
- Protective factors that can be supported to reduce the likelihood of mental health problems include family cohesion and social support, interpersonal relationships, safe and supportive environments, and appropriate nutrition.

Recommendations

- As mental health problems frequently commence in adolescence, there is a strong case for embedding mental health promotion in schools ²⁸⁶.
- Mental health promotion in the school setting should ideally:
 - address risk and protective factors;
 - reduce stigma and discrimination;
 - promote and build mental health literacy through understanding triggers for mental ill health and avenues of support;
 - build resilience and coping ability;
 - create opportunities for improvement in physical health, exercise, recreation, nutrition, expression of spirituality, creative outlets and stress management; and
 - utilise culturally-relevant approaches to ensure inclusivity of people from diverse backgrounds ²⁸⁷.
- With almost all adolescents using the internet on a daily basis, e-mental health care is an opportunistic way of supporting young people – from promotion and prevention through to treatment and recovery ²⁸⁷.
- E-mental health services provide treatment and support through telephone, computer and online applications, and can range from the provision of information, peer support services, virtual applications and games, through to real time interaction with trained clinicians. Promotion of the availability of e-mental health services should be a feature of school mental health promotion initiatives ²⁸⁵.

Cautions / things to avoid

- Most non-suicidal self-injury is in response to intense pain, distress, or overwhelming negative feelings, thoughts or memories and is not a form of ‘copy-cat’ behaviour. Avoid referring to intentional self-harm as ‘a trend’ or ‘an epidemic’ within a school community as this may increase the stigma attached to mental ill-health.
- Anxiety is a risk factor for depression which can in turn trigger suicidal thoughts or behaviours. In addition to promoting positive mental health, it is important to educate young people on suicide warning signs and effective help-seeking to prevent youth suicide ²⁹⁰.
- Avoid limiting mental health promotion to facilitation of selective programs for high risk students. School-based mental health promotion should ideally involve all students and comprehensively address skills such as problem solving, identifying and managing distress, the provision of support to peers, and awareness of when to seek help from trusted adults ²⁹¹.
- Supporting school staff to better understand the mental health concerns of young people can facilitate their de-stigmatisation of mental health issues, support them in the delivery of effective resiliency building programs, and assist them to identify young people with concerns and facilitate their access to appropriate services. Encouraging school staff to undertake the Youth Mental Health First Aid Course would support their mental health literacy (Visit: <https://mhfa.com.au/cms/youth-course-information> for further information).
- Targeting health promotion activities towards supporting school staff to recognise and seek support for their own mental health concerns may further enhance the help-seeking culture within the school community.



MindMatters | www.mindmatters.edu.au

Emphasises the importance of a whole-of-school approach to mental health promotion and provides on-line professional development for teachers and learning modules mapped to the National Curriculum.

ReachOut | <http://au.professionals.reachout.com/>

Resources to support mental health promotion in schools. Includes fact sheets, links to evidence-based apps and on-line therapy programs, teaching resources, and professional development webinars.

RUOK? | <https://www.ruok.org.au/inspire-conversations/ruok-at-school>

Provides class-room tool boxes which address suicide prevention with secondary school students.

Headspace | www.headspace.org.au/what-works/school-support/services

Provides a range of youth-friendly information sheets to support mental health promotion in schools.

The Resourceful Adolescent Program (RAP) | www.rap.qut.edu.au/

An evidence-based universal resilience building program for teenagers which may be readily implemented in a school setting.

beyondblue's SenseAbility is a strengths-based resilience program for young people to enhance and maintain emotional and psychological resilience.

www.beyondblue.org.au/resources/schools-and-universities/secondary-schools-and-tertiary/senseability

Ed-Linq is a state-wide QH initiative aimed at supporting CYMHS, and the education and PHC sectors to work collaboratively to enhance the early identification and treatment of mental health problems and disorders affecting school aged children and young people. Contact the Ed-Linq coordinator in your local area.

Beacon | <http://beacon.anu.edu.au>

A Commonwealth funded website providing a comprehensive directory of e-health applications (websites, mobile applications and internet support groups), including reviews, expert ratings and user comments.



Refer to *Chronic Conditions Manual*



Tune In Not Out | www.tuneinnotout.com

Provides tip sheets, stories and youth-friendly videos surrounding a wide range of health issues.

The BRAVE Program is an interactive on-line program for the prevention and treatment of anxiety. www.youthbeyondblue.com/do-something-about-it/treatments-for-anxiety-and-depression/the-brave-program

Youthbeyondblue has developed a Check-in app to assist young people to engage their friends in conversation surrounding their mental health and wellbeing. www.youthbeyondblue.com/do-something-about-it/thecheckin

Bullying / cyberbullying / cybersafety

Prevalence

- Bullying is a systematic abuse of power, whereby the perpetrator repeatedly engages in aggressive behaviour with the intent of hurting or intimidating another. The behaviour may be overt (face-to-face verbal or physical abuse) or covert via cyber technology ²⁸⁴.
- Cyberbullying comprises abusive or hurtful messages or videos transmitted via texts, emails or on-line networking forums. It may entail mimicry, slander, nasty on-line gossip and chat, or the dissemination of compromising images (such as those obtained via ‘sexting’).
- The general prevalence for 10-17 year old Australians experiencing cyberbullying in a year is around 20%.
- The peak age for prevalence of cyberbullying is 12-15 years ²⁰⁹.
- About three quarters of victims of cyberbullying are female, whereas the perpetrators of cyberbullying are equally likely to be male or female ²¹².
- Less than half of all cyberbullying incidents to secondary school students are reported to schools²¹².
- Young people are being impacted by cyberbullying to the point where some engage in self-harm and suicidal ideation ²⁰⁹.
- There are further threats to young people’s safety on line through cyberstalking, which can include frequent and intrusive threats, cryptic messages and sexual innuendo. Some adult predators engage in on-line grooming by creating fake profiles to befriend and gain the trust of young people on-line. The prevalence of cyberstalking in Australia is unknown ²¹¹.

Recommendations

- Cyberbullying may be an extension of face-to-face bullying, but can also be a separate phenomenon due to the anonymity factor, the breadth of the audience and the 24/7 nature of the setting.
- As there is no easy division between ‘traditional’ bullying and cyberbullying, interventions and preventions should look at strategies which deal with both of these.
- Strategies to address ‘traditional’ bullying may include a disciplinary approach by school staff; support for victims to cope more effectively when being bullied; mediation by trained teachers or peer-mediators; restorative practices to promote reflection upon unacceptable behaviour; and a ‘no blame’ support group approach ²⁸⁴.
- It is important to note that a high proportion of cyberbullying victims are also cyberbullies.

- Research with young people has indicated that effective health promotion will include real life examples, a focus on behaviours not technologies, and on promoting respectful positive behaviours.
- Health promotion messages should communicate the seriousness of cyberbullying, including the potential legal and social consequences ²⁰⁹.
- Students are more likely to cyberbully others when there is a lack of parental monitoring of online activities. A coordinated approach is therefore needed so that young people, parents and schools are involved in the process of raising awareness of risks, and developing measures to counter inappropriate on-line behaviour ²⁸¹.
- Health promotion efforts should also incorporate support for young people to understand their vulnerability to online predators and the need to activate appropriate privacy settings on social media sites to mediate this risk.
- Young people should also be warned of the risks of ‘sexting’, which is the transmission of sexually explicit images of themselves to friends or other people via mobile phone technology. This poses the risk of these images being widely disseminated to others. If uploaded to the internet these images are impossible to remove. There are also legal penalties for sexting ²⁸².

Cautions / things to avoid

- Anti-bullying programs need to be adapted to the specific needs and attitudes of the entire school community.
- Teacher buy-in is extremely significant to the success of anti-bullying programs, and it is therefore important to first gain the support of teachers by educating them about the need for bullying and cyberbullying prevention programs ²⁸¹.
- The evidence-base for effective interventions for cyberbullying is still being built ²¹¹.
- Telling young people that they should not go on-line is an ineffective harm minimisation strategy because young people experience many benefits from engaging in an on-line environment, including connection, socialisation and self-expression, with many having grown up with technology as a key part of their identity ²⁸³.
- It is important to note that many online risk behaviours are also influenced by ‘offline’ factors such as existing bullying dynamics, and/or attitudes and perceptions about risk taking behaviour in the ‘real’ world. These factors need to be considered in health promotion efforts to address cyberbullying and cybersafety with young people.
- If on-line bullying is perpetrated at home but impacts on the wellbeing of someone at school, there are recommendations to view this as school-related behaviour and address it accordingly. Whole-of-school communities must take responsibility rather than relying on arbitrary schoolyard boundaries. Pre-emptive policies and prevention programs should be implemented in the school to support these actions ²⁸¹.



The Safe Schools Hub | www.safeschoolshub.edu.au/home

Provides details of the National Safe Schools Framework, and includes links to a school audit tool and professional learning modules to support a whole-of-school approach to addressing bullying.



Bullying: No Way! | www.bullyingnoway.gov.au/teachers/school-strategies/resources.html
Includes a range of curriculum resources to support teaching staff to address incidents of bullying.

National Centre Against Bullying | www.ncab.org.au/cyberbullyingpractices/
Includes links to a series of articles addressing cyberbullying, online relationships and safe practices.

Cybersmart | www.cybersmart.gov.au/Schools.aspx
Commonwealth Government site with a variety of resources on cybersafety
Also has information on digital safety in indigenous communities – www.cybersmart.gov.au/Indigenous.aspx

ThinkUKnow | www.thinkuknow.org.au/site/index.asp
An internet safety program – includes interactive training for parents, carers and teachers

eSmart | www.esmartschools.org.au/Pages/default.aspx
eSmart is a whole school system for cybersafety and wellbeing which compliments the HPS framework

Reachout | <http://au.reachout.com/cyberbullying>
Useful information about cyberbullying for young people

The **Queensland Police Service** provides an e-brochure which facilitates parents' understanding of how to support their children to maintain on-line safety.
www.police.qld.gov.au/programs/cscp/personalSafety/children/childProtection/Documents/whoschattingebook.pdf

Sexuality and healthy relationships

Prevalence

- Sexual development is a normal part of adolescence. Most young people will go through these changes without significant problems if they receive support, information and care.
- In 2013, 22.7% of year 10 and 50.4% of year 12 students reported having had sexual intercourse.
- During their last sexual encounter, 58% reported using a condom, 39% reported using the contraceptive pill, 15% reported using the withdrawal method, and 3.5% reported using emergency contraception ²⁷⁹.
- Teen pregnancy and Sexually Transmitted Infections (STIs) are potential risks which can jeopardise the short and longer term safety and wellbeing of the young person.
- 1 in 25 live births in Australia in 2011 were to teenage mothers. Teenage pregnancy has a number of associated risks to the baby (premature birth, low birth weight) and the mother (interruption to schooling) ²⁷¹.
- Chlamydia is the most frequently reported STI in young people, with rates of notification steadily rising. Gonorrhoea is the second most frequently notified STI in young people ²²⁰.
- In 2008 there were 119 notifications of new cases of HIV among young people aged 12-24 years (an overall rate of 3.1 per 100,000 which has increased from 2.1 per 100,000 in 1998) ²⁸⁰.

Recommendations

- Health education surrounding sexual health and healthy relationships should be tailored to the maturity level of the young person, and ideally be delivered in a scaffolded environment and in a sequential fashion through the curriculum across each year of schooling.
- SBYHNs may work with their school communities to ensure school-based policies and responses reflect sexual inclusivity (eg via policies addressing sexual harassment and anti-homophobia and anti-bullying).

- SBYHNs may facilitate information sessions for parents to support their role as sexual health educators of their children, and for teaching staff to increase their confidence with delivery of the sexual health curriculum.
- SBYHNs may support the sexual health and wellbeing of their school communities through provision of a condom distribution and pregnancy testing service. SBYHNs must meet relevant competency standards to deliver this service, and approval must be granted by the HHS and schools in which they are working.
- SBYHNs may also facilitate students' access to a free chlamydia testing program offered through Queensland Health.
- Comprehensive and inclusive health education on this topic should be delivered systematically in accordance with the National Curriculum and encompass issues such as: puberty and healthy development, the reproductive cycle, sexuality, decision-making surrounding sexual relationships (including values, cultural and societal influences, and legal implications), negotiating safe and healthy relationships, contraception, safer sex and STI prevention (including HPV vaccination), sexual health checks, pregnancy and unplanned pregnancy options and accessing appropriate services.

Cautions / things to avoid

- Avoid the delivery of 'one-off' health education sessions surrounding sexual health and wellbeing.
- If supporting teaching staff with sexual health lessons, be mindful of establishing boundaries to create a safe and positive learning environment.
- When delivering information about pregnancy options, it is important for SBYHNs to bracket any personal opinions and present all options in an unbiased fashion.
- Long Acting Reversible Contraception (LARCs) such as Intra-Uterine Devices are no longer contraindicated for nulliparous young women ²⁹².
- 50% of young people expressed significant dissatisfaction with sex education at schools, citing irrelevance to their real experiences, lack of relationship advice and lack of discussion of same-sex issues as problems ²⁷⁹. SBYHNs may therefore advocate for the inclusion of young people in supporting the development of appropriate and effective sexual health education in their school communities.
- Due to their developmental stage and a sense of invulnerability, young people are often more concerned about the social consequences of STI rather than the health consequences. Consequently, sexual health education should not only highlight the health risks associated with contracting STI, but also seek to raise awareness of public health contact tracing and the potential impact this may have on young people's reputation ²⁹³.



Family Planning Queensland | www.fpqteachers.com.au/

Comprehensive teaching and learning resources for purchase.

Also has a wide range of fact sheets and brochures available for download from www.fpq.com.au/publications/fsBrochures/publications_complete_list.php

i stay safe | www.health.qld.gov.au/istaysafe

A Queensland Health site for young people, providing information about sex and sexual health.

Children By Choice | www.know4sure.org.au

Offers comprehensive youth-friendly information about pregnancy options.


Tune In Not Out | www.tuneinnotout.com

Provides tip sheets, stories and youth-friendly videos surrounding a wide range of health issues.

Love Bites is a school-based domestic and family violence and sexual assault prevention program. Further information available at: <http://growingrespect.org.au/love-bites/about/what-is-love-bites/>

Core of Life | www.coreoflife.org.au

A 'hands on' pregnancy and parenting program for young people. A team of presenters including midwives and other youth/health/education and community representatives delivers an education program that encourages increased self confidence in making informed decisions regarding sexual and reproductive health choices, thus discouraging unplanned teenage pregnancy.

The website also has a 'teen' section with youth friendly information and resources surrounding sexual and reproductive health.

Queensland Health offers free at-home chlamydia urine testing kits.

www.health.qld.gov.au/sexhealth/chlamydia/



Queensland Health has published a guide to supporting adolescent Aboriginal and Torres Strait Islander sexual health. Visit: http://qheps.health.qld.gov.au/atsihb/docs/adolescent_sexual_health_guideline.pdf

Substance use

Prevalence

- Adolescence is an age when young people may begin to experiment with substances.
- Recent data surrounding the proportion of young people aged 12-17 years who have engaged in substance use indicate:
 - 40% have had a full serve of alcohol;
 - 23% have smoked cigarettes;
 - 17% have tried inhalants;
 - 14.8% have tried cannabis;
 - 3% have tried hallucinogens;
 - 2.7% have tried ecstasy;
 - 2% have tried steroids (without a doctor's prescription);
 - 1.7% have tried cocaine; and
 - 1.6% have tried heroine ²³⁶.
- Substance use can have a variety of short and long term consequences.
- Young people may experience reduced ability to think clearly and decreased inhibitions. This may lead to engagement in antisocial behaviour; unsafe sexual activity risking sexual assault, STI or unplanned pregnancy; blood-borne viruses through unsafe injecting practices; traffic or pedestrian accidents and injury; risk of overdose; and disengagement from school.
- In the longer term, substance use can contribute to the risk of chronic disease; it may impact on future relationships, education and employment; and cannabis use in particular has been shown to affect the developing brain and increase the risk of serious mental illness.

Recommendations

- Current evidence supports a harm reduction approach to school-based alcohol and other drug education (AOD), particularly with regard to the use of alcohol due to the difficulty overcoming the cultural traditions that impact on alcohol use by young people.

Recommendations

- It is ideal to encourage young people to delay the onset of alcohol use, and even doing so for a year or two can reduce short and long term harms. However, it is important that school-based drug education programs also incorporate harm minimisation principles to support young people to be able to cope with alcohol use situations and problems, and in particular avoid high risk behaviours such as binge drinking²³⁷.
- Drug education programs need to focus on the drugs most likely to be used within the target group and those that are most likely to cause harm to individuals and others within the community.
- Some cultural groups and those who are socially disadvantaged have proportionately high experience with drugs. Targeted interventions are needed to address those young people who are at a higher risk of drug use problems. However, it is critical that assumptions or stereotyping about drug use among particular cultural groups do not form the basis of drug education decision-making
- As well as including AOD education in the curriculum, SBYHNs may work with schools to reduce personal and social risk factors that influence young people's substance use and promote protective factors that make use less likely and have a less negative impact.
- Protective factors include feeling connected to and enjoying school, having quality peer and adult relationships, and having an optimistic view of the future.

Cautions / things to avoid

- Drug education is best taught within a broader social, cultural or health curriculum rather than as a discrete subject. Isolated and ad hoc programs that lack progression and continuity are less effective.
- Education messages should avoid highlighting the proportion of young people who do engage in substance use and emphasise the larger proportion who do not.
- Interactive strategies are a critical component of effective AOD programs. If Fatal Vision Goggles are used to support these programs, activities should be well-coordinated to ensure the use of this resource does not inadvertently promote the appeal of intoxication. Experiential effects of the goggles are also significantly greater than the onlooker effects, so it is ideal for each student involved in the health education session to experience use of the goggles.
- Due to the strong influence of parental role modelling, parent involvement in drug education should be conceived as integral to the drug education process, rather than as separate and additional to it.
- Health promotion initiatives should be tailored to the needs of specific school communities through consultation with stakeholders such as students, parents and teachers, and piloting of proposed AOD prevention programs.
- In addition to prevention and harm-minimisation AOD education, schools should support early intervention and referral through active engagement with staff from relevant community agencies.



Dovetail | www.dovetail.org.au/about-us.aspx

A range of fact sheets and professional development resources to support those who engage with young people affected by alcohol and other drugs.

OxyGen | www.oxygen.org.au/

Fact sheets, curriculum resources and youth-focused activities to support smoking prevention.

Game On: Know Alcohol (GO:KA) | <http://gameon.rcs.griffith.edu.au/>

An evidence-based curriculum resource made up of online games and practical activities.



The National Cannabis Prevention and Information Centre | <https://ncpic.org.au>

Information, stories and brief motivational interviewing activities targeted at young people as well as classroom activities for secondary school students.

<https://ncpic.org.au/youngpeople/>

<https://ncpic.org.au/workforce/teachers/cannabis-and-consequences/>

The site also has an education program specific to Aboriginal and Torres Strait Islander secondary school students called “Making the Link Indigenous Program”

<https://ncpic.org.au/workforce/teachers/making-the-link-indigenous/>

School Health and Alcohol Harm Reduction Project

<http://ndri.curtin.edu.au/research/shahrp/ypaa/focus.cfm>

An evidence-based classroom program supported by the National Drug Research Institute.

Sun safety and skin cancer prevention

Prevalence

- Exposure to ultraviolet radiation (UVR) during outdoor activity and inadequate sun protection increases a young person’s risk of developing skin cancer.
- Despite a high level of knowledge about sun safety, adolescents less frequently adopt sun protection behaviours than adults and it can be more difficult to achieve behaviour change in this group.
- In 2010, 80% of young people aged 16-24 years in Queensland admitted to getting sunburnt in the previous 12 month period ¹⁷⁸.
- Melanoma is the most dangerous type of skin cancer with a strong causative link to sunlight exposure. It is the most common cancer in young Australians aged 15–39 years old.
- In this age group, melanoma comprises 20% of all cancer cases and is responsible for 8% of all cancer deaths.
- In 20–34 year-olds, melanoma kills more young Australians than any other single cancer.
- The treatment of melanoma varies depending on how advanced or aggressive the tumour is, and therefore in addition to promoting sun safe behaviours, promoting early detection through routine skin checks is also very important from an early age ^{247, 251}.

Recommendations

- Sun safe behaviours during childhood and adolescence are vital to preventing the development of skin cancer and it is important to reinforce and resource sun safety education in schools.
- The key messages to promote to young people include the need to protect themselves from skin cancer in five ways:
 - Seek shade;
 - Wear sun protective clothing that covers as much of their body as possible;
 - Put on a broad-brimmed hat that shades their face, neck and ears;
 - Wear wrap-around sunglasses;
 - Apply SPF30+ or higher broad spectrum water resistant sunscreen liberally to clean, dry skin, at least 20 minutes before being exposed to the sun, and reapply at least every two hours when outdoors.
- Young people should be encouraged to protect themselves from UVR using multiple sun safe behaviours even when going outdoors for a short time, and especially during periods when the UVR level is at its highest (between 10am – 2pm).

Recommendations

- Young people should be encouraged to check their skin regularly for melanoma, with the first sign usually being the appearance of a new spot, or a change in an existing freckle or mole. They should be taught the 'ABCDE' guidelines for the early detection of melanoma:
 - **A** is for **ASYMMETRY**: One-half of a mole or birthmark does not match the other.
 - **B** is for **BORDER** irregularity: The edges are irregular, ragged, notched, or blurred.
 - **C** is for **COLOUR** variegation: The colour is not the same all over, but may have differing shades of brown or black, sometimes with patches of red, white, or blue.
 - **D** is for **DIAMETER**: The area is larger than 6 mm or is growing larger.
 - **E** is for **EVOLVING**. Changes in size, shape, colour, elevation, or another trait (such as itching, bleeding or crusting).
- A comprehensive Health Promoting Schools approach is needed to promote and support sun safety. Sun safety behaviour should be sequentially taught through the curriculum with messages reinforced through the promotion of a sun-safe environment in the school setting. This includes the development of sun safe policies surrounding access to shade and wearing of sun safe uniforms; scheduling of outdoor activities to minimise sun exposure during peak UVR periods; and effective role modelling of sun-safe behaviours by school staff. The school should also develop collaborative partnerships with organisations that support sun safety, such as Queensland Cancer Council.
- SBYHNs can support sun safety awareness by facilitating health promotion displays during school sporting events, and advocacy to ensure the ready availability of sunscreen at these events.

Cautions / things to avoid

- For maximum UVR protection, avoid using sun screen which has passed its use by date.
- Caution young people that even if they are sitting in the shade they need to protect themselves against reflected UVR (eg from concrete, water and sand).
- A history of repeated episodes of sunburn and blistering, especially in childhood and adolescence, increases the risk of developing melanoma. Caution young people to avoid this behaviour.
- Sunbeds and solariums also emit UVR, so young people should be advised of the risks associated with tanning and cautioned to avoid this behaviour.
- Due to their stage of psychosocial development, young people are generally less inclined to be concerned about future health risks, and more inclined to worry about not fitting in with their peers. Sun safety promotion may therefore be more effective if aligned with holistic health promotion efforts to support self-confidence and positive body image.
- Additionally, promoting the use of fashionable and comfortable sun safety apparel and raising awareness of celebrity role models who engage in sun safe behaviours may also be helpful^{252, 300}.



Sun Safety | www.sunsafety.qld.gov.au

Provides resources for supporting sun safe behaviours in secondary schools, including the development of a sun safe strategy, uniforms that minimise UV exposure and relevant curriculum resources.

QUEST | <https://quest.org.au/quest/schools/>

A Cancer Council Queensland site offering a library of tools and resources to assist schools to promote and support healthy choices, including sun safe behaviours. Schools have to register to access these resources.

Melanoma Institute Australia

www.melanoma.org.au/about-melanoma/detection-and-screening/checking-your-skin.html
Information and a video to support education of young people about skin checks for melanoma.

Asthma

Prevalence

- Asthma, a chronic inflammatory condition of the airways, is one of the most common long-term conditions affecting young Australians.
- In 2007–08, an estimated 396,000 or 11% of young people aged 12–24 years reported asthma as a long-term condition.
- The overall prevalence of self-reported asthma among young people was similar for males and females (both 11%).
- Of those young people aged 15–24 years reporting asthma as a long-term condition, almost one in five had days away from work, school or study ²⁴⁷.
- Less than one in five (18%) Australian adolescents have a written asthma action plan, and only 28% have discussed their asthma management plan with their GP within the previous 12 months ²⁵³

Recommendations

- Asthma symptom control can be jeopardised during adolescence due to their developmental stage. Young people may deny their disease, underreport symptoms, abandon medication regimens, and engage in risk-taking behaviours that impact on their condition, such as smoking tobacco and cannabis. Mental health problems such as anxiety and depression can further compound the challenges of asthma management during this lifespan period ²⁵⁴.
- Chronic conditions should routinely be assessed for in conjunction with a HEADDSSS assessment. SBYHNs should encourage young people with asthma to:
 - visit their GP for an updated asthma action plan and provide a copy to the school;
 - recognise and avoid their asthma triggers;
 - avoid smoking; and
 - carry a reliever inhaler with them at all times, so they can use it immediately if they experience asthma symptoms.
- Encourage self-management and provide support and education appropriate to the individual's stage of psychosocial development ²⁵³.
- Providing asthma education messages through technologies that adolescents use every day (e.g. internet, phones, interactive video) may be an effective way to deliver asthma health messages, compared with traditional media or with strategies that are not tailored for adolescents ²⁵⁴.

Cautions / things to avoid

- It is the role of DETE nurses to support education with teachers and students surrounding asthma management in the school setting. However, SBYHNs can work collaboratively with them to support health education initiatives as required.
- SBYHNs may encourage their schools to participate in the Asthma Friendly Schools Program to promote a safe environment for students with asthma.



The **National Asthma Council Australia** has endorsed the Asthma Buddy smart-phone app which can support asthma self-management. The app can be used to remind young people of their daily asthma medications; recognise if their asthma is getting worse and know how to respond; and maintain a journal of peak flow readings, asthma symptoms and possible triggers.
www.nationalasthma.org.au/asthma-tools/asthma-action-plans/asthmabuddy



Asthma Foundation Queensland facilitates an Asthma Friendly Schools Program which recognises schools that make an extra effort to provide a safer environment for students with asthma by granting them Asthma Friendly status. An Asthma Friendly School is one that meets the following four criteria:

- 1. Education and training:** The majority of staff have current Asthma Australia approved Asthma First Aid training;
- 2. Equipment:** Asthma Emergency Kits are accessible to staff and include in-date reliever medication and single person use spacers;
- 3. Information:** Asthma First Aid posters are on display and staff and parents can access asthma information.
- 4. Policies:** First Aid and other health and safety policies explicitly include asthma.

See www.asthmaaustralia.org.au/Asthma-Friendly-Schools.aspx

Oral health

Prevalence

- Dental caries (decay) is one of the most prevalent health issues in Australia across all age groups.
- Over two-thirds of young people aged 15-24 years have experienced some dental caries, and almost 1 in 5 have at least one tooth missing due to dental disease.
- Children and young people living in rural and remote areas or in low socio-economic status areas have significantly worse oral health than those living in metropolitan areas.
- Poor oral health can not only impact on a young person's psychosocial wellbeing, but can also lead to long term health problems due to the association of periodontitis with heart disease.
- Dental caries are highly preventable, with most being related to dietary issues. Young people have increasing control over their diet, with dietary choices being strongly influenced by peer pressure and media influences. During growth spurts young people may also be frequently hungry between meals and snacking on high sugar foods that contribute to dental caries^{255, 257}.
- Dental caries are also caused by excessive plaque build-up through infrequent substandard tooth cleaning²⁴⁷.

Recommendations

- Health education messages surrounding oral health should focus on promoting:
 - a balanced diet and healthy snack choices;
 - chewing sugar free gum (with Xylitol) between meals;
 - avoiding carbonated beverages and sports drinks which are high in sugar (and particularly avoid sipping these which promotes contact with teeth over a prolonged period);
 - avoiding diet drinks which still contain preservatives such as citric and phosphoric acid which contribute to tooth erosion.
- Regular dental checks and routine tooth brushing with fluoridated toothpastes should also be promoted²⁵⁶.
- Informing young people of how cariogenic bacteria may be transmitted from parents to their infant children and strategies to avoid this will also support the prevention of dental caries in future generations²⁵⁷.
- SBYHNs should provide opportunistic health messages around oral health during the conduct of a HEEADDSSS assessment with young people.
- Smoking, alcohol and drug misuse can also impact on oral health, as can Bulimia and Anorexia. SBYHNs should be mindful of promoting oral health where these issues are a concern.

Oral health

Cautions / things to avoid

- Young people who live in areas where the water supply is fluoridated should drink this in preference to bottled water.
- Even if a young person is seeing an orthodontist on a regular basis they should still have routine dental checks to assess the health of their teeth.
- Young people should be deterred from having intra-oral piercings due to the potential for these to cause chipped or fractured teeth. Cracks are often difficult to treat and result in the loss of the tooth.
- If young people already have intra-oral piercings, encourage them to replace metallic jewellery with plastic jewellery which causes less damage to teeth. They should also brush piercings with a soft tooth brush twice per day, and periodically remove and clean the jewellery, as well as remove jewellery during sleep and sporting activities.
- Young people engaged in contact sporting activities should be encouraged to wear mouthguards to protect their teeth ²⁵⁶.
- Improvements in knowledge regarding the aetiology of dental caries and instruction in how to brush effectively do not necessarily transform into more positive attitudes or oral health behaviours ²⁴⁵. Health promotion strategies may be more effective in the short term if they target psychological / social wellbeing associated with preventative oral health measures with young people (eg avoiding embarrassment and teasing associated with missing teeth) ²⁵⁸.



All Queensland resident children four years of age or older who have not completed Year 10 of secondary school are eligible for publicly funded oral health care via Queensland Health's Child and Adolescent Oral Health Services (previously referred to as the School Dental Service/Program).
www.health.qld.gov.au/oralhealth/services/school.asp

Young people may also qualify for subsidised basic dental care through private dentists under the Australian Government's Child Dental Benefit Schedule. For further information and eligibility criteria, see:
www.humanservices.gov.au/customer/services/medicare/child-dental-benefits-schedule

Queensland Health has produced a 'Teeth Talk' oral health presentation to support information exchange with young people in the classroom.



Queensland Health also has a range of Healthy Teeth for Life fact sheets available on QHEPS that may be used to support health promotion surrounding oral health.



Refer to *Chronic Conditions Manual*

Injury prevention

Prevalence

- Transport accidents (including pedestrian, rider and passenger) and assaults are leading causes of injury in young people, and injury and poisoning are the leading causes of hospitalisation and death.
- Young males are hospitalised for injury at more than twice the rate of females.
- Mortality rates resulting from injury reveal strong associations with risk-taking behaviour.
- Risk-taking behaviours leading to injury are influenced by adolescents' immature hazard perception and decision making skills; a sense of invulnerability; and a strong desire for peer acceptance.
- Risk-taking behaviour is more prevalent among males, early school leavers, as well as young people with less parental supervision, peers who also actively engage in risk-taking behaviour, negative attitudes to authority and high alcohol use ^{261, 247-248}.

Recommendations

- The likelihood that injury occurs as a result of adolescent risk-taking is related to the social context and individual factors. The likelihood of adolescent injury risks is reduced if the young person:
 - has had training in attitudes towards injury avoidance and risk management;
 - is a member of a school community marked by connectedness and support;
 - feels personally accepted, respected, included and supported by others in the school (which is related to increased student retention, decreases in delinquency, aggression and violent behaviour, and reduced substance abuse);
 - has peers who are likely to take protective steps to care for each other; and
 - has close and supportive family associations ^{260,262}.
- Multiple strategies and a whole-of-school approach are therefore needed to address injury prevention in young people ²⁶¹. These may include:
 - health education with young people to support risk management decision making skills, conflict resolution and prosocial behaviour;
 - health information for parents to foster parental supervision of their children during adolescence and role model safe driving behaviour;
 - teacher professional development to support the creation of a supportive psychosocial environment;
 - school-wide policies and programs to promote and support respectful behaviour and school connectedness;
 - partnership development with relevant organisations such as police and RACQ to support school initiatives to address adolescent safety; and
 - modifications to the school environment to better support the physical safety and wellbeing of students ²⁶².

Cautions / things to avoid

- Only providing young people with information about safety and what constitutes dangerous or risky behaviour is ineffective, as it does not address the range of reasons why young people engage in risky behaviours.
- Avoid the use of one-off student education sessions surrounding injury prevention. Programs should fit within the school curriculum, be developmentally appropriate and sequentially delivered over time for maximum effect ²⁶³.

Injury prevention

- Fear-based appeals that demonstrate the negative health consequences of life-endangering behaviours (such as visiting a trauma ward) have been found to have minimal effect in motivating young people to moderate their current risky behaviour or adopt safer alternative behaviour.
- Interactive safety awareness programs that generate an exchange of ideas and experiences can provide a catalyst for change and opportunities to practice new skills and obtain feedback on the skills that are practised.
- If a simulated road accident is performed for students as part of safety awareness education (such as the RACQ Docudrama), ensure that adequate support personnel are on hand to counsel young people who are adversely affected by their experience of this event.



Skills for Preventing Injury in Youth (SPIY) is targeted at Year 9 students. The program incorporates an 8-week, teacher delivered attitude and behaviour change curriculum with peer protection and first aid messages; and professional development for program teachers focusing on strategies to increase students' connectedness to school. Preliminary evaluation in a small number of schools has shown promising results in regards to prevention of students' health risk behaviour and injuries ²⁶⁴.

RACQ has been funded by the Qld Government to provide a docudrama program which teaches Year 12 students about the consequences of careless or irresponsible behaviour when driving. Young people witness the re-enactment of a car crash, and then participate in a debriefing session to discuss how the tragedy could have been averted.

Visit www.racq.com.au for more details.

The **Transport Accident Commission (TAC)** Victoria has a range of curriculum resources and video clips surrounding driver and pedestrian safety. See www.tac.vic.gov.au/road-safety/schools/school-resources#muck

One Punch Can Kill | <http://opck.qhvsq.org.au/get-smart>

Provides presentations to schools to highlight the issues affecting young people and educating them in how to ensure greater self-control during times of challenge. The presentations are targeted at Years 10, 11 and 12 students.

Party Safe | www.police.qld.gov.au/programs/cscp/personalSafety/youth/partySafe/

Queensland Police Service site providing information and checklists for parents and young people to promote a safe approach to partying; clarification of associated legal issues; and a portal to register upcoming parties.

Red Frogs Australia | <http://au.redfrogs.com/education/im-a-teacher/Year-12-pre-schoolies-program>

Offer Pre-Schoolies Presentations to educate Year 12 students on the dangers associated with post-school celebrations, teaching them how to set appropriate boundaries and make informed decisions regarding their behaviour during these events.

Immunisation

Prevalence

- In Australia, the School Immunisation Program (SIP) is the primary method to deliver nationally recommended vaccines to young people. The coverage achieved in Australia's SIP is higher than in settings where adolescent vaccines are delivered through the community sector or private practice. However, despite this well-established SIP, completion of adolescent immunisation schedules in Australia is sub-optimal ²⁴⁰.
- In 2012 of all Australian states, Queensland had the second lowest rates of HPV vaccination coverage rates for females turning 15 years of age ²⁴¹.
- In 2008, there were 2,816 notifications for vaccine-preventable diseases amongst young people aged 12-24 years (a notification rate of 73 per 100,000). Most of these notifications were for pertussis ²⁴².

Recommendations

- Although SIP requires parental consent for student participation, young people are beginning to take on responsibilities for their independent care, and it is therefore suitable to target messages to them regarding immunisation as a means of protection from vaccine preventable diseases.
- Providing teachers and administrative staff with written information or education sessions regarding immunisation may improve the success of SIP as their influence with students can increase immunisation rates.
- SBYHNs may advocate for the provision of SIP information to parents and students at the start of the year, as well as inclusion of information within school diaries, newsletters and websites.
- Supporting minority groups through the provision of information and consent forms in specific languages can optimise return of forms.
- SBYHNs may develop effective and supportive relationships with the SIP coordinators in order to provide information regarding how to work successfully in the specific school context. This may include information about specific communication systems which may offer opportunities for SIP to work with schools in alternative ways to achieve increased vaccination compliance, including email reminders and texting to remind students and parents of consent form return dates or vaccine.
- SBYHNs may also advocate for the inclusion of immunisation information into the curriculum, particularly addressing vaccinations for HPV during sexual health lessons.
- SBYHNs can also encourage young people to find and complete their immunisation records ^{240, 243}

Cautions / things to avoid

- It is important that myths about the HPV vaccination leading to risky sexual behaviour are not perpetuated, and that communication about the vaccine does not stigmatise high risk groups ²³⁹.
- Be aware of negative messages propagated by anti-vaccine movements so you may answer questions accurately and counter concerns through your health promotion efforts ²⁴³.



School Immunisation Program resources including consent forms and fact sheets.

www.health.qld.gov.au/clinical-practice/guidelines-procedures/diseases-infection/immunisation/schools/default.asp

There is also resource kit for vaccine service providers implementing a SIP:

www.health.qld.gov.au/publications/clinical-practice/guidelines-procedures/sbvp-vsp-resource-kit.pdf

Immunise Australia | www.immunise.health.gov.au

Comprehensive information about immunisation including strategies to address myths and misconceptions.

Early identification

Strategies to identify need and risk

- SBYHNs are well-positioned to work with their school communities to facilitate the identification of young people in need of early-intervention support. This may be achieved through:
 - The coordination and/or facilitation of information sessions for school staff and parents/caregivers surrounding: Risk factors for various health and wellbeing issues; how to recognise young people in need of support; and how to negotiate access to appropriate services. This would include an explanation of how staff and parents may facilitate young people's access to the SBYHN service.
 - Participation in Student Welfare Committee meetings, which may involve other school support staff, year level coordinators and senior administrative staff. SBYHNs may negotiate student referrals, as well as support staff to recognise other appropriate avenues of support for issues students are contending with. (Note: Participation in meetings where school staff share details of students' personal situations may foster an expectation for SBYHNs to engage in reciprocal information sharing regarding students who have consulted with them. SBYHNs should be mindful of the legislation pertaining to their practice as health professionals, and routinely clarify these parameters with school staff.)
 - With the explicit consent of the young person, SBYHNs may disclose pertinent information to relevant school staff regarding young people they are working with in order to facilitate support in the school setting. Depending on the circumstances this could involve strategies such as advocating for extensions for assessment items, or the provision of a 'time out' card to enable the young person to absent him/herself from class when needed.
 - When young people are noted to have significant school absences, are routinely late for school or are engaged in disciplinary procedures for misbehaviour, the SBYHN may advocate for referral to his/her service to facilitate the conduct of a psychosocial health assessment to determine underlying issues of concern. (Note: The SBYHN should avoid the perception that he/she is aligned with school disciplinary procedures, and clarify with the young person the voluntary nature of the consultation).
 - All students may benefit from universal resiliency-building mental health and wellbeing programs implemented through the curriculum, however more targeted interventions are required for those at higher risk of mental health problems. As part of a comprehensive mental health program SBYHNs may work collaboratively with teaching staff and local mental health services to administer evidence-based screening tools to identify students at high risk of mental health concerns. Identified students may be supported through engagement in selective intervention strategies such as small group sessions, or referral to other appropriate services for early intervention. (Note: SBYHNs should adhere to school policies with regard to parental/caregiver consent for students' participation in screening activities).
 - SBYHNs may lend support for selective interventions for other identified high risk groups within the school as well, including minority groups such as Aboriginal and Torres Strait Islander or refugee young people. They may also support indicated intervention programs for young people with specific needs such as pregnant and parenting students; youth involved in criminal/anti-social behaviour, self-harm, substance abuse and disengagement from school; or those who are known to have experienced issues of grief and loss.
 - SBYHNs may work proactively with their school communities to promote a help-seeking culture. They can facilitate young people's understanding of how to recognise when their friends may need help, and support them with ways to broach this issue with their friends and facilitate their access to appropriate services. This may entail promotion and support for a peer-mentor program within the school, which may represent an intermediate step to facilitating access for young people to support services.
 - SBYHNs may also advocate for and facilitate the development of school protocols and procedures for identifying and supporting students at risk of specific health issues. These may incorporate

a description of risk factors; reporting requirements for young people deemed to be at risk; delineation of the roles various people within the school have around the identification of the health issue; and confidentiality and duty of care surrounding provision of support for young people contending with the health issue.

Vulnerable groups

Pregnant and parenting students

- Pregnant and parenting young people are at a higher risk of not completing their education, which impacts on their employment opportunities, financial security and their ability to effectively provide for their children. DETE is committed to supporting the retention of pregnant and parenting young people in education, and SBYHNs may be instrumental in facilitating this support through:
 - Provision of advocacy for the young person with school staff surrounding flexible arrangements in timetabling, attendance, uniform and child care.
 - Referral to appropriate support services outside of the school, and negotiation for community agency staff to come to the school for appointments with students to facilitate access.
 - Health education surrounding strategies to support a healthy pregnancy and optimal infant growth and development.
 - Maintenance of communication at key times including following the birth of the baby, illness of the parent or child, prior to exams, beginning of school terms and during any unexpected or sustained absences.
 - Advocacy for use of appropriate facilities to accommodate the individual needs and circumstances of students, for example, access to a private space for breast-feeding and child care.
 - Promotion of strategic partnerships with community groups to support students' needs, e.g. exploring transport options for students and their children, nappy services for students at school etc.
 - Provision of advice to school staff on contagious conditions (e.g. listeria, influenza, measles, chicken pox) and precautions needed to minimise infection transmission to pregnant students.
- Further information regarding ways to support pregnant and parent students (including links to other useful websites) may be found on the DETE website: <http://education.qld.gov.au/schools/inclusive/pregnant-parenting-students.html>

Refugee students

- The developmental and social challenges encountered during adolescence can be compounded by the traumatic nature of the refugee experience. Factors including cultural dislocation, loss of established social networks, and the demands of resettlement such as engaging in school, making new friends, and learning a new language and culture are all difficulties young refugees are experiencing whilst they are still negotiating family and community expectations. This can be exacerbated by pre-migration experiences which are commonly characterised by significant and often repeated exposure to traumatic situations.
- Refugee young people are at heightened risk of developing psychological problems such as post-traumatic stress disorder, anxiety, sleep disorders, and depression. They are also at increased risk of co-morbid substance use disorders, with many using alcohol and other drugs as a means of coping with stressors relating to both pre-migration and settlement experiences ²⁰⁶.
- Providing appropriate supports to cater to the complex needs of refugee students can prove very challenging, particularly from an educational perspective as some young refugees have never engaged in schooling prior to arriving in Australia. Negative educational experiences can further disempower this sub-group of students and heighten risks to their health and wellbeing ²⁶⁵.

- A whole-of-school approach is needed to support the development of an inclusive school environment that caters to the needs of refugee young people. SBYHNs may support their school communities to draw on strategies from the Health Promoting Schools Framework to progress this, and in particular facilitate their access to appropriate resources and their engagement with relevant community agencies to assist with this process:
 - Queensland Program of Assistance to Survivors of Torture and Trauma (QPASTT) is a state-wide service that provides resources and professional development to build the capacity of schools to support refugee students. Visit: <http://qpastt.org.au/what-we-do/children-and-youth-programs/support-for-schools/>
 - The Queensland Transcultural Mental Health Centre is a state-wide service that can help to organise a culturally appropriate assessment and/or psycho-education for a young person or their family members; provide specific information for a cultural group you are working with; organise a workshop on a particular mental health issue in your community; and also provide other resources surrounding transcultural mental health issues. Visit: <http://www.health.qld.gov.au/metrosouthmentalhealth/qtmhc/>
- Further multicultural health resources are available from the Queensland Health Multicultural Health website, including practice guides, cultural information and community profiles. Visit: www.health.qld.gov.au/multicultural/

Aboriginal and Torres Strait Islander young people

- Aboriginal and Torres Strait Islander young people experience comparatively higher rates of mental health problems, STIs, and substance use than non- Aboriginal and Torres Strait Islander young people²⁹⁸. They therefore represent an at-risk sub-group that would benefit from engagement in selective prevention programs to address risk behaviours and build resilience.
- Programs targeted at Aboriginal and Torres Strait Islander young people should be culturally relevant and delivered in a culturally-safe manner, and tailored to the specific needs of the community.
- The Aboriginal and Torres Strait Islander Health Worker will have a major role in facilitating these programs and building links between young people, schools, their families and the community.
- Specific interventions may include:
 - implementing school and peer-based education programs that promote safe behaviours in collaboration with young people;
 - programs to increase physical activity, decrease inhalant or tobacco use, and reduce violence and crime;
 - implement the well person's health check;
 - implement and evaluate programs such as SmokeCHECK and Foetal Alcohol Syndrome (FAS) education;
 - provide accessible health promotion and primary care services for those attending secondary school (including those at risk of early school leaving and homelessness) in collaboration with the SBYHN;
 - develop, implement, monitor and evaluate young pregnant and parenting programs;
 - collaborate with education and community to develop, implement, monitor and evaluate life skills programs;
 - in partnership with young people, their families and communities develop community-based health promotion and other services to meet major needs (e.g. sexual health, substance use, emotional wellbeing);
 - develop and implement pathways to support young people with their specific needs (e.g. those who experience violence, abuse and neglect);
 - implement, monitor and evaluate coordinated services for mature minors who are not attending school or accessing health services;

- implement, monitor and evaluate relevant strategies from the Queensland Government's 'Making tracks toward closing the gap in health outcomes for Indigenous Queenslanders by 2033' strategic framework.

Young people in out-of-home care

- Children and young people in out-of-home care are among the most vulnerable in our society. Many have experienced situations of abuse or neglect in their family of origin, and often find themselves placed with intolerant carers who do not adequately meet their care needs, or further subject them to physical or emotional abuse ²⁹⁹.
- Children and young people in care may experience family and cultural disconnectedness and disenfranchised grief, which can contribute to the development of attachment problems which negatively impact on their sense of safety and security and hinder their personal development. They may receive inadequate practical support to develop self-care and social skills, which may further impact on their self-esteem and self-concept and inhibit their ability to function effectively in society. This can lead to chronic problems with personal and family relationships, negatively influence employment opportunities, as well as increase their susceptibility to exploitation and involvement with the criminal justice system ^{39,266}.
- Young people in out-of-home care may also experience a much higher prevalence of clinically significant mental health problems, including post-traumatic stress disorder, major depression and disruptive behavioural disorders. They also have higher rates of substance abuse and suicidal behaviour. Homeless youth, or those with precarious housing situations due to adverse family histories but no formalised care arrangements, are equally at risk for these mental health issues ²⁶⁷.
- The Child Protection system in Queensland is currently under reform with one of the aims being to redress these adverse outcomes for children and young people in care ²⁶⁸.
- Understanding the risk factors that may impact on the wellbeing of a young person in care is the first step for the SBYHN in tailoring support for their particular care needs. Assisting young people in care to understand their rights through information provision and advocacy can also help to ensure their needs are appropriately met.
 - The Department of Communities, Child Safety and Disability Services has published an Information Kit for Children and Young People in Care regarding their entitlements and avenues through which to report concerns with their out-of-home care experience (<http://www.communities.qld.gov.au/childsafety/foster-care/children-and-young-people/info-kit-for-children-and-young-people-in-care>).
 - The Create Foundation aims to connect young people in care with those in similar situations to promote peer support and decrease isolation. The Foundation also provides programs to empower young people to develop self-confidence and self-esteem, and the skills to enable them to speak up and advocate for improvements to the foster care system (<http://www.create.org.au/about-us>).
 - Schools also have a responsibility to provide appropriate educational support for children and young people in care, and SBYHNs may provide advocacy to ensure they are actively involved in the development and ongoing review of an education support plan to help them reach their goals (<http://education.qld.gov.au/students/incare/resources.html>)

Responding to need

- A variety of strategies are employed by the SBYHN and Aboriginal and Torres Strait Islander Health Worker to respond to identified need within the school setting. This may involve the provision of individual support to young people through confidential consultations involving age-appropriate assessment, brief intervention and referral to appropriate health services or community agencies; small group programs with young people experiencing a common identified concern; or other health promotion initiatives targeting identified need within the school community.

Care planning

- SBYHNs work collaboratively with young people to tailor appropriate and acceptable plans of care that consider the young person's stage of psychosocial development, the acuity of their concern/s; service availability and suitability, and access issues such as affordability and transportation.
- It is recommended that SBYHNs familiarise themselves with locally-based services that are suitable to address the wide range of adolescent health issues. In addition to knowledge of referral pathways, intake processes, relative costs and opening hours, SBYHNs should seek information regarding any limitations to services provided to young people through these services, the requirement for parental involvement, and the availability of youth-friendly practitioners. Information such as this will assist young people to navigate the health care system effectively and seek appropriate and timely support. Providing guidance for young people on how they may access information themselves over the phone or internet can further build their health literacy and support their future help-seeking endeavours ²⁶⁹.
- Unless the young person is deemed to be at imminent risk of harm, consent should always be obtained to refer the young person to another service. Depending on the situation, young people may need time to contemplate referral recommendations and subsequent consultations may be required to review the young person's decision in this regard. Where appropriate the SBYHN would encourage the young person to discuss the referral options with his/her parents/caregivers. If consent were forthcoming to contact the parents/caregivers, the SBYHN may then devise a suitable plan of care in collaboration with the young person and his/her family which may help to mediate service access barriers such as affordability and transportation.

Facilitating a family-centred approach to care planning

- Although SBYHNs provide a youth-focused service and work to empower young people to increasingly assume control for their own healthcare decisions, it is important to be mindful of the context of the family and community in which young people live and how this influences their health and wellbeing. Parents have little access to the information being provided to their children unless the young person chooses to initiate discussion with them regarding their help-seeking endeavours. The generation gap as well as cultural issues can create distance between parents and their children and exacerbate communication difficulties. PHC care practice with young people requires that access, equity, self-determination and cultural sensitivity be extended not only to the adolescent group, but also to their parents and relevant community members.
- SBYHNs should explore the young person's relationships with their family members and assess how they function together as a family unit. A simple and effective way of achieving this is by explicitly asking young people to identify their family strengths. The Australian Family Strengths Nursing Assessment Guide provides an overview of the types of strengths that indicate resilience and effective family functioning. The guide details questions the nurse may use to elicit qualities in the family such as: togetherness; sharing activities; affection; support; communication; acceptance; and commitment ¹³⁴ (refer to Appendix 1). Once it has been established that the family may be receptive to involvement and contact would not further jeopardise the young person's situation, the SBYHN may seek permission from the young person to engage with family members and offer to advocate on behalf of the young person as required to support communication and facilitate connections and a partnership approach to addressing the issue at hand. The SBYHN will then have the opportunity to explore the situation

from the family's perspective, as well as gain a more comprehensive understanding of other factors pertaining to the family's situation which may be impacting on the health and wellbeing of the young person and offer support and referral as required.

- The Commonwealth Government has a website called Family Relationships Online which has links to useful factsheets to support healthy relationships and effective communication between young people and their families: www.familyrelationships.gov.au/Pages/default.aspx
- SBYHNs may draw on the Family Partnership Model to support their communication with parents/ caregivers and young people and facilitate the development of effective working relationships. The model consists of a series of eight interrelated steps, each of which represents an important task: Partnership; Exploration; Understanding; Goal-setting; Strategic planning; Implementation; Reviewing and ending. The model supports practitioners to reflect on their interpersonal skills and personal qualities which influence the process of developing a genuine and respectful partnership that builds self-esteem and self-efficacy, and facilitates a family-centred approach to addressing the issue at hand. Information regarding training in the use of the Family Partnership Model can be found on QHEPS: <http://qheps.health.qld.gov.au/ccyfhs/html/statewide-child-health.htm>
- SBYHNs should seek to determine whether young people followed up with referral recommendations in order to assess the suitability of the referral pathway, and ascertain whether subsequent care planning is required to better meet the needs of the young person.

Care coordination for clients with complex care needs

- Considering the autonomous nature of the SBYHN role, it is recommended that SBYHNs have supportive processes in place to assist them with the effective coordination of care for clients with more complex care needs.
- Clients with complex care needs will be identified by the SBYHN through the conduct of a HEEADSSS assessment during an individual consultation. This may include young people who:
 - have been harmed or are at risk of harm according to the Child Safety Unit Fact Sheet – “Clinical Risk Factors and Indicators of Harm in Children 13-18 years”;
 - have recently engaged in self-harming behaviour or are at risk of harming self or others;
 - are involved in risk-taking behaviours due to mental health concerns; or
 - are deemed to have multiple risk factors which jeopardise their health and wellbeing.
- Support with care coordination may involve initial liaison with clinical line managers to report and discuss the management of clients with identified complex care needs, as well as periodic reviews to provide ongoing collegial support with revisions to care planning. Additional strategies may also be helpful, such as presentation of de-identified information regarding clients with complex care needs at a case conference with medical and/or allied health staff to provide an inter-disciplinary perspective to support case management and referral pathways (such as staff from the local CYMHS).
- Timeframes for scheduling care reviews will be commensurate with the level of risk identified. This will also influence whether the care review occurs with colleagues face-to-face, over the telephone or via tele- or video-conference. The following timeframes are recommended:
 - For clients deemed to be at imminent risk, SBYHNs will seek immediate contact with their clinical line manager to discuss the care requirements (and the CPLO if there is a child safety concern). Depending on the client's circumstances, reviews would then be scheduled in accordance with recommendations by the clinical line manager. It may also be appropriate to discuss the client's situation at the next case conference to seek inter-disciplinary input into the care coordination.
 - For clients who are not deemed to be at imminent risk, an initial and subsequent review/s should be scheduled at the frequency deemed appropriate by the clinical line manager and/or case conference team coordinator.

- SBYHNs will maintain a written record of discussions held with other health professionals regarding the management of clients with complex care needs, including the recommendations made and the resultant plans of care. This may entail the use of specific care review documentation (refer to Appendix 14 for an example) or relevant notations in the client's progress notes.

Small group programs to address identified need

- Often the SBYHN, in conjunction with other members of the student welfare team, will identify a number of students who are contending with a similar issue. It can be beneficial to coordinate an indicated preventative intervention such as a small group program to collectively address the students' identified need while facilitating a supportive peer environment which may help to normalise the student's situation and provide an additional measure of support²⁷⁰.
- A number of health and wellbeing concerns may be addressed through small group programs with a variety of evidence-based resources available to facilitate this. There are cognitive behaviour based programs to address anxiety and depression (such as FRIENDS for Life – Visit: <http://www.pathwayshrc.com.au/>); loss and grief education programs to strengthen the social and emotional wellbeing of young people who are dealing with significant loss or change (including the death of a loved one, parental divorce or separation, the experience and aftermath of natural disaster and moving house or school) (such as Seasons for Growth – Visit: <https://www.goodgrief.org.au/children-and-young-people>); and programs to support students at risk of disengagement from school (such as Rock and Water – Visit: <http://www.newcastle.edu.au/research-and-innovation/centre/fac/resources>). The coordination and co-facilitation of small group programs in the school setting can present an ideal opportunity to forge links with external service providers in the local community.
- There are a number of factors to consider when coordinating small group programs:
 - the availability and cost of educational resources to support program delivery;
 - the availability and cost of facilitator training to support program delivery;
 - the availability of other support personnel (within or external to the school) to co-facilitate the program;
 - the availability of a suitable venue to conduct the small group program;
 - ensuring that participating students attend during different classes each week to avoid impacting on their educational progress in one particular subject;
 - facilitating students' discrete attendance to avoid potential stigmatisation by their peers;
 - striving to ensure that students are compatible in relation to age, temperament and any other factors which may influence the 'culture' of the group, including group dynamics, individual participation and on-going group attendance;
 - fulfilling requirements regarding parental/caregiver permission for student participation;
 - setting and maintaining appropriate group boundaries to ensure that group members are respectful of one another, they maintain confidentiality of information shared within the group, and they stay on track with program objectives; and
 - data collection surrounding process and impact measures to evaluate the success of the program (in accordance with specific school and HHS requirements).

Other service initiatives to respond to identified need in the school community

- The SBYHN service is founded on a PHC model that promotes positive health outcomes for young people and their families through the delivery of accessible, acceptable, appropriate and culturally respectful PHC services in the school setting.
- The ongoing and rising problems of STI's and unwanted/unplanned pregnancy underscore the need to provide sexual health and contraceptive services for young people that recognise their unique developmental stage and are delivered in a way that overcome barriers to access, and support positive health and help-seeking behaviours^{220,247,271}. Additionally, the provision of health education regarding sexual safety is important, but unless this is skills-based and is coupled with ready access to contraception its effects are likely to be limited^{272,273,274}.

- The discretionary provision of condoms to young people and urine pregnancy testing via the SBYHN service reflects the principles of PHC and supports early intervention/prevention of ill health. These discretionary services should occur in the context of individual consultations and involve supportive education. These services should only be delivered if agreed upon by the Principal of the school concerned and the HHS in which the nurse practices. It may also be appropriate to seek the approval of the schools Parents and Citizens Association.
- The parameters of the discretionary condom distribution and urine pregnancy testing service must also be agreed upon by the Principal of the school concerned and the HHS. This would include negotiation regarding: responsibility for budgetary requirements; provision of equipment required; and procedures for disposal and storage of consumables. Documentation regarding the outcome of these negotiations should be developed in accordance with HHS policy.

Distribution of condoms within the school setting

- During a young person's initial presentation, the SBYHN will explain the parameters of the service and bounds of confidentiality prior to the young person disclosing personal information. In addition to applying the Gillick Principle to assess whether a young person is of sufficient maturity and understanding to access a consultation with the SBYHN, the Fraser Guidelines should be applied when offering contraceptive services to people under the age of 16 without parental knowledge or permission. This involves a determination that: The young person understands the advice being given and cannot be convinced to involve parents/carers (or allow you to do so on their behalf); it is likely that the young person will begin or continue having intercourse with or without treatment/contraception; unless he or she receives treatment/contraception the young person's physical and/or mental health is likely to suffer; and the young person's best interests require contraceptive advice, treatment or supplies to be given without parental consent ²⁷⁵.
- When it is deemed that a young person meets the requirements to participate in a discretionary condom distribution service, the SBYHN is to provide opportunistic education around sexual health, STIs and sexual safety, sexual decision making, and contraception, and if agreed facilitate referral to appropriate community services relative to the young person's identified need/s. If during the course of the consultation there are deemed to be child safety concerns, the SBYHN will act in accordance with relevant child safety legislation and mandatory reporting requirements.
- It is recommended that HHSs supporting discretionary condom distribution in secondary schools have in place an appropriate work instruction, checklist to guide the consultation process, and guidelines pertaining to the achievement of educational criteria/competency standards by SBYHNs to support the delivery of this service.

Pregnancy testing within the school setting

- If the discretionary provision of supported urine pregnancy testing is to be considered it must be delivered within the context of individual consultations and in conjunction with supportive education and appropriate referral for young people who present with a potential pregnancy. It should also be considered as one strategy within a whole-of-school approach to addressing teenage pregnancy.
- On initial presentation the SBYHN will explain to the young person the parameters of the service and bounds of confidentiality prior to the young person disclosing personal information. The SBYHN will assess if the young person has a sufficient level of maturity and understanding with regard to the issues and the health service proposed (i.e. Gillick Competence) and determine whether the young person comprehends and can consent to the service. In line with good practice, the SBYHN will explore with the student the possibility of involving a parent/caregiver. If the request is declined, the possibility for this can be revisited once rapport has been built between the SBYHN and young person.
- If discussions with the young person suggest a potential pregnancy, a potential pregnancy history checklist should be completed followed by the conduct of a urine pregnancy test (if the young person consents to this and if the provision of this service has been approved by the Principal of the school concerned and the HHS in which the SBYHN practices). The SBYHN will explain the procedure to the young person and highlight the need to perform the test and discuss the results in the presence of the client and SBYHN only.

- If there are deemed to be child safety concerns during the consultation the SBYHN will act according to relevant child safety legislation and mandatory reporting requirements. The identification of child protection issues should not deter the SBYHN from performing a urine pregnancy test if there is an indicated need for this.
- The provision of a discretionary supported pregnancy testing service by the SBYHN will facilitate the delivery of:
 - pre- and post-pregnancy test counselling with the young person in a youth-friendly environment; and
 - accurate, non-judgemental information regarding pregnancy options, the time restrictions surrounding choice, counselling opportunities, referral pathways to services, and holistic support to empower young women to make informed decisions regarding their health and wellbeing.
- If the urine pregnancy test result is positive, the SBYHN has a duty of care to provide the student with accurate non-judgemental information regarding all of the options available to her to facilitate informed decision making.
- If the test result is negative, a follow-up test may be required to exclude pregnancy. If a second test is negative, referral for further assessment of amenorrhoea may need to be negotiated with the student.
- The SBYHN should explore with the student other important health considerations such as sexual health and protection from STIs, sexual decision making, sexual safety and contraception. A subsequent consultation may be needed to facilitate these discussions.
- If a referral to an external service is indicated and the young person is deemed to be legally capable of making informed decisions regarding their own health care, it is the young person's responsibility to follow through with the referral recommendations. At the time of negotiating the referral, the SBYHN can request the young person's consent to facilitate follow up with staff from the referral service to ensure the appropriate action has been taken to support the young person.
- Should the SBYHN assess that the young person is:
 - not capable of understanding the implications of the health care decision;
 - is under 14 years of age; or
 - is at risk due to the nature of the sexual encounter (i.e. age difference or power imbalance between participants, or non-consensual sexual activity),
 the SBYHN needs to consider relevant child safety legislation and mandatory reporting requirements.
- It is recommended that HHSs supporting discretionary urine pregnancy testing in secondary schools have in place an appropriate work instruction, checklist to guide the consultation process, and guidelines pertaining to the achievement of educational criteria/competency standards by SBYHNs to support the delivery of this service. It is the responsibility of the school, HHS and SBYHN to negotiate appropriate professional development for the SBYHN to facilitate this service delivery.



Dealing with requests for information from Queensland Police Service

SBYHNs may at times be approached by Queensland Police for information; be requested to provide a statement or be interviewed by police; or be approached by the Queensland Police Service to attend court to give evidence. Should any of these situations occur, it is essential to first discuss the matter with your line manager who will seek advice from HHS management/medico-legal services as required, and direct you to specific HHS policies and procedures addressing the matter.

APPENDIX 1

Australian Family Strengths Nursing Assessment Guide

Togetherness

- In your family, what shared beliefs really matter to you?
- Do you share beliefs that really matter together that you would like to follow during this admission/time of health care?
- What are some of the things that cause you to celebrate together?
- Tell me about some of your family's shared memories.

Shared activities

- When does the family spend time together?
- What is it you like about when you plan activities together?
- How often would you play together as a family?
- Tell me about when you have good times together in your family.

Affection

- In your family, when is it most easy to tell others how you feel about them?
- How best do you show your love for each other?
- In what ways do you demonstrate consideration for each other?
- How would others know you care about each other?
- If I were to ask your best friend about how you care about each other, what would they say?
- What sort of things do you do for each other?

Support

- Tell me of times when you as a family 'share the load'.
- How would an observer seeing your family know that you help each other?
- Can you think of ways you look out for each other?
- What does it mean in your family to be 'there for each other'?
- In what ways do you encourage others to try new things?

Communication

- When do you listen to each other?
- Tell me about when you talk openly with each other.
- Tell me about some of the times when you laugh together.

Acceptance

- In what ways do you accept your individual differences?
- When are you most likely to give each other space?
- How do you show the members of your family that you respect each other's point of view?
- What does forgiveness of each other look like in your family?
- What different responsibilities does each of you have?

Commitment

- When do you feel safe and secure with each other?
- How would others know that you trust each other?
- List some of the things your family does for your community.
- What rules do you have in your family and how should these be followed during this admission?

Resilience

- In what ways has this admission changed your plans?
- What helps keep each other hopeful?
- Can you tell me about when your family pulled together in a crisis?
- When you have a problem, what helps you discuss your problems?
- What do other people say they admire in your family?

Excerpt from Barnes, M., & Rowe, J. (2013). *Child, youth and family health: Strengthening communities* (2nd ed.). Chatswood NSW: Elsevier Australia.

APPENDIX 2

Children's Health Queensland Hospital and Health Service

Building Healthy Brains – The Eleven Key Messages

Why are the 'Eleven Key Messages' important?

Early childhood development is critical as it impacts significantly on children later on in life, particularly in terms of their emotional wellbeing (Knitzer, 2001; Shonkoff & Phillips, 2000; Tsiantis et al., 2000; Keating & Hertzman, 1999; Heckman 2006; Mustard 2004 & 2006). It has been identified that the aspects that make up the 'Eleven Key Messages' are vital to early childhood development and will therefore increase the wellbeing of children and their families.

Background

The 'Eleven Key Messages' is a product of the *Engaging Families in the Early Childhood Development (ECD) Story Project* which aimed to maximise early childhood outcomes by enabling parents, carers and the community to better understand the neurosciences surrounding early childhood development. As one of the strategies to increase awareness and understanding of the messages to parents, the Qld Centre for Children's Health and Wellbeing has developed 11 newsletters that provide useful facts and strategies for building healthy children. The Centre aims to promote the newsletters to families and organisations working with families to support their parenting journey and help to build knowledge and skills in enhancing child development and wellbeing.

'Eleven Key Messages'

The first five years matter and last a lifetime	Nurture, communicate and play with your baby as a strong foundation builds a brain that allows for growth and later learning.
Good nutrition, health and exercise are critical	Be a good, healthy model for your child as they learn from you. Eat healthy meals together – lots of fruit and vegetables.
Children are born ready to learn	Experiences shape how you child's brain grows, learns and develops. Play games with your child and establish predictable routines.
The best learning happens in nurturing relationships	Your child's brain develops healthily through loving, caring, stable and supportive relationships. Hold, caress, cuddle and talk to your baby.
The brain develops through use	Make sure your child is able to use their senses. Involve your child in everyday activities such as helping around the house.
Children's wellbeing is critical to brain development	You need to grow your child's heart and mind. Avoid situations that are stressful. Do things together such as washing the dog and preparing meals.
Children learn through being engaged and doing	Play helps your child to develop skills they need to do well later on in life. Allow your child to explore things by themselves.
Children learn from watching and copying	Being a positive role model is vital for your child's learning. Talk about feelings and name them. Model and include your child in concern and care for others.
Children's self control is critical for learning and relationships	Your child learns self-control and how to manage their feelings by watching what you do. Encourage pretend play and encourage your child to be cooperative and sociable.
Children learn language by listening to it and using it	Your child learns words when you name the things they are playing with or looking at. Talk about what you are doing in your tasks to your children, tell stories, sing and write with your child.
Children are born ready to use and learn mathematics	By trying and finding things out for themselves, your child learns maths more effectively. Play counting games with your child and provide opportunities for your child to use maths – when shopping, ask your child to collect items.

Contact


Centre for Children's Health & Wellbeing: (07) 3412 2936

View all four project reports at:

http://www.mceecdya.edu.au/mceecdya/engaging_families_in_the_early_childhood_dev_story,32784.html




APPENDIX 3


 <p>Children's Health Queensland Child Health Service</p> <p>Family Health Assessment</p>	(Affix patient identification label here)		
	URN:.....	Sex:	<input type="checkbox"/> M <input type="checkbox"/> F
Family Name:			
Given Names:			
Address:			
Date of Birth: Telephone:			
This page is to be completed at the first contact			
Referral source: <input type="checkbox"/> Self <input type="checkbox"/> Hospital <input type="checkbox"/> GP <input type="checkbox"/> Other: (please state):			
Introductory conversation (please tick):			
<input type="checkbox"/> AIDET: Explanation of Child Health service & roles, Family Health Assessment and working in partnership (Refer to Section 1 of the guideline)			
Who participated in this interview? (please tick)			
<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Grandparent <input type="checkbox"/> Other, Please state: <input type="checkbox"/> Interpreter present			
Family members and other's living in the household:			<input type="checkbox"/> Genogram completed (tick)
Surname	Given Name/s	Date of Birth	Relationship to Child
Other Services supporting the family (please tick & state name):			
<input type="checkbox"/> General Practitioner..... <input type="checkbox"/> Paediatrician.....			
<input type="checkbox"/> Allied Health Professional..... <input type="checkbox"/> Mental Health Professional.....			
<input type="checkbox"/> Child Safety Service <input type="checkbox"/> Other:.....			
Family / Social Circumstances – Protective Factors (please tick):			
<input type="checkbox"/> Partner employed <input type="checkbox"/> Family support <input type="checkbox"/> Community support <input type="checkbox"/> Child-care arrangements			
<input type="checkbox"/> Able to access support <input type="checkbox"/> Other (Please state):			
<input type="checkbox"/> Does the parent identify any immediate concerns for their child/ren's health or wellbeing? If yes, describe:			
.....			
.....			
.....			
Staff Signature:		Date: / / Time:	
Name & Designation:			

FAMILY HEALTH ASSESSMENT

V9 24/04/2014

 <p>Children's Health Queensland Child Health Service</p> <p>Family Health Assessment</p>	<p style="text-align: right;">(Affix patient identification label here)</p> <p>URN: Sex: <input type="checkbox"/> M <input type="checkbox"/> F</p> <p>Family Name:</p> <p>Given Names:</p> <p>Address:</p> <p>Date of Birth: Telephone:</p>
<p>Social Circumstances and Family Functioning</p> <p><i>(Discuss using suggested questions in Section 2 of the Family Health Assessment guideline)</i></p>	
<p>What cultural or social issues are identified with the family that may impact on the child and / or parenting? (tick & describe)</p> <p> <input type="checkbox"/> Nil <input type="checkbox"/> Language barriers <input type="checkbox"/> Health/Parenting beliefs <input type="checkbox"/> Low level of educational attainment </p> <p> <input type="checkbox"/> Financial stress <input type="checkbox"/> Housing stress <input type="checkbox"/> Lone parent </p> <p> <input type="checkbox"/> Mother aged < 18 years <input type="checkbox"/> Transition times/critical events <input type="checkbox"/> >4 siblings <input type="checkbox"/> Other </p> <p>Maternal</p> <p>.....</p> <p>.....</p> <p>.....</p> <p>Paternal</p> <p>.....</p> <p>.....</p> <p>.....</p> <p style="text-align: right;">Clinician Initials Date:/...../.....</p>	
<p>Parental Physical and Mental Wellbeing</p> <p><i>(Discuss using suggested questions in Section 3 of the Family Health Assessment guideline)</i></p>	
<p>What parental health issues are identified with the family that may impact on the child and / or parenting? (Tick & describe)</p> <p> <input type="checkbox"/> Nil <input type="checkbox"/> Medical illness <input type="checkbox"/> Physical disability <input type="checkbox"/> Intellectual disability </p> <p> <input type="checkbox"/> History of mental illness <input type="checkbox"/> Current mental health problem <input type="checkbox"/> Other </p> <p>Maternal</p> <p>.....</p> <p>.....</p> <p>.....</p> <p>Paternal</p> <p>.....</p> <p>.....</p> <p>.....</p> <p style="text-align: right;">Clinician Initials Date:..... /...../.....</p>	

DO NOT WRITE IN THIS BINDING MARGIN

 <p>Children's Health Queensland Child Health Service</p> <p>Family Health Assessment</p>	<p style="text-align: center;">(Affix patient identification label here)</p> <p>URN: Sex: <input type="checkbox"/> M <input type="checkbox"/> F</p> <p>Family Name:</p> <p>Given Names:</p> <p>Address:</p> <p>Date of Birth: Telephone:</p>
--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------

Domestic and Family Violence

(Discuss using suggested questions in Section 4 of the Family Health Assessment guideline)

What relationship issues are identified with the family that may impact on their child and / or parenting?
(Tick & describe)

- Nil
 Past abuse – abuse as a child
 Current environment abusive
 Other

Maternal

.....

.....

.....

Paternal

.....

.....

.....

Clinician Initials Date: / /

Alcohol, Tobacco and Other Drug Use

(Discuss using suggested questions in Section 5 of the Family Health Assessment guideline)

What substance use issues are identified with the family that may impact on their child and / or parenting?
(Tick & describe)

- Nil
 Alcohol use
 > 2 standard drinks /day
 Tobacco use
- > 5 standard drinks on any one occasion
 Prescribed medications
 Other
- Psychoactive drug use

Maternal

.....

.....

.....

.....

Paternal

.....

.....


.....

.....

Clinician Initials Date: / /


FAMILY HEALTH ASSESSMENT

V9 24/04/2014

 <p>Children's Health Queensland Child Health Service</p> <p>Family Health Assessment</p>	<p>(Affix patient identification label here)</p> <p>URN: Sex: <input type="checkbox"/> M <input type="checkbox"/> F</p> <p>Family Name:</p> <p>Given Names:</p> <p>Address:</p> <p>Date of Birth: Telephone:</p>
<p>Pregnancy Outcomes</p> <p><i>(Discuss using suggested questions in Section 6 of the Family Health Assessment guideline)</i></p>	
<p>What pregnancy / birth issues are identified with the family that may impact on their child and / or parenting? (Tick & describe)</p> <p><input type="checkbox"/> Nil</p> <p><input type="checkbox"/> Ambivalence (current pregnancy) <input type="checkbox"/> Assisted Reproduction</p> <p><input type="checkbox"/> Perinatal loss <input type="checkbox"/> Other e.g. obstetric complication/s, birth trauma</p> <p>.....</p> <p>.....</p> <p>.....</p> <p style="text-align: right;">Clinician Initials Date:/...../.....</p>	
<p>Infant Health</p> <p><i>(Discuss using suggested questions in Section 6 of the Family Health Assessment guideline)</i></p>	
<p>What infant health issues are identified with the family that may impact on their child and / or parenting? (Refer to Newborn Assessment & describe)</p> <p>.....</p> <p>.....</p> <p>.....</p> <p style="text-align: right;">Clinician Initials Date/...../.....</p>	
<p>Family Strengths and Resources (protective factors)</p>	
<p>What strengths and resources does the parent/carer identify that support their child and / or parenting? (describe)</p> <p>.....</p> <p>.....</p> <p>.....</p> <p>.....</p>	
<p>Concluding conversation (at completion of assessment)</p>	
<p>To help us develop a plan of care with you, what is most important to you regarding your child's health? How can our service support you? (Record response):</p> <p>.....</p> <p>.....</p> <p><input type="checkbox"/> Peer/interdisciplinary review required <input type="checkbox"/> Care plan documented</p> <p style="text-align: center;"><i>Thank the parent for their participation.</i></p>	

DO NOT WRITE IN THIS BINDING MARGIN

APPENDIX 4


 <p>Children's Health Queensland Child Health Service</p> <p>DVI Assessment Form</p>	(Affix patient identification label here)	
	URN:.....	Sex: <input type="checkbox"/> M <input type="checkbox"/> F
Family Name:		
Given Names:.....		
Address:		
Date of Birth:Telephone:		
<p>Health professional to explain the following in own words:</p> <ul style="list-style-type: none"> In this health service, we are concerned about your health and safety, so we ask all women the same questions about violence at home; This is because violence is very common and we want to improve our response to families experiencing violence. 		
<p>Health worker to ask the following questions of ALL female patients on their own.</p>		
1. Are you afraid of your partner?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
2. In the last year, has your partner hit, kicked, punched or otherwise hurt you?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
3. In the last year, has your partner put you down, humiliated you or tried to control what you can do?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
4. In the last year, has your partner threatened to hurt you?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<p>If domestic violence has been identified in any of the above questions, continue to questions 5 & 6</p>		
5. Would you like help with any of this now?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
6. This could be important information for your health care. Would you like us to send a copy of this form to your doctor?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Name of Doctor:		Signature of Client:
Address:		
Phone:.....		Date:
<p>DV Risk Status:</p> <p>Domestic violence not identified <input type="checkbox"/></p> <p>Domestic violence identified, help refused <input type="checkbox"/></p> <p>Domestic violence identified, help provided <input type="checkbox"/></p> <p>Provided with:</p> <p>Contact phone numbers for DV <input type="checkbox"/></p> <p>Written information for DV <input type="checkbox"/></p> <p>Referral to hospital-based service <input type="checkbox"/></p> <p>Referral to community DV service <input type="checkbox"/></p> <p>Referral to GP <input type="checkbox"/></p> <p>Other (state):.....</p>		<p>Screening Not Completed due to:</p> <p>Presence of Partner <input type="checkbox"/></p> <p>Presence of family members/friends <input type="checkbox"/></p> <p>Absence of interpreter <input type="checkbox"/></p> <p>Women refused to answer the questions <input type="checkbox"/></p> <p>Additional Comments:</p> <p>Staff Signature:</p> <p>Name & Designation:.....</p> <p>Date / Time</p>

DO NOT WRITE IN THIS BINDING MARGIN

V4 24/04/2014

DVI ASSESSMENT FORM

APPENDIX 5


 <p>Children's Health Queensland Child & Youth Community Health Service</p> <p>Edinburgh Postnatal Depression Scale (EPDS)</p>	<p>(Affix patient identification label here)</p> <p>URN: Sex: <input type="checkbox"/> M <input type="checkbox"/> F</p> <p>Family Name:</p> <p>Given Names:</p> <p>Address:</p> <p>Date of Birth: Telephone:</p>												
<p>We would like to know how you have been feeling in the past week. Please indicate which of the following comes closest to how you have felt <u>IN THE PAST 7 DAYS</u>, not just how you feel today.</p> <p>Please colour in the circle using a dark pencil or pen.</p>													
<p>Here is an example already completed</p> <p>I have felt happy:</p> <table style="width: 100%;"> <tr> <td style="width: 50%;">Yes, all the time</td> <td style="width: 10%; text-align: center;"><input type="radio"/></td> <td style="width: 40%;">This would mean "I have felt happy most of the time during the past week"</td> </tr> <tr> <td>Yes, most of the time</td> <td style="text-align: center;"><input checked="" type="radio"/></td> <td>Please complete the other questions in the same way</td> </tr> <tr> <td>No, not very often</td> <td style="text-align: center;"><input type="radio"/></td> <td></td> </tr> <tr> <td>No, not at all</td> <td style="text-align: center;"><input type="radio"/></td> <td></td> </tr> </table>		Yes, all the time	<input type="radio"/>	This would mean "I have felt happy most of the time during the past week"	Yes, most of the time	<input checked="" type="radio"/>	Please complete the other questions in the same way	No, not very often	<input type="radio"/>		No, not at all	<input type="radio"/>	
Yes, all the time	<input type="radio"/>	This would mean "I have felt happy most of the time during the past week"											
Yes, most of the time	<input checked="" type="radio"/>	Please complete the other questions in the same way											
No, not very often	<input type="radio"/>												
No, not at all	<input type="radio"/>												
<p>In the past 7 days:</p>													
<p>1. I have been able to laugh and see the funny side of things.</p> <p>As much as I always could <input type="radio"/></p> <p>Not quite so much now <input type="radio"/></p> <p>Definitely not so much now <input type="radio"/></p> <p>Not at all <input type="radio"/></p>	<p>6*. Things have been getting on top of me</p> <p>Yes, most of the time I haven't been able to cope at all <input type="radio"/></p> <p>Yes, sometimes I haven't been coping as well as usual <input type="radio"/></p> <p>No, most of the time I have coped quite well <input type="radio"/></p> <p>No, I have been coping as well as ever <input type="radio"/></p>												
<p>2. I have looked forward with enjoyment to things</p> <p>As much as I always did <input type="radio"/></p> <p>Rather less than I used to <input type="radio"/></p> <p>Definitely less than I used to <input type="radio"/></p> <p>Hardly at all <input type="radio"/></p>	<p>7*. I have been so unhappy that I have had difficulty sleeping</p> <p>Yes, most of the time <input type="radio"/></p> <p>Yes, sometimes <input type="radio"/></p> <p>Not very often <input type="radio"/></p> <p>No, not at all <input type="radio"/></p>												
<p>3*. I have blamed myself unnecessarily when things went wrong</p> <p>Yes, most of the time <input type="radio"/></p> <p>Yes, some of the time <input type="radio"/></p> <p>Not very often <input type="radio"/></p> <p>No, never <input type="radio"/></p>	<p>8*. I have felt sad or miserable</p> <p>Yes, most of the time <input type="radio"/></p> <p>Yes, quite often <input type="radio"/></p> <p>Not very often <input type="radio"/></p> <p>No, not at all <input type="radio"/></p>												
<p>4. I have been anxious or worried for no good reason</p> <p>No, not at all <input type="radio"/></p> <p>Hardly ever <input type="radio"/></p> <p>Yes, sometimes <input type="radio"/></p> <p>Yes, very often <input type="radio"/></p>	<p>9*. I have been so unhappy that I have been crying</p> <p>Yes, most of the time <input type="radio"/></p> <p>Yes, quite often <input type="radio"/></p> <p>Only occasionally <input type="radio"/></p> <p>No, never <input type="radio"/></p>												
<p>5*. I have felt scared or panicky for no very good reason</p> <p>Yes, quite a lot <input type="radio"/></p> <p>Yes, sometimes <input type="radio"/></p> <p>No, not much <input type="radio"/></p> <p>No, not at all <input type="radio"/></p>	<p>10*. The thought of harming myself has occurred to me</p> <p>Yes, quite often <input type="radio"/></p> <p>Sometimes <input type="radio"/></p> <p>Hardly ever <input type="radio"/></p> <p>Never <input type="radio"/></p>												
<p>Administered/Reviewed by: Name and Designation:</p>	<p>Date: Time:</p>												

DO NOT WRITE IN THIS BINDING MARGIN

EDINBURGH POSTNATAL DEPRESSION SCALE

V9 24/04/2014

Source: Cox JL, Holden JM & Sagovsky R, 1987 Detection of postnatal depression: Development of the 10-item Edinburgh Postnatal Depression Scale. *British Journal of Psychiatry* 150: 782-786
 CHS-PCP-653
 CMR ASS 950

 <p>Children's Health Queensland Child & Youth Community Health Service</p> <p>Edinburgh Postnatal Depression Scale (EPDS)</p>	<p>(Affix patient identification label here)</p> <p>URN: Sex: <input type="checkbox"/> M <input type="checkbox"/> F</p> <p>Family Name:</p> <p>Given Names:</p> <p>Address:</p> <p>Date of Birth: Telephone:</p>
<p align="center">Edinburgh Postnatal Depression Scale¹ (EPDS)</p> <p>Postpartum depression is the most common complication of childbearing.² The 10-question Edinburgh Postnatal Depression Scale (EPDS) is a valuable and efficient way of identifying patients at risk of "perinatal" depression. The EPDS is easy to administer and has proven to be an effective screening tool.</p> <p>Mothers who score above 13 are likely to be suffering from a depressive illness of varying severity. The EPDS score should not override clinical judgement. A careful clinical assessment should be carried out to confirm the diagnosis. The scale indicates how the mother has felt during the previous week. In doubtful cases it may be useful to repeat the tool after 2 weeks. The scale will not detect mothers with anxiety neuroses, phobias or personality disorders.</p> <p>More information and support for women is available through Beyond Blue: the national depression initiative, 2007 Information Line: 1300 22 4636 W: www.beyondblue.org.au</p>	
<p align="center">SCORING</p> <p>QUESTION 1, 2 & 4 (without an *) Are scored 0, 1, 2 or 3 with top box scored as 0 and the bottom box scored as 3.</p> <p>QUESTIONS 3, 5-10 (marked with an *) Are reverse scored, with the top box scored as a 3 and the bottom box scored as 0.</p> <p>Maximum score: 30 Possible Depression: 10 or greater Always look at item 10 (suicidal thoughts)</p> <p>Users may reproduce the scale without further permission, providing they respect copyright by quoting the names of the authors, the title, and the source of the paper in all reproduced copies.</p>	
<p>Instructions for using the Edinburgh Postnatal Depression Scale:</p> <ol style="list-style-type: none"> The mother is asked to check the response that comes closest to how she has been feeling in the previous 7 days. All the items must be completed. Care should be taken to avoid the possibility of the mother discussing her answers with others. (Answers come from the mother or pregnant women). The mother should complete the scale herself, unless she has limited English or has difficulty with reading. <p>¹Source: Cox, J.L., Holden, J.M., and Sagovsky, R. 1987. Detection of postnatal depression: Development of the 10-item Edinburgh Postnatal Depression scale. <i>British Journal of Psychiatry</i> 150:782-786.</p> <p>²Source: K.L. Wisner, B.L. Parry, C.M. Piontek, Postpartum Depression N Engl J Med vol. 347, No3, July 18, 2002 194-199.</p>	

DO NOT WRITE IN THIS BINDING MARGIN

APPENDIX 6 Edinburgh Postnatal Depression Scale scoresheet

The EPDS is a 10-item questionnaire. Women are asked to answer each question in terms of the past seven days.

1. I have been able to laugh and see the funny side of things

As much as I always could (score of 0)

Not quite so much now (score of 1)

Definitely not so much now (score of 2)

Not at all (score of 3)

Score

2. I have looked forward with enjoyment to things

As much as I ever did (score of 0)

Rather less than I used to (score of 1)

Definitely less than I used to (score of 2)

Hardly at all (score of 3)

Score

3. I have blamed myself unnecessarily when things went wrong

Yes, most of the time (score of 3)

Yes, some of the time (score of 2)

Not very often (score of 1)

No, never (score of 0)

Score

4. I have been anxious or worried for no good reason

No, not at all (score of 0)

Hardly ever (score of 1)

Yes, sometimes (score of 2)

Yes, very often (score of 3)

Score

5. I have felt scared or panicky for no very good reason

Yes, quite a lot (score of 3)

Yes, sometimes (score of 2)

No, not much (score of 1)

No, not at all (score of 0)

Score

6. Things have been getting on top of me

Yes, most of the time I haven't been able to cope at all (score of 3)

Yes, sometimes I haven't been coping as well as usual (score of 2)

No, most of the time I have coped quite well (score of 1)

No, I have been coping as well as ever (score of 0)

Score

7. I have been so unhappy that I have had difficulty sleeping

Yes, most of the time (score of 3)

Yes, sometimes (score of 2)

Not very often (score of 1)

No, not at all (score of 0)

Score

8. I have felt sad or miserable

Yes, most of the time (score of 3)

Yes, quite often (score of 2)

Not very often (score of 1)

No, not at all (score of 0)

Score

9. I have been so unhappy that I have been crying

Yes, most of the time (score of 3)

Yes, quite often (score of 2)

Only occasionally (score of 1)

No, never (score of 0)

Score

10. The thought of harming myself has occurred to me

Yes, quite often (score of 3)

Sometimes (score of 2)


Hardly ever (score of 1)

Never (score of 0)

Score

Total score


APPENDIX 7

 <p>Children's Health Queensland Child Health Service</p> <p>Developmental Profile 2 Month Assessment</p>	(Affix patient identification label here)				
	URN: Sex: <input type="checkbox"/> M <input type="checkbox"/> F Family Name: Given Names: Address: Date of Birth: Telephone:				
Assessment age:					
Subjective:					
.....					
.....					
.....					
.....					
.....					
Physical Development:					
Weight and Percentile (P):	Chest / abdomen:				
Length and Percentile (P):	Femoral Pulses:				
Head Circumference and Percentile (P):	Hips:				
Head / Fontanelles:	Genitalia:				
Eyes / Vision:	Limbs:				
Hearing:	Skin:				
Otoscopy (A&TSI only):	Other:				
Mouth / palate:					
Nutrition and Infant Feeding (refer to definitions below):					
<input type="checkbox"/> Exclusive Breastfeeding	Feeding behaviour / pattern: <input type="checkbox"/> Feed observed				
<input type="checkbox"/> Full Breastfeeding				
<input type="checkbox"/> Partial Breastfeeding				
<input type="checkbox"/> Full Bottlefeeding (type & quota):				
<input type="checkbox"/> Weaned, reason:				
Parent / Infant Interaction and Responsiveness (observe & describe):					
.....					
.....					
Developmental Assessment:					
Has the parent / carer any concerns with their child's development? <input type="checkbox"/> Yes <input type="checkbox"/> No					
	Parent		Staff		Comments / Concerns
	Y	N	Y	N	
Posture and Large Movements					
<input checked="" type="checkbox"/>	Supine: large active movements of arms and legs, generally spontaneous motor activity				
<input checked="" type="checkbox"/>	Prone: lifts head up and holds effectively in line with body				
<input checked="" type="checkbox"/>	Supported sitting: head held steady, rounded back				
Vision and Fine Movements					
<input checked="" type="checkbox"/>	Turns head and eyes towards light source				
<input checked="" type="checkbox"/>	Follows a dangling object at 30-45 cm from midline to each side and back				
<input checked="" type="checkbox"/>	Watches face and follows with his / her eyes				
	Reflex grasp, clenches and unclenches hands				
Signature:				Date: / / Time:	
Name & Designation:					

DO NOT WRITE IN THIS BINDING MARGIN

2 MONTH ASSESSMENT

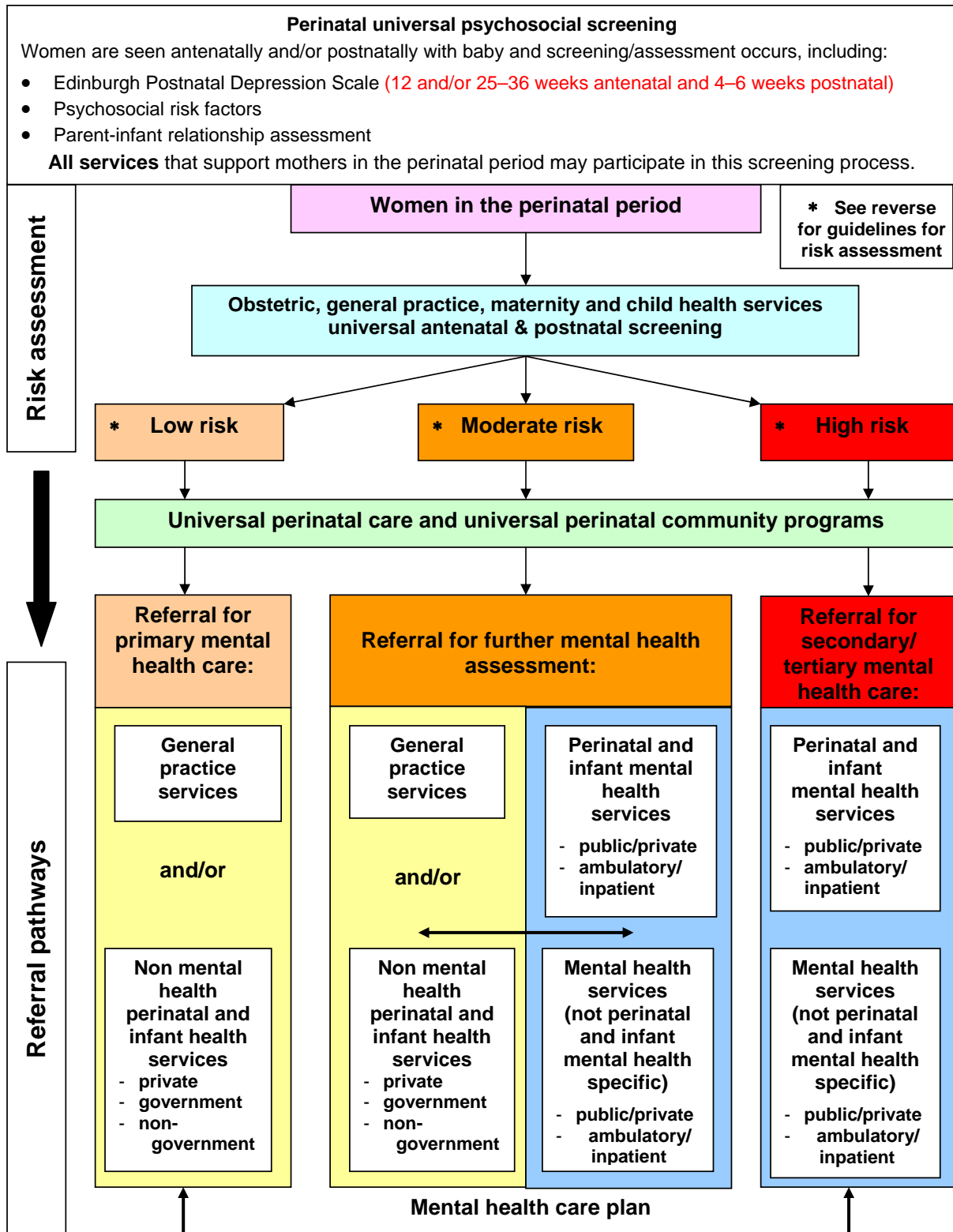
V15 24/04/2014

 <p>Children's Health Queensland Child Health Service</p> <p>Developmental Profile 2 Month Assessment</p>	<p style="text-align: center;">(Affix patient identification label here)</p> <p>URN: Sex: <input type="checkbox"/> M <input type="checkbox"/> F</p> <p>Family Name:</p> <p>Given Names:</p> <p>Address:</p> <p>Date of Birth: Telephone:</p>																																									
Communication and Hearing	<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th colspan="2"></th> <th colspan="2">Parent</th> <th colspan="2">Staff</th> <th rowspan="2">Comments / Concerns</th> </tr> <tr> <th colspan="2"></th> <th>Y</th> <th>N</th> <th>Y</th> <th>N</th> </tr> </thead> <tbody> <tr> <td><input checked="" type="checkbox"/></td> <td>Startled by sudden noises</td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td><input checked="" type="checkbox"/></td> <td>Listens to sound</td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td><input checked="" type="checkbox"/></td> <td>Vocalising little guttural noises ("ooo", "gah", "aah")</td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td><input checked="" type="checkbox"/></td> <td>Sucks well</td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> </tbody> </table>			Parent		Staff		Comments / Concerns			Y	N	Y	N	<input checked="" type="checkbox"/>	Startled by sudden noises						<input checked="" type="checkbox"/>	Listens to sound						<input checked="" type="checkbox"/>	Vocalising little guttural noises ("ooo", "gah", "aah")						<input checked="" type="checkbox"/>	Sucks well					
		Parent		Staff		Comments / Concerns																																				
		Y	N	Y	N																																					
<input checked="" type="checkbox"/>	Startled by sudden noises																																									
<input checked="" type="checkbox"/>	Listens to sound																																									
<input checked="" type="checkbox"/>	Vocalising little guttural noises ("ooo", "gah", "aah")																																									
<input checked="" type="checkbox"/>	Sucks well																																									
Social Behaviour and Play	<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th colspan="2"></th> <th>Y</th> <th>N</th> <th>Y</th> <th>N</th> <th rowspan="2">Comments / Concerns</th> </tr> </thead> <tbody> <tr> <td><input checked="" type="checkbox"/></td> <td>Alertness, social smile</td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td></td> <td>Consolability when picked up</td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td></td> <td>Hand to mouth</td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> </tbody> </table>			Y	N	Y	N	Comments / Concerns	<input checked="" type="checkbox"/>	Alertness, social smile							Consolability when picked up							Hand to mouth																		
		Y	N	Y	N	Comments / Concerns																																				
<input checked="" type="checkbox"/>	Alertness, social smile																																									
	Consolability when picked up																																									
	Hand to mouth																																									
<p>Guidelines for Developmental Assessment</p> <ul style="list-style-type: none"> <input checked="" type="checkbox"/> indicates that this particular skill should have been acquired at appropriate age level If in any one section (eg. 'Posture and Large Movements'; 'Communication and Hearing'; etc.) one <input checked="" type="checkbox"/> is not achieved consult appropriately if required and/or implement a plan and then review. If two or more skills with the <input checked="" type="checkbox"/> have not been achieved at the appropriate age level in any section, consult appropriately if required and/or refer. <p>Assessment including the decision to consult and/or refer should take into account the child's history, previous and current assessments.</p>																																										
<p>Assessment Outcome:</p> <p><input type="checkbox"/> Satisfactory / Pass <input type="checkbox"/> Review <input type="checkbox"/> Refer</p>																																										
<p>Anticipatory Guidance: (tick if discussed)</p> <p><small>Items need only be ticked / used as required. They provide some guidance as to relevant issues for the age. Prioritise according to need.</small></p> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 25%; vertical-align: top;"> <input type="checkbox"/> Infant feeding <input type="checkbox"/> Expressing/storing breastmilk <input type="checkbox"/> Safe use of infant formula <input type="checkbox"/> Feeding equipment hygiene <input type="checkbox"/> Immunisation <input type="checkbox"/> Oral health <input type="checkbox"/> Infant sleep <input type="checkbox"/> Normal infant behaviour / cues <input type="checkbox"/> Stimulating language <input type="checkbox"/> Interacting with your baby/play </td> <td style="width: 25%; vertical-align: top;"> <input type="checkbox"/> Adjustment to parenting <input type="checkbox"/> Being a family <input type="checkbox"/> Maternal/family mental health & wellbeing <input type="checkbox"/> Infant attachment <input type="checkbox"/> Parent self-care <input type="checkbox"/> Parent supports / groups <input type="checkbox"/> Contraception <input type="checkbox"/> Recommended health checks <input type="checkbox"/> Personal Health Record / Information booklet </td> <td style="width: 25%; vertical-align: top;"> <input type="checkbox"/> Never shake baby <input type="checkbox"/> Safe sleeping / SUDI <input type="checkbox"/> Safe medication administration & storage <input type="checkbox"/> Transport related <input type="checkbox"/> Sun safety </td> <td style="width: 25%; vertical-align: top;"> <input type="checkbox"/> Clothing <input type="checkbox"/> Falls prevention <input type="checkbox"/> Burns/scalds prevention <input type="checkbox"/> Water safety – bathing <input type="checkbox"/> Pets <input type="checkbox"/> Choking </td> </tr> </table>		<input type="checkbox"/> Infant feeding <input type="checkbox"/> Expressing/storing breastmilk <input type="checkbox"/> Safe use of infant formula <input type="checkbox"/> Feeding equipment hygiene <input type="checkbox"/> Immunisation <input type="checkbox"/> Oral health <input type="checkbox"/> Infant sleep <input type="checkbox"/> Normal infant behaviour / cues <input type="checkbox"/> Stimulating language <input type="checkbox"/> Interacting with your baby/play	<input type="checkbox"/> Adjustment to parenting <input type="checkbox"/> Being a family <input type="checkbox"/> Maternal/family mental health & wellbeing <input type="checkbox"/> Infant attachment <input type="checkbox"/> Parent self-care <input type="checkbox"/> Parent supports / groups <input type="checkbox"/> Contraception <input type="checkbox"/> Recommended health checks <input type="checkbox"/> Personal Health Record / Information booklet	<input type="checkbox"/> Never shake baby <input type="checkbox"/> Safe sleeping / SUDI <input type="checkbox"/> Safe medication administration & storage <input type="checkbox"/> Transport related <input type="checkbox"/> Sun safety	<input type="checkbox"/> Clothing <input type="checkbox"/> Falls prevention <input type="checkbox"/> Burns/scalds prevention <input type="checkbox"/> Water safety – bathing <input type="checkbox"/> Pets <input type="checkbox"/> Choking																																					
<input type="checkbox"/> Infant feeding <input type="checkbox"/> Expressing/storing breastmilk <input type="checkbox"/> Safe use of infant formula <input type="checkbox"/> Feeding equipment hygiene <input type="checkbox"/> Immunisation <input type="checkbox"/> Oral health <input type="checkbox"/> Infant sleep <input type="checkbox"/> Normal infant behaviour / cues <input type="checkbox"/> Stimulating language <input type="checkbox"/> Interacting with your baby/play	<input type="checkbox"/> Adjustment to parenting <input type="checkbox"/> Being a family <input type="checkbox"/> Maternal/family mental health & wellbeing <input type="checkbox"/> Infant attachment <input type="checkbox"/> Parent self-care <input type="checkbox"/> Parent supports / groups <input type="checkbox"/> Contraception <input type="checkbox"/> Recommended health checks <input type="checkbox"/> Personal Health Record / Information booklet	<input type="checkbox"/> Never shake baby <input type="checkbox"/> Safe sleeping / SUDI <input type="checkbox"/> Safe medication administration & storage <input type="checkbox"/> Transport related <input type="checkbox"/> Sun safety	<input type="checkbox"/> Clothing <input type="checkbox"/> Falls prevention <input type="checkbox"/> Burns/scalds prevention <input type="checkbox"/> Water safety – bathing <input type="checkbox"/> Pets <input type="checkbox"/> Choking																																							
<p>Comments / Plan:</p> <p>.....</p> <p>.....</p> <p>.....</p> <p>.....</p> <p>.....</p> <p>.....</p>																																										
<p>Signature:</p> <p>Name & Designation:</p>	<p>Date: / / Time:</p>																																									
<p>Breastfeeding Status Definitions (Australian National Breastfeeding Strategy 2010-2015)</p> <p>Exclusive breastfeeding - Infant receives only breast milk (including expressed milk) and medicines (including oral rehydration solutions, vitamins and minerals) but no infant formula or non-human milk.</p> <p>Full breastfeeding - In addition to breast milk and medicines the infant may receive water or water-based drinks, tea or fruit juice (which are not recommended for babies) but no non-human milk or formula.</p> <p>Partial breastfeeding - Infant receives solid or semi-solid food in addition to or instead of breast milk, including expressed milk. This may include any food or liquid, including non-human milk and formula.</p> <p>Full bottlefeeding - Infant is receiving a full bottle feeding regime and medicines (including oral rehydration solutions, vitamins and minerals) but no human milk or food (solid or semi-solid).</p>																																										

DO NOT WRITE IN THIS BINDING MARGIN

APPENDIX 8: sample referral pathway

Perinatal and infant mental health universal risk assessment and referral pathways



Guidelines to assist in perinatal and infant mental health universal risk assessment and referral to care pathways

- As most women access health services at some time during pregnancy, childbirth or in the postnatal period, there is a universal opportunity to complete a brief psychosocial assessment, to identify those women at risk of emotional distress and/or significant psychosocial stressors.
- Psychosocial assessment in the perinatal period includes psychological, social, emotional, cultural and spiritual aspects of emotional health and wellbeing.
- Psychosocial assessment is based on the concept that there are multiple factors (biological, psychological, and social or environmental) that may individually or cumulatively contribute to the risk of emotional distress, just as there are multiple protective factors that mitigate this risk. Psychosocial assessment seeks to identify these risk and protective factors.
- An integrated approach to perinatal assessment, referral and the use of care pathways provides an opportunity for maternity, child health, GPs and mental health services staff to ensure that there is a holistic approach to addressing the perinatal and infant mental health needs of these women, their infants and families and to support the development of individual care plans based on the level of risk and the presence of protective factors.
- Perinatal and infant mental health services assess and support the mother preconception to 24 months postnatally and the infant preconception to 36 months postnatally
- The table below is a guide to risk assessment in the perinatal period, utilising the EPDS, a psychosocial assessment tool and parent-infant relationship assessment.
- While a single risk factor may be sufficient to determine risk, it is important to also consider the combination of risk and protective factors that a woman presents with. It is often the assessment of risk versus protective factors that helps to determine a final decision about risk.

Low Risk	Moderate Risk	High Risk
<ul style="list-style-type: none"> • EPDS of 9 or less • no past history of psychiatric illness • no history of past abuse • no past attachment issues • no domestic violence history • no drug and alcohol abuse history • only 1-2 environmental risk factors • no significant concerns about parent-infant relationship • no significant concerns about infant's mental health 	<ul style="list-style-type: none"> • EPDS 10 - 12 • past history of psychiatric illness • past history abuse • past attachment issues • domestic violence history • drug and alcohol abuse history • 2-3 environmental risk factors • possible or uncertain concerns about parent-infant relationship • no significant concerns about infant's mental health 	<ul style="list-style-type: none"> • EPDS >12 and/ or Q10 on EPDS scored 1,2 or 3 • acute psychiatric distress or crisis • current or past psychiatric history • current or past history abuse • past attachment issues • current domestic violence • current drug and alcohol abuse • > 3 environmental risk factors • definite concerns about parent-infant relationship • significant concerns about infant's mental health

APPENDIX 9: sample business plan for SBYHN program

Business Plan

Semester ____ to end Semester ____

School Based Youth Health Nurse Program, Queensland Health

_____ Hospital & Health Service

in partnership with

_____ State High School

Department of Education Training & Employment, _____ Region

We the undersigned, as representatives of the School Based Youth Health Nurse Service of the _____ Hospital & Health Service, and _____ State High School, Department of Education Training and Employment, _____ Region, hereby agree to work together to achieve the strategies outlined in this Operational Plan between Semester , 20 and end Semester , 20. A report will be given at each Local Consultative Team meeting on activities outlined.

Should issues of concern arise, these will be managed in a timely and collaborative manner, with the Principal and the School Based Youth Health Nurse informally discussing identified issues and attempting resolution at the local school level. If such issues remain unresolved, the Principal will discuss with the Nurse Line Manager..

School Based Youth Health Nurse Service:

Nurse Line Manager _____ **Signed** _____ **Date** _____

Youth Health Nurse _____ **Signed** _____ **Date** _____

_____ **State High School:**

Principal _____ **Signed** _____ **Date** _____

Contact details

Nurse Line Manager, SBYHN Service. Tel: _____ Email _____

School Based Youth Health Nurse. Tel: _____ Email _____

_____ State High School. Tel: _____ Email _____



Mission statements

.....**Hospital & Health Service:**
[Strategic objectives for HHS]

-
-
-
-

School Based Youth Health Nurse Service:

Assisting young people and the whole school community to achieve and maintain the best possible state of health and wellbeing.

.....**State High School Mission Statement:**

.....**State High School Motto:**

HHS Strategic Objective (NB: Dept. of Health objectives have been used for example purposes only.)	Goal (NB: Provide an overall snapshot of what you intend to achieve relative to the stated strategic objective.)	Action Steps (NB: Generic activities are provided for example purposes only. It is recommended that specific activities relative to each strategic objective be contextualized to the individual school community and build upon recommendations from the previous LCT report.)	Persons involved &/or responsible (NB: SBYHNs generally assume a supportive role with activities progressed in collaboration with other key stakeholders.)	Timeframe (NB: Activities may be ongoing or planned for a specific timeframe during the business plan period.)	Resources required (NB: Delineating resource requirements reinforces the school's commitment to supporting SBYHN service provision. Example resources are provided.)	Expected outcomes (NB: Where possible include a quantitative projection of outcomes to facilitate subsequent reporting. Examples are provided but these obviously need to be aligned with specific activities.)
Healthy Queenslanders	Facilitate the delivery of an integrated primary health care service that promotes and supports the health and wellbeing of the school community	<ul style="list-style-type: none"> Provision of one-to-one confidential consultations and small group consultations, with referrals to other services as appropriate. Maintenance of data surrounding client activity. Identification of emerging health issues within the school community and collaborative planning to address identified issues 	<p>SBYHN</p> <p>SBYHN</p> <p>SBYHN / LCT</p>	<p>Ongoing</p> <p>Ongoing</p> <p>Prior to next scheduled LCT</p>	<ul style="list-style-type: none"> Confidential appointment System Appropriate accommodation Secure client records Referral resource file Private telephone Internet / Intranet access Confidential data collection system. 	<ul style="list-style-type: none"> Anticipated number of 1:1 consultations. Anticipated number of small groups (including projected participant numbers). Report to LCT regarding emerging health issues within the school community and proposed activities to address concerns.
Accessible Services	Provide equitable access to a safe, timely and quality health service in the school community	<ul style="list-style-type: none"> Publish information relating to the SBYHN role in school newsletter and student / staff notices Present information relating to SBYHN role at: <ul style="list-style-type: none"> - Assemblies - Staff meetings - Orientation Day/s - Classes 	<p>SBYHN / relevant Admin staff member/s</p> <p>SBYHN / Heads of Dept / Year level coordinators / Teachers</p>	Outline the proposed timeframes for each specific activity	<ul style="list-style-type: none"> Confidential appointment system Appropriate accommodation (affording privacy for consultations) Access to relevant computer system/s. 	<ul style="list-style-type: none"> Anticipated number of role promotion publications. Anticipated number of role promotion presentations. Anticipated number of activities undertaken to promote student familiarity.

School Based Youth Health Nurse Service – Business Plan Semester , to end Semester

HHS Strategic Objective	Goal	Action Steps	Persons involved &/or responsible	Timeframe	Resources required	Expected outcomes
Innovation and Research	Foster the implementation of innovative and evidence-based health promotion initiatives, and undertake routine service evaluations to promote quality care and outcomes, and health service improvement	<ul style="list-style-type: none"> Support provided for a comprehensive and integrated approach to health promotion via the Health Promoting Schools (HPS) Framework, targeting adolescent priority health issues and identified need within the school community (<i>ie list the specific activities to be undertaken in accordance with the HPS framework</i>). 	SBYHN / LCT / Heads of Dept / Year level coordinators etc	Outline the proposed timeframes for each specific activity	<ul style="list-style-type: none"> Internet / Intranet access Photocopier access AV equipment Evidence-based health educational / promotional material Internet / Intranet access Photocopier access 	<ul style="list-style-type: none"> Anticipated number of articles published in school newsletter. Anticipated number of displays. Anticipated number of classroom presentations. Anticipated number of professional development sessions facilitated for staff.
Governance and Partnerships	Promote service accountability and engage with key partners to provide a primary health care service that is sustainable and provides value for money	<ul style="list-style-type: none"> Involvement in relevant school coalitions and activities (<i>list coalitions and proposed activities</i>). Regular participation in student wellbeing committee to facilitate appropriate student referrals. 	SBYHN Heads of Dept / Year level coordinators etc SBYHN / Committee coordinator	Outline the proposed timeframes for each specific activity	<ul style="list-style-type: none"> Computer/email access Phone access Photocopier access Data collection system LCT report, agenda and minutes 	<ul style="list-style-type: none"> Anticipated number of relevant meetings attended Anticipated number of activities involved in LCT report outlining partnership activities Anticipated number of LCT meetings during the business plan period.
Workforce	Cultivate an engaged, capable, innovative and efficient workforce	<ul style="list-style-type: none"> Participation in relevant professional development opportunities to advance knowledge and skills relative to role and specific health needs identified in the school community (<i>list events registered for/activities planned during business plan period</i>). 	SBYHN / LCT	Outline the proposed timeframes for each specific activity	<ul style="list-style-type: none"> Computer / internet access to facilitate engagement in on-line learning and professional networking opportunities. 	<ul style="list-style-type: none"> LCT report detailing engagement in professional development opportunities and summarizing how the acquired knowledge/skills will be applied to the SBYHN role.

School Based Youth Health Nurse Service – Business Plan Semester, to end Semester

APPENDIX 10: sample local consultative team meeting report (SBYHN program)




Local Consultative Team MeetingState High School

Meeting Date:.....
Reporting Period:.....

Strategic Objective	Goal	Actions/ Strategies	Persons involved / responsible	Expected Outcomes	Progress	Recommendations

Strategic Objective	Goal	Actions/ Strategies	Persons involved / responsible	Expected Outcomes	Progress	Recommendations

APPENDIX 11

 Queensland Government Children's Health Services COMMUNITY CHILD HEALTH SERVICE Adolescent Health Record HISTORY	(Affix patient identification label here)	
	URN:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F
School: Year Level:	Family Name:	
	Given Names:	
	Address:	
	Date of Birth: Telephone:	
Genogram		
<input type="checkbox"/> Male <input type="radio"/> Female ? Sex unknown _____ Married/Partner --/-- Separated, ^ Twins <input type="triangle-up"/> Pregnant O/ <input type="checkbox"/> (Shaded) Deceased --/-- Divorced ----- boundary around people who live together		
Support Staff		
<input type="checkbox"/> Guidance Officer <input type="checkbox"/> Learning Support/Special Needs <input type="checkbox"/> Chaplain <input type="checkbox"/> Youth Support Coordinator <input type="checkbox"/> Indigenous Worker <input type="checkbox"/> Other Who else have you seen outside of School for support:		
Health History – General		
Health History / Investigation / Illnesses / Surgery / Allergies / Dental Health		
Medications, prescribed / over the counter	General Practitioner	
Family history including mental health, medical, alcohol & drugs		
Immunisation History		
13 years (year 8)	15 years (Year 10)	
Gardasil <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Diphtheria, tetanus, & acellular pertussis <input type="checkbox"/>	
Hepatitis B <input type="checkbox"/> <input type="checkbox"/>		
Varicella <input type="checkbox"/>		
Staff Signature:		Date: / / Time:
Name & Designation:		

DO NOT WRITE IN THIS BINDING MARGIN


V10 11/02/2011

ADOLESCENT HEALTH RECORD - HISTORY

CHS-PCP-522

MR 705560

APPENDIX 12

 <p>Queensland Government Children's Health Services COMMUNITY CHILD HEALTH SERVICE Adolescent Health Record HEEADSSS* Assessment</p> <p>School: Year Level:</p> <p>Date of Assessment:</p>	<p style="text-align: center;">(Affix patient identification label here)</p> <p>URN: Sex: <input type="checkbox"/> M <input type="checkbox"/> F</p> <p>Family Name:</p> <p>Given Names:</p> <p>Address:</p> <p>Date of Birth: Mobile Phone No:</p>
Psychosocial Assessment	
<p>H – Home Who is in your family? Who lives with you? How do you get along with your family? (mum, dad, siblings) Who are you closest to in your family? Who could you go to if you needed help in your family? (Consider living arrangements, transience, relationships with carers/significant others community support supervision, childhood experiences, recent family/life events and cultural identity.)</p>	
<p>E – Education Employment. What do you like/not like about school? What are you good at or not good at? What are your grades like? Have your grades changed? How do you get on with teachers? Other students? (Consider school/work retention & relationships, bullying, study progress & goals) Do you have a part time job? Where? How many hours do you work?</p>	
<p>E. Eating & Exercise. What do you usually eat for breakfast, lunch, dinner, snacks? Have you had any changes in your weight or what you have been eating? What do you like/not like about your body? What do you do for exercise? Consider physical activity other than a sport eg: do you walk to school, ride bike etc. (nutrition, vegetarianism, eating patterns, weight gains/loss, fitness energy.)</p>	
<p>Breakfast Lunch Dinner Snacks</p>	
<p>A- Activities/Spirituality Hobbies & Peer Relationships. What sort of things do you do in your free time? What do you do for fun? Who are your main friends in or out of school? What is your favourite music? What sort of things do you do with friends? How much time do you spend watching TV or on the internet? Do you belong to a faith group or a church? (Consider hobbies belonging to peer group, peer activities & venues, lifestyle factors)</p>	


DO NOT WRITE IN THIS BINDING MARGIN




ADOLESCENT HEALTH RECORD - HEEADSSS ASSESSMENT

V10 14/02/2011

NAME:	DOB:	URN:
<p>D – Drug use/Cigarettes/Alcohol. Many young people at your age starting experimenting with cigarettes/drugs/alcohol. Have any of your friends tried these? If yes then explore. (consider caffeine, 'energy drinks', Guarana, prescription/illicit drugs and type, quantity, frequency, administration, interaction, access, recent increase/decreases, past treatments, how they pay for drugs, any problems due to drug use)</p>		
<p>S – Sexual Activity & Sexuality Many young people your age become interested in romance and sometimes sexual relationships. Have you been in any romantic relationships or started seeing someone special? Have you ever had a sexual relationship with anyone? Male/Female. (Older adolescent - Do you identify yourself as being heterosexual or gay, lesbian, bisexual, transgender or questioning your sexuality.) (Consider- sexual activity, age of onset puberty/menstruation, safe sex practices, same sex attraction, STI screening, pregnancy & children.) (NB: sexual activity in students under 14 years is a reportable behaviour under QLD Health policy.)</p>		
<p>S- Suicide, Self Harm, Depression. How have you been feeling lately, happy/sad/teary? How would you describe your happiness on a scale 1 – 10? Sometimes when people feel really down they feel like hurting themselves. Have you ever felt that way? Explore self harm, recency, plans, lethality and protective factors. Develop Safety Plan if appropriate (consider normal vs clinical depression, anxiety, reactions to stress, sleep, mood, if appropriate, mental status exam, risk assessment, relapse plan)</p>		
<p>(Sad) 110 (Happy)</p>		
<p>S- Safety – Some people have had some traumatic things happen in their life, has anything happened to you? Have you ever been seriously hurt? Do you use safety equipment for sports? Is there a lot of violence at home/school/neighbourhood? Have you ever got into physical fights? Have you ever been in trouble with the police? Have you ever felt like you needed to carry a weapon? Do you use safety equipment for sports or recreation? Eg: helmet, mouth guards, sun screen</p>		
Staff Signature:		Date: / / Time:
Name & Designation:		

 DO NOT WRITE IN THIS BINDING MARGIN
 


APPENDIX 13

 <p>Queensland Government</p> <p>Children's Health Services COMMUNITY CHILD HEALTH SERVICE</p> <p>Adolescent Health Record Mental Health Assessment</p>	<p style="text-align: center;">(Affix patient identification label here)</p> <p>URN: Sex: <input type="checkbox"/> M <input type="checkbox"/> F</p> <p>Family Name:</p> <p>Given Names:</p> <p>Address:</p> <p>Date of Birth: Telephone:</p>
Appearance: physical maturation, body type, distinguishing features, grooming, dress	
Behaviour: activity, posture, fine and gross motor coordination, abnormal movements, mannerisms, rituals	
Voice, Speech & Language: rate, rhythm, volume, articulation, comprehension, vocabulary, gesture, accent.	
Affect & Mood: range, lability, congruity, depression, anxiety, anger, neuro-vegetative features.	
Relationship with examiner: eye contact, cooperation, anxiety, hostility, indifference, over familiarity	
Thought form: flight of ideas, coherence	
Thought content: obsession, delusions, suicidal ideation, flashbacks, body image, preoccupations, wishes hopes, self concept	
Perception: hallucination, illusions	
Cognitive functioning: concentration, memory, est. intelligence, general knowledge, abstract ability	
Awareness, Motivation & Judgement: nature of problem, desire for help	
Staff Signature: Name & Designation:	Date: / / Time:

DO NOT WRITE IN THIS BINDING MARGIN


ADOLESCENT HEALTH RECORD - MENTAL HEALTH ASSESSMENT

V7 17/02/2011

 Queensland Government Children's Health Services COMMUNITY CHILD HEALTH SERVICE Adolescent Health Record Mental Health Assessment				(Affix patient identification label here)			
URN: Sex: <input type="checkbox"/> M <input type="checkbox"/> F				Family Name:			
Given Names:				Address:			
Date of Birth:				Telephone:			
Checklist for Suicide Risk Assessment							
Risk Factors	Yes	No	Not Known	Risk Factors	Yes	No	Not Known
Symptoms of depression Current state of; Hopelessness Despair				Increased will to suicide			
Psychiatric diagnosis				Has suicide plan and/or has available means			
Peer Suicide - When: Family Suicide - When				Previous self harm Previous suicide attempts			
Major physical Illness/disability				Expressing high levels of distress			
Relationship break up				Giving away belongings/saying farewells			
School issues/ employment issues				Use of alcohol & or drugs			
Member of minority group				Reduced family connectedness			
Aboriginal and/or Torres Strait islander				Preoccupation with suicide or death			
Loss or death or separation of friend/other family member				Recent significant life events			
Exposure to domestic violence				Anniversary of significant life events			
History of bullying				Sexual identity issues			
Male				Withdrawal or self isolating			
Poor self worth				Impulsivity			
Protective factors				Yes	No	Not Known	
Access to close family/friends							
Moral / Religious objection							
Capacity to manage stress, anxiety, depression							
Responsibility to society							
Positive self esteem							
Communication skills							
Has dependant children							
Has current or previous contact with Mental Health Services				<input type="checkbox"/> No <input type="checkbox"/> Yes			
Imminent Danger Assessment (for high and medium – high risk)							
Can the person do all of the following:	Yes	No		Yes	No		
Identify self positives			Identify emergency supports				
Identify suicide provoking situations			Negotiate an agreed safety plan				
List planned alternatives							
Risk of harm	<input type="checkbox"/> Yes <input type="checkbox"/> No						
SBYH CNC Contacted:	<input type="checkbox"/> Yes <input type="checkbox"/> No						
CYMHS Contacted:	<input type="checkbox"/> Yes <input type="checkbox"/> No						

DO NOT WRITE IN THIS BINDING MARGIN

APPENDIX 14

 Queensland Government Children's Health Services COMMUNITY CHILD HEALTH SERVICE Adolescent Health Record Case Review		URN: Sex: <input type="checkbox"/> M <input type="checkbox"/> F Family Name: Given Name: Address: Date of Birth: Telephone:																																																
School: Year Level:																																																		
Identity	Review Type: <input type="checkbox"/> Clinical Nurse Consultant / Peer Review <input type="checkbox"/> Interdisciplinary Case Review																																																	
	Clinician Details: Name / Designation: Service: Signature: Date:																																																	
	Reason for presentation:																																																	
Situation	HEEADSSS/ Circumstances- critical events		Presenting Issues: (Tick appropriate box)																																															
	Home <input type="checkbox"/> Yes Education <input type="checkbox"/> Yes Eating/Exercise <input type="checkbox"/> Yes Activities <input type="checkbox"/> Yes Drugs <input type="checkbox"/> Yes Sexual Activity <input type="checkbox"/> Yes Suicidality/Depression/Mental Health <input type="checkbox"/> Yes Safety <input type="checkbox"/> Yes		<table border="0" style="width: 100%;"> <thead> <tr> <th></th> <th style="text-align: center;">Student</th> <th style="text-align: center;">Parents</th> </tr> </thead> <tbody> <tr><td>Medical illness</td><td style="text-align: center;"><input type="checkbox"/> Yes</td><td style="text-align: center;"><input type="checkbox"/> Yes</td></tr> <tr><td>Mental health concern</td><td style="text-align: center;"><input type="checkbox"/> Yes</td><td style="text-align: center;"><input type="checkbox"/> Yes</td></tr> <tr><td>Drug usage</td><td style="text-align: center;"><input type="checkbox"/> Yes</td><td style="text-align: center;"><input type="checkbox"/> Yes</td></tr> <tr><td>Tobacco usage</td><td style="text-align: center;"><input type="checkbox"/> Yes</td><td style="text-align: center;"><input type="checkbox"/> Yes</td></tr> <tr><td>Alcohol usage</td><td style="text-align: center;"><input type="checkbox"/> Yes</td><td style="text-align: center;"><input type="checkbox"/> Yes</td></tr> <tr><td>Relationship – B/G</td><td style="text-align: center;"><input type="checkbox"/> Yes</td><td style="text-align: center;"><input type="checkbox"/> Yes</td></tr> <tr><td>Relationship – Family</td><td style="text-align: center;"><input type="checkbox"/> Yes</td><td style="text-align: center;"><input type="checkbox"/> Yes</td></tr> <tr><td>Relationship – Peer</td><td style="text-align: center;"><input type="checkbox"/> Yes</td><td style="text-align: center;"><input type="checkbox"/> Yes</td></tr> <tr><td>Abuse</td><td style="text-align: center;"><input type="checkbox"/> Yes</td><td style="text-align: center;"><input type="checkbox"/> Yes</td></tr> <tr><td>Bullying</td><td style="text-align: center;"><input type="checkbox"/> Yes</td><td style="text-align: center;"><input type="checkbox"/> Yes</td></tr> <tr><td>Loss</td><td style="text-align: center;"><input type="checkbox"/> Yes</td><td style="text-align: center;"><input type="checkbox"/> Yes</td></tr> <tr><td>Disability</td><td style="text-align: center;"><input type="checkbox"/> Yes</td><td style="text-align: center;"><input type="checkbox"/> Yes</td></tr> <tr><td>Stress</td><td style="text-align: center;"><input type="checkbox"/> Yes</td><td style="text-align: center;"><input type="checkbox"/> Yes</td></tr> <tr><td>Sexual Health</td><td style="text-align: center;"><input type="checkbox"/> Yes</td><td style="text-align: center;"><input type="checkbox"/> Yes</td></tr> <tr><td>Other</td><td style="text-align: center;"><input type="checkbox"/> Yes</td><td style="text-align: center;"><input type="checkbox"/> Yes</td></tr> </tbody> </table>		Student	Parents	Medical illness	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	Mental health concern	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	Drug usage	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	Tobacco usage	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	Alcohol usage	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	Relationship – B/G	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	Relationship – Family	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	Relationship – Peer	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	Abuse	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	Bullying	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	Loss	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	Disability	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	Stress	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	Sexual Health	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	Other	<input type="checkbox"/> Yes
	Student	Parents																																																
Medical illness	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes																																																
Mental health concern	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes																																																
Drug usage	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes																																																
Tobacco usage	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes																																																
Alcohol usage	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes																																																
Relationship – B/G	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes																																																
Relationship – Family	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes																																																
Relationship – Peer	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes																																																
Abuse	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes																																																
Bullying	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes																																																
Loss	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes																																																
Disability	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes																																																
Stress	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes																																																
Sexual Health	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes																																																
Other	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes																																																
Referral/ Plan	Current Plan/ Actions: Current Services: <input type="checkbox"/> CYMHS <input type="checkbox"/> Hospital <input type="checkbox"/> Child Safety Services <input type="checkbox"/> GP <input type="checkbox"/> Counsellor <input type="checkbox"/> Guidance Officer <input type="checkbox"/> YSC <input type="checkbox"/> Other:																																																	
	Assessment Level of Risk: <input type="checkbox"/> Low <input type="checkbox"/> Moderate <input type="checkbox"/> High Type of Risk: Protective Factors: <input type="checkbox"/> Social network <input type="checkbox"/> Family support <input type="checkbox"/> Religious belief <input type="checkbox"/> Medical support <input type="checkbox"/> Positive Self Esteem <input type="checkbox"/> School network <input type="checkbox"/> Other:																																																	
Recommendation	Response <input type="checkbox"/> Urgent action <input type="checkbox"/> Monitor <input type="checkbox"/> Nil																																																	
	Date of next review Additional response information																																																	

DO NOT WRITE IN THIS BINDING MARGIN

ADOLESCENT HEALTH RECORD - CASE REVIEW

V2 17/02/2011

References

1. Australian Government Department of Health and Ageing, National framework for universal child and family health services, 2011.
2. Australian Confederation of Paediatric and Child Health Nurses. Competencies for the specialist paediatric and child health nurse (2nd ed.). 2006 [cited 2014 Oct 27]; Available from: <http://www.accypn.org.au/downloads/competencies.pdf>
3. Ward, M., National school nursing professional practice standards 2nd ed ed. 2012, Melbourne, Vic: Australian Nursing Federation, Federal Office.
4. Queensland Child and Youth Clinical Network, Queensland universal child health framework, Universal Model of Care Working Group, Editor 2011, Queensland Health: Brisbane.
5. Queensland Child and Youth Clinical Network, Queensland universal child health framework – Implementation guide, Child Health Subnetwork, Editor 2014, Queensland Health: Brisbane.
6. National Health and Medical Research Council, National guidance on collaborative maternity care, Department of Health and Ageing, Editor 2010, NHMRC: Canberra.
7. Australian Health Ministers' Advisory Council, Clinical practice guidelines: Antenatal care - Module 1, Department of Health and Ageing, Editor 2012, Australian Government: Canberra.
8. Queensland Centre for Mothers & Babies. Having a Baby in Queensland http://www.havingababy.org.au/choosing_where_to_have_your_pregnancy_care 2012 [cited 2014 May 6].
9. Queensland Maternity and Neonatal Clinical Guidelines Program, Queensland maternity and neonatal operational framework, Queensland Health, Editor 2010, Queensland Health: Brisbane.
10. The Royal Australian and New Zealand College of Obstetricians and Gynaecologists, Routine antenatal assessment in the absence of pregnancy complications, in College Statement, 2013, RANZCOG: Melbourne.
11. beyondblue, Clinical practice guidelines for depression and related disorders - anxiety, bipolar disorder and periperal psychosis - in the perinatal period - a guideline for primary care health professionals. 2011, Melbourne: beyondblue: the national depression initiative.
12. Post and Antenatal Depression Association (PANDA). Antenatal depression. 2010 [cited 2014 Oct 2]; Available from: <http://www.panda.org.au/practical-information/about-postnatal-depression/27-antenatal-depression>.
13. DiPietro, J.A., Psychological and psychophysiological considerations regarding the maternal–fetal relationship. *Infant & Child Development*, 2010. 19(1): p. 27-38.
14. The Royal Australian and New Zealand College of Obstetricians and Gynaecologists, Perinatal anxiety and depression, in College Statement, 2012, RANZCOG: Melbourne.
15. Mental Health Directorate - Queensland Health, Mind essentials, 2010, Queensland Health: Brisbane.
16. DV connect. Domestic violence hotline - Queensland. 2014 [cited 2014 May 6]; Available from: <http://www.dvconnect.org/>.
17. Commonwealth of Australia, Protecting children is everyone's business - National framework for protecting Australia's children 2009–2020, Department of Health, Editor 2009, Commonwealth of Australia: Canberra.
18. Richards, K., Children's exposure to domestic violence in Australia. *Trends & Issues in Crime & Criminal Justice*, 2011(419): p. 1-7.
19. The University of New South Wales, The impact of domestic violence on children: A literature review, The Australian Domestic and Family Violence Clearinghouse, Editor 2011, for the Benevolent Society.
20. Mitchell, L., Domestic Violence in Australia—an overview of the issues, Social Policy Section, Editor 2011, Parliament of Australia: Canberra.
21. Queensland Centre for Domestic and Family Violence Research, Babies and toddlers - Keeping them safe, 2011, Queensland Government: Brisbane.
22. Mund, M., Louwen, F., Klingelhofer, D & Gerger, A., Smoking and pregnancy - a review on the first major environmental risk factor of the unborn. *International Journal of Environmental Research and Public Health*, 2013. 10: p. 6485-6499.
23. Queensland Maternity and Neonatal Clinical Guidelines Program, Neonatal abstinence syndrome, 2012, Queensland Government: Brisbane.
24. Hockenberry, M., Wilson, D., Wong's essentials of pediatric nursing. 9th ed. 2013, Missouri: Elsevier mosby.
25. Child and Youth Community Health Services, Family Health Assessment - A guide for child health nurses and other child health clinicians, Children's Health Queensland Hospital and Health Service, Editor 2012, Queensland Health: Brisbane.
26. Baxter, J., Smart., D., Fathering in Australia among couple families with young children - research highlights. *Australian Institute of Family Studies*, 2011. 88: p. 15-26.
27. Department for Communities, Father inclusive practice, Department for Communities, Editor 2012, Government of Western Australia: Perth.
28. Meedya, S., K. Fahy, and A. Kable, Factors that positively influence breastfeeding duration to 6 months: A literature review. *Women and Birth*, 2010. 23(4): p. 135-145.
29. Kurti, L., Holloway, L., Hudson, S., Descriptive analysis of the Strong Fathers Strong Families Programme - Final Report, 2013, URBIS: Brisbane.
30. National Health and Medical Research Council, Nutrient Reference Values for Australia and New Zealand, Department of Health and Ageing, Editor 2006, Commonwealth of Australia: Canberra.
31. National Health and Medical Research Council, Iodine supplements for pregnant and breastfeeding women, Department of Health and Ageing, Editor 2010, Commonwealth of Australia: Canberra.
32. Queensland Health. Healthy teeth for life - fact sheets. 2014 [cited 2014 May 7]; Available from: http://www.health.qld.gov.au/oralhealth/healthy_teeth/fact_sheet.asp.
33. Royal College of Obstetricians and Gynaecologists, Exercise in pregnancy (Statement no. 4) 2013, RCOG: London.
34. American Congress of Obstetricians and Gynecologists. Exercise during pregnancy - Frequently asked questions. 2014 [cited 2014 Oct 22]; Available from: <http://www.acog.org/Patients/FAQs/Exercise-During-Pregnancy>.
35. Callaway, L.K., O'Callaghan, M.J., McIntyre, H.D. , Barriers to addressing overweight and obesity before conception. *Medical Journal of Australia*, 2009. 191(8): p. 425–428.

36. Mamun, A.A., Kinarivala, M., O'Callaghan, M.J., Williams, G.M., Najman, J.M., Callaway, L.K., Associations of excess weight gain during pregnancy with long-term maternal overweight and obesity: evidence from 21 y postpartum follow-up. *American Journal of Clinical Nutrition*, 2010. 91(5): p. 1336-1341.
37. Dodd, J.M., Grivell, R.M., Crowther, C.A., Robinson, J.S., Antenatal interventions for overweight or obese pregnant women: a systematic review of randomised trials. *British Journal of Obstetrics & Gynaecology*, 2010. 117(11): p. 1316-1326.
38. Royal Australian and New Zealand College of Obstetricians and Gynaecologists, Management of obesity in pregnancy, in College Statement, 2013, RANZCOG: Melbourne.
39. Queensland Health, Baby feeding cues, 2012, Queensland Government: Brisbane.
40. Redshaw, M., Henderson, J., Learning the hard way: Expectations and experiences of infant feeding support. *Birth: Issues in Perinatal Care*, 2012. 39(1): p. 21-29.
41. National Health and Medical Research Council, Eat for health - Infant feeding guidelines - Information for health workers, Department of Health and Ageing, Editor 2012, Australian Government: Canberra.
42. Queensland Health. Growing Strong: Feeding you and your baby. 2013 [cited 2014 May 7]; Available from: http://www.health.qld.gov.au/ph/documents/hpu/growing_strong.asp.
43. Statewide Multicultural Health Program, Multicultural clinical support resource, Queensland Health, Editor 2013, Queensland Government Brisbane.
44. Queensland Health. Baby friendly health initiative. 2014 [cited 2014 May 7]; Available from: <http://www.health.qld.gov.au/breastfeeding/bfhi.asp>.
45. Sids and Kids Organisation. Safe sleeping. 2013 [cited 2014 May 8]; Available from: <http://www.sidsandkids.org/safe-sleeping/>.
46. Kidsafe Queensland. Home safety. 2012 [cited 2014 May 8]; Available from: <http://www.kidsafeqld.com.au/home-safety>.
47. Australian Government. The Australian Immunisation Handbook 10th Edition website. 2013 [cited 2014 May 8]; Available from: <http://www.immunise.health.gov.au/internet/immunise/publishing.nsf/Content/Handbook10-home>.
48. Queensland Government. Queensland immunisation schedule. 2014 [cited 2014 Oct 21]; Available from: <http://www.health.qld.gov.au/clinical-practice/guidelines-procedures/diseases-infection/immunisation/schedule/default.asp>.
49. Australian Institute of Health and Welfare, Aboriginal and Torres Strait Islander health performance framework 2012: detailed analyses, 2013, AIHW: Canberra.
50. Department of Health. Care for kid's ears - strong hearing, strong start. 2013 [cited 2014 Oct 22]; Available from: <http://www.careforkidsears.health.gov.au>.
51. Commonwealth of Australia, The Health and welfare of Australia's Aboriginal and Torres Strait Islander Peoples, Oct 2010, Australian Bureau of Statistics, Editor 2012: Canberra.
52. National Institute for Health and Clinical Excellence, Pregnancy and complex social factors - A model for service provision for pregnant women with complex social factors, 2010, NHS: United Kingdom.
53. Queensland Health. Multicultural health - Cultural dimensions of pregnancy, birth and post-natal care. 2013 [cited 2014 Oct 22]; Available from: http://www.health.qld.gov.au/multicultural/health_workers/cultdiver_guide.asp#pregnancy.
54. Parenting Research Centre. HealthyStart - A national strategy for children of parents with learning difficulties. 2010 [cited 2014 June 5]; Available from: <http://www.healthystart.net.au/>.
55. Kemp, L., et al., Child and family outcomes of a long-term nurse home visitation programme: a randomised controlled trial. *Archives of Disease in Childhood*, 2011. 96(6): p. 533-540.
56. Sawyer, M., Frost, L., Bowering, K., Lynch, J., Effectiveness of nurse home-visiting for disadvantaged families: results of a natural experiment. *British Medical Journal Open*, 2013. 3(e002720 doi:10.1136/bmjopen-2013-002720): p. 1-9.
57. Arabena, K., The first 1000 days: catalysing equity outcomes for Aboriginal and Torres Strait Island children. *Medical Journal of Australia*, 2014. 200(8).
58. Pillitteri, A., Maternal and child health nursing: Care of the childbearing and childrearing family. 2014, Philadelphia: Wolters Kluwer / Lippincott Williams and Wilkins.
59. Children's Health Queensland Hospital and Health Service, Child health service model of care, Child and Youth Community Health Services, Editor 2014, Queensland Government: Brisbane.
60. Queensland Health, Queensland Health Personal Health Record, 2014, Queensland Government: Brisbane.
61. Barlow, J., Smailagic, N., Huband, N., Roloff, V., Bennett, C., Group-based parent training programmes for improving parental psychosocial health. *The Cochrane Collaboration*, 2014. 5.
62. Queensland Health, Child health information - Your guide to the first 12 months, Queensland Health, Editor 2014, Queensland Government: Brisbane.
63. Eve, P., Byrne, M. & Gagliardi, C., What is good parenting? The perspectives of different professionals. *Family Court Review*, 2014. 52(1).
64. Burchinal, M., Skinner, D. & Steven Reznick, J., European American and African American mothers' beliefs about parenting and disciplining infants: A mixed-method analysis. *Parenting - Science and Practice*, 2010. 10: p. 79-96.
65. Davis, H.D., C., Working in partnership: The family partnership model. 2010, United Kingdom: Pearson Education.
66. Queensland Health, Assessment of infant / child nutrition, growth and development, within the primary health care setting, Statewide Child and Youth Clinical Network, Editor 2012, Children's Health Queensland Hospital and Health Service: Brisbane.
67. Children's Health Queensland Hospital and Health Service. AIDET and SBAR toolkit - Communications with patients and families,. 2014 [cited 2014 May 5]; Available from: <http://qheps.health.qld.gov.au/childrenshealth/html/nursing/nursing-aidetsbar.htm>.
68. Cousins, J., Assessing and responding to infant mental health needs. *Community Practitioner*, 2013. 86(8): p. 33-36.
69. Powell, B., Cooper, G., Hoffman, K. & Marvin, B., The circle of security intervention. 2014, New York: Guildford.
70. Matthey, S., Lee, C., Crncec, R., Trapolini, T., Errors in scoring the Edinburgh Postnatal Depression scale. *Arch Womens Ment Health* 2013. 16: p. 117-122.
71. The Department of Health, Clinical practice guidelines antenatal care - Module 1, 7.7 Domestic Violence, The Department of Health, Editor 2013, Australian Government: Canberra.

72. Queensland Health. Healthy hearing program - Newborn hearing screening. 2013 [cited 2014 May 21]; Available from: <http://www.health.qld.gov.au/healthyhearing/default.asp>.
73. Queensland Health. Queensland hearing loss family support service. 2013 [cited 2014 Oct 21]; Available from: <http://www.health.qld.gov.au/healthyhearing/pages/family.asp>.
74. Bhattacharya, K., Wotton, T. & Wiley, V., The evolution of blood-spot newborn screening. *Translational Pediatrics*, 2014. 3(2): p. 63-70.
75. Gallagher, E., Hing, A., Cunningham, M., Evaluating fontanels in the newborn skull. *Contemporary Pediatrics*, 2013: p. 12-20.
76. Looman, W., Flannery, A., Evidence-based care of the child with deformational plagiocephaly, Part 1: Assessment and diagnosis. *Journal of pediatric health care*, 2012. 26(4): p. 242-250.
77. Burn, S., Flat back of head: positional or pathological? *Infant*, 2013. 9(5): p. 153-155.
78. Shamji, M.F., et al., Cosmetic and cognitive outcomes of positional plagiocephaly treatment. *Clinical And Investigative Medicine. Médecine Clinique Et Experimentale*, 2012. 35(5): p. E266-E266.
79. Cummings, C., Canadian paediatric society community paediatrics committee, Positional plagiocephaly. *Paediatric child health*, 2011. 16(8): p. 493-494.
80. Department of Education and Early Childhood Development. Developmental dysplasia of the hip. 2011 [cited 2014 June 3]; Available from: <http://surgicalmultimedia.com/DDH/player.html>.
81. National Health and Medical Research Council, Eat for health - Australian dietary guidelines - Information for health workers, Department of Health and Ageing, Editor 2012.
82. Centre for Disease Control and Prevention. Growth Charts. 2014 [cited 2014 May 21]; Available from: http://www.cdc.gov/growthcharts/who_charts.htm.
83. Children's Health Queensland Hospital and Health Service, Procedure - Corrected Age for Assessment of Preterm Infants, 2013, Queensland Health: Brisbane.
84. National Health and Medical Research Council, Clinical practice guidelines for the management of overweight and obesity in adults, adolescents and children in Australia, Department of Health, Editor 2013, Australian Government: Canberra.
85. Daymont, C., Zabel, M., Feudtner, C. and Rubin, D., The test characteristics of head circumference measurements for pathology associated with head enlargement: a retrospective cohort study. *BMC Pediatrics*, 2012. 12(9).
86. Shields, B., Wacogne, I., Wright, C., Weight faltering and failure to thrive in infancy and early childhood. *BMJ*, 2012. 345 p. 37-41.
87. Taveras, E., Rifas-Shiman, S., Sherry, B., Oken, E., Haines, J., Kleinman, K., Rich-Edwards, J., Gillman, M., Crossing Growth percentiles in infancy and risk of obesity in childhood. *American Medical Association* 2011. 165(11): p. 993 - 998.
88. Cole, S., Lanham, J., Failure to thrive: An update. *American Academy of Family Physicians*, 2011. 83(7): p. 829-834.
89. The Royal Australasian College of Physicians - Paediatric & Child Health Division, Position Statement- Early Intervention for Children with developmental disabilities, 2013, RACP: Sydney.
90. Community Child Health Services - Children's Health Services, The "Red Flag" early intervention referral guide for children 0-5 years, in Queensland Government, Children's Health Queensland in conjunction with GP partners, Editor 2010, Queensland Government: Brisbane.
91. Centre for Community Child Health. Monitoring Child Development. 2014 [cited 2014 June 3]; Available from: http://www.rch.org.au/ccch/resources_and_publications/Monitoring_Child_Development.
92. Garber, J., Oral-motor function and feeding intervention. *Physical & Occupational Therapy In Pediatrics*, 2013. 33(1): p. 111-138.
93. Lau, C., Interventions to improve oral feeding performance of preterm infants. *Perspectives on Swallowing & Swallowing Disorders (Dysphagia)*, 2014. 23(1): p. 23-45.
94. World Health Organisation. Nutrition - Exclusive breastfeeding. 2014 [cited 2014 June 17]; Available from: http://www.who.int/nutrition/topics/exclusive_breastfeeding/en/
95. Food Standards Australia New Zealand. Food Standards Code: Infant formula products 2013 [cited 2014 May 21]; Available from: <http://www.foodstandards.gov.au/code/infant/Pages/default.aspx>.
96. Newman, J. Breast compression. *BreastFeeding Inc* 2009; Available from: www.breastfeedinginc.ca/content.php?pagename=doc-BC.
97. The Academy of Breastfeeding Medicine Protocol Committee, ABM Clinical Protocol #9: Use of Galactagogues in initiating or augmenting the rate of maternal milk secretion. *Breastfeeding Medicine*, 2011. 6(1): p. 41 -49.
98. Australian Breastfeeding Association. Breastfeeding Information. 2013 [cited 2014 Jun 3]; Available from: <https://www.breastfeeding.asn.au/bfinfo/index.html>.
99. Ochi, J., Treating tongue-tie - assessing the relationship between frenotomy and breastfeeding symptoms. *Clinical lactation*, 2014. 5(1): p. 20-28.
100. Edmunds, J., Miles, S., Fulbrook, P., Tongue-tie and breastfeeding: a review of the literature. *Breastfeeding Review*, 2011. 19(1): p. 19-26.
101. Disantis, K., Collins, B., Fisher, J., Davey, A., Do infants fed directly from the breast have improved appetite regulation and slower growth during early childhood compared with infants fed from a bottle? *The International Journal of Behavioural Nutrition and Physical Activity*, 2011. 8(1).
102. More, J., Weaning: developing infant's feeding skills. *Practice nursing* 2013. 24(8): p. 373-381.
103. Praveen, P., Deshpande, G., Patole, S., Oral probiotics for infantile colic (Protocol). *The cochrane collaboration*, 2014. 2014(3): p. 1-14.
104. Drug and Therapeutics Bulletin, Management of infantile colic. *Drug And Therapeutics Bulletin*, 2013. 51(1): p. 6-9.
105. Anabrees, J., et al., Probiotics for infantile colic: a systematic review. *BMC Pediatrics*, 2013. 13: p. 186-186.
106. de Weerth, C., Fuentes, S. de V. and Willem M., Crying in infants: on the possible role of intestinal microbiota in the development of colic. *Gut Microbes*, 2013. 4(5): p. 416-421.
107. Kaltner, M., Kenardy, J., Le Brocque, R., Page, A., Infant abusive head trauma incidence in Queensland, Australia. *Injury Prevention*, 2014. 19: p. 139-142.
108. The Royal Children's Hospital Melbourne. Clinical practice guidelines: gastrooesophageal reflux in infants 2014 [cited 2014 Aug 18]; Available from: http://www.rch.org.au/clinicalguide/guideline_index/Gastrooesophageal_Reflux_in_infants/.
109. Chilton, H., Baby on board: understand your baby's needs in the first 12 months, ed. r. edition. 2013, ACT: Griffin Press.

110. Onyeador, N., Paul, S., Sandhu, B., Paediatric gastroesophageal reflux clinical practice guidelines. *BMJ - Arch Dis Child Educ Pract Ed*, 2014. o(2014): p. 1-4.
111. Cickero, J., Nicolson, T., September, C., Thickened milk for the management of feeding and swallowing issues in infants: a call for interdisciplinary professional guidelines. *Journal of Human Lactation*, 2013. 29(2): p. 132-135.
112. Mathers, M., Keyes, M. and Wright, M., A review of the evidence on the effectiveness of children's vision screening. *Child: Care, Health & Development*, 2010. 36(6): p. 756-780.
113. Sharma, A., Developmental examination: birth to 5 years. *Archives Of Disease In Childhood. Education And Practice Edition*, 2011. 96(5): p. 162-175.
114. Lowth, M., Detecting developmental delay. *Practice Nurse*, 2014. 44(5): p. 24-28.
115. Carter, K.A., Hathaway, N. E. and Lettieri, C. F., Common sleep disorders in children. *American Family Physician*, 2014. 89(5): p. 368-377.
116. Mares, S., Newman, L., Warren, B., Clinical skills in infant mental health - the first three years, 2012, ACER Press: Camberwell, Victoria.
117. Sidhu, M., P. Malhi, and J. Jerath, Multiple risks and early language development. *Indian Journal Of Pediatrics*, 2010. 77(4): p. 391-395.
118. Lawrence, R. and N. Bateman, 12 minute consultation: An evidence-based approach to the management of a child with speech and language delay. *Clinical Otolaryngology*, 2013. 38(2): p. 148-153.
119. Bryant, T., Tandem Nursing: A Review and Guidelines. *International Journal of Childbirth Education*, 2012. 27(4): p. 84-88.
120. Raising children network (Australia) limited. Raising children network - the australian parenting website. 2006-2014 21/7/14]; Available from: <http://raisingchildren.net.au/>.
121. World Health Organization. Health promotion. Health topics 2014 [cited 2014 Oct 23]; Available from: http://www.who.int/topics/health_promotion/en/.
122. Queensland Health, Health promotion in primary health care, Statewide Child and Youth Clinical Network, Editor 2012, Queensland Government: Brisbane.
123. Sharry, J., Counselling children, adolescents and families : A strengths-based approach., 2004, SAGE Publications Inc. : London.
124. The Department of Health, Marketing in Australia of infant formulas: Manufacturers and importers agreement - The M.A.I.F. Agreement, Department of Health, Editor 2003, Commonwealth Department of Health and Ageing: Canberra.
125. Mackerras, D.E.M. and C.J. Eastman, Estimating the iodine supplementation level to recommend for pregnant and breastfeeding women in Australia. *The Medical Journal Of Australia*, 2012. 197(4): p. 238-242.
126. Smith, J.P., et al., Workplace support, breastfeeding and health. *Family Matters*, 2013(93): p. 58-73.
127. Education Services Australia Ltd, A practice guide for working with families from pre-birth to eight years - Engaging families in the early childhood development story, 2013, Education Services Australia Ltd: Victoria.
128. Belsky, J., de Hann, M., Annual research review: Parenting and children's brain development: the end of the beginning. *Journal of Child Psychology and Psychiatry*, 2011. 52(4): p. 409-428.
129. Wastell, D., White, S., Blinded by neuroscience: social policy, the family and the infant brain. *Families, relationships and societies*, 2012. 1(3): p. 397-414.
130. Svanberg, P., Mennet, L., Spieker, S., Promoting a secure attachment: A primary prevention practice model. *Clinical Child Psychology and Psychiatry*, 2010. 15(3): p. 363-378.
131. Bicking Kinsey, C., Hupcey, J., State of the science of maternal-infant bonding: A principle-based concept analysis. *Midwifery*, 2013. 29(29): p. 1314-1320.
132. Bennett, R., *Your sleepless baby - The rescue guide*. 2012, Woollahra: Pacific books.
133. Mawji, A., Vollman, A., Hatfield, J., McNeil, D., Sauve, R., The incidence of positional plagiocephaly: A cohort study. *Pediatrics*, 2013. 132(2): p. 298-304.
134. Barnes, M., & Rowe, J., *Child, youth and family health: Strengthening communities - 2nd edn*. 2013, Chatswood, NSW: Elsevier Australia.
135. Stearns, C.A., Cautionary tales about extended breastfeeding and weaning. *Health Care for Women International*, 2011. 32(6): p. 538-554.
136. Queensland Health. Get up & grow. 2013; Available from: http://www.health.qld.gov.au/health_professionals/childrens_health/getup&grow.asp.
137. Kiddoo, D.A., Toilet training children: when to start and how to train. *Canadian Medical Association Journal*, 2012. 184(5): p. 511-512.
138. Kaerts, N., et al., Readiness signs used to define the proper moment to start toilet training: a review of the literature. *Neurourology And Urodynamics*, 2012. 31(4): p. 437-440.
139. Rogers, J., Daytime wetting in children and acquisition of bladder control. *Nursing Children & Young People*, 2013. 25(6): p. 26-33.
140. Black, M., Aboud, F., Responsive feeding is embedded in a theoretical framework of responsive parenting. *The Journal of Nutrition*, 2011.
141. Torres and Cape Hospital and Health Service, Apunipima Cape York Health Council, Royal Flying Doctor Service (Queensland Section). *Chronic Conditions Manual*. 1st ed. Cairns Australia: Torres and Cape Hospital and Health Service; 2015.
142. Queensland, S.o., *The Beginning of change - Queensland child oral health survey 2010-2012*, Q. health, Editor 2014.
143. Do, L.G., et al., Common risk factor approach to address socioeconomic inequality in the oral health of preschool children - a prospective cohort study. *BMC Public Health*, 2014. 14(1): p. 1-12.
144. Australian Institute of Health and Welfare, *A picture of Australia's children 2012.*, AIHW, Editor 2013: Canberra.
145. Chrisopoulos, S. and J. Harford, *Oral health and dental care in Australia - Key facts and figures 2012*, Australian Institute of Health and Welfare, Editor 2013, AIHW: Canberra.
146. Voogd, C., Addressing tooth decay in children and young people. *British Journal of School Nursing*, 2014. 9(6): p. 276-281.
147. Lussier, P., Corrado, R. and Tzoumakis, S., Gender differences in physical aggression and associated developmental correlates in a sample of Canadian preschoolers. *Behavioral Sciences & The Law*, 2012. 30(5): p. 643-671.
148. Department of Human Services. *Australian Childhood Immunisation Register statistics*. Australian Government. 2014 [cited 2014 Jul 9]; Available from: <http://www.medicareaustralia.gov.au/provider/patients/acir/statistics.jsp>.

149. Queensland Government, Queensland immunisation strategy 2014-17, Department of health, Editor 2014.
150. Queensland Government. What's your date to vaccinate. 2014 [cited 2017 July 10]; Available from: <http://vaccinate.initiatives.qld.gov.au/know-your-dates/>.
151. Department of Health and Ageing, National Vaccine Storage Guidelines - Strive for 5, 2nd edn., 2013, Commonwealth of Australia: Canberra.
152. Blair, P.S., Byard, R. W. and Fleming P. J., Sudden unexpected death in infancy (SUDI): suggested classification and applications to facilitate research activity. *Forensic Science, Medicine and Pathology*, 2012. 8(3): p. 312-315.
153. Canadian Paediatric Society, Child and youth injury prevention: A public health approach, in Position Statement 2012.
154. Kidsafe QLD, Newsletter January 2014, Kidsafe Qld, Editor 2014.
155. Royal Life Saving Society - Australia, National drowning report, 2013, Royal Life Saving Society - Australia: Canberra.
156. Queensland Injury Prevention Council, Putting the brakes on low speed vehicle run over: an opportunity to act, Queensland Government, Editor 2012, Queensland Injury Surveillance Unit: Brisbane.
157. Centre for Community Child Health - The Royal Children's Hospital Melbourne, Promoting child and family social and emotional wellbeing. *Community Paediatric Review*, 2013. 21(2): p. 1-4.
158. Aboriginal and Torres Strait Islander Cultural Capability Team, Aboriginal and Torres Strait Islander - Patient care guideline, Queensland Health, Editor 2014, Queensland Government: Brisbane.
159. Thorley, M., Lim, S.M., Considerations for occupational therapy assessment for Indigenous children in Australia. *Australian occupational therapy journal*, 2011. 58: p. 3-10.
160. Byers, L., Kulitja, S., Lowell, A., Kruske, S., 'Hear our stories': Child-rearing practices of a remote Australian Aboriginal community. *The Australian Journal of Rural Health*, 2012. 20: p. 293-297.
161. Commonwealth of Australia, Australian Aboriginal and Torres Strait Islander Health Survey: Updated results, 2012-13, Australian Bureau of Statistics, Editor 2014, Australian Government: Canberra.
162. Queensland Health's Statewide Aboriginal and Torres Strait Island Ear Health Program. *Deadly Ears - Helping little people to hear, talk, learn and play*. 2014 [cited 2014 August 5]; Available from: http://www.health.qld.gov.au/deadly_ears/
163. Department of Health, Recommendations for clinical care guidelines on the management of otitis media in Aboriginal and Torres Strait Islander populations, 2011, Australian Government: Canberra.
164. DiGiacomo, M., Davidson, P., Abbott, P., Delaney, P., Dharmendra, T., McGrath, S., Delaney, J., Vincent, F., Childhood disability in Aboriginal and Torres Strait Islander peoples: a literature review. *International Journal for Equity in Health*, 2013. 12(7): p. 1-18.
165. Australian Institute of Health and Welfare, The health and welfare of Australia's Aboriginal and Torres Strait Islander People: An overview, Australian Institute of Health and Welfare, Editor 2011: Canberra.
166. Department of Aboriginal and Torres Strait Islander and Multicultural Affairs, Queensland cultural diversity policy, Department of Aboriginal and Torres Strait Islander and Multicultural Affairs, Editor 2013, Queensland Government: Brisbane.
167. Woodland, L., Burgner, D., Paxton, G., Zwi, K., Health service delivery for newly arrived refugee children: A framework for good practice. *Journal of paediatrics and child health*, 2012. 2010(46): p. 560-567.
168. Gilmore, B., McAuliffe, E., Effectiveness of community health workers delivering preventive interventions for maternal and child health in low- and middle-income countries: a systematic review. *BMC Public Health*, 2013. 13(847): p. 1-14.
169. Carlson, M.J. and L.M. Berger, What kids get from parents: packages of parental involvement across complex family forms. *Social Service Review*, 2013. 87(2): p. 213-249.
170. Whitson, M., Martinez, A., Ayala, C., Kaufman, J., Predictors of parenting and infant outcomes for impoverished adolescent parents. *Journal of family social work*, 2011. 14: p. 282-297.
171. Laslett, M., Ferris, J., Dietze, P., Room, R., Social demography of alcohol-related harm to children in Australia. *Addiction*, 2012. 107: p. 1082-1089.
172. Crouch, S.R., et al., Parent-reported measures of child health and wellbeing in same-sex parent families: a cross-sectional survey. *BMC Public Health*, 2014. 14(1): p. 1412-1434.
173. Llewellyn, G., Parents with intellectual disability and their children: Advances in policy and practice. *Journal of Policy & Practice in Intellectual Disabilities*, 2013. 10(2): p. 82-85.
174. Bennett, C., Barlow, J., Huband, N., Smailagic, M., Roloff, V., Group-based parenting programs for improving parenting and psychosocial functioning: A systematic review. *Journal of the Society for Social Work and Research*, 2013. 4(4): p. 300-332.
175. Spangaro, J., Poulos, R., Zwi, A., Pandora doesn't live here anymore: Normalization of screening for intimate partner violence in Australian antenatal, mental health and substance abuse services. *Violence and Victims*, 2011. 26(1): p. 130-144.
176. Psaila, K., et al., Discontinuities between maternity and child and family health services: health professional's perceptions. *BMC Health Services Research*, 2014. 14 (1): p. 1-22.
177. Arauz Boudreau, A., et al., Care Coordination and Unmet Specialty Care Among Children With Special Health Care Needs. *Pediatrics*, 2014. 133(6): p. 1046-1053.
178. Queensland Health, The Health of Queenslanders 2010. Third report of the Chief Health Officer Queensland, 2010, The State of Queensland: Brisbane.
179. Kim, J., Identifying and addressing infant allergy to cow's milk protein. *Clinical Advisor*, 2013. 16(11): p. 77-85.
180. Hughes, I., Confusing terminology attempts to define the undefinable. *Archives Of Disease In Childhood*, 2007. 92(2): p. 97-98.
181. Jeong, S., Nutritional approach to failure to thrive. *Korean Journal of Paediatrics* 2011. 54(7): p. 277-281.
182. Jan, J., Reiter, R., Bax, M., Ribary, U., Freeman, R., Wasdell, M., Long-term sleep disturbances in children: A cause of neuronal loss. *European Journal of Paediatric Neurology*, 2010. 14(2010): p. 380-390.
183. Dunning, M., Giallo, R., Fatigue, parenting stress, self-efficacy and satisfaction in mothers of infants and young children. *Journal of Reproductive and Infant Psychology*, 2012. 30(2): p. 145-159.
184. Cooklin, A., Giallo, R., Rose, N., Parental fatigue and parenting practices during early childhood: an Australian community survey. *Child: Care, Health & Development*, 2011. 38(5): p. 654-664.
185. Queensland Health, Ellen Barron Family Centre responsive settling - theory and practice guidelines, Queensland

- Health, Editor 2010.
186. Beyondblue. Beyondblue - depression, anxiety. 2014 [cited 2014 Aug 20]; Available from: <http://www.beyondblue.org.au/>.
 187. Commonwealth of Australia. Infant Mortality. 2011 [cited 2014 Aug 20]; Available from: <http://www.abs.gov.au/ausstats/abs@.nsf/Lookup/by+Subject/1367.0~2012~Main+Features~Infant+Mortality~4.17#>.
 188. Borrow, S., A. Munns, and S. Henderson, Community-based child health nurses: An exploration of current practice. *Contemporary Nurse: A Journal for the Australian Nursing Profession*, 2011. 40(1): p. 71-86.
 189. Queensland Health, Factsheet 4.7: Clinical risk factors and indicators of harm in children. Factsheet 4.11: Risk versus protective factor assessment framework, C. safety, Editor 2009.
 190. Bass, C., Glaser, D., Fractitious disorders 1 - Early recognition and management of fabricated or induced illness in children. *Lancet*, 2014. 383(April 19, 2014): p. 1412-21.
 191. de Haan, I. and K. Manion, Building safety and deepening our practice. *Social Work Now: The Practice Journal of Child, Work & Family*, 2011. 47: p. 35-43.
 192. Baigrie, K.A., School nursing in regional and rural Queensland. *British Journal of School Nursing*, 2011. 6(1): p. 22-27.
 193. Seigart, D., Dietsch, E., Parent, M., Barriers to providing school-based health care: International case comparisons. *Collegian*, 2013. 20(2013): p. 43-50.
 194. McNab, A., Gagnon, F., & Stewart, D., Health promoting schools: Consensus, strategies and potential. *Health Education Journal*, 2013. 114(3): p. 170-185.
 195. Hughes, D., Attachment-focused Parenting. 2009, New York: W.W.Norton & Company.
 196. Oberklaid, F., Drever, K., Is my child normal? Milestones and red flags for referral. *Australian Family Physician*, 2011. 40(9): p. 666-670.
 197. Ruxton, C. and E. Derbyshire, Strategies to encourage healthy eating among children and young adults. *Primary Health Care*, 2014. 24(5): p. 33-41.
 198. Bruce, E., Klein, R., & Keleher, H., Parliamentary inquiry into Health Promoting Schools in Victoria: Analysis of stakeholder views. *Journal of School Health*, 2012. 82(9): p. 441-447.
 199. Gugglberger, L. and D. Wolfgang, Capacity building in and for health promoting schools: Results from a qualitative study. *Health Policy*, 2011. 101(1): p. 37-43.
 200. McDermott, B.M., et al., Longitudinal correlates of the persistence of irregular eating from age 5 to 14 years. *Acta Paediatrica (Oslo, Norway: 1992)*, 2010. 99(1): p. 68-71.
 201. Healthdirect. Teeth-cleaning. 2011 [cited 2014 Aug 20]; Available from: <http://www.healthdirect.gov.au/teeth-cleaning>.
 202. Kim, H.T., Emotional Bonds with Parents, Emotion Regulation, and School-Related Behavior Problems Among Elementary School Truants. *Journal of Child & Family Studies*, 2013. 22(6): p. 869-878.
 203. Cabaj, J.L., S.W. McDonald, and S.C. Tough, Early childhood risk and resilience factors for behavioural and emotional problems in middle childhood. *BMC Pediatrics*, 2014. 14: p. 166-166.
 204. Government, A., Australia's physical activity and sedentary behaviour guidelines. , D.o.H.a. Ageing., Editor 2014.
 205. Inspire Foundation. ReachOut.com. Building better coping skills 2014 [cited 2014 Oct 22]; Available from: <http://au.reachout.com/building-better-coping-skills>.
 206. Posselt, M., Galletly, C., de Crespigny, C., & Procter, N., Mental health and drug and alcohol comorbidity in young people of refugee background: a review of the literature. . *Mental Health and Substance Use*, 2014. 7(1): p. 19-30.
 207. Sanderson, W., Skirbekk, V., Stonawski, M., Young adult failure to thrive syndrome. *Finnish Yearbook of Population Research*, 2013. 48(169).
 208. Engle, P.L., Pelto, G. H. , Responsive feeding: Implications for policy and program implementation. *The Journal of Nutrition*, 2011. 141(3): p. 508-511.
 209. Spears, B., Keeley, M., Bates, S., & Katz, I., Research on youth exposure to, and management of, cyberbullying incidents in Australia: Part A Literature review on the estimated prevalence of cyberbullying involving Australian minors (SPRC Report 9/2014), 2014, UNSW Australia: Sydney.
 210. KidsHelpline. School-related bullying. Hot Topics, 2012 [cited 2014 Oct 29]; Available from: http://www.kidshelp.com.au/grownups/news-research/hot-topics/bullying.php#cite-note_3.
 211. Dooley, J., Cross, D., Hearn, L., & Treyvaud, R. , Review of existing Australian and international cyber-safety research, 2009, Edith Cowan University: Perth.
 212. Spears, B., Taddeo, C., Swirski, T., Keeley, M., Katz, I., Collin, P., Daly, T., & Bates, S. , Research on youth exposure to, and management of, cyberbullying incidents in Australia: Part C An evidence-based assessment of deterrents to youth cyberbullying (SPRC Report 11/2014), 2014, UNSW Australia: Sydney.
 213. Australian Institute of Health and Welfare, Australia's health 2014, AIHW, Editor 2014: Canberra.
 214. Sawyer, S., Afi fi, R., Bearinger, L., Blakemore, S., Dick, B., Ezeh, A., & Patton, G., Adolescence: a foundation for future health. *Lancet*, 2012(379): p. 1630-40.
 215. Carlsson, D., School health services, health promotion and health outcomes: an investigation of the Health Promoting Schools approach as supported by school nurses, in School of Public Health, 2005, Queensland University of Technology: Brisbane.
 216. Kliegman, R., Stanton, B., St. Geme, J., Schor, N. & Behrman, R., Nelson Textbook of Pediatrics, 19th ed. , 2011, Elsevier, Inc. p. .
 217. Slee, P., Campbell, M., & Spears, B., Child, adolescent and family development. 2012, Cambridge: Cambridge University Press.
 218. Viner, R., Ozer, E., Denny, S., Marmot, M., Resnick, M., Fatusi A., & Currie, C., Adolescence and the social determinants of health. *Lancet*, 2012. 379: p. 1641-52.
 219. Hale, D., Fitzgerald-Yau, N., & Viner, R. , A systematic review of effective interventions for reducing multiple health risk behaviors in adolescence. *American Journal of Public Health*, 2014. 104: p. e19-e41.
 220. Commission for Children and Young People and Child Guardian, Snapshot 2012: Children and Young People in Queensland, 2012, CCYPCG: Brisbane.
 221. The Kirby Institute, Bloodborne viral and sexually transmitted infections in Aboriginal and Torres Strait Islander People: Surveillance and Evaluation Report 2012, University of New South Wales: Sydney.
 222. Chalmers, K., Bond, K., Jorm, A., Kelly, C., Kitchener, B., & Williams-Tchen, A. , Providing culturally appropriate mental health first aid to an Aboriginal or Torres Strait Islander adolescent: development of expert consensus

- guidelines. *International Journal of Mental Health Systems*, 2014. 8(1): p. 2-20.
- 223.** Hutchinson, L., & St John, W., Creating connections: Strategies to improve adolescent boys' access and engagement with school-based health services. *Contemporary Nurse: Health Care Across the Lifespan*, 2012. 40(2): p. 258-268.
- 224.** Muir, K., Powell, A., & McDermott, S., 'They don't treat you like a virus': youth-friendly lessons from the Australian National Youth Mental Health Foundation. *Health and Social Care in the Community*, 2012. 20(2): p. 181-189.
- 225.** Patulny, R.M., K., Powell, A., Flaxman, S., & Oprea, I., Are we reaching them yet? Service access patterns among attendees at the headspace youth mental health initiative. *Child and Adolescent Mental Health*, 2013. 18(2): p. 95-102.
- 226.** Wright, J., From childhood to adulthood, part 2: Age of consent. *British Journal of School Nursing*, 2012. 7(4): p. 200-201.
- 227.** beyondblue. Clinical practice guidelines: Depression in adolescents and young adults. 2010 [cited 2014 Oct 21]; Available from: <https://www.bspg.com.au/dam/bspg/product?client=BEYONDBLUE&prodid=BL/0890&type=file>.
- 228.** The Office of the Queensland Parliamentary Counsel, Hospital and Health Boards Act 2011, State of Queensland, Editor 2014.
- 229.** Procter, N., Hamer, H., McGarry, D., Wilson, R., & Froggatt, T., *Mental Health: A Person-centred Approach*. 2014, Port Melbourne, Victoria: Cambridge University Press.
- 230.** Bennett, D., Kang, M., & Chown, P., Promoting cultural competence in adolescent health care, in *Challenges in Adolescent Health: an Australian Perspective*, S.T. D. Bennett, E. Elliott & J. Merrick Editor. 2009, Nova Science Publishers, Inc.: New York. p. 189-204.
- 231.** Queensland Health, Aboriginal and Torres Strait Islander adolescent sexual health guideline, Nursing and Midwifery Office and Queensland and the Aboriginal & Torres Strait Islander Cultural Capability Team, Editor 2013, Queensland Health: Brisbane.
- 232.** Westerman, T., Engaging Australian Aboriginal youth in mental health services. *Australian Psychologist*, 2010. 45(3): p. 212-222.
- 233.** Bradford, S., & Rickwood, D., Psychosocial assessments for young people: A systematic review examining acceptability, disclosure and engagement, and predictive utility. *Adolescent Health, Medicine and Therapeutics*, 2012. 3: p. 1-15.
- 234.** Parker, A., Hetrick, S., & Purcell, R., Psychosocial assessment of young people: refining and evaluating a youth friendly assessment interview. *Australian Family Physician*, 2010. 39(8): p. 585-588.
- 235.** Chown, P., Kang, M., Sancic, L., Newnham, V., Bennett, D., *Adolescent Health: Enhancing the skills of General Practitioners in caring for young people from culturally diverse backgrounds*, G.P. Resource Kit 2nd ed. 2008, Sydney: NSW Centre for the Advancement of Adolescent Health and Transcultural Mental Health Centre.
- 236.** The Royal Australasian College of Physicians. A training resource in adolescent health. 2012 [cited 2014 Oct 31]; Available from: <http://www.racp.edu.au/index.cfm?objectid=8EA22123-DFDD-37A6-C951EDAFDD735678>.
- 237.** Busch, V., de Leeuw, J., de Harder, A., & Schrijvers, A., Changing multiple adolescent health behaviors through school-based interventions: a review of the literature. *Journal of School Health*, 2013. 83(7): p. 514-523.
- 238.** Prevention and Population Health Branch, Evaluation framework for health promotion and disease prevention programs., Department of Health, Editor 2010, Victorian Government: Melbourne.
- 239.** Rose, S., Lanumata, T., & Lawton, B., Promoting uptake of the HPV vaccine: The knowledge and views of school staff. *Journal of School Health*, 2011. 81(11): p. 680-687.
- 240.** Marshall, H., Provec, C., Collins, J., Tooherc, R., O'Keefe, M. et al., Eliciting youth and adult recommendations through citizens' juries to improve school based adolescent immunisation programs. *Vaccine*, 2014. 32: p. 2434-2440.
- 241.** Register, N.H.V.P. HPV Vaccination Coverage 2012. 2014; Available from: <http://www.hpvregister.org.au/research/coverage-data/vaccination-2012>
- 242.** Hull, B., Dey, A., Menzies, R., Brotherton, J., & McIntyre, P., Immunisation coverage annual report 2011. *Communicable Diseases Intelligence*, 2013. 37(4): p. e-291-e-312.
- 243.** Paul, P., & Fabio, A., Literature review of HPV vaccine delivery strategies: Considerations for school- and non-school based immunization program. *Vaccine*, 2014. 32(3): p. 320-326.
- 244.** National Health and Medical Research Council, *Eat for health - Australian dietary guidelines, Providing the scientific evidence.....* Department for Health and Ageing, Editor 2013, Australian Government: Canberra.
- 245.** Bailey, A., Parker, A., Colautti L., Hart, L., Liu, P., & Hetrick, S., Mapping the evidence for the prevention and treatment of eating disorders in young people. *Journal of Eating Disorders*, 2014. 2(5).
- 246.** National Eating Disorders Collaboration, *Eating disorders in schools: Prevention, early identification and response*, NEDC, Editor 2014, Australian Commonwealth Government: Crows Nest.
- 247.** Australian Institute of Health and Welfare, *Young Australians: their health and wellbeing 2011*, AIHW: Canberra.
- 248.** Australian Institute of Health and Welfare, *Hospital separations due to injury and poisoning, Australia 2008-09., 2012(a)*.
- 249.** White, V., & Bariola, E., Australian secondary school students' use of tobacco, alcohol, and over-the counter and illicit substances in 2011, 2012.
- 250.** McKay, M., McBride, N., Sumnall, H. & Cole, J., Reducing the harm from adolescent alcohol consumption: Results from an adapted version of SHAHRP in Northern Ireland. *Journal of Substance Use*, 2011: p. 1-24.
- 251.** Australian Institute of Health and Welfare, *Cancer in Australia 2012: an overview*, AIHW, Editor 2012(b): Canberra.
- 252.** Norton, E., Holloway, I., & Galvin, K., Comfort vs risk: a grounded theory about female adolescent behaviour in the sun. *Journal of Clinical Nursing*, 2014. 23: p. 1889-1899.
- 253.** National Asthma Council, *Australian Asthma Handbook - Supporting adolescents and young adults to self-manage their asthma*. 1st ed. 2014, Melbourne: National Asthma Council Australia.
- 254.** Sadof, M., & Kaslovsky, R., Adolescent asthma: A developmental approach. *Current Opinion in Pediatrics*, 2011. 23: p. 373-378.
- 255.** National Advisory Council on Dental Health, *Final Report of the National Advisory Council on Dental Health 2012*, Department of Health and Ageing: Canberra.
- 256.** Felton, A., Chapman, A., & Felton, S., *Basic guide to oral health education and promotion*. 2nd ed. 2013, Somerset, NJ: John Wiley & Sons.

257. The Royal Australian College of Physicians, Oral Health in Children and Young People, in Position Statement 2013, RACGP.
258. Brukiene, V., & Aleksejunien, J., An overview of oral health promotion in adolescents. *International Journal of Paediatric Dentistry*, 2009. 19(3): p. 163-171.
259. Baker, S., Mat, A., & Robinson, P., What psychosocial factors influence adolescents' oral health? *Journal of Dental Research*, 2010. 89(11): p. 1230-1235.
260. Centre for Accident Research and Road Safety – Queensland. State of the road: Adolescent risk-taking fact sheet. 2010; Available from: http://www.carrsq.qut.edu.au/publications/corporate/adolescent_risktaking_fs.pdf
261. Hemphil, C., & Smith, R., Preventing youth violence: What does and doesn't work and why? An overview of the evidence on approaches and programs, 2010, Australian Research Alliance for Children & Youth: Melbourne.
262. Schmidt, E., & Frelick Goekler, S., Partnering with schools to prevent injury and violence. In *Injury prevention for children and adolescents: Research, practice & advocacy*, 2nd Edn., K. DeSafey Liller, Editor. 2012, American Public Health Association: Washington DC.
263. Glendon, A., McNally, B., Jarvis, A., Chalmers, S. & Salisbury, R., Evaluating a novice driver and pre-driver road safety intervention. *Accident Analysis and Prevention*, 2014. 64: p. 100-110.
264. Chapman, R., Buckley, L., Sheehan, M., & Shochet, I., Pilot evaluation of an adolescent risk and injury prevention programme incorporating curriculum and school connectedness components. *Health Education Research*, 2013. 28(4): p. 612-625.
265. Taylor, S., Schooling and the settlement of refugee young people in Queensland: '...The challenges are massive'. *Social Alternatives*, 2008. 27(3): p. 58-65.
266. McFarlane, K., From care to custody: Young women in out-of-home care in the criminal justice system. *Current Issues in Criminal Justice*, 2010. 22(2): p. 345-353.
267. Harpin, S., Kenyon, D., Kools, S., Bearinger, L., & Ireland, M., Correlates of emotional distress in out-of-home youth *Journal of Child and Adolescent Psychiatric Nursing*, 2013. 26: p. 110-11.
268. Carmody, T., Taking Responsibility: A roadmap for Queensland child protection, Queensland Child Protection Commission of Inquiry, Editor 2013, Queensland Child Protection Commission of Inquiry: Queensland.
269. Lambert, V., & Keogh, D., Health literacy and its importance for effective communication. *Nursing Children & Young People*, 2014. 26(3): p. 31-37.
270. Garmy, P., Berg, A., & Clausson, E., Supporting positive mental health development in adolescents with a group cognitive intervention. *British Journal of School Nursing*, 2014. 9(1): p. 24-29.
271. Li, Z., Zeki, R., Hilder, L. & Sullivan, E., Australia's mothers and babies 2011, A.N.P.E.a.S. Unit, Editor 2013, Australian Institute of Health and Welfare: Canberra.
272. Clark, T., Crengle, S., Sheridan, J., Rowe, D., & Robinson, E., Factors associated with consistent contraception and condom use among Maori secondary school students in New Zealand. *Journal of Paediatrics and Child Health*, 2013. 50(4): p. 258-265.
273. Denny, S., Robinson, E., Lawler, C., Bagshaw, S., Farrant, B. et al., Association between availability and quality of health services in schools and reproductive health outcomes among students: A multilevel observational study. *American Journal of Public Health*, 2012. 102(10): p. e14-e20.
274. Dixon, V., *Special considerations when providing contraception advice and information to young people*. *British Journal of School Nursing*, 2014. 9(4): p. 170-176.
275. Queensland Sexual Health, *Queensland Sexual Health Clinical Management Guidelines*, Queensland Health, Editor 2010b, Queensland Health: Brisbane.
276. Godley, D., *Assessment, diagnosis, and treatment of developmental dysplasia of the hip*, *Journal of the American Academy of Physician Assistants*, 2013. 26(3): p. 54-58.
277. Department of Communities, Child Safety and Disability Services, Changes to Queensland's child protection legislation - Resource sheet 1, Queensland Government 10108_V8.
278. Queensland Government, *Head lice fact sheet*, 2014, [cited 2014 Nov 8]; available from http://access.health.qld.gov.au/hid/infectionsandparasites/parasites/headlice_fs.asp
279. Mitchell, A., Patrick, K., Heywood, W., Blackman, P., Pitts, M., *5th National survey of Australian secondary students and sexual health*, Monograph Series No. 97. 2014, Melbourne: La Trobe University, the Australian Research Centre in Sex, Health and Society.
280. AIHW 2011. *Australia's welfare 2011*. Australia's welfare no. 10. Cat. no. AUS 142. Canberra: AIHW.
281. Stauffer, S., Heath, M., Coyne, S., Ferrin, S., *High school teachers' perceptions of cyberbullying prevention and intervention strategies*, *Psychology in the Schools*, 2012. 49(4): p. 352-367.
282. Queensland Police Service, *Sexting*, 2014, [cited 2014 Nov 8]; available from www.police.qld.gov.au/.../children/childProtection/sexting.htm
283. Australian Youth Affairs Coalition. *Submission in response to The Joint Select Committee on Cyber Safety Inquiry into cyber safety issues affecting children and young people*, 2010. Retrieved from <http://www.ayac.org.au/uploads/AYAC%20Submission%20-%20Cyber%20safety%20issues.pdf>
284. Rigby, K., *What can schools do about cases of bullying?* *Pastoral Care in Education*, 2011, 29(4), 273-285.
285. Australian Government Department of Health and Ageing. *Australian Government response to: Before it's too late: report on the inquiry into early intervention programs aimed at reducing youth suicide*. 2013. Retrieved from <http://www.health.gov.au/internet/main/publishing.nsf/Content/mental-pubs-a-before>
286. Prymachuk, S., Graham, T., Haddad, M., and Tylee, A., *School nurses' perspectives on managing mental health problems in children and young people*. *Journal of Clinical Nursing*, 2011. 21, 850-859. doi: 10.1111/j1365-2702.2011.03838.x
287. Victorian Government Department of Health., *The National Practice Standards for the Mental Health Workforce* 2013. [cited 2014 Nov 8]; available from [http://www.health.gov.au/internet/main/publishing.nsf/Content/5D7909E82304E6D2CA257C430004E877/\\$File/wkstd13.pdf](http://www.health.gov.au/internet/main/publishing.nsf/Content/5D7909E82304E6D2CA257C430004E877/$File/wkstd13.pdf)
288. Yi-Erh, S., Sendall, M., Fleming, M., & Lidstone, J., *School based youth health nurses and a true health promotion approach: The Ottawa what?* *Contemporary Nurse*, 2013. 44(1), 32-44.
289. Blanchard, M., Hosie, A., & Burns, J., *Embracing technologies to improve wellbeing for young people: An Australian view of evidence and policy implications*. 2013. Retrieved from <http://www.youngandwellcrc.org.au/knowledge-hub/publications/embracing-technologies-improve-wellbeing-young-people/>

290. Suicide Prevention Australia. *Position statement: Youth Suicide*. 2010. Retrieved from <http://suicidepreventionaust.org/wp-content/uploads/2012/01/SPA-Youth-Suicide-Prevention-Position-Statement.pdf>
291. Woodhouse, A., *Is there a future in mental health promotion and consultation for nurses?* Contemporary Nurse, 2010, 34(2), 177-189.
292. Harvey, C., McNamee, K., & Stewart, M., A practical guide to contraception. Part 2: Long-acting reversible methods. *Medicine Today*, 2013, 14(8), 39-51. Retrieved from <http://www.fpq.com.au/pdf/PracticalGuidetoContraception2MedicineToday.pdf>
293. Royer, H., & Zahner, S., *Providers' experiences with young people's cognitive representations and emotions related to the prevention and treatment of sexually transmitted infections*. *Public Health Nursing*, 2009, 26(2), 161-17.
294. Muryk, M., Bloom, D., Shope, T., *Efficacy of neonatal release of ankyloglossia: A randomised trial*, *Pediatrics*, 2014, 128 (2), p. 280-288.
295. Todd, D., *Tongue-tie in the newborn: what, when, who and how? Exploring tongue-tie division*. *Breastfeeding Review*, 2014, 22(2), p. 7-10.
296. Queensland Government, *Sun safety*, 2014, [cited 2014 Nov 8]; available from <http://www.sunsafety.qld.gov.au>
297. Australian Institute of Health and Welfare (AIHW), *Australia's health 2014*. Australia's health services no. 14., Cat. no. AUS 178. Canberra: AIHW.
298. Australian Institute of Health and Welfare (AIHW), *The health and welfare of Australia's Aboriginal and Torres Strait Islander People: An overview*. 2011. Cat. no. IHW 42. Canberra: AIHW.
299. Redshaw, S., *Understanding the needs of children and young people in care: Towards a taxonomy of needs*. *Communities, Children and Families Australia*, 2012, 6 (1), 13-29.
300. Whilte, K., Hyde, M., O'Connor, Elk Naumann, L., and Hawkes, A., *Testing a belief-based intervention encouraging sun-safety among adolescents in a high risk area*. *Preventing Medicine*, 2010, 51 (34), 325-328.



Queensland
Government

