

Child and Youth Health Practice Manual



Acknowledgements

Child health nurses have been providing primary health care services to families in Queensland since 1918. In 2020, 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 Owners of the land on which we walk, work and live.

We pay respects to Elders past, present and all generations of Aboriginal and Torres Strait Islander peoples now and into the future.



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Suggested referencing

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Child and Youth Health Practice Manual, Queensland Child and Youth Clinical Network – Child Health Sub-Network.

Children's Health Queensland Hospital and Health Service, 2020

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.

In 2014, the manual was redrafted to align with The National Framework for Universal Child and Family Health Services and include 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 clinician

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

In May 2020, a project sponsored by the Queensland Child & Youth Clinical Network, in collaboration with Children's Health Queensland, commenced to review the Child and Youth Health Practice Manual with the aim to incorporate the latest evidence relating to

contemporary clinical practice for child and youth health clinicians and health workers. Consultation with child and youth health professionals and clinical content experts 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 2014 - 2020 and inclusive of evidence based clinical practice guidelines, government documents, professional frameworks and professional College Statements.

The following databases were also searched: Google Scholar; The Cochrane Collaboration; Clinicians Knowledge Network which searches twenty four databases at the time of this project.

Resources and information were reviewed and updated, contemporary clinical practices included, and emerging public health priorities incorporated. A summary of new additions to the 2020 review are listed in the front of the manual.

Redraft completion date: October 2020

Recommended review: 2025

Photography: Photos are for illustrative purposes only. Aboriginal and/or Torres Strait Islander peoples should be aware that this publication may contain images of people who may have died.

Artwork on page 262 produced for Queensland Health by Gilimbbaa.

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Acronyms and abbreviations

A	ABA	Australian Breastfeeding Association	L	HPSF	Health Promoting Schools Framework
	AIR	Australian Immunisation Register		HPV	Human papilloma virus
	ADHD	Attention deficit hyperactivity disorder		HHS	Hospital and health service
	AHPRA	Australian Health Practitioner Registration Agency		Hz	Hertz
B	ASQ	Ages and stages questionnaire	M	LGBTIQ+	Lesbian, gay, bisexual, transgender, gender diverse, intersex, queer, asexual and questioning
	BFHI	Baby Friendly Health Initiative		MAIF	Marketing in Australia of infant formula
C	BMI	Body mass index	N	MMR	Measles, mumps, rubella vaccine
	CALD	Culturally and linguistically diverse		MOU	Memorandum of understanding
D	CDC	Centre for disease control		NEMO	Nutrition education materials online
	CHD	Congenital heart disease		NHMRC	National Health and Medical Research Council
	CKN	Clinician’s Knowledge Network	P	NIPS	National Immunisation Program Schedule
	CPA	Child protection advisor		PaRROT	Pathways to Rural and Remote Orientation and Training
CPLO	Child protection liaison officer	PCCM		Primary Clinical Care Manual	
DASS	Depression, Anxiety and Stress Scale	PEDS		Parent’s Evaluation of Developmental Status	
E	dB	Decibels	R	PHR	Personal Health Record book
	DKA	Diabetic ketoacidosis		PND	Postnatal depression
	DoE	Department of Education	Q	QHEPS	Queensland Health Electronic Publishing Service
	dTpa	Diphtheria, tetanus and acellular pertussis vaccine		QHLFSS	Queensland Hearing Loss Family Support Service
F	DFV	Domestic and family violence	R	RN	Registered nurse
	EIC /EIPC	Early intervention clinician / Early intervention parenting clinician		SBYHN	School-based youth health nurse
G	EPDS	Edinburgh (Postnatal) Depression Scale	S	SIP	School immunisation program
	FGM	Female genital mutilation		SIDS	Sudden infant death syndrome
H	FASD	Foetal alcohol spectrum disorder	V W	SUDI	Sudden and Unexpected Death in Infancy
	GORD	Gastro-oesophageal reflux disease		VSP	Vaccine service provider
	GP	General practitioner		WHO	World Health Organisation
	HEEADSSS	A framework for psychosocial health assessment. Each letter represents a theme: H ome; E ducation/ employment; E ating and E xercise; A ctivities and peer relationships; D rugs (Smoking, Alcohol and other); S exuality and relationships; S uicide/low mood; S afety; O ther			

Summary of additions - 2020 Review

Aim:

Review the current version of the Child & Youth Health Practice Manual, updating and incorporating the latest evidence-based information and contemporary clinical practice changes within the Queensland Health, primary health care setting.

Additions:

- Aboriginal and Torres Strait Islander families [pg. 262](#)
 - Rewritten to reflect national frameworks and strategies: *The National Framework for Health Services for Aboriginal and Torres Strait Islander Children and Families* (2016); the *National Aboriginal and Torres Strait Islander Health Plan 2013–2023* and the *Queensland Health Closing the gap: Performance Report 2018*
 - Cultural needs section created
 - Health needs section created
 - Resources section created
- Breastfeeding, new information
 - Cleaning expressing equipment [pg. 120](#)
 - Tongue-tie (ankyloglossia) [pg. 134](#)
 - Management of inadequate milk supply [pg. 124](#)
- Child Protection
 - New 'Child Protection Resources' section [pg. 316](#)
- Congenital Heart Disease [pg. 94](#)
 - New section
 - Statewide developmental long-term care pathway for children undergoing open heart surgery
- Foetal Alcohol Spectrum Disorder (FASD) [pg. 280](#)
 - New inclusion
- LGBTIQ+ young people
 - New inclusions [pg. 387](#) and [pg. 429](#)
- Lift the Lip / oral health screening [pg. 156](#)
 - New 'Practice Tips: Conducting a Lift the Lip/oral health screen'
 - Oral health promotion updated [pg. 219](#) & [pg. 237](#)
- Nutrition and healthy eating [pg. 234](#)
 - New information, healthy eating habits, promotion of 'body satisfaction'
- Obesity in childhood [pg. 297](#) & [pg. 368](#)
 - New section. Health priority area
 - Childhood obesity resources section created
 - Clinicians Hub – Health and Wellbeing Qld included
- Safe sleep [pg. 255](#)
 - Language and terminology around SIDS and SUDI
 - Shared Sleeping information included - consistent with Queensland Paediatric Quality Council guidelines
- Stillbirth prevention [pg. 43](#)
 - New section.
 - Antenatal messages and clinical practice recommendations consistent with prevention program 'The Safer Baby Bundle'
- Type 1 Diabetes [pg. 419](#)
 - New section
 - Clinical practice changes - recognise and respond to prodromal symptoms of hyperglycaemia
 - iLearn training module: primary prevention and early identification of hyperglycaemia in children to reduce the rate of DKA at diagnosis
- Vision screening
 - Parr 4m Letter Matching Vision Test [pg. 158](#)
 - Primary School Nurse Health Readiness Program [pg. 322](#)
- Assessment of hearing and ear health [pg. 81](#)
 - Parent-evaluated Listening and Understanding Measure (PLUM) and the Hearing and Talking Scale (HATS)
 - New assessment tools for Aboriginal and Torres Strait Islander children

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 within this manual.

National Framework Core Service Element¹

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 • Lactation aids in breastfeeding support • Supporting a mother formula feeding • Vision screening • Hearing and ear health check 	<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"> • Care Coordination • Brief practice interventions • The premature infant • Cow's milk protein allergy • Weight faltering /malnutrition • Obesity in childhood • Sleep dysrhythmia • Post-natal depression • Protecting children • Clinical practice tips: <ul style="list-style-type: none"> • Developing a safety plan

National Framework Core Service Element¹

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 coordination 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 Chronic Conditions Manual

<https://www.publications.qld.gov.au/dataset/chronic-conditions-manual-2nd-edition-2020>



Refer to the Primary Clinical Care Manual

<https://www.health.qld.gov.au/rscsu/html/PCCM>



Refer to the Pathways to Rural and Remote Orientation and Training

<https://ilearncatalogue.health.qld.gov.au/program/17/parrot-primary-care>



e-learning

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:

Hockenberry, M; Rodgers C & Wilson, D. (2020). **Wong's Essentials of Pediatric Nursing** (11th ed.) St Louis, Missouri: Mosby Elsevier.

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.

Shajani, Z & Snell D. (2013). **Wright & Leahey's Nurses and families: A Guide to Family Assessment and Intervention**, (7th ed.). Philadelphia, Pennsylvania: F.A.Davis Company.



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.

Although produced for Queensland Health Child Health staff, it is acknowledged that much of it can be utilised by any person who works within the primary health community setting with families, children and young people (0-18 years). For example, staff in General Practice or Midwives with extended practice qualifications. Currently, Queensland Health child health staff includes:

- Child health nurses
- School-based youth health nurses
- Aboriginal and Torres Strait Islander advanced health workers (maternal, child & youth)
- Aboriginal and Torres Strait Islander health practitioners
- Early intervention clinicians/early intervention parenting clinicians (psychologist or social worker)

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 with AHPRA and in 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>

Health professional	Registration/qualifications	Example of key duties and responsibilities
Child health nurse (school-based)	<p>Registration as a registered nurse with AHPRA and in possession of an annual practicing licence.</p> <p>A relevant qualification in child, youth and family health is highly regarded.</p>	<p>Optimise the health and wellbeing of Queensland children during their transition to primary school, with a focus on vision screening.</p> <p>Utilise a primary health care approach to build community capacity through delivery of health education to relevant stakeholders.</p> <p>Work collaboratively with school communities and other key stakeholders to coordinate vision screening activities in assigned schools.</p>
School-based youth health nurse (SBYHN)	<p>Registration as a Registered Nurse with AHPRA and in 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 young people in secondary schools across Queensland.</p> <p>Support young people 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>
Aboriginal and Torres Strait Islander advanced health worker	<p>HWO04: Certificate IV in Aboriginal and/or Torres Strait Islander Primary Health Care from a registered tertiary institution/facility, or equivalent.</p> <p>HWO05: Diploma in Aboriginal and/or Torres Strait Islander Primary Health Care from a registered tertiary institution/facility, or equivalent.</p>	<p>Support and liaise with health care professionals to enhance the provision of primary health care to Aboriginal and Torres Strait Islander people.</p> <p>Deliver a range of evidence-based interventions in a culturally safe and effective manner including the provision of intake assessments, cultural aspects of assessment and treatment plans, direct therapeutic interventions, referrals and cultural support to patients of the Women, Children and Family in Women's business.</p> <p>Help Aboriginal and Torres Strait Islander women and their partner/family to make health lifestyle and health care choices and reduce risk behaviours during pregnancy and thereafter.</p>

Health professional	Registration/qualifications	Example of key duties and responsibilities
Aboriginal and Torres Strait Islander health practitioner	Registered with AHPRA and possession of an annual practicing licence.	<p>Provide clinically focused advice and support in order to improve health outcomes for Aboriginal and Torres Strait Islander people.</p> <p>Deliver specific primary health care programs.</p> <p>Assess and treat Aboriginal and Torres Strait Islander people.</p>
Early intervention clinician (EIC)/ early intervention parenting clinicians (EIPC)	<p>Psychologist: Registration with AHPRA and an AHPRA approved tertiary qualification in Psychology.</p> <p>Social worker: A recognised degree in social work and eligibility for membership with the Australian Association of Social Workers.</p>	<p>Deliver high level, specialist early intervention/parenting and related services and programs for families with children with complex needs.</p> <p>Provide support to Health Service Community Child and Youth Health staff and key stakeholders on relevant early intervention and parenting issues.</p> <p>Work collaboratively with relevant government and non-government agencies to address contemporary health issues.</p>

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 advanced health worker, Aboriginal and Torres Strait Islander health practitioner, unless specifically stated otherwise.
 - The Child Health Psychologist/Social Worker/ Early Intervention Clinician/ Parenting Clinician are integral to many Child, Youth and Family Services within Queensland and will be abbreviated as 'EIC / EIPC'.

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 support 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.
 - 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. Standards of Practice for Children and Young Peoples Nurses², National School Nursing Standards for Practice: Registered Nurse³, Australian Psychology Society.
 - › Legislative frameworks, Professional Codes and Guidelines, e.g. AHPRA and National Boards - Codes of conduct, Standards for practice and Codes of ethics⁴.
- Many child/youth health professionals' practice 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)⁵
 - Queensland Universal Child Health Framework – Implementation Guide, Queensland Health (2014)⁶
 - National Framework for Health Services for Aboriginal and Torres Strait Islander Children and Families (2016)⁷



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



Australian Government

National Framework for Universal Child and Family Health Services

<https://www1.health.gov.au/internet/main/publishing.nsf/Content/nat-fram-ucfhs>

Australian Government

National Framework for Health Services for Aboriginal and Torres Strait Islander Children and Families

<https://www1.health.gov.au/internet/main/publishing.nsf/Content/national-framework-health-services-aboriginal-and-torres-strait-islander-children-and-families>

Australian College of Children and Young Peoples ACCYPN

Standards of Practice for Children and Young People's Nurses

<https://www.accypn.org.au/knowledge-centre/standards-of-practice/>

Maternal, Child and Family Health Nurses Australia

National Standards of Practice for Maternal, Child and Family Health Nursing Practice in Australia

<https://www.mcafhna.org.au/Resources.aspx#52611-standards>

Australian Nursing & Midwifery Federation

National School Nursing Standards for Practice: Registered Nurse

<http://anmf.org.au/pages/school-nursing-standards>

AHPRA and National Boards

<https://www.ahpra.gov.au/>



Section 1: **Antenatal**



Section 1: Antenatal

There is unequivocal evidence to confirm the significance of the first 1,000 days of life (the period from conception until the child's second birthday) on outcomes for health⁸. Information about the antenatal stage of the continuum of care has been included in this manual to enhance the child health professional's knowledge of antenatal best practice and to promote communication and collaboration between primary care providers to support a smooth transition of care between maternity and child and family health services^{1, 9, 10}.

Developmental surveillance and health monitoring

Antenatal care incorporates health surveillance and monitoring of the mother and fetus 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 dependent 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^{9, 10}:

1. Midwife care – midwives are the primary providers of care; this may be through a caseload model (one known midwife who works on-call), midwifery group practice (a small number of midwives managing and sharing a caseload) or team midwifery (a team of midwives who work rostered shifts sharing the care of a defined group of women).
2. Shared care – several health professionals are involved in the care including GP, obstetrician, hospital doctors and midwives.
3. 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.

A maternity care plan is recommended to support collaborative care principles^{9, 10}. 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.

- Recognise the importance of father/ partner/extended family who will be involved in the child's life and involve them in appropriate health education and decision-making.
- 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.
- Optimising the health of the mother, baby and their family.

A child health professional may engage with a family during the antenatal period to:^{1, 9, 10}

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

Other health professionals may have an integral role in the antenatal care team⁵, for example:

- Aboriginal and Torres Strait Islander advanced health workers
- Maternity liaison officers
- Bilingual or multilingual health workers
- Psychologists
- Social workers
- Dietitian/Nutritionists
- Drug and alcohol workers
- Mental health workers
- GP, Psychiatrist

The pregnancy health record

<https://clinicalexcellence.qld.gov.au/sites/default/files/docs/clinical-pathways/pregnancy-health-record.pdf>

The pregnancy health record provides a complete record of pregnancy care and is an endorsed document for effective information sharing between care providers from early pregnancy to birth. It supports shared decision making between women and their maternity care provider. Women are also encouraged, to access the educational links and document their birth plan. There are sections in the record for all members of the health team to complete¹¹.



National Health and Medical Research Council

www.nhmrc.gov.au

National Guidance on Collaborative Maternity Care

<https://webarchive.nla.gov.au/awa/20150324003339/http://www.nhmrc.gov.au/guidelines-publications/cp124>

Brochure for families:

“Your health professionals working together with you and your baby”

<https://webarchive.nla.gov.au/awa/20150324003339/http://www.nhmrc.gov.au/guidelines-publications/cp124>

Clinical Practice Guidelines

Pregnancy Care

<https://www.health.gov.au/resources/pregnancy-care-guidelines>

Antenatal assessment

Physical assessment

Antenatal assessment monitors physical and developmental health of the mother and fetus. Comprehensive clinical assessment in early pregnancy and a schedule of follow up antenatal visits according to the woman's clinical needs This includes^{10, 12}:

- Gestational Weight Gain monitoring¹³ - using a pregnancy weight gain chart provides an objective tool to guide conversations about weight gain progress¹⁴.
- 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, syphilis, glucose tolerance.
- Routine risk assessment and serology for syphilis is recommended due to a re-emergence of syphilis in the community, and the impact of congenital syphilis on the foetus/child¹⁵.
- Referral may be required, for example, blood screening identifies Human Immunodeficiency Virus, syphilis or Gestational Weight Gain monitoring identifies obesity and risk of excess weight gain throughout pregnancy¹².

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 includes¹⁰:

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

Consideration of risk to the unborn child is inclusive within this screening process¹⁰.



Clinical Practice Guidelines

Pregnancy Care

<https://www.health.gov.au/resources/pregnancy-care-guidelines>

Queensland Clinical Guidelines

Maternity and Neonatal Clinical Guidelines

<https://www.health.qld.gov.au/qcg/publications>

Social and emotional wellbeing

During the perinatal period a mixture of physiological and psychosocial factors put women (and their partners) at increased risk of experiencing perinatal depression¹⁶⁻¹⁸ including:

- past or present mental illness
- a family history of mental illness
- pregnancy and birth complications and/or receiving disrespectful maternity care
- young or older maternal age
- 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
- quality of her own childhood experiences, e.g. attachment with her own mother
- having unrealistic expectations about motherhood^{17, 19}, for example, that:
 - mothers bond with their babies straight away
 - mothers know instinctively what to do
 - motherhood is a time of joy



One in ten expectant mothers and one in twenty expectant fathers in Australia are thought to experience anxiety and/or depression during the antenatal period. Health professionals should encourage discussion about the wellness of significant others and when and how to seek support¹⁶.

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 resilience²⁰.

Recent research into perinatal depression recommends^{10, 16, 17, 21}

- 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.
- Provide advice about the risk of relapse during pregnancy and especially in the early postpartum period to women who have a new, existing or past mental health condition and are planning a pregnancy.
- Depression screening as 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 page 68 [Practice Tips: Conducting and scoring the EPDS](#).
- All pregnant women and their partners should be asked about their emotional wellbeing at every antenatal contact and be provided with information and resources on emotional health in the perinatal period.

- The health care provider should consider the impact of the parent's social and emotional wellbeing on the parental-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 mental health services or the Child Health multidisciplinary team.
 - See [Appendix 8 Perinatal and infant mental health universal risk assessment and referral pathways](#)
- Resources need to be culturally appropriate and address the needs of particular groups, such as, Aboriginal and Torres Strait Islander mothers or mothers having multiple births.
- Women are more satisfied and cultural safety is improved for women who receive their care in a midwifery continuity of carer model²².
- 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.



Australian Family Strengths Nursing Assessment Guide

See Appendix 1

Practice tips: Conducting and scoring the EPDS

See page 68



Clinical Practice Guidelines

Pregnancy Care

<https://www.health.gov.au/resources/pregnancy-care-guidelines>

Keeping Well During Pregnancy and Beyond Booklet

Practical tips for parents to help with stress, anxiety and depressive symptoms

https://metrosouth.health.qld.gov.au/sites/default/files/keeping_well_booklet_web.pdf

Centre of Perinatal Excellence

National Perinatal Mental Health Guideline.

<https://www.cope.org.au/health-professionals/health-professionals-3/review-of-new-perinatal-mental-health-guidelines/>

Queensland Centre for Perinatal and Infant Mental Health

<https://www.childrens.health.qld.gov.au/chq/our-services/mental-health-services/qcpimh/>

COPE Centre of Perinatal Excellence

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

<https://www.cope.org.au/health-professionals>

Raising Children Network

Information for families on pregnancy and birth

<http://raisingchildren.net.au>



Yarning about mental health: an easy guide to mental health assessment

HealthInfoNet Flipchart

<https://healthinonet.ecu.edu.au/key-resources/resources/?id=19702>

PANDA

<http://www.panda.org.au>

PANDA Resources specific for fathers

<https://www.panda.org.au/info-support/how-is-dad-going>

Domestic and family violence

The contemporary understanding of domestic and family violence (DFV) is a person being subjected to an ongoing pattern of abusive behaviour by an intimate partner or family member.

This behaviour is motivated by a desire to dominate, control or oppress the other person and cause fear. It includes behaviour that is physically, sexually, emotionally, psychologically or economically abusive; threatening or coercive; or any other way controls or dominates another person causing fear^{23, 24}.

Women are at greater risk of violence from intimate partners during pregnancy, or after separation^{23, 25}. DFV has serious impacts on women's health. These impacts can include injuries, homicide, poor mental health and reproductive health problems. In Australia DFV is the leading preventable contributor to death and illness for women aged 18-44²³.

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 living in a violent home^{23, 26}.

Routine screening for DFV is a core component of antenatal care. It is vital that information obtained on antenatal assessment is used in a supportive and protective way^{10, 27}. All responses to a disclosure of DFV should include consideration of the safety of any children including an unborn child²³.

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 (i.e. when she is alone) and accompanied by local information and resources^{10, 28}.

Health professionals are often the first point of contact for women experiencing DFV and Queensland Health has developed a range of resources and tools to support front line workers.

<https://www.health.qld.gov.au/clinical-practice/guidelines-procedures/patient-safety/duty-of-care/domestic-family-violence/healthcare-workers>



Practice tips: Conducting the domestic violence screen

See page 71

Child Protection

See page 53



Queensland Health DFV Toolkit

*Information, resources and training and including the **Online Portal link** for Queensland families impacted by DFV*

<https://www.health.qld.gov.au/clinical-practice/guidelines-procedures/patient-safety/duty-of-care/domestic-family-violence>

Family Health Assessment – A guide for child health clinicians practicing within the primary health care setting

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

Child safety (QHEPS) factsheets

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



DV-alert (Domestic Violence Response Training)

Free accredited training program for health professionals

www.dvalert.org.au

Domestic Violence helplines – Womensline, Mensline, Sexual Assault Helpline, 1800RESPECT

www.dvconnect.org

Queensland Centre for Domestic and Family Violence Research

<https://noviolence.org.au/factsheets/>

Safe and Together Institute

Resources, training and tools for working with DFV

<https://safeandtogetherinstitute.com/>

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^{10, 29, 30}:
 - 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
- Smoking cigarettes during pregnancy is associated with a range of serious health problems for both the pregnant women and her unborn child^{10, 31}.
 - Pregnancy often motivates parents to change their smoking habits, so it is an important time to provide brief advice – Ask, Assess, Assist.
 - A specialised quit smoking support program, ‘Quit for You...Quit for Baby’ has been developed for pregnant women and their partners. The free program is delivered by Queensland Quitline service and combines behavioural support with 12-week supply of nicotine replacement therapy. Individuals can self-refer by calling 13 7848 or be referred by their health professional.
 - See *Smoking, alcohol and substance misuse* page 280 for further information.

- 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^{10, 30, 32}:
 - prescribed medications /over-the-counter medications
 - alcohol
 - tobacco, including passive smoking
 - other substances (cannabis, stimulants, inhalants and un-prescribed use of benzodiazepines)
- Both the pattern and frequency of use are important^{30, 32}:
 - occasional use
 - regular recreational or non-dependent use
 - habitual, regular or dependent use
 - binge use
- Consideration of the impact of misuse of substances on the developing fetus is important, e.g. Foetal Alcohol Spectrum Disorder (FASD), Neonatal Abstinence Syndrome^{10, 32, 33}.
- FASD is a diagnostic term for the range of physical, cognitive, behavioural and neurodevelopmental abnormalities which can result from maternal drinking during pregnancy³⁴.
 - Alcohol crosses the placenta and may irreparably damage the brain of the developing fetus.
 - No safe level for alcohol consumption in pregnancy has been established.
 - FASD has lifelong consequences and can lead to significant secondary impairments, such as difficulties accessing education services, substance use, mental ill-health, difficulties living independently, problems obtaining and maintaining employment and early contact with the justice system³⁴. A recent study on the prevalence of FASD within the juvenile justice system found that 36% of 10-18 year olds in Banksia Hill Detention Centre (WA) were diagnosed with FASD³⁵.
 - Antenatal care should include clear messages about the risks and consequences of alcohol consumption in pregnancy, brief interventions for those using alcohol during pregnancy, and specialised treatment for women who are alcohol dependent³⁴.



Quitline

<http://www.qld.gov.au/quithq>

Centre for Excellence in Indigenous Tobacco Control

<http://www.ceitc.org.au/>

Alcohol and Drug Support (ADIS)

24/7 support for people in Queensland with alcohol and other drug concerns.

P: 1800 177 833

Insight - Centre for alcohol and other drug training and workforce development

<https://insight.qld.edu.au/>

Raising Children Network

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

<http://raisingchildren.net.au>

Qld Clinical Guidelines

Maternity and Neonatal Clinical Guidelines

<https://www.health.qld.gov.au/qcg/publications#psu-neo>

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 ²⁷. Refer to further information and resources in *Child Protection* section.



Child Protection
See page 53

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 within their community. Whenever possible, health education and promotion should include both the woman and her partner/support persons.

Antenatal health promotion and early intervention strategies can have a positive effect during this critical stage of life as they provide care to pregnant and parenting women. High quality evidence shows that continuity of midwifery care across the full maternity continuum improves outcomes for women, infants and midwives³⁶.

The potential return on investment for high quality antenatal and postnatal care and interventions that target modifiable risk factors such as maternal smoking, pre-term birth, maternal mental health, maternal alcohol use, poverty and household stress is significant³⁷.



Freepik.com

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 child¹.

- Family structures are varied including^{7, 38}:
 - extended families e.g. grandparents, aunts and uncles, Elders and kinship carers
 - foster families
 - single parent, step and blended families
 - lesbian, gay, bisexual, transgender, intersex, queer, gender diverse, asexual and questioning (LGBTIQ+) parents
- Understanding and respecting different child-rearing practices is important for planning and delivering services that reflect individual parenting choices and styles⁷.
- 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 whole³⁹.

It is recommended that services facilitate greater involvement of fathers/partners/extended family by considering a range of strategies⁴⁰. 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 and offering telehealth options for fathers who are away^{39, 41}.
- Recognise father/ partner/extended family 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^{39, 42}.
- Involve father/ partner/extended family 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 practices⁴³.
- Discuss transition to parenthood issues including parenthood roles, lifestyle and relationships changes⁴⁰.
- Change service environments to account for possible barriers that prohibit father/ partner/ 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, consideration of offering single gender (dads) groups^{39, 44}.
- Use a strengths-based approach when working with fathers⁴¹.
- Family members are encouraged to attend appointments with the child and attendance at group-based parenting programs is also encouraged. Parenting groups (e.g. Triple P; Circle of Security) 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^{44, 45}.
- Aboriginal and Torres Strait Islander families should be supported with access and engagement to primary care services.
 - Having Aboriginal and Torres Strait Islander staff, who are well respected and well connected to the community, and a culturally welcoming environment, facilitates inclusiveness of Aboriginal and Torres Strait Islander families^{39, 40, 42}.

- There may be barriers for families in attending an in-person appointment, which may be overcome with the use of telehealth services. Therefore, it is important to⁴⁶:
 - › Raise awareness with families about the availability of telehealth
 - › Help with resourcing at the clients end if needed
 - › Provide cultural support to arrange the telehealth appointment and during the appointment
 - › Support the attendance of family

- Cultural knowledge, skills and behaviours are essential to communicating and engaging when working with Aboriginal and Torres Strait Islander peoples³².

Cultural Practice Programs are available for Queensland Health Staff, for more information see <https://www.health.qld.gov.au/public-health/groups/atsihealth/cultural-capability>



Aboriginal and Torres Strait Islander families

See page 262



Webinar - Child Family Community Australia (CFCA)

Refining the task of father-inclusive practice

<https://aifs.gov.au/cfca/events/refining-task-father-inclusive-practice>

Family Action Centre, Newcastle University

Resources and education for staff on father-inclusive practice

<https://www.newcastle.edu.au/research-and-innovation/centre/fac/about-us>

Raising Children Network

Resources (video and fact sheets) on a variety of topics

<http://raisingchildren.net.au>

PANDA

Resources for paternal perinatal anxiety and depression

<https://www.panda.org.au/info-support/how-is-dad-going>

Quality information and education

Providing evidence-based health education in the antenatal period supports participative decision making¹⁰, 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)
- antenatal practices that reduce preventable stillbirth
- 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
- Group information sessions
 - information provided to prospective parents in groups
 - effectively encourages networking and building possible supportive contacts for the longer term ¹⁰.



Building Healthy Brains – The Eleven Key Messages

See Appendix 2

Practice tips: Facilitating a group parenting session

See page 192



Nutrition Education Materials Online (NEMO)

<https://www.health.qld.gov.au/nutrition/patients>

Keep a healthy smile - Oral Health Information

Queensland Health

https://www.health.qld.gov.au/oralhealth/healthy_smile

Beyond Blue - Healthy Families

Resources on emotional and mental health for the whole family

<https://healthyfamilies.beyondblue.org.au/>

'Growing Strong: Feeding You and Your Baby' suite of resources for Aboriginal and Torres Strait Islander families

Queensland health

<https://www.health.qld.gov.au/nutrition/patients#>

Global Health Media

Breastfeeding videos (multiple languages)

<https://globalhealthmedia.org/>

Red Nose Australia

<https://rednose.org.au/resources/education>

National Centre for Immunisation Research and Surveillance

<http://www.ncirs.org.au/public>

Healthy Hearing Program

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

Raising Children Network

<http://raisingchildren.net.au/>

Queensland Transcultural Mental Health Centre

Multilingual resources relating to mental health issues

<https://metrosouth.health.qld.gov.au/transcultural-mental-health?provider=168>



Refer to the Chronic Conditions Manual

<https://www.publications.qld.gov.au/dataset/chronic-conditions-manual-2nd-edition-2020>



Refer to Primary Clinical Care Manual

<https://www.health.qld.gov.au/rrcsu/html/PCCM>

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 pregnancy^{10, 47}. Metabolic adaptations and a high quality, balanced, dietary intake is generally enough to meet the increased nutrient needs. The exception to this is folate and iodine^{10, 48}, where routine supplementation is now recommended for most 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 groups^{10, 47, 49}.

- As the immune system in pregnancy is suppressed, pregnant women are more susceptible to foodborne illness such as listeriosis and salmonella. Foods that should be avoided include: unpasteurized 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 salads and raw eggs^{10, 49}. Listeriosis can be transmitted to the unborn child and may cause miscarriage, premature birth or stillbirth^{10, 49}.

Additionally, foetal exposure to high levels of mercury may cause developmental delays. Pregnant women should be advised to take care with consumption of some larger fish species (e.g. shark/flake, swordfish and catfish) due to the potentially higher mercury content¹⁰.

- 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 vomiting ^{10, 50}.
- Reinforce nutrition and oral health care messages such as: limiting the frequency of snacking throughout the day; eating a low-fat and low-sugar diet; drinking plenty of tap water and adopting regular oral hygiene practices, such as twice daily brushing with a soft toothbrush and a fluoride toothpaste⁵⁰.

Frequent vomiting can weaken tooth enamel and may increase the risk of decay and erosion. Do not brush teeth straight after vomiting as this can speed up tooth wear. Instead, rinse the mouth with a fluoride mouth rinse or with tap water. If using tap water, smear a small amount of fluoride toothpaste on the teeth after rinsing. Chewing sugar free gum increases saliva flow and this can also help protect against decay and erosion⁵⁰.

- 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 health ⁵⁰.
- For most pregnant women it is recommended doing some physical activity every day and accumulate 150–300 minutes of moderate-intensity physical activity each week. 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 ^{10, 51}.
- The following are benefits associated with physical activity during pregnancy¹⁰:
 - reduces depressive symptoms
 - improves health-related quality of life
 - pelvic floor exercises can prevent urinary tract infections
 - improves and maintains physical fitness (with associated health benefits)
 - supports appropriate weight gain during pregnancy
- Obesity in pregnancy is one of the most common, and potentially one of the most modifiable, risk factors for adverse pregnancy outcomes and has associated short and long-term adverse outcomes for mothers and children. Appropriate steady weight gain during pregnancy is important to optimise maternal and infant health ⁴⁹.

Health professionals should¹⁴:

- calculate maternal BMI at the first antenatal visit to inform gestational weight gain
- give women advice about appropriate weight gain during pregnancy in relation to their pre-pregnancy weight at the first antenatal visit
- offer women the opportunity to be weighed and encourage self-monitoring of weight gain at every antenatal visit
- discuss a woman's gestational weight gain progress, healthy eating and physical activity at each antenatal visit

- Use culturally appropriate tools for education on nutrition such as:
 - Growing Strong - feeding you and your baby resources ⁵². This is a resource developed to assist health staff talk with Aboriginal and Torres Strait Islander families about nutrition for mothers, babies and young children. There are a range of resources available.
<https://www.health.qld.gov.au/nutrition/patients#>
 - The Good Start Program has a range of culturally tailored resources for Maori and Pacific Islander families and communities ⁵³
<https://www.childrens.health.qld.gov.au/service-good-start-resources/>
 - Multicultural nutrition resources - including *Infant feeding for African communities*, a suite of resources designed in partnership with African women covering all aspects of feeding and nutrition⁵⁴.
<https://metrosouth.health.qld.gov.au/multicultural-nutrition-resources>
 - Raising Children Network has articles, videos and picture guides translated into multiple languages⁵⁵
<https://raisingchildren.net.au/for-professionals>



Nutrition Education Materials Online (NEMO)

<https://www.health.qld.gov.au/nutrition/patients>

Maternal and Infant Nutrition – healthy lifestyle for mothers during pregnancy *Queensland Health*

<https://www.health.qld.gov.au/clinical-practice/guidelines-procedures/clinical-staff/maternity/nutrition/lifestyle/pregnancy>

Keep a healthy smile – Oral Health Information *Queensland Health*

https://www.health.qld.gov.au/oralhealth/healthy_smile

Australian Dietary Guidelines *Eat for Health*

www.eatforhealth.gov.au

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 ^{43, 56}.
- There is no specific evidence-based, physical preparation of the breast or nipple for breastfeeding required in the antenatal period. The health care professional should examine the breasts and discuss any concerns, e.g. previous breast surgery, nipple shape, breast hypoplasia ⁵⁶⁻⁵⁸.
- Environmental factors and societal considerations have an impact on a mother's commitment to and ability to continue breastfeeding. Potentially modifiable antenatal factors that negatively influence initiation and continuation of breastfeeding include maternal obesity; maternal diabetes; separation of mother and baby after birth; delay in onset of milk (e.g. following caesarean section); early use of bottles or pacifiers; offering supplementary feeds (water, glucose or formula milk) when there is no medical reason ¹⁰.

- Health professionals empower mothers to breastfeed by ^{56, 57, 59, 60}:
 - informing families of the benefits of breastfeeding
 - informing families of the risks of not breastfeeding
 - discussing the importance of exclusive breastfeeding of the infant to around six months and ongoing breastfeeding with the introduction of complementary foods
 - supporting partners and other family members, recognising the importance of their role in encouraging and maintaining breastfeeding
 - discussing the importance of uninterrupted skin-to-skin contact at birth and early breastfeeding, including the benefits of colostrum for the infant
 - promoting maternal self-care
 - discussing the practical aspects of breastfeeding (e.g. antenatal breast care issues, how to promote a good latch to the breast after birth, frequency of feeding)
 - discussing normal newborn behaviour including feeding cues
 - encouraging the family to use expressed breastmilk when the mother and infant are separated, including returning to work
 - encouraging the family to avoid the use of teats and pacifiers until breastfeeding is well established
 - providing information on when to seek advice and the range of support services available, e.g. Australian Breastfeeding Association (ABA); Pregnancy, Birth and Baby website and the Raising Children website, Lactation Consultants of Australia and New Zealand (LCANZ)
 - supporting the principles of the Baby Friendly Health Initiative (see below)
- Be culturally sensitive and where possible utilise culturally specific resources to discuss breastfeeding with parents such as the Growing Strong - feeding you and your baby resources⁵² or the Global Health Media breastfeeding videoclips (available in multiple languages)⁶¹. See resources box below.
- While breastfeeding is recognised as the physiological normal and natural way to feed infants, some women will make an informed decision not to breastfeed ⁵⁶. This decision should be respected, and support provided⁵⁶. Some studies have reported some 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. 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 ¹⁰.
- Health workers have a responsibility to promote breastfeeding first but, where it is needed, to educate and support parents about formula feeding. Information and education to pregnant women and families who choose to feed their baby with infant formula can be provided during a one-on-one consultation⁵⁶.
- The NHMRC Infant Feeding Guidelines⁵⁶ discusses the health benefits of breastmilk 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. Other topics specific to infant nutrition should include information about Vitamin K administration after birth.
- The Baby Friendly Health Initiative (BFHI) is a joint World Health Organisation (WHO) and UNICEF initiative that aims to create a healthcare environment where breastfeeding is the norm, and practices known to promote the well-being of all mothers and infants are promoted⁶². It provides an accreditation framework that assists facilities to implement The Ten Steps to Successful Breastfeeding. There is substantial evidence that implementing the Ten Steps significantly improves breastfeeding rates⁶³.

The TEN STEPS to Successful Breastfeeding⁶³



Have a written infant feeding policy that is routinely communicated to all health care staff.



Ensure that staff have sufficient knowledge, competence and skills to support breastfeeding.



Discuss the importance and management of breastfeeding with pregnant women and their families.



Facilitate immediate and uninterrupted skin-to-skin contact and support mothers to initiate breastfeeding as soon as possible after birth.



Support mothers to initiate and maintain breastfeeding and manage common difficulties.



Do not provide breastfed newborns any food or fluids other than breastmilk, unless medically indicated.



Enable mothers and their infants to remain together and to practice rooming-in throughout the day and night.



Support mothers to recognize and respond to their infants' cues for feeding.



Counsel mothers on the use and risks of feeding bottles, teats and pacifiers.



Coordinate discharge so that parents and their infants have timely access to ongoing support and care.

Infographics downloaded from World Health Organisation <https://www.who.int/activities/promoting-baby-friendly-hospitals/ten-steps-to-successful-breastfeeding>



Growing Strong: Feeding You and Your Baby' suite of resources

Queensland Government

<https://www.health.qld.gov.au/nutrition/patients#>

Maternal and Infant Nutrition – Breastfeeding (breastfeeding information and includes specific resources for Aboriginal and Torres Strait Islander families and multicultural families).

Queensland Health

<https://www.health.qld.gov.au/clinical-practice/guidelines-procedures/clinical-staff/maternity/nutrition/breastfeeding>

Nutrition Education Materials Online (NEMO) nutrition resources developed by health professionals

Queensland Government

<https://www.health.qld.gov.au/nutrition>

Multicultural Nutrition Resources, Metro South Health

A suite of resources designed in partnership with local communities covering all aspects of feeding and nutrition

<https://metrosouth.health.qld.gov.au/multicultural-nutrition-resources>

Global Health Media

Breastfeeding videos (multiple languages)

<https://globalhealthmedia.org/>

Raising Children's Network

<https://raisingchildren.net.au/newborns>

Australian Breastfeeding Association

<https://www.breastfeeding.asn.au/bfinfo/feeding-cues>

Infant Feeding Guidelines – Information for Health Workers

National Health and Medical Research Council

<https://www.nhmrc.gov.au/about-us/publications/infant-feeding-guidelines-information-health-workers>

Australian National Breastfeeding Strategy: 2019 and Beyond

COAG Health Council

<https://www1.health.gov.au/internet/main/publishing.nsf/Content/health-pubhlth-strateg-brfeed-index.htm>



Refer to the Chronic Conditions Manual

<https://www.publications.qld.gov.au/dataset/chronic-conditions-manual-2nd-edition-2020>



Refer to the Pathways to Rural and Remote Orientation and Training

<https://ilearncatalogue.health.qld.gov.au/program/17/parrot-primary-care>

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.
- Suggest that parents use the Kidsafe Queensland *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 ⁶⁴.
- Offer evidence-based information on safe infant sleeping and refer parents to resource support/ brochures, e.g. Red Nose Australia ⁶⁵.



Sudden unexpected death in infants (SUDI)

See page 255



Red Nose Australia

Multiple resources and information statements, in multiple languages regarding all aspects of safe infant sleeping

<https://rednose.org.au/resources/education>

Kidsafe Queensland

www.kidsafeqld.com.au

Raising Children Network

Range of resources available in multiple languages, pictures or videos.

<http://raisingchildren.net.au>

Stillbirth prevention

Stillbirth is a serious public health issue with far reaching impacts for families and society, with little improvement in rates in Australia for more than two decades⁶⁶. In 2015 and 2016, late-term stillbirth (≥ 28 weeks of pregnancy) resulted in the loss of nearly 1500 babies in Australia⁶⁷.

- Consistent, sensitive, evidence-based information needs to be provided to pregnant women about the risk factors for stillbirth⁶⁶.
- Programs, such as The Safer Baby Bundle, recommend antenatal clinical practices that may reduce late pregnancy stillbirths. The Safer Baby Bundle consists of 5 elements, these being:
 - Smoking cessation.
 - Improved detection and management of foetal growth restriction.
 - Raising awareness and improving care for women with decreased foetal movements.
 - Sleeping on side after 28 weeks of pregnancy.
 - Improved decision making about timing of birth for women with risk factors for stillbirth.
- Smoking cigarettes during pregnancy is associated with a range of serious health problems for both the pregnant women and her unborn child^{10, 31}. Pregnancy often motivates parents to change their smoking habits, so it is an important time to provide brief advice – Ask, Assess, Assist. Child health professionals should refer to specialised quit smoking support programs, for example ‘Quit for You... Quit for Baby’ (Quitline)

See *Smoking, alcohol and substance misuse* page 280 for further information.

- If a woman reports changes or concerns about her foetal movements, child health professionals should encourage her to immediately contact her maternity provider, or attend an emergency department for an assessment⁶⁸.
- After 28 weeks of pregnancy, pregnant women should be advised about the risks of lying/sleeping on their backs. Lying on their back presses on major blood vessels which can reduce blood flow to the uterus and the oxygen supply to the unborn child. It is suggested that pregnant women start every sleep lying on their side (both for daytime naps and at night)⁶⁹. *It is important that this message is conveyed in a sensitive way so as not to cause anxiety.*
- Planned birth, to reduce the risk of stillbirth, should be targeted according to a woman's individualised risk and preferences, weighing up the benefits against the risks of an early birth⁷⁰. Child health professionals should encourage pregnant mothers to see their maternity care provider regularly to ensure care can be tailored and risk factors managed safely to get as close to the baby's full term estimated birth date as possible.
- Best practice models of care such as Midwifery Continuity of Carer models should be available to pregnant women. High quality evidence shows that continuity of midwifery care throughout the entire pregnancy, labour and birth journey, including the immediate post-natal and transition to early parenting period, improves outcomes for women, infants and the workforce³⁶.

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. 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 diseases⁷¹.
Pregnancy is an opportune time for discussion regarding immunisation programs. This includes assessment of the immunisation status of mother, partner, close family members particularly⁷¹:
 - 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)
- For further advice about vaccination in pregnancy, advise to discuss the issue with the GP/Medical Officer. Parents, families and carers are also able to contact 13HEALTH, where they can receive immunisation advice from a child health nurse or a specialist immunisation nurse over the phone.
- Discussions about infant vaccinations offered at birth and the recommended immunisation schedule are also important as some vaccines have a strict time frame for administration⁷². The Immunisation Program Schedule Queensland⁷³ is updated regularly in line with the national schedule.



Department of Health

Immunisation

<https://www.health.gov.au/health-topics/immunisation>

Queensland Specialist Immunisation Service (QSI)

<https://www.childrens.health.qld.gov.au/service-qsis-info-for-health-professionals/>

Immunisation Schedule Queensland

<https://www.health.qld.gov.au/clinical-practice/guidelines-procedures/diseases-infection/immunisation>

The Australian Immunisation Handbook (online)

<https://immunisationhandbook.health.gov.au/>

Immunisation – Information for families

- **National Centre for Immunisation Research and Surveillance (NCIRS)**
<http://www.ncirs.org.au/public>
- **SKAI Sharing Knowledge About Immunisation**
<http://www.talkingaboutimmunisation.org.au/>
- **Queensland Government Immunisation**
<https://www.qld.gov.au/health/conditions/immunisation>
- **Translated Immunisation factsheets**
<https://www.qld.gov.au/health/conditions/immunisation/translated-fact-sheets>



Refer to the Pathways to Rural and Remote Orientation and Training

<https://ilearncatalogue.health.qld.gov.au/program/17/parrot-primary-care>



Refer to Primary Clinical Care Manual

<https://www.health.qld.gov.au/rrcsu/html/PCCM>

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.

The potential return on investment for high quality antenatal and postnatal care and interventions that target modifiable risk factors such as maternal smoking, pre-term birth, maternal mental health, maternal alcohol use, poverty and household stress is significant³⁷.

Social determinants of health and wellbeing

There are many biological, psychological and social factors that may influence a person's ability to parent. The environment in which a child lives and grows can have a profound lifelong impact on the trajectory and outcomes of their health, well-being and development⁸.

The National Action Plan for the Health of Children and Young People: 2020-2030⁷⁴ was developed to ensure that all Australian children and young people, have the same opportunities to fulfil their potential, and are healthy, safe and thriving.

- Additional needs may be identified when the following factors are present^{1, 38, 75, 76}.

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

- Socioeconomically disadvantaged children and families.
- Single parents, parents with multiple re-partnering experiences, stepfamilies and blended families, young parents.
- 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.
- History of perinatal loss or loss of an infant / child.
- Families with chronic illnesses and / or disability.
- Substance misuse.
- Family violence.
- Isolated families e.g. living in remote areas.
- Aboriginal and Torres Strait Islander families.
- Refugee families.
- Families from a culturally and linguistically diverse (CALD) background.



For more information and supporting literature for these vulnerabilities, see *Family Health Assessment Guide*

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

Aboriginal and Torres Strait Islander people

- The *National Framework for Health Services for Aboriginal and Torres Strait Islander Children and Families* identifies key approaches that support appropriate care for Aboriginal and Torres Strait Islander people including⁷:
 - culturally competent workforce;
 - family-centred care to identify and respond to the needs and structures of individual families;
 - relationship-based care;
 - a focus on social and emotional wellbeing; and
 - strengths-based approaches.
- Antenatal health promotion and early intervention strategies can have a positive effect during this critical stage of life. High quality evidence shows that continuity of midwifery care across the full maternity continuum improves outcomes for women, infants and midwives³⁶. Models of care that promote continuity of care by the same provider can increase engagement and reduce risks of limited antenatal care⁷⁷.
- Antenatal care may be especially important for Aboriginal and Torres Strait Islander women, as they are at a higher risk of giving birth to low birthweight babies, and have greater exposure to other risk factors such as anaemia, poor nutritional status, hypertension, diabetes, genital and urinary tract infections and smoking^{7,76}. Health promotion and early interventions should target modifiable risk factors such as maternal smoking, maternal mental health, maternal alcohol use, maternal nutrition.
- Aboriginal and Torres Strait Islander women experience significantly more morbidities and mortality than non-Aboriginal counterparts being overrepresented in all infant deaths in Queensland ^{37,76-78}. This group of families need sensitive, respectful care.
- The maternal smoke rate for Indigenous Queensland mothers is four times higher than non-Indigenous mothers⁷⁹ and 57% of Indigenous Queensland children live in a household with a smoker⁸⁰.
- Aboriginal and Torres Strait Islander advanced health workers/practitioners have specific knowledge and skills to engage with women and families, this includes values that recognise connection to land and country and an overarching philosophy of ‘Women’s Business’.
- Improving access to care is imperative. Where possible, provide antenatal care in outreach clinics, community centres or home visiting.
- Create a physical and attitudinal environment that welcomes Aboriginal and Torres Strait Islander families. This may include having relevant visual materials, artwork and resources and using culturally specific tools for education.
- Follow local referral pathways according to need. This may include referral to ¹⁰:
 - Aboriginal and Torres Strait Islander advanced health workers and community agencies
 - perinatal and infant mental health services
 - adult mental health services
 - sexual health services
 - specialised quit smoking support for Indigenous Queenslanders e.g. Quitline 13 7848 www.qld.gov.au/quithq
 - drug and alcohol support services



Aboriginal and Torres Strait Islander families

See page 262



Australian Indigenous HealthInfoNet

Links to multiple resources specific to Aboriginal and Torres Strait Islander peoples

<https://healthinfonet.ecu.edu.au/key-resources/resources/>

Breastfeeding video guide for health workers

<https://www.health.qld.gov.au/clinical-practice/guidelines-procedures/clinical-staff/maternity/nutrition/breastfeeding/how-to/video>

Growing Strong: Feeding You and Your Baby

Suite of resources on nutrition

<https://www.health.qld.gov.au/nutrition/patients#>

Yarning about mental health: an easy guide to mental health assessment

HealthInfoNet Flipchart

<https://healthinfonet.ecu.edu.au/key-resources/resources/?id=19702>



Emerging Minds e-Learning course

Working with First Nations Families and Children - A Framework for Understanding

<https://learning.emergingminds.com.au/>

Connected Parenting

Circle of Security in the context of Aboriginal and Torres Strait Islander families

<https://www.sjog.org.au/for-medical-professionals/connected-parenting/e-learning-resource>

Families from culturally and linguistically diverse backgrounds

- Culture plays a major role in the way a woman perceives and prepares for her birthing experience. Women may subscribe to health beliefs which differ from the Australian health system and they may have different expectations and previous experiences about antenatal and maternity services⁸¹.
- 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 infant ^{10, 82}.
- Research general customs, values and beliefs of different cultures to prepare for an appointment with a CALD family. This may enhance your ability to gain information and develop a rapport⁸².
- Where possible, provide antenatal care in outreach clinics and community centres. Welcoming cultural diversity as a strength helps eliminate discrimination and strengthens community cohesion. Encourage families to share their cultural beliefs. Recognise that everyone will view other cultures through their own 'cultural lens'.
- Ensure that interpreter services are used routinely and are culturally and linguistically acceptable by considering gender and ethnicity preferences (including dialect). Avoid using family members as interpreters as this may breach confidentiality and information may be inaccurate⁸². Families may benefit from engaging with multicultural health workers who have a better understanding of families' cultural perspectives.

- Follow local referral pathways according to need. This may include referral to¹⁰:
 - 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
 - refugee health / trauma support services



Multicultural Nutrition Resources, Metro South Health

Food and cultural profiles.

Information about the food and food practices of selected communities, background on their country and their health profile in Australia

<https://metrosouth.health.qld.gov.au/multicultural-nutrition-resources>

Raising Children Network

Articles, videos and picture guides translated into multiple languages

<http://raisingchildren.net.au>

Global Health Media videoclips

<https://globalhealthmedia.org/>

Refugee Health Network

Translated Resources

<http://www.refugeehealthnetworkqld.org.au/translated-resources/>

Immunisation factsheets

Translated into nine languages

<https://www.qld.gov.au/health/conditions/immunisation/translated-fact-sheets>

Queensland Program of Assistance to Survivors of Torture and Trauma (QPASTT)

Resources for those who have suffered trauma prior to arriving in Australia.

www.qpastt.org.au

National Child Traumatic Stress Network (NCTSN)

<https://www.nctsn.org/trauma-informed-care>



Family Health Assessment – A guide for child health clinicians practicing within the primary health care setting

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

Young parents

Adolescent women are likely to seek antenatal care later in pregnancy, have higher levels of social disadvantage, higher incidence of domestic violence, higher rates of smoking in pregnancy and lack of social supports. While a higher risk of poor birth outcomes is seen for teenage women, this is likely to be related more to the social circumstances of these young women, rather than their age ¹⁰.

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 care¹⁰. Provide additional support to young people in settings such as: schools (SBYH nurse) and community centres (e.g. young parents support programs).
- Use posters, pamphlets and reading material that are youth-friendly and ensure waiting areas convey a welcoming environment for all people.
- 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 regard.
- Young prospective fathers experience considerable anxiety around relationship difficulties, lifestyle changes, financial resources and role expectations ^{40, 42}. 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 ³⁹.
- Provide young fathers with information about⁴⁰:
 - normal pregnancy and baby development
 - a young father's role
 - creating support networks and how to use them
 - provide Aboriginal and Torres Strait Islander young men with appropriate support in what it means to be a young Aboriginal and Torres Strait Islander father
- 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
 - targeted home visiting services after birth



Raising Children Network

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 may have a higher risk of poor health outcomes in the perinatal period ⁸³.

- It is important to use additional strategies that will enable parents with learning difficulties to acquire the skills for parenting. Strategies include ⁸³:
 - use visual aids as prompts for learning e.g. picture stories, doll to teach child/infant cares 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
- Follow local refer pathways according to need. This may include referral to:
 - disability support services
 - perinatal and infant mental health services



Healthy Start

Parenting Research Centre

Resources for health professionals supporting parents who have learning difficulties

<https://www.parentingrc.org.au/programs/healthy-start/>



Freepik.com

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 vital ⁹.

Multidisciplinary early intervention⁹

- 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. This may include:
 - child health professional
 - Aboriginal and Torres Strait Islander health workers
 - dietitian/nutritionists
 - 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.
- 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.

Home visiting

- Evidence-based home visiting programs provide the opportunity for identified families to access a higher level of care when key risks are identified ⁸⁴ such as:
 - domestic and family violence
 - maternal mood disorder
 - financial disadvantage
- 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 ^{84, 85}.
- Families are more likely to actively engage in service provision over a number of visits when it is delivered in their home ^{84, 85}.
- Sustained home visiting programs have shown trends of improved health outcomes specific to breastfeeding, warm parenting, parent-child interaction, play opportunities and safety in the home ^{84, 85}.
- Ensure local referral pathways are followed so that families are provided with services according to their specific needs⁹.

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^{27, 86}.

- 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^{27, 86}.
- Ongoing work with the family where the unborn child/child is at risk of harm requires the child health professional to^{9, 27}:
 - 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
- Antenatal assessment of risk⁸⁷:
 - Midwifery assessments in the antenatal period should:
 - › consider family and social history as well as obstetric history
 - › detail the family strengths as well as concerns
 - › emphasis should be placed on exploring areas such as domestic abuse, substance misuse, mental health difficulties and care of previous children as well as other issues that may impact on parental capacity.
 - › fathers / partners should be included within this assessment as well as any other family members who may have a significant role to play in caring for the child or supporting the parents. However, it is important to note that enquiries regarding domestic abuse should not be carried out when the partner is present as this can heighten the risk to the victim and any children.
 - Some risk factors and indicators in families may include^{87, 88}:
 - › history of previous harm to a child
 - › unwanted/concealed pregnancy
 - › lack of awareness or care for unborn baby's health
 - › social or geographic isolation, lack of supports
 - › cultural and language backgrounds
 - › financial stress
 - › history of domestic and family violence
 - › physical or mental health issues with potential to affect ability to parent
 - › abuse of alcohol or other drugs with potential to affect ability to parent
 - › behaviours, such as the inability to manage stress or anger
 - It must be remembered that these indicators are clues that suggest possible risk of harm. They do not prove abuse or neglect will occur but they do require further assessment, interpretation and consultation^{87, 88}
- There are numerous factors to consider when determining a suspicion of abuse or neglect.

At times, a single factor e.g. physical violence aimed at pregnant women's stomach, may clearly indicate the need to 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 ^{32, 89}. See Child Safety QHEPS website for sample [risk/protective factors framework](#).

Child Protection Resources

- The **Child Safety QHEPS site** provides all Queensland Health staff with information on individuals' responsibilities regarding child protection, how to recognise child abuse and neglect and how to report reasonable suspicions of child abuse and neglect. Education modules, online support tools, factsheets and support services can be found on the site. <https://qheps.health.qld.gov.au/csu>
- The **Child Protection Guide** provides guidance and support in decision making for staff who have concerns for the safety and /or welling of a child/young person. The guide is intended to complement, not replace, clinical judgement, expertise or critical thinking. <https://www.csyw.qld.gov.au/about-us/partners/child-family/our-government-partners/queensland-child-protection-guide>
- The **Reporting and Referring Child Protection Concerns flowchart** is a useful tool to inform of the process regarding reporting and referring child protection concerns. https://qheps.health.qld.gov.au/_data/assets/pdf_file/0019/408430/qhreportreferflowchart_facc.pdf
 - Child Protection Guidelines <https://qheps.health.qld.gov.au/csu/policy>
 - Reporting and responding to a reasonable suspicion of child abuse and neglect
 - Health professionals child protection capability requirements
 - Prioritisation of health services for children and young people in the child protection system
- The Child Protection **Reporting Tips** and **Reporting forms**, support staff to understand the reporting processes for health professionals. <https://qheps.health.qld.gov.au/csu/reportingforms>
- **Child Protection Liaison Officers** (CPLO) and Child Protection Advisors (CPA) provide support to local HHS staff when managing child protection issues. Contact lists can be found on the [Child Safety QHEPS site](#).
- The **Information sharing in child protection - Key Messages** summarizes the purpose for information sharing, consent, documentation etc. https://qheps.health.qld.gov.au/_data/assets/pdf_file/0026/2239361/ISCP_keymessagesfactsheet.pdf
- There are multiple factsheets available on the Child Safety QHEPS page. Some examples include:
 - Presenting characteristics of child abuse and neglect
 - Clinical risk factors and indicators (for Physical abuse; Emotional abuse; Sexual abuse and Neglect)
 - Risk versus protective factor assessment framework
 - Female genital mutilation
 - Documentation in child protection
 - High risk population groups

- The Queensland Family and Child Commission has produced an **Information Kit on Child Protection for Professionals**, which provides key facts about the Queensland child protection system for anyone who works with children or families. <https://www.qfcc.qld.gov.au/supporting-our-sector/information-kits-practice-resources/information-kit-child-protection>



Dealing with requests for information from Queensland Police Service

Clinicians 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.



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Section 2: **Birth to five years**

2

Section 2: Birth to five years

Providing optimal, evidence-based health care during the early years of life, particularly the first thousand days, has been shown to significantly improve health outcomes for the child⁸. Interventions in the early years target the most receptive stage of human development and many challenges in adulthood including mental health issues, obesity, heart disease, diabetes, criminality and poor literacy and numeracy can be traced back to origins in early life⁹⁰. Integration of services at local and regional levels, across government and non-government sectors is promoted to support proportionate universalism, that is, equity of access to services, as well as provision of additional services to those in greater need ^{1, 37, 91}.

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, 6, 92}.

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, telehealth, group work^{1, 6}.

Universal child and family health services work in partnership to provide integrated service delivery and 'seamless' transitions for families from one service to another¹, and recognise the importance of well-coordinated, holistic services that support and build upon family strengths ⁷.

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 services⁹³.

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 child¹.

- Family structures are varied including^{7, 38}:
 - extended families e.g. grandparents, aunts and uncles, Elders and kinship carers
 - foster families
 - single parent, step and blended families
 - lesbian, gay, bisexual, transgender, intersex, queer, asexual, gender diverse and questioning (LGBTIQ+) parents
- Understanding and respecting different child-rearing practices is important for planning and delivering services that reflect individual parenting choices and styles⁷.

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 whole³⁹.

It is recommended that services facilitate greater involvement of fathers/partners/extended family by considering a range of strategies⁴⁰. 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 and offering telehealth options for fathers who are away ^{39, 41}.
- Recognise father/ partner/extended family 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^{39, 42}.
- Involve father/ partner/extended family 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 practices⁴³.
- Discuss transition to parenthood issues including parenthood roles, lifestyle and relationships changes⁴⁰.
- Change service environments to account for possible barriers that prohibit father/ partner/ 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, consideration of offering single gender (e.g. dads) groups ^{39, 44}.
- Use a strengths-based approach when working with fathers⁴¹.
- Family members are encouraged to attend appointments with the child, and attendance at group-based parenting programs is also encouraged. 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^{44, 45}.
- Aboriginal and Torres Strait Islander families should be supported with access and engagement with child health primary care services.
 - Having Aboriginal and Torres Strait Islander staff, who are well respected and well connected to the community, and a culturally welcoming environment, facilitates inclusiveness of Aboriginal and Torres Strait Islander families^{39, 40, 42}.

- There may be barriers for families in attending an in-person appointment, which may be overcome with the use of telehealth services. Therefore, it is important to⁴⁶:
 - › Raise awareness with families about the availability of telehealth.
 - › Help with resourcing at the clients end if needed.
 - › Provide cultural support to arrange the telehealth appointment and during the appointment.
 - › Support the attendance of family.



Aboriginal and Torres Strait Islander families

See page 262



Webinar - Refining the task of father-inclusive practice

Child Family Community Australia (CFCA)

<https://aifs.gov.au/cfca/events/refining-task-father-inclusive-practice>

Family Action Centre, Newcastle University

Resources and education for staff on father-inclusive practice

<https://www.newcastle.edu.au/research-and-innovation/centre/fac/about-us>

Raising Children Network

<http://raisingchildren.net.au>

PANDA

Resources for paternal perinatal anxiety and depression

<https://www.panda.org.au/info-support/how-is-dad-going>



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Introduction

Section 1: Antenatal

Section 2:
Birth to five years

Section 3: Five to twelve years



Appendix & References



Child Health Information booklet

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The schedule of well child health checks recommended in the first year include ⁹³:

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 if appropriately trained

Other health checks

- Additional population screening through health checks are offered to rural and remote populations as part of the Chronic Conditions Manual recommendations⁹⁵.
 - 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 diseases⁹⁵.
 - Additional screening/assessments are recommended e.g.
 - annual body measurements from 4 years;
 - additional ear and hearing assessments;
 - additional clinical measurements e.g. Red eye reflex, heart sounds and haemoglobin; annual BMI from 2 years of age.

- Aboriginal and Torres Strait Islander children are eligible for a health assessment by a GP/Practice Nurse/Aboriginal health worker/practitioner every 9 months as part of the ‘Aboriginal and Torres Strait Islander Peoples Health Assessment’⁹⁶



Refer to the Chronic Conditions Manual Section 3 – Child Health Checks

<https://www.publications.qld.gov.au/dataset/chronic-conditions-manual-2nd-edition-2020>



Refer to the Pathways to Rural and Remote Orientation and Training

<https://ilearncatalogue.health.qld.gov.au/program/17/parrot-primary-care>

Family health assessment

All families are unique and come from diverse backgrounds. There are many biological, psychological and social factors that may influence a person’s ability to parent. Completing a family health assessment provides an opportunity to get to know the family. It enables the child health professional to develop a relationship with the family, whilst identifying the family’s strengths and complexities³⁸. This is vitally important as the evidence suggests a child’s family and the environment in which they live and grow can have a profound lifelong impact on the trajectory and outcomes of their health, well-being and development^{8, 97}. Nurturing an infant in the early years impacts how children develop, their capacity to learn, their behaviour and ability to regulate their emotions, and their risks for disease in later life⁸

- There is no universal standard of what ‘good’ parenting is, however, there are characteristics that appear to enrich the parenting role such as^{37, 98-100}:
 - 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.
 - Consistent, kind and positive parent-child interactions (e.g. warm, responsive and supportive parenting).
 - The ability to be consistent yet flexible when necessary, in response to the changing demands within family life.
- The purpose of family health assessment is to^{1, 38, 101}:
 - Gain a clear understanding of the factors relating to the health and wellbeing of the child that may potentially impact upon family functioning.
 - Engage with the family using a partnership approach, develop a therapeutic relationship and work from a strengths-based perspective to build upon their parenting capacity and skills.
 - Identify family strengths, resources and needs to support formulation of an individualised plan of care with the family.
- A comprehensive family health assessment is foundational to child health surveillance and health monitoring^{37, 38}. Identification of family needs enables appropriate interventions and referral to appropriate services and supports. Child health professionals utilise advanced communication skills to engage with families and address sensitive issues, including domestic and family violence and mental health issues, and work in partnership with the family to negotiate, plan, implement and evaluate the most appropriate, culturally responsive care for the child and their family.

- If available, Aboriginal and Torres Strait Islander Advanced Health Workers should be involved in the family health assessment conversation and in developing the cultural aspects of the care plan for Indigenous families.
- Social circumstances and family functioning also impact on the health outcomes of children. Population groups where additional needs may be identified include: ^{1, 38, 75, 76}
 - Families where drug and alcohol misuse is a problem.
 - Families with low incomes; unstable housing.
 - Family structured with single parents, parents with multiple re-partnering experiences, blended families, teenage mothers.
 - 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.
 - Aboriginal and Torres Strait Islander families.
 - Refugee families.
 - Families with CALD backgrounds.
 - Critical events (e.g. loss of employment, illness, disability or death of a family member).
- 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



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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, 6, 38, 101, 102}. This should be updated, or the complete assessment should be redone if family circumstances change during their engagement with child and family health services. (Refer to your local guidelines).

A partnership approach is empowering for the client and more likely to result in ongoing engagement with the health service. It draws on the knowledge, expertise and experience of both the parent and clinician.

The consultation and interview should include the following stages:

1. **Engagement** – commence the interaction with the family using the AIDET principles¹⁰³.

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 normalise the family health assessment and let the parents know⁹⁷:

- ***What kinds of questions will be asked and why.***
For example, “We ask all families these questions, because we know they can potentially impact on how you manage with parenting. It also gives us a chance to think about any other services or supports that may be helpful. If there is anything that you would prefer not to discuss today that is fine.”
- ***Privacy, confidentiality, informed consent and management of client information when information sharing may be required.***
For example, “the information you provide will not be discussed with anyone else, unless I have safety concerns for you or your child”
- ***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. Active listening by the clinician encourages parents to participate in their care, therefore clinicians should avoid the urge to take over the conversation and give uninvited advice¹⁰⁴. Utilising appropriate, evidence-based resources or tools can support discussions with parent/s and support the parent/carers decision-making.
 - 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^{38, 102}
 - Social Circumstances and Family Functioning
 - › Cultural background, health beliefs, health practices and linguistic needs of Aboriginal and Torres Strait Islander communities
 - › Health beliefs, health practices and needs of children from Culturally and Linguistically Diverse (CALD) backgrounds and Refugees
 - › Parental education level
 - › Family income
 - › Housing conditions
 - › Family structure
 - › Family functioning (e.g. psychosocial wellbeing of parents/carers, the home environment and the community in which they live; critical events; social supports and family resources)
 - Parental Physical and Mental Wellbeing
 - › Physical Illness or Disability
 - › Mental Health and Wellbeing
 - › Intellectual Disability
 - Family Violence
 - › Domestic and Family Violence
 - › Past Abuse – Parent abused as a child
 - Alcohol, Tobacco and Other Drug Use
 - Pregnancy and Infant Health
 - › 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

Positive indicators	Problem indicators
Parent <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 	Parent <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 • Unable to delight in the child or enjoy activities with the child • Unable to cope with their child's distress • Does not ensure the child is safe or is overprotective / excessively worried about the child • 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
Child <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 	Child <ul style="list-style-type: none"> • Overly friendly/overly fearful with strangers • Avoids looking at/towards the parent • Does not seek out the parent for comfort • Appears apprehensive around the parent • Does not explore its environment • Flat affect or emotionally under-responsive • Lack of crying, limited vocalizing • Irritable, constant crying, extremely difficult to settle • Difficulty separating from parent (age-dependent)



When risk factors are identified additional care may be required.

See relevant area in *Responding to Need* pg. 288 and *Early Identification* sections pg. 260



Example Family Health Assessment

See Appendix 3

Health Promotion : Parent – Infant interaction

See page 205

Aboriginal and Torres Strait Islander families

See page 262



Family Health Assessment – A guide for child health clinicians practicing within the primary health care setting

<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>



Assessing Mother-Infant interaction

Centre of Perinatal Excellence (COPE)

<https://www.cope.org.au/wp-content/uploads/2018/07/Assessing-Mother-infant-Interaction.pdf>



Freepik.com



Practice tips: Conducting and scoring the EPDS ¹⁰⁵

- The EPDS is a screening tool used in the antenatal and postnatal period to assist in identifying possible symptoms of depression and is also useful in identifying symptoms of anxiety.
- The tool provides a means to open a conversation with the parent regarding their emotional health. Clinicians should discuss the non-diagnostic nature, the purpose of the EPDS and clearly explain that answering the EPDS requires the woman to answer each question in terms of the past seven days.
- Not only is it important to provide an explanation/ context around using the EPDS, but privacy to complete it should be ensured. It is also very important to discuss the score with the woman.
- All women should complete the EPDS at least once, preferably twice, in both the antenatal period and the postnatal period (ideally 6-12 weeks after the birth). The EPDS can be repeated whenever clinically indicated.

Scoring and referral

- A score is calculated by adding the individual responses for each question (note some items have reversed scoring). 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.
- Clinical judgement is integral to interpreting EPDS Scores. In some cases, the score may not accurately represent a person's mental health.
For example, a low score even though there is reason to believe that she/he is experiencing depressive symptoms. A very high EPDS score could suggest a crisis, other mental health issues or unresolved trauma.
- A total score of 10-12 requires a repeat of the EPDS within a two to four-week period.
- A total score of 13 or more is considered a flag for need for follow up of possible depressive symptoms.
If the scoring indicates a concern, referral to a GP/Perinatal 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
 - Follow-up may also be required if the score on Questions 3,4,5 suggest possible symptoms of anxiety
 - 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.
- Referral is combined with ongoing support by the child health professional.



Ray Cash for Children's Health Queensland



When a parent discloses thoughts of self-harm e.g. a positive response to Question 10, it is important that further exploration and assessment occurs.

Such enquiry does not induce thoughts of suicide, rather it provides an opportunity to ensure the safety of the parent and child, and arrange appropriate follow-up care¹⁰⁶.

If the parent/carer has scored 1, 2 or 3 to Question 10, the health care professional is required to:

- ask about the **frequency** and **persistence** of suicidal thoughts
- explore whether the parent has a **plan** and what method she/he has chosen
- assess the lethality of the **method** and whether she/he has the **means** to carry out any plans
- consider other **risk and protective** factors
- assess **risk of harm** to any infants and children in her/his care and take appropriate action
 - › ask if the parent has had any thoughts of harming their child
 - › assess if the parent is willing and able to provide care for their child
- develop a **safety plan** with the client and her/his family and support agencies and refer appropriately

- The Centre of Perinatal Excellence (COPE) has developed a guide for Assessing Suicide Risk, available at <https://www.cope.org.au/health-professionals/clinical-tools-health-professionals/>



Child safety concerns will require a Report of Suspected Child in Need of Protection, see page 311

Cultural considerations^{105, 107}:

- Scores used to identify possible depression in Aboriginal and Torres Strait Islander and Culturally and Linguistically Diverse populations are generally lower than those used in the general population.
 - Consider cultural practices such as family members present, and perceived degree of stigma associated with depression in influencing the performance of the EPDS.
 - Consider an explanation of the EPDS using the women's own language style will be accepted more easily, e.g. "Some women have a lot of stress when they are pregnant/after baby is born. We want to find out how you are going".
- EPDS has been validated and is available in a range of languages other than English.
- For Aboriginal and Torres Strait Islander women, the Kimberley Mum's Mood Scale (KMMS) was developed in the Kimberley through large scale community consultation. This validated tool is based on the mental health screening questions in the EPDS and it includes a 'part 2' that involves yarning topics that were identified as important through the consultation process to build trust and understanding and thereby improving perinatal care¹⁰⁸. Child health professionals should refer to local HHS process decisions.

Consideration of Paternal depression and anxiety

- Up to 1 in 10 new dads in Australia will experience perinatal depression¹⁰⁹
- Transition to parenthood for fathers can bring similar challenges, confusion and stress. Recent studies have identified that fathers want to be included in perinatal health care and welcome the opportunity to be engaged by health professionals about their health and wellbeing.
- Several studies have validated the EPDS for use with fathers¹¹⁰. Although there are different study results regarding optimal score for possible depression in men, it is generally accepted to be a lower cut off than for women, at around a score of 9/10^{110, 111}.
- Clinical judgement is integral to interpreting EPDS scores in fathers. Considerations should take into account that some fathers may express their low mood in behaviours, such as restlessness, anger and irritation, which may not be captured through the EPDS questions around sadness and crying^{111, 112}.



Example EPDS

See Appendix 5

Parental mental health and wellbeing

See page 285

Postnatal Depression (PND)

See page 304

Aboriginal and Torres Strait Islander families

See page 262



Centre for Perinatal Excellence

Screening & Assessment Tools for Health Professionals

<https://www.cope.org.au/health-professionals/clinical-tools-health-professionals/>

Centre for Perinatal Excellence

Perinatal Mental Health Guideline

https://www.cope.org.au/wp-content/uploads/2018/05/COPE-Perinatal-MH-Guideline_Final-2018.pdf

Queensland Centre for Perinatal and Infant Mental Health (QCPIMH)

<https://www.childrens.health.qld.gov.au/chq/our-services/mental-health-services/qcpimh/infant-perinatal-mental-health/>

PANDA

Resources for paternal perinatal anxiety and depression

<https://www.panda.org.au/info-support/how-is-dad-going>

ZERO to THREE website

<https://www.zerotothree.org/>

Yarning about mental health: an easy guide to mental health assessment

HealthInfoNet Flipchart

<https://healthinonet.ecu.edu.au/key-resources/resources/?id=19702>



Practice tips: Conducting the domestic violence screen

- The WHO recommends that all health professionals be trained in first-line response to domestic and family violence²⁸. Training supports the health care professional in discussing concerns regarding domestic and family violence screening with a parent and improves the health professional's confidence in responding effectively when domestic and family violence is disclosed. The steps are to listen, believe, inquire about needs, validate the person's experience, enhance safety and offer ongoing support.

Recognise:

- Undertake the screen when the parent is alone.
- Children over the age of 3 years should not be present.
- Explain that enquiry about domestic and family violence is a routine part of care and that it aims to identify women who would like assistance.
- Be guided by the DVI tool in the use of open-ended questions to explore the disclosures of domestic and family violence, this should be done immediately and without delay.
- Rapport building is important - a parent may not disclose information about domestic and family violence until she/he has built up sufficient trust and confidence in the health professional.

Respond:

- Respond sensitively, communicate belief, and validate that it takes courage to disclose an experience of domestic and family violence.
- 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).

Refer

- Family and child safety is the prime consideration.
- Work with the parent to enhance safety planning.
- Use language that is culturally appropriate and easily understood. Engage interpreters where necessary.
- Listen carefully to determine the client's needs, and present a range of options and services, including referral processes.
- Document your concerns, referral details and details of any information shared with other agencies in the clinical record.



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 Child Protection pg. 311



Domestic Violence Inventory (DVI)

See Appendix 4

Domestic and family violence / past abuse / parent abused as child

See page 283



DV-alert (Domestic Violence Response Training)

Free accredited training program for health professionals

www.dvalert.org.au

Queensland Centre for Domestic and Family Violence Research

<https://noviolence.org.au/factsheets/>



Queensland Health DFV Toolkit

Information, resources and training and including the Online Portal link for Queensland families impacted by DFV

<https://www.health.qld.gov.au/clinical-practice/guidelines-procedures/patient-safety/duty-of-care/domestic-family-violence>

Infant health assessment

Universal newborn hearing screen⁴³

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, although observing a startle reflex does not confirm the infant has normal hearing and does not replace the need for hearing screening and assessment.
- The **Healthy Hearing Program** aims to identify children with sensorineural hearing loss as soon as possible after birth. 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.
- It is important that child health professionals:
 - Check in the PHR book that this screening has been conducted and follow up with the parents if it has not been done.
 - 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.
- 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.

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** (QLHFSS) 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. QLHFSS will offer support from birth through to completion of Year 1 at school.
- General information and translated brochures which describe the program and provide contacts within each area are available on the Healthy Hearing website.



Healthy Hearing Program

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

Queensland Hearing Loss Family Support Service

Tel: 1800 352 075

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



Freepik.com

Neonatal screening test ¹¹⁴

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 if any of these disorders are diagnosed.
- 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 birth . Families are only notified if results are ‘positive’ indicating that further clinical evaluation is required via their GP / paediatrician to determine whether they are affected by a disorder.
- It is important that child health professionals check that the test has been conducted and recorded in the PHR.

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 infant 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 contact ⁹².
- Following birth, the maternity care provider completes a complete ‘head to toe’ examination which is 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 age ⁹². 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 practitioners ⁹².
- Ongoing physical assessments are undertaken by the child health professional according to the well child checks schedule in the PHR and at additional contacts at the discretion of the child health professional ¹⁰².
- An overview of the full head to toe physical assessment is contained in the Appendix of the Guideline Assessing infant / child nutrition, growth and development within the Queensland Health, primary health care setting.
- Additional assessment / screening is recommended for infants and children living in rural and remote Queensland populations. See the Chronic Conditions Manual – Section 2: Child Health Checks.



Guideline: Assessing infant / child nutrition, growth and development within the Queensland Health, primary health care setting.

Queensland Child and Youth Clinical Network

<https://www.childrens.health.qld.gov.au/wp-content/uploads/PDF/qcycn/growth-guideline.pdf>



Refer to the Pathways to Rural and Remote Orientation and Training

<https://ilearncatalogue.health.qld.gov.au/program/17/parrot-primary-care>



Refer to the Chronic Conditions Manual

<https://www.publications.qld.gov.au/dataset/chronic-conditions-manual-2nd-edition-2020>



Refer to Primary Clinical Care Manual

<https://www.health.qld.gov.au/rccsu/html/PCCM>



Ray Cash for Children's Health Queensland



Practice tips: Conducting a ‘head-to-toe’ assessment

General considerations ^{32, 92, 102}

- 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.
- **Workplace 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
- Ensure appropriate cultural and linguist supports are provided. e.g. interpreter, Aboriginal and Torres Strait Islander health liaison / health worker or cultural translator as needed by the client.
- 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.
- Conduct the physical assessment in partnership with the parent/carer, explaining the process and your findings as you progress.
- To be most effective in observing the health status of the child, a methodical, systematic approach – head to toe, front to back - ensures maximum information is obtained with a minimum of time and effort. However, it can be done in any order depending on the infant’s activity at the time of the examination.
- Role model positive interaction with the infant. For example:
 - talking and making eye contact
 - promote the value of parent-infant attachment
 - observe the interactions between the parent and infant
- Demonstrate and provide the parent/carer with developmentally appropriate anticipatory guidance. For example:
 - observe and discuss infant cues and behaviour
 - demonstrate developmentally appropriate skills, such as tummy time
 - promote infant safety and injury prevention, such as safe sleeping practices and not leaving infant unattended on change mat

- Document assessment findings in the PHR and appropriate clinical form.
- 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).

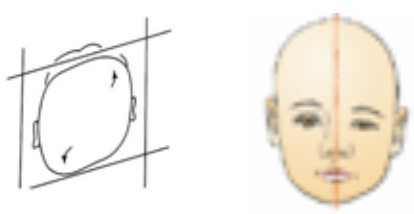
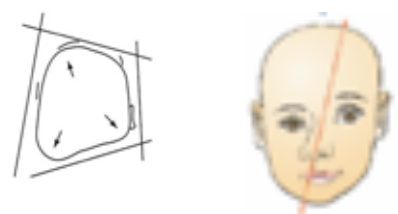
The QCYCN Child Health Sub Network Guideline Assessing infant / child nutrition, growth and development within the Queensland Health, primary health care setting provides a standardised approach to infant assessment in line with the well health checks in the Personal Health Record.

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 ¹¹⁵.
 - 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 between 12 and 18 months, with all infants expected to have a closed anterior fontanelle by two years.
- General observation of the contour of the head is important to detect plagiocephaly (flattening or asymmetry of infant's head shape)¹¹⁶⁻¹¹⁸
 - Plagiocephaly is the most common type of flat head syndrome and refers to an asymmetrical head shape with a flattening to one side of the head.
 - Brachycephaly refers to a flattened occiput.
 - The majority of misshapen heads are a result of positional moulding, known as deformational or positional plagiocephaly/ brachycephaly.
 - Needs to be distinguished from the rare condition, craniosynostosis, which is a premature fusion of one or more cranial sutures. Craniosynostosis can occur alone or as part of a syndrome and is treated surgically.
 - Deformational plagiocephaly/brachycephaly 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

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

Deformational plagiocephaly	Craniosynostosis
<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  <ul style="list-style-type: none"> Nose generally straight Ear shift forward on the same side No sutural ridging The flatness can be on the side (lateral) or there can be a central flattening of the back of the head (posterior or Brachycephaly) Treatment includes counter or repositioning measures and referral for further assessment, particularly if torticollis is suspected/present 	<ul style="list-style-type: none"> Overall head shape trapezium or rhomboid shape with characteristics such as a pointed triangular forehead  <ul style="list-style-type: none"> Nose root deviates towards fused suture Ear shift backwards on the flattened side of the skull Orbit on affected side enlarged and eyebrow elevated Ridging along a suture line Infants should be referred for further investigation. Treatment is surgical. 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

- Estimates of prevalence of deformational plagiocephaly are as high as 48% in infants under 1 year¹¹⁸. The risk is higher with¹¹⁷:
 - history of gestational uterine constraints (e.g. multiple birth) or birth history e.g. prematurity
 - torticollis (tightening of the neck muscles)
 - any condition causing neurodevelopmental delay and poor head movement / head control
 - infants that sleep well from an early age
 - sleep positioning
- Prevention and early intervention strategies are simple and effective for the vast majority of infants with deformational plagiocephaly. There is no good evidence to support the use of cranial remodeling helmets in most cases, especially in infants that are developing normally^{116, 117}.

- Mild plagiocephaly will often resolve on its own as the pressure on the flattened area lessens as the infant spends more time playing on its tummy and sitting. Child health professionals can provide information on preventative and early intervention strategies, head repositioning measures such as:
 - alternating the head position on the right and left occiput during sleep
 - ensuring prone “tummy time” while awake
 - varying the position for holding and carrying the infant

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.
- Outcomes and treatment will depend on the severity. 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 MO/GP, where physiotherapy and use of a moulding device (helmet) may be considered.



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.



Physical activity / play

See page 214

Assessment of vision and eye function ⁹⁵

- The current standards for conducting evidence-based early detection recommend vision assessment and examination of the eyes in the newborn period¹
- Universal health check at key ages as per PHR, include an examination of the infant’s eye.

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 can momentarily fixate on a bright or moving object that is within 20 cm and in the midline of the visual field.
- Examination should include:
 - **observe** the eyes for:
 - › symmetry
 - › location of the eyes in relation to the nose
 - › structural abnormality
 - › abnormal movements (nystagmus)
 - › inflammation, swelling or discharge

- **Fixation and following objects:** use an interesting toy to slowly track in a 'H' pattern about 30 cms away from the infant/child to see if the infant/child is tracking the object and then gradually move away to about 6 metres from the infant/child with the toy. From 6 months the infant should be able to track the object without any abnormal eye movements
- **A red eye reflex: completed by trained staff.** 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 (completed from 6 months onwards)** 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 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, 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 equal).
- 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 the Pathways to Rural and Remote Orientation and Training

<https://ilearncatalogue.health.qld.gov.au/program/17/parrot-primary-care>



Refer to the Chronic Conditions Manual

<https://www.publications.qld.gov.au/dataset/chronic-conditions-manual-2nd-edition-2020>

Assessment of hearing and ear health: 0–12 months⁹⁵

- Aboriginal and Torres Strait Islander children currently have one of the highest rates of otitis media in the world. In 2016, *Deadly Kids, Deadly Futures*, Queensland's Aboriginal and Torres Strait Islander ear and hearing health policy recommended ear health and hearing surveillance be embedded as a routine component of all age child health services¹¹⁹.
- 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. Training in ear and hearing health assessments, together with the use of the PLUM and HATS resources, is funded by the Australian Government and delivered across Australia by NSW TAFE <https://www.tafensw.edu.au/eartrain>.
- For Aboriginal and Torres Strait Islander children, the Parent-evaluated Listening and Understanding Measure (PLUM) and the Hearing and Talking Scale (HATS) are validated checklists that assess how a child's hearing and communication skills are developing. They are recommended for use in Aboriginal and Torres Strait Islander children 6months to 6 years of age and scoring assists clinicians determine appropriate referral pathways. The PLUM screens for hearing and listening concerns and the HATS screens for communication concerns. Further information can be found on the website, including step by step guides, information for parents and both online and downloadable versions of the tools. Child health professionals should follow local HHS process decisions. <https://plumandhats.nal.gov.au/download-plum-and-hats/>



Do not proceed with ear health and hearing check 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 Manual¹²⁰.

Do not proceed if there is a history of ear surgery in the past 4 weeks.

- Ask the parent/carer if they have any concerns, or if any other people have expressed concerns (e.g. educators, extended family) about their child's hearing, ear health, speech and language development and developmental progress. Some suggested questions are outlined below.
- Always start with the right ear as a point of reference.
- Determine if the child requires otoscopy and/or tympanometry (age dependent – see table below).

When both are required the sequencing of tests will be:

1. otoscopy
2. tympanometry



iStock.com/davidf

Hearing and ear health check 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 e.g. startles; listens to sounds? Is your baby making little guttural noises? ('ooo', 'gah', 'aah') Has your baby been free of ear infections or discharge? 	Otoscopy (Aboriginal and/or Torres Strait Islander children)
Four months	<ul style="list-style-type: none"> Do you think your baby can hear you e.g. looks at you when you're speaking? Does your baby make sounds? e.g. babble, giggle, squeals. Does your baby settle with familiar sounds or voices? Has your baby been free of ear infections or discharge? 	Otoscopy (Aboriginal and/or Torres Strait Islander children)
Six months	<ul style="list-style-type: none"> Are you happy about your baby's hearing? e.g. turns towards sounds or voices. Do you have any concerns about how your child makes speech sounds? e.g. ba, da, ra. Do you have any concerns about how your child understands what you say? e.g. watches and listens to speech and vocalizes in response to chat. Has your baby been free of ear infections or discharge? 	<p>Otoscopy (Aboriginal and/or Torres Strait Islander children)</p> <p>Tympanometry (Aboriginal and/or Torres Strait Islander children)</p>
Twelve months	<ul style="list-style-type: none"> Are you happy about your child's ears and hearing? E.g. recognizes own name. Do you have any concerns about how your child talks and makes speech sounds? e.g. tuneful babble and double syllables da-da, ma-ma. Do you have any concerns about how your child understands what you say? e.g. understands simple instructions like 'give me'. Has your child been free of ear infections or discharge? 	<p>Otoscopy (Aboriginal and/or Torres Strait Islander children)</p> <p>Tympanometry (Aboriginal and/or Torres Strait Islander children)</p>



Practice tips: Conducting a hearing and ear health check

See page 161

Aboriginal and Torres Strait Islander families

See page 262

Mouth check / lift the lip

- Queensland's children have one of the highest rates of dental decay in Australia⁸⁰. One of the foundational areas of Australia's National Oral Health Plan¹²¹ includes recommending that relevant health and wellbeing checks incorporate oral health components.
- As such, oral health screening, including checking for healthy mouths, should be included in the routine head to toe examination of infants and children.
- The primary purpose of screening is to identify tooth decay early so that preventive measures can be implemented to prevent further progress of decay. This decay is easy to recognize as it generally always starts on the outer surfaces of the upper front teeth near the gum line.
- Position the infant/child in a position that will allow reasonable view of the mouth e.g. lying on an examination table or sitting on parent's lap in front of you.
 - pink moist mucous membranes
 - pink firm gums (not red or swollen)
 - intact palate
 - presence of teeth, number of teeth
 - teeth should be whitish, smooth and free from plaque
 - › there should be no chalky white spots or patches, or yellow/brown discolouration
 - presence of any visible dental caries (holes)
 - presence of unusual lumps, sores, infections or abscesses
- Oral health promotion and disease prevention should be explored and discussed with parents/ carers (see *Oral Health Promotion* pg. 219).
- Refer to *Practice tips: Conducting a Lift the Lip / oral health assessment* pg. 156



Adapted from original concept developed by South Australia Dental Services and Oral Health Services Tasmania with permission.

Documentation

Detail findings of the examination and any actions taken in the child's medical record.

Referral

Any abnormalities should be referred to an oral health professional for assessment and treatment. Early decay (white spot lesions/lines) are reversible if treated early. Advanced decay or abscesses require immediate referral and treatment.



Practice Tips: Conducting a Lift the Lip / oral health assessment

See page 156

Oral Health Promotion

See page 219



Refer to the Pathways to Rural and Remote Orientation and Training

<https://ilearncatalogue.health.qld.gov.au/program/17/parrot-primary-care>



Refer to the Chronic Conditions Manual

<https://www.publications.qld.gov.au/dataset/chronic-conditions-manual-2nd-edition-2020>

Examination of the hips (0-4 weeks, 2months, 4months, 6 months)^{92, 122}

- Infants should be examined for hip function and to rule out Developmental Dysplasia of the Hip (DDH). Early detection of this condition is vital, as late diagnosis requires complex surgical correction and generally results in a poorer functional outcome for the child.
- Infants with DDH are not always born with the condition. It may develop in the weeks or months after birth. One or both hips can be affected, and although it is not painful in babies, if not identified and treated it can result in hip pain and early osteoarthritis.
- DDH has a higher incidence in females, if there is a family history and in a first, breech or multiple pregnancy.
- The most sensitive sign of DDH in older infants is a limitation in hip abduction. Other signs may be shortening of the limb and unequal skin folds/creases.
Note – asymmetrical skin folds can be normal and should be appreciated in the context of the rest of the examination.
- Child health professionals need to observe for **asymmetry** and **limitation of hip abduction**:
 - Lay the undressed (waist to feet) child on examination table in a supine position.
 - When relaxed extend the infants legs, ensure the pelvis is horizontal to the table and observe for equal leg length and equal skin creases.
 - The hip and knee joints are then flexed to right angles. Ensure hips are horizontal to the table and in neutral position (neither abduction nor adduction).
 - With eyes level to the top of the knees, the examiner observes for equal height of knees in the vertical plane. This is the easiest and most accurate way to identify asymmetry in 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 examiner then attempts full abduction of both legs. This is done slowly, allowing the infant to relax and hips to stretch out. It may need to be repeated a few times while the infant relaxes.
 - Compare the range of abduction. Note the presence of limited abduction or unequal abduction.
 - When in prone position, observe for deep/unequal gluteal folds or extra creases.

Documentation

Detail findings of the examination and any actions taken in the child's medical 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, e.g. limited abduction of both or either leg, leg lengths unequal.



Developmental Dysplasia of the Hip Education Module

Royal Children's Hospital Melbourne

<http://www.ddheducation.com/>

Examination of the genitalia (0-4 weeks; 2 months; 4 months; 6months) ^{92;95}

- Male infants
 - 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. evidence of rash; swelling; grazing; bruising; congenital abnormalities; incomplete development or sex organ ambiguity
 - Inspect the penis for variation from normal e.g. placement of urethral opening, microphallus.
 - Examine scrotum to ensure testes have descended:
 - › 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.
- Female infants
 - 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. evidence of rash; grazing; bruising; congenital abnormalities
 - Gently separate the outer labia to reveal the inner labia and clitoris
 - › note any variation from normal e.g. fused labia, discharge, female genital mutilation, incomplete development or sex organ ambiguity

Documentation

Detail findings of the examination and any actions taken in the child's medical record e.g. right and left testes descended into scrotum.

Referral

If examination reveals any abnormality, refer to General Practitioner/medical officer.

Femoral pulses (0-4 weeks; 2months) ⁹²

- 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.

Documentation

Detail findings of the examination and any actions taken in the child's medical record
e.g. femoral pulses equal and strong.

Referral

Refer any abnormality of pulses, e.g. weak, absent, unequal.



Developmental Assessment Form (sample)
see Appendix 7



Refer to the Chronic Conditions Manual
<https://www.publications.qld.gov.au/dataset/chronic-conditions-manual-2nd-edition-2020>



Children's Health Queensland

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 level⁴⁹. Weight gain and increase in size of the infant occurs as body systems mature.

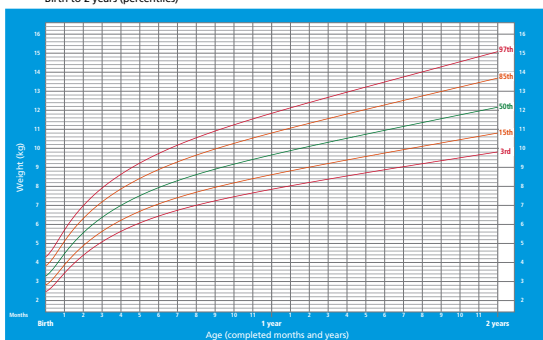
- Physical growth is best assessed by measuring weight, length or height and head circumference and comparing these measures with a growth reference^{49, 92}. A series of measurements over time are needed to assess a child's growth. One-off measurements show a child's size but not their growth.
- Accuracy is crucial in obtaining all physical measurements. Components of accurate measuring:
 - Technique that is standardised, e.g. bare weigh children less than two years old.
 - Equipment that is accurate. Regular calibration and checking before use is essential.
 - Examiners that are trained so they are accurate and reliable.
 - Use the same scales whenever possible.
 - Follow manufacturer's instructions on transportation of portable scales.
- Faltering growth has been associated with preterm birth, neurodevelopmental concerns, and maternal postnatal depression and anxiety¹²³

Growth charts ^{56, 92, 124}

- Growth charts are used as a reference to critically analyse growth measurements of weight, length or height and head circumference.
- There are currently several 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 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.
- Growth charts are monitoring or screening tools, not diagnostic instruments. The pattern of the infant's growth is used in conjunction with a clinical assessment in determining satisfactory growth.
- Factors that influence a child's growth can include gender, genetics, health, environmental factors (e.g. nutrition).
- Children who are not following the shape of the curve over several readings are referred for further assessment according to recognised referral guidelines.
- Always ensure the correct chart is being used (e.g. gender).
- Growth charts contain several lines representing average growth trajectories of infants and children. By definition, 50% of the population will fall below the 50th percentile and 3% of the population will be below the 3rd percentile etc. ⁵⁶. Health professionals need to ensure parents understand the importance of the pattern of growth following a trajectory along the percentiles, more so than the specific percentile.

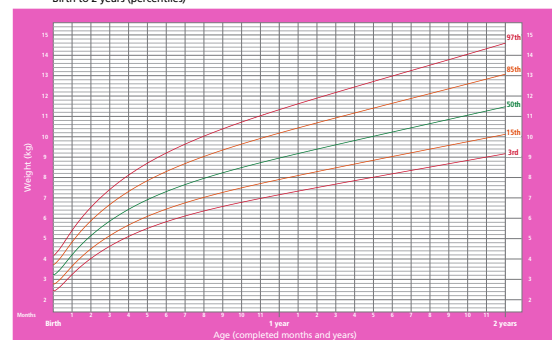
Weight-for-age BOYS

Birth to 2 years (percentiles)



Weight-for-age GIRLS

Birth to 2 years (percentiles)





WHO Growth Standards

<https://www.who.int/childgrowth/en/>

Top 10 things you need to know about growth charts:

Royal Children's Hospital, Melbourne

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



Child growth e-Learning

Royal Children's Hospital, Melbourne

https://www.rch.org.au/childgrowth/Child_growth_e-learning/

Allowance for gestational age

- Allowance for gestational age for growth and development is made for infants born before 37 completed weeks gestation until 2 years of age^{124, 125}.
 - Infants born at 37 weeks, or beyond, do not require age correction^{124, 125}.
 - Correction beyond two years may be required as directed by a tertiary specialist¹²⁶.
- To correct age for prematurity, subtract the number of weeks the infant was born prematurely from the chronological age (in weeks) and assess the child's growth and development for the corrected age.

Corrected age = Actual age - number of weeks premature

- For example, if an infant is born at 34 weeks gestation visits a child health center 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).



Prematurity

See page 291



Corrected Age for Assessment of Preterm Infants

Children's Health Queensland Procedure

https://qheps.health.qld.gov.au/__data/assets/pdf_file/0026/711179/proc_00199.pdf

Weight^{56, 92, 123, 124}

- 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)⁴⁹.
- Growth monitoring, particularly weighing activities, 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.
- A clinical assessment should be used in conjunction with growth monitoring, particularly before making a decision that may affect the infants feeding^{56, 123}.
- An initial weight loss (up to 10% of the birth weight is normal) followed by the infant gaining weight by four to six days of age and returning to birth weight by around two weeks of age⁵⁶

- In general, infant weight gain is assessed on a *4-week average*, with the rate of growth being the most important factor in assessment. The amount of weight gain per week is variable.
- Preferably, an appropriate growth chart should be used to assess the pattern of growth. *If a growth chart is not available*, then an approximate guide to average weight gain per week is:
 - 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 months

Note: this is the average weight gain per week – it is not the *minimally acceptable weight gain per week*¹²⁷.

- Health professionals need to critically analyse growth patterns deviating from an individual infant's previous growth pattern. 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:
 - The rising rates of obesity in children and teens in Australia^{128, 129}.
 - The unacceptable rates of Diabetic Ketoacidosis at diagnosis of Type 1 diabetes in Queensland¹³⁰. Recent weight loss can be a sign of Type 1 diabetes.
 - Population groups such as Aboriginal and Torres Strait Islander families who have a higher prevalence of ^{1, 131, 132}:
 - › weight faltering
 - › obesity
 - › early onset type 2 diabetes and other chronic diseases

Documentation

- Documentation should include the child health professional's assessment of the weight measurement.

Length/height ^{32, 92, 124}

- 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.
- Infants who are not following the shape of the curve over several readings are referred for further assessment according to recognised referral guidelines.

Documentation

Documentation should include the child health professional's assessment of the length/height measurement.

Head circumference ^{32, 92, 93, 133}

- 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 two years of life because changes in head circumference during this period may be predictive of later developmental outcomes.
- A routine measurement of head circumference is intended to identify deviations in head growth and brain development and 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 GP.

Referral

- Referral to GP/MO is essential if:
 - The head circumference growth line crosses the percentiles upwards and the child shows symptoms or signs of hydrocephalus.
 - The head circumference growth line crosses the percentiles downwards associated with other abnormality, (e.g. weight loss).
- 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

Documentation should include the child health professional's assessment of the head circumference measurement.



Child growth e-Learning

Royal Children's Hospital, Melbourne

https://www.rch.org.au/childgrowth/Child_growth_e-learning/



WHO Growth Standards

<https://www.who.int/childgrowth/en/>



Guideline - Assessing infant / child nutrition, growth and development within the Queensland Health, primary health care setting

QCYCN Child Health Sub Network

<https://www.childrens.health.qld.gov.au/wp-content/uploads/PDF/qcycn/growth-guideline.pdf>



Refer to the Chronic Conditions Manual

<https://www.publications.qld.gov.au/dataset/chronic-conditions-manual-2nd-edition-2020>



Practice tips: Weighing and measuring an infant

Weight 32, 92, 95, 124, 134

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, including batteries and last calibration date.
 2. Check that the area around the scales is clear and that nothing is touching the scales. They need to be far enough away from items (e.g. walls) so that the infant does not touch anything when on the scales.
 3. Tare ('o') the scales (if electronic) before placing naked infant on the scales so that the weight is distributed evenly.
 4. When the infant is lying quietly, weight is recorded to the nearest 10grams.
 5. Record in client record / PHR and plot on the appropriate growth percentile chart.
 - For preterm infants, use the Fenton Advanced Growth Chart from 22-50 weeks.
 - Once the infant reaches their expected birth date use the WHO 0 – 2 years growth chart.
 - From 2 years of age use the CDC 2 – 20-year growth chart.
 - Other growth charts are available for children with specific conditions¹²⁷.
- **Indicators of poor growth**
 - Weight and/or length plateauing or tracking downwards on the percentile growth chart¹²⁴.
 - **Indicators of excessive growth¹²⁴**
 - Weight and/or length for age tracking upwards on the percentile growth chart.
 - If measuring BMI for children over 2 years of age, a BMI above the 85th percentile.

Referral

- Referral for further investigation will be required if¹²⁴:
 - any sudden or unexplained weight loss, weight plateau or weight not re-gained following acute illness
 - growth chart patterns indicate poor or excessive growth
- Monitor weight for age less than the 3rd percentile or greater than the 97th percentile. (There will always be a bottom and top 3% and that these measures do not necessarily indicate a growth problem.)



Shutterstock.com/Photobac

Length ^{32, 92, 124}

Length/height is a mandatory component of the growth assessment, weight alone does not provide an overall indication of growth, it is important that both the weight and length are measured.

1. 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 infant'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 tabletop, 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 and knees and lie flat against the tabletop; arms rest against the sides of the trunk.
6. Ensure any nappies are not restricting hips from extending / knees from lying flat against the tabletop (loosen fasteners or remove if necessary).
7. The measurer must ensure that the legs remain flat on the table and must shift the movable board against the heels. The length is recorded to the nearest 0.1cm.
8. Complete the measurement as quickly as possible.
9. Record in client record, PHR and plot on appropriate percentile chart.

- **Indicators of poor growth**

- Weight and/or length tracking downwards on the percentile growth chart. ^{124, 127}

- **Indicators of excessive growth**

- Weight and/or length for age tracking upwards on the percentile growth chart. ¹²⁴

Referral

Generally, weight and height should follow similar percentiles with variations among children from different cultural backgrounds.

- Refer for further investigation if growth chart patterns indicate poor or excessive growth.
- Monitor length/height for age less than the 3rd percentile or greater than the 97th percentile. (There will always be a bottom and top 3% and that these measures do not necessarily indicate a growth problem.)

Head circumference ^{32, 92, 135}

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. Remove objects such as hairpins from the hair, if necessary.
3. Head 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.
4. The measurement is recorded to the nearest 0.1cm.
5. 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.
6. Record in client record, PHR and plot on appropriate percentile chart.

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.
- If the head circumference growth line crosses the percentiles upwards or downwards 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.



Child growth e-Learning

Royal Children's Hospital, Melbourne

https://www.rch.org.au/childgrowth/Child_growth_e-learning/



Refer to the Chronic Conditions Manual

<https://www.publications.qld.gov.au/dataset/chronic-conditions-manual-2nd-edition-2020>



Refer to the Pathways to Rural and Remote Orientation and Training

<https://ilearncatalogue.health.qld.gov.au/program/17/parrot-primary-care>

Developmental assessment (birth to 12 months)

- The first year of life for an infant incorporates not only growing rapidly in physical size, but also in the ability to perform tasks and develop social relationships^{32, 92}. It is a period of significant opportunity, but also vulnerability for a child's development, growth, health and general well-being, all of which are affected by a complex interaction of biological, psycho-social, and environmental factors¹.
- 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 involved³⁷.
- Regular child health developmental surveillance and developmental screening, undertaken in the early years offers an opportunity to identify and intervene early, altering health trajectories of vulnerable children^{1, 8}. (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^{1, 32, 92}.
- Gathering information from the child's parent/carer reliably informs the clinician about the child's development, as research suggests that parents are very accurate observers of their child's developmental strengths and weaknesses¹³⁶.
- Developmental delays, disorders and differences¹³⁷:
 - *Developmental delay* often describes a lag in the acquisition of a skill/developmental milestone.
 - *Developmental disorder* is used when a child's developmental trajectory is significantly impacted, and some milestones may not be achieved.
 - *Developmental differences* can simply reflect the different / unique experiences each child has in their lives, rather than reflecting a developmental delay or disorder.
- Early and accurate identification of infants with developmental delays, disorders and differences 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 outcome^{1, 37}.

Congenital Heart Disease

- Children undergoing open heart surgery for congenital heart disease (CHD) under 12 months of age are known to be at higher risk for neurodevelopmental deficits, including¹³⁸:
 - motor, cognitive, visual perceptual, social and language impairments
 - behaviour difficulties such as inattention, hyperactivity and impulsivity and impaired executive functioning
- These difficulties can be very subtle in infants and young children, and the extent of impairment can be overlooked or not fully recognised until more complex developmental skills are expected, such as at entry to formal schooling^{138, 139}. Accurate identification through assessment and referral for early intervention is known to improve health outcomes^{1, 37}.

- A statewide, developmental long-term care pathway has been developed to support these children and their families. It recommends¹⁴⁰:
 - Growth and development surveillance and parenting support
 - › All families are encouraged to access services within their community that support growth and development e.g. child health services, Indigenous health services, GP. Rural and remote families may access services through alternative providers as available within the HHS.
 - Secondary level developmental screening
 - › Targeted secondary level screening through the Ages and Stages Questionnaire (ASQ-3) is recommended at developmental health checks.
 - › Key time points for screening/assessment: 6mths, 12mths, 18mths, 2-3yrs, 4-5yrs, 11-12yrs, 15+yrs.
 - › Secondary level developmental screening should continue even if no concerns were identified at the previous health check.
 - Documentation
 - › Screening and assessment results should be documented and scanned into leMR (where available).
 - › If no leMR and with parental consent, local providers may be contacted to provide clinical information to Queensland Paediatric Cardiac Service's CHD LIFE (Long-term Improvement in Functional hEalth) Program database.
- Families of infants eligible for the pathway receive education about the care pathway prior to hospital discharge.
 - An education resource will be placed in the front cover of the child's PHR
 - An 'I need an Ages and Stages' sticker on the front of the PHR
 - An Alert is placed in leMR: 'Cardiac Developmental Long-term Care Pathway'
 - A referral is sent to relevant child health service upon discharge. Referral will identify the care pathway and the need for secondary level developmental screening
 - Clinical Nurse Consultant CHD LIFE Program at Queensland Children's Hospital is available for any queries



CHD LIFE Program Pathway

Long-term care pathway for children with congenital heart disease following open heart surgery before 12 months

<https://www.childrens.health.qld.gov.au/wp-content/uploads/PDF/qcycn/Long-Term-Care-Pathway-Congenital-Heart-Disease.pdf>

CHD LIFE Program

Supporting the long-term developmental needs of children with congenital heart disease ***and their families (the Pink Book)***

<https://www.childrens.health.qld.gov.au/chq/health-professionals/qcyc-network/resources/>

Validated screening tools

The purpose of developmental screening is to identify those children that require further screening or comprehensive developmental assessment.

- There are a number of tools that are available for developmental assessment in the primary care setting.
 - The Parents Evaluation of Developmental Status (PEDS) and the Ages and stages questionnaire (ASQ-3) are the developmental screening tools recommended for use in the community child health practice setting¹⁴¹.
- All Child health professionals utilising the PEDS and ASQ-3 developmental screening tools must be appropriately trained in their use¹⁴¹.
- The PEDS screening tool is utilised as the primary developmental screening tool and is recommended to be universally administered in child health settings from 6 months.
- **Parents Evaluation of Developmental Status (PEDS)**
 - **Age:** 0 – 8 years
Why is it used: To detect developmental and behavioural issues.
When is it used: All universal well-child health checks from 6 months.
Completed by:
 - › The PEDS questions are in the PHR from 6 months. The parents can complete the questions in the PHR before their appointment or at the time of their appointment.
 - › The PEDS questions are used to facilitate a conversation between the parent and child health professional about the infant/child's development and behaviour. It is intended to guide the developmental assessment consultation.
 - › Scoring and interpretation: Completed by the child health professional at the appointment and discussed with the parent/s.
 - **Documentation:**
 - › The outcome of the PEDS will be documented in the child's medical record.
 - › Should also include examples of the developmental milestones which the child has achieved across each of the PEDS developmental domains i.e. Receptive language, fine motor, gross motor, behaviour, expressive language, social-emotional, self-help and school/pre-school skills. For example: Gross motor – rolls from front to back.
 - **Resources:**
 - › **e-Learning:** http://www.rch.org.au/ccch/training-dev/PEDS_training/
 - › **PEDS developmental milestone checklist:** <https://qheps.health.qld.gov.au/ccyfh/html/resources>
- If child development concerns are identified through the PEDS screen, an additional secondary screen may be indicated¹⁴¹. The ASQ-3 is the recommended secondary developmental screening tool
 - **Ages and stages questionnaire (ASQ-3)**
Age: 3 months – 5 years
Why it is used: to identify developmental delays
When is it used: As the secondary screen if concerns are identified through primary screening
 - **Completed by:**
 - › Parents and explored with child health professionals during the follow-up developmental assessment appointments

- **Scoring and interpretation:**
 - › Completed by the child health professional at the appointment. Outcomes explained and follow up discussed with the parent.
- **Documentation:**
 - › Outcomes, interventions and follow up plans should be documented in the child's medical record. Appropriate referrals should be submitted.
- **Resources:**
 - › **Screening tools and user guides:** <https://agesandstages.com/>
 - › **Ages and stages parent information sheets:** <https://www.childrens.health.qld.gov.au/chq/our-services/community-health-services/child-health-service/>
- **ASQ-TRAK** is a developmental screening tool, based on the ASQ, adapted to create more culturally appropriate questionnaires. For observing and monitoring the developmental progress of Australian Aboriginal children at 2 months, 6 months, 12 months, 18 months, 24 months, 36 months and 48 months of age. It is available in multiple languages.
<https://asq-trak.education.unimelb.edu.au/>
- Various other validated tools for assessing development are available, including the Brigance Screens and the Child Development Inventory (CDI). There are also validated tools that assess child socioemotional wellbeing, for example the Strengths and Difficulties Questionnaire (SDQ) and the Modified Checklist for Autism in Toddlers (M-CHAT). Child health professionals should follow local HHS process decisions. <https://www1.health.gov.au/internet/publications/publishing.nsf/Content/nat-fram-ucfhs-html~appendices~appendix3>

Referral

- When concerns are raised following a thorough developmental assessment, a referral is recommended.
 - PEDS pathways¹⁴²:
 - › Pathway A: 2 or more predictive concerns - use secondary screen (ASQ-3) to support and inform the referral.
 - › Pathway B: 1 predictive concern only – use secondary screen (ASQ-3)
 - ASQ-3¹²⁵:

Children whose scores indicate a need for monitoring:

 - › Provide learning activities and follow up/monitor
 - › Refer for further assessment as per clinical judgement or if no progress

Children whose scores indicate a need for further assessment:

 - › Total scores that fall below the cut-off values require referral for further assessment
- 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 Developmental Service/Infant-Mental Health Service. Use local referral pathways.

The [Red Flags Early Identification Guide \(for children birth to five years\)](#)¹⁴³ can be used as a guide.



Knowledge of typical infant/child development is required to undertake developmental assessment and screening.
Clinical judgement is paramount in all clinical decision making.



Child growth e-Learning

Royal Children's Hospital, Melbourne

https://www.rch.org.au/childgrowth/Child_growth_e-learning/



Brain Architecture

Center on the Developing Child - Harvard University

<https://developingchild.harvard.edu/science/key-concepts/brain-architecture/>



PEDS developmental milestone checklist

CHQ Staff Resources

<https://qheps.health.qld.gov.au/ccyfh/html/resources.htm>

Guideline - Assessing infant / child nutrition, growth and development within the Queensland Health, primary health care setting

QCYCN Child Health Sub Network

<https://www.childrens.health.qld.gov.au/wp-content/uploads/PDF/qcycn/growth-guideline.pdf>

The Red Flags Early Identification Guide (for children birth to five years)

Queensland Health

<https://qheps.health.qld.gov.au/ccyfh/html/resources>



From birth to five years: Practical developmental examination

Sharma & Cockerill ¹⁴⁴

From birth to five years: Children's developmental progress

Sheridan et al ¹⁴⁵

Wong's Essentials of Pediatric Nursing (11th ed.)

Hockenberry et al ³²



Refer to the Chronic Conditions Manual

<https://www.publications.qld.gov.au/dataset/chronic-conditions-manual-2nd-edition-2020>



Refer to the Pathways to Rural and Remote Orientation and Training

<https://ilearncatalogue.health.qld.gov.au/program/17/parrot-primary-care>

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 ⁹⁹.
- Children who show signs of communication delay or difficulty, should be referred for further assessment and intervention as early as possible. Early intervention rather than a 'wait and see' approach is recommended to provide the best long-term outcomes ^{143, 146}.
- Some factors are known to increase the probability of a child experiencing a communication difficulty. These risk factors include ¹⁴⁶⁻¹⁴⁸:
 - 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 number 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 (e.g. fine motor and gross motor)
- The development of communication and interaction may also be impacted by difficulties with parent-infant relationship, such as ^{17, 99}:
 - The parent/carer does not respond to the infant's communication, e.g. does not respond consistently to cues, does not soothe when distressed, does not pay attention to reactions, is not in tune with the infant.
 - The parent/carer has limited interactions, e.g. does not make eye contact, smile or talk to the infant, or may use a harsh or negative communication style.



Australian Family Strengths Nursing Assessment Guide

See Appendix 1

Building Healthy Brains – The Eleven Key Messages

See Appendix 2

Health Promotion: Parent – Infant interaction

See page 205



Brain Architecture

Center on the Developing Child - Harvard University

<https://developingchild.harvard.edu/science/key-concepts/brain-architecture/>



The Red Flags Early Identification Guide (for children birth to five years)

Queensland Health

<https://qheps.health.qld.gov.au/ccyfhs/html/resources>

Age-appropriate interaction, speech and language skills (birth to one year) ^{93, 143, 145, 147}

Age	Interaction	Speech	Understanding	Expression	When to refer
0-3 mts	<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 mts	<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. recognise 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"> recognise several words can identify two body parts by 12 month understand no and will pause momentarily when ‘no’ is said in a stern voice 	<ul style="list-style-type: none"> points and grunts use gesture shake head ‘no’ by about ten months some words may emerge use 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, 92, 93,} 102, 143

- Developmental assessment involves:
 - eliciting and discussing parents' concerns
 - making accurate and informative observations of a child
 - obtaining relevant developmental history
 - promoting development
- The PHR has specific questions about development for the parent to consider prior to attending for routine health checks. From 6 months, the questions are the PEDS screening questions.
- Use these questions as discussion points with parents, exploring concerns and eliciting developmental history.
- Use a systematic approach (often this is done in combination with the head to toe assessment) to clinically 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).
- Observe parental-infant interaction:
 - Consider:
 - › How the parent describes their child e.g. in a positive or negative way.
 - › The tone of voice, affect, and facial expression of the parent when they are talking to and about their child, and their feelings for the child.
 - › How satisfied the caregiver is with their role.
 - › The child's reaction to their caregiver e.g. emotional expression on the child's face or whether they seek closeness to them.
 - Observe:
 - › Is there eye contact, touch, and does the caregiver talk to their child?
 - › Do the child and caregiver mirror one another e.g. one smiles and the other smiles?
 - › Does the caregiver respond to their child in a timely and appropriate way?
- In an emotionally healthy relationship, delight between caregiver and infant is evident.
- See *Health Promotion –Parent-Infant interaction* section pg. 205
- Clearly document in the child's medical record:
 - all developmental assessment findings
 - specific advice, information and education provided to the parent/carer
 - follow up plan and any referrals completed
 - use the developmental assessment profile form recommended in your HHS
 - › The developmental profile assessment form provides a template to document assessment findings and other relevant information; nutrition, feeding, growth and physical assessment, parent/infant interaction, child development, anticipatory guidance, information and education provided to the parent/carer.
 - › See [Appendix 7](#) for an example of a developmental profile template

- If concerns are identified through the primary PEDS screen, it is recommended a secondary screen is completed in 2-4 weeks¹⁴² using the ASQ-3 screening tool.
- If available, Aboriginal and Torres Strait Islander Health Workers with training in child development can assist/undertake the PEDS screen and should discuss findings with the child health nurse (as necessary).

Referral

- When concerns are raised following a thorough developmental assessment a referral is recommended.
 - **PEDS pathways¹⁴²:**
 - › Pathway A: 2 or more predictive concerns - use secondary screen (ASQ-3) to support and inform the referral.
 - › Pathway B: 1 predictive concern only – use secondary screen (ASQ-3).
 - **ASQ-3¹²⁵:**
Children whose scores indicate a need for monitoring:
 - › Provide learning activities and follow up/monitor and/or
 - › Refer for further assessment as per clinical judgement or if no progress.
 Children whose scores indicate a need for further assessment: Total scores that fall below the cut-off values require referral for further assessment.
- 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 Developmental Service/Infant-Mental Health Service. Use local referral pathways.

Note: If referral for further developmental assessment is indicated, it is important to ensure that the parent/carer has a clear understanding of why and what their child is being referred for.

The Red Flags Early Identification Guide (for children birth to five years)¹⁴³ can be used as a guide.



Developmental Assessment Form (sample)

See Appendix 7



Refer to the Pathways to Rural and Remote Orientation and Training

<https://ilearncatalogue.health.qld.gov.au/program/17/parrot-primary-care>



Refer to the Chronic Conditions Manual

<https://www.publications.qld.gov.au/dataset/chronic-conditions-manual-2nd-edition-2020>

Assessing infant nutrition



Also see Health Promotion - Promotion of optimal nutrition p.222

Nutritional assessment is an opportune time for discussion and anticipatory guidance around healthy eating within the family. Considerations of the social determinants of health, environmental and cultural factors are important during these discussions ^{1,7}.

Nutrition in the first 1000 days, (the period from conception to the end of the child's second year), is one of the most significant factors that influence child health and development^{59, 149, 150}. Breastfeeding is internationally recognised as one of the most highly effective preventive measures a mother can take to protect the health of her infant and herself ⁵⁹.

Stages of feeding development ^{32, 92, 151-153}

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.

Oral structures

- At birth the mouth is fully filled by the tongue, in close proximity to the cheeks, hard palate, and soft palate. The tongue also protrudes past the alveolar ridge to maintain contact with the lower lip, forming a cupping shape to assist with lip seal at the sides of the mouth.
- This close proximity of these anatomical structures and the infant's subcutaneous fat deposits in the cheeks (buccal pads), provide positional stability.
- The infant's oro-facial structures should be symmetrical, have good tone and the expected range of movements should not be restricted/impaired.
- As the infant matures, structures move further apart and postural stability is provided.

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 milk from the mouth to the stomach¹⁵².

Sucking can be nutritive or non-nutritive. Non-nutritive sucking matures earlier than nutritive sucking¹⁵¹. Both behaviours seen in infants vary in a number of ways ¹⁵²:

	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^{152, 154}:

Suction: closure of the nasal passages with the soft palate, a tight seal of the lips around the breast or teat and a lowering of the mandible and posterior tongue results in a negative intra-oral pressure (a vacuum).

Expression: elevation of the tongue toward the hard palate results in compression of the breast or teat, expression of the fluid and the creation of positive pressure.

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 maternal factors e.g. varied shapes, sizes and function of the breast and nipple ¹⁵¹.

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.
- 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.

Reflexes	<ul style="list-style-type: none"> • Rooting reflex <ul style="list-style-type: none"> ○ Reflex is stimulated by touch to the cheek or corner of the mouth ○ Response: turns the head toward the touch • Suck reflex <ul style="list-style-type: none"> ○ Reflex is stimulated by touch to the infant's mouth ○ Response: forward-backward movement of the tongue • Gag reflex <ul style="list-style-type: none"> ○ Reflex is stimulated by touch to the posterior tongue ○ Response: contraction of palate and pharynx • Tongue protrusion reflex <ul style="list-style-type: none"> ○ Reflex is triggered by touch to anterior tongue ○ Response: tongue moves anteriorly and protrudes outside of mouth • Transverse tongue reflex <ul style="list-style-type: none"> ○ Reflex is triggered by touch to the lateral surface (side) of the tongue Response: tongue moves towards stimulus • Phasic bite reflex <ul style="list-style-type: none"> ○ 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 fills the oral cavity and works with the other structures to create suction and expression • lips and tongue function as a total unit when feeding
Sucking	<ul style="list-style-type: none"> • infant uses a suckle pattern (front to back tongue movement) • 1:1 suck to swallow ratio, may decrease to 2:1 or 3:1 as the feed progresses • bursts of sucking followed by pauses. Pauses may increase over the course of the feed • support required to achieve midline orientation
Cup drinking	<ul style="list-style-type: none"> • not a main method of feeding • cup feeding may be particularly useful when small volumes of breastmilk/colostrum are being given during emergency situations
Solids	<ul style="list-style-type: none"> • not introduced

Three months ^{32, 56, 92, 151, 152, 155}

Reflexes	<ul style="list-style-type: none"> • rooting reflex may start to diminish (though may be present until 6 months) • all other reflexes (e.g. tongue protrusion, phasic bite) still present
Oro-motor skills	<ul style="list-style-type: none"> • head and neck control improve along with oro-motor skills • increased control of oral and facial movement 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	<ul style="list-style-type: none"> • not a main method of feeding • cup feeding may be particularly useful when small volumes of breastmilk/colostrum are being given during emergency situations
Solids	<ul style="list-style-type: none"> • not introduced

Four months ^{32, 56, 92, 151, 152, 155}

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"> • suckle starts to mature into suck pattern (includes up down tongue movement). Facilitated by oral cavity growth • sucking reflex starts to diminish and comes under voluntary control

Cup drinking	not main method of feeding
Solids	World Health Organisation guidelines recommend introducing solids around six months

Six months ^{32, 56, 92, 151, 152, 155}

Reflexes	<ul style="list-style-type: none"> reflexes diminishing <ul style="list-style-type: none"> suck reflex rooting reflex tongue protrusion reflex
Oro-motor skills	<ul style="list-style-type: none"> wide jaw excursion on presentation of breast/teat/cup or spoon increased active oral exploration with toys, other objects and fingers gag reflex gradually moves further back as more experience with solids is gained (gag reflex may persist into adulthood) can be fed in a supportive upright posture (e.g. support from highchair or caregiver) Suckle pattern matures into suck pattern (facilitated by growth of the oral cavity)
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 may be able to hold bottle independently
Cup drinking	<ul style="list-style-type: none"> cup drinking should be introduced fluid often lost anteriorly (out mouth) some coughing may be observed due to poor regulation of fluid flow while learning to coordinate parents may use a spout cup to minimise loss and regulate flow a wide lipped cup can help with lip closure and provide greater stability and therefore less fluid loss

Solids	<ul style="list-style-type: none"> all nutritional needs are met with breastmilk or artificial infant formula up to around 6 months old; for good health, infant needs to start eating solids introduce smooth purees - moving from pureed to lumpy to normal textures between 6-12 months. For parents following self-feeding/ baby-led feeding - cooked or soft fruit, vegetable and meat pieces may be introduced sucking pattern used for oral transit (i.e. to remove solids from spoon) jaw moves in an up and down motion to facilitate bolus manipulation tongue protrusion may be observed during swallowing (i.e. some food is pushed out of the mouth)
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Seven to nine months 32, 56, 92, 151, 152, 155

Reflexes	<ul style="list-style-type: none"> gag reflex diminishes transverse tongue reflex diminishes phasic bite reflex still present
Oro-motor skills	<ul style="list-style-type: none"> hand to mouth control improves greater range of babbling coordinated lip, tongue and jaw movements infants can sit in a highchair 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/bottle-feeding
Cup drinking	<ul style="list-style-type: none"> large jaw excursions with open cup fluid loss continues with increasing open cup experience: <ul style="list-style-type: none"> improved cup drinking using lower lip as stabiliser mouth starts to close around rim
Solids	<ul style="list-style-type: none"> introduction of thicker textured foods, lumpy puree and soft finger foods tongue should no longer protrude when eating puree emergence of tongue lateralisation where the child transfers food from the middle of their tongue to the gum/molar-area for chewing enjoys exploring food with fingers and self-finger feeding

Reflexes	<ul style="list-style-type: none"> gag reflex diminished (but may persist into adulthood) 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 can sit independently in highchair or booster seat new sequences of sounds in babble first single 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 is able to keep tongue in mouth when drinking (but may still use tongue under the cup to help stabilize) may continue to have single cough whilst drinking due to flow rate 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 Improving ability to use upper lip to clear food from spoon controlled sustained bite able to lateralise food for chewing most of the time starting to use a combination of up-down chewing pattern and diagonal rotary chew (improving speed and precision of jaw movement) holds spoon in either hand and transfers from hand to hand uses utensils turns spoon over in mouth <p>For further information on introducing solids refer to the NHMRC Infant Feeding Guidelines</p>

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 (solid) foods are added with continued breastfeeding up to 2 years of age or beyond, for as long as the mother and child desire ^{56, 59, 156}.
- The benefits of breastfeeding are understood by most women, and they want to breastfeed, but they need high-quality accessible support to overcome societal, family and health service barriers⁵⁹.
- Timely access to child health services in the community ensure families are provided with professional support, encouragement of breastfeeding. Services can be provided in a range of modes, e.g. telephone support, clinic visits, home visiting, group sessions¹.
- Use culturally appropriate tools for education on breastfeeding and infant nutrition such as:
 - Growing Strong - feeding you and your baby resources ⁵². This is a resource developed to assist health staff talk with Aboriginal and Torres Strait Islander families about nutrition for mothers, babies and young children. There are a range of resources available. <https://www.health.qld.gov.au/nutrition/patients#>
 - The Good Start Program has a range of culturally tailored resources for Maori and Pacific Islander families and communities ⁵³. <https://www.childrens.health.qld.gov.au/service-good-start-resources/>
 - Multicultural nutrition resources - including *Infant feeding for African communities*, a suite of resources designed in partnership with African women covering all aspects of feeding and nutrition⁵⁴. <https://metrosouth.health.qld.gov.au/multicultural-nutrition-resources>
 - Raising Children Network has articles, videos and picture guides translated into multiple languages⁵⁵. <https://raisingchildren.net.au/for-professionals>
 - The Global Health Media breastfeeding videoclips are available in multiple languages ⁶¹. <https://globalhealthmedia.org/videos/>
 - The Australian Breastfeeding Association has a range of multicultural breastfeeding factsheets available in a number of different languages⁶⁰. <https://www.breastfeeding.asn.au/bf-info/other-languages>
- Health professionals empower mothers to breastfeed by^{56, 57, 59, 60}:
 - informing families of the benefits of breastfeeding
 - informing families of the risks of not breastfeeding
 - supporting partners and other family members, recognising the importance of their role in encouraging and maintaining breastfeeding
 - discussing the importance of exclusive breastfeeding to around when the infant is 6 months old and ongoing breastfeeding with the introduction of complementary foods
 - 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 breastmilk and the infants microbiome
 - encouraging the family to use expressed breastmilk when the mother and infant are separated including returning to work and breastfeeding
 - encouraging the family to avoid the use of teats and pacifiers no earlier than 4 weeks of age and after breastfeeding has been established⁵⁶
 - normalising and discussing newborn and infant behaviours, including feeding cues

- supporting families if they have specific breastfeeding concerns, e.g. perceived milk supply concerns, painful breasts, inverted nipples
- exploring strategies with families to overcome challenges
- providing information on the range of support services available e.g. Australian Breastfeeding Association (ABA); Pregnancy, Birth and Baby website and the Raising Children website, Lactation Consultants of Australia and New Zealand (LCANZ)
- supporting the principles of the Baby Friendly Health Initiative (*see Health Promotion Section page 195*).
- Whilst exclusive breastfeeding is the best option for infants, not all families are able to do this and it is important that any feelings of grief/loss are acknowledged and the family be reassured that any breastfeeding is better than none^{56, 57}.
- Some women will make an informed decision not to breastfeed, others may choose to stop breastfeeding. This decision should be respected, and support provided. In the absence of breastfeeding, Queensland Health recommends the use of a breastmilk substitute that conforms to the recommendations of NHMRC and meets the Food Standards of Australia New Zealand.^{56, 57, 157}.
- Identify community partnerships and opportunities for services to work together to support, promote and protect optimal infant nutrition including¹:
 - local hospital/s
 - general practitioners
 - birthing units and postnatal services
 - breastfeeding support organisations (e.g. ABA, LCANZ - Lactation Consultants)
 - dietitian/nutritionists
 - speech pathologists
 - local pharmacies
 - oral health services.
- Support, protect and promote breastfeeding through undertaking a comprehensive assessment of breastfeeding and lactation. See Appendix 6 for example assessment form



Health Promotion : Breastfeeding

See page 195

Clinician Assessment of Breastfeeding & Lactation form

See Appendix 6



‘Growing Strong: Feeding You and Your Baby’ suite of resources

Queensland Government

<https://www.health.qld.gov.au/nutrition/patients#>

Global Health Media breastfeeding videos

Available in multiple languages

<https://globalhealthmedia.org/>

Raising Children's Network

<https://raisingchildren.net.au/newborns>

Australian Breastfeeding Association

<https://www.breastfeeding.asn.au/bfinfo/feeding-cues>

Multicultural Nutrition Resources, Metro South Health

A suite of resources designed in partnership with local communities covering all aspects of feeding and nutrition

<https://metrosouth.health.qld.gov.au/multicultural-nutrition-resources>

Infant Feeding Guidelines – Information for Health Workers

National Health and Medical Research Council

<https://www.nhmrc.gov.au/about-us/publications/infant-feeding-guidelines-information-health-workers>

Australian National Breastfeeding Strategy: 2019 and Beyond

COAG Health Council

<https://www1.health.gov.au/internet/main/publishing.nsf/Content/health-pubhlth-strateg-brfeed-index.htm>

Queensland Health – Baby Friendly Health Initiative

<https://www.health.qld.gov.au/clinical-practice/guidelines-procedures/clinical-staff/maternity/nutrition/bfhi>



Refer to the Pathways to Rural and Remote Orientation and Training

<https://ilearncatalogue.health.qld.gov.au/program/17/parrot-primary-care>



Refer to the Chronic Conditions Manual

<https://www.publications.qld.gov.au/dataset/chronic-conditions-manual-2nd-edition-2020>



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Initiation and establishment of lactation

- The initiation of lactation is hormonally driven following a drop-in progesterone levels with the delivery of the placenta. The hormone prolactin is necessary for milk production, and oxytocin initiates the milk-ejection reflex.
 - However adequate, frequent and effective removal of milk from the breasts is necessary to establish and maintain lactation.
 - Unrestricted breastfeeds and effective removal of milk from the breasts are the most important factors contributing to successful breast feeding ^{56, 158}.
- 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.
 - The length of each feed is highly variable, and during the early neonatal period feeds can take up to an hour.
 - Unrestricted feeding, both day and night, is an important factor in successfully establishing breastfeeding and results in optimum milk production.
 - Refer the family to Breastfeeding – Getting Started in the Child Health Information booklet ⁹⁴.
- 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 ^{56, 158}.
 - Health care professionals must 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.
 - 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.
 - › For example - on average, women who exclusively breast feed will produce around 800mls a day, but 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, who will need to feed more frequently⁵⁶.
- The colour of milk is irrelevant to the quality of the milk.
 - Colour variations occur between women, from feed to feed and even between breasts at the same feed¹⁵³.
 - The colour of colostrum varies from clear to pale yellow to bright orange and mature breastmilk varies from creamy to opalescent.
- The composition of breastmilk is complex, containing essential compounds and fluids that meet all the infant’s requirements for at least the first six months of life⁵⁶.
 - Changes from feed to feed to meet with the child’s need, whether nutritional, thirst quenching or for comfort¹⁵⁸.
 - No additional fluids are required even in hot climates⁵⁶.
 - In general, at the start of a breastfeed when the breasts are more full, the fat content is lower with an increasing rise as the breast is drained (noting that the breast is never fully drained)¹⁵⁸.
- Variations in feeding patterns are normal and should be carefully explained to new mothers ^{56, 158}.

- Babies are generally offered both breasts at each feed, based on their feeding cues, however the infant may not feed from 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^{56, 159}:
 - at least four to six single use, or six to eight very wet cloth nappies in 24 hours
 - pale yellow, in-offensive smelling urine
 - weight gain - averaged over a month
 - infant is reasonably content after most 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 loose, mustard-yellow, curdy bowel motions per day (although colour and frequency variations can be normal in a healthy breastfed infant). Less frequent stools from around 6 weeks reflects a change in whey : casein ratio in breastmilk.

Refer family to the information

- Australian Breastfeeding Association [Is my baby getting enough milk?](#)
- CHQ Fact Sheets [Breastfeeding – is my baby getting enough breastmilk?](#)
- Child Health Information Booklet [Breastfeeding – Getting Started](#)

Nipple care and management

A mother's nipples may feel sensitive on attachment for the first few days. However, continuing pain is not normal and could be a sign of a problem.

The nipple is vulnerable because of its repeated exposure to trauma and bacteria. There are a number of possible causes of breastfeeding pain, both maternal and infant factors such as ^{56, 158}:

- incorrect positioning and attachment 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 (restriction in tongue movement, high arched palate, receding chin, hyper/hypotonic infant, large nipple and small mouth)
- vasospasm (e.g. Raynaud's Phenomenon)

Tips for managing nipple pain can include^{56, 158}:

- Provision of postural stability of the in infant at the breast to support optimal infant positioning and attachment.
- Apply warm water compresses or small amounts of expressed breastmilk on the nipple after feeding. Allow nipples to air dry. (Note: air drying *would not* be helpful for mother's experiencing pain from vasospasm).
- To minimise risk of infection in cracked nipples, encourage frequent changing of breast pads when damp and rinse nipples/skin with clean water after feeds¹⁵⁹.

- Avoid using shampoos and soaps on the nipples and generally avoid applying ointments, sprays, tinctures and powders.
- If infection or a dermatological condition is suspected, refer to a medical officer for review.
- Expressing breastmilk may be needed to manage some breastfeeding difficulties where the pain is intolerable or, despite every effort, the trauma worsens. Should be used as a last resort, with ongoing support of the health professional and the infant should be returned to the breast as soon as possible.
- Infants may need further assessment and referral (e.g. tongue-tie) if nipple trauma does not resolve. See page 134 - *Ankyloglossia (Tongue-Tie)*
- Nipple pain may inhibit the milk ejection reflex (letdown) or result in inadequate drainage of the breast if feeds are reduced or limited due to painful feeding. Milk supply and milk transfer may be compromised. Management of nipple pain should always include assessment of milk supply and infant growth. See page 124 *Management of inadequate milk supply*

Refer family to the information

- Child Health Information booklet Common Breastfeeding Concerns: Common Early Problems – Tender or Cracked Nipples
- Australian Breastfeeding Association Common concerns – mum
- CHQ Fact Sheets Breastfeeding – nipple shields for breastfeeding
- CHQ Fact Sheets Tongue-tie in babies
- Australian Breastfeeding Association Tongue-tie and breastfeeding – includes a short video clip by Lisa Amir – Tongue-tie



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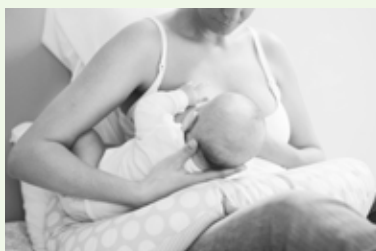
Practice tips: Promoting optimal positioning of the infant at the breast

Correct positioning at the breast and a good attachment is the key to successful breastfeeding ^{56, 160}.

There are many different positions that mothers can use such as reclining; side-lying; football hold; cross arm hold; cradle hold or semi-reclined/laid-back



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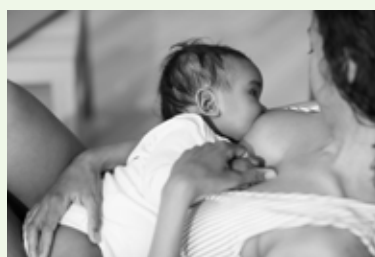
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1. Whatever the position, it is important the mother is comfortable with adequate support for her back, arms and feet and her clothing non-restrictive.
2. The infant is unwrapped to enable easy handling and promote skin to skin contact.
3. The infant is held facing the mother (chest to chest) and close to the mother's body.
4. The infant's body should be held snug against the mother's body and supported behind the shoulders to provide midline and shoulder girdle stability. The head should have freedom of movement.
5. The infant's nose is level with the mother's nipple, chin is touching the breast.
6. By touching and stroking the nipple on the infant's nose and upper lip, the infant will tilt his head back slightly and open his mouth wide, maintaining chin contact with the breast below the nipple. The tongue should come down and forward.
7. Mother brings infant toward the breast as the mouth opens to come over the nipple.
8. Bring the infant to the breast, not the breast to the infant.

Indicators of correct latch ^{56, 160}

- 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. (Pauses are a normal part of the feed and they become more frequent as the feed continues)
- 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 initially be tender
- nipples should be slightly elongated with no signs of pinching or trauma upon detachment

Refer family to the information:

- The Raising Children's Network [Breastfeeding videos](#)
- Australian Breastfeeding Association [Breastfeeding Basics video](#)
- Child Health Information booklet [Breastfeeding: How do I start breastfeeding?](#)



Ankyloglossia (Tongue-Tie)

See page 134

Expressing breastmilk ^{56, 57, 60, 158, 159}

A large proportion of mothers in Australia express breastmilk at some time before their infant is 6 months.

- A mother may need or choose to express breastmilk for a number of reasons, and studies show that mothers who expressed, were more likely to breastfeed to 6 months ⁵⁶.
- It is important the mother knows how to express and store the breastmilk; this may support her feeling of breastfeeding competence and increase her achieving maximum time breastfeeding⁵⁷.
- Importantly, there is no evidence that measurement of expressed breastmilk quantity is indicative of adequate milk supply⁵⁶.

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 sit well-supported and not be interrupted (e.g. phone off, nice music)
- consider use of relaxation techniques to facilitate breast expression
- collect breastmilk in a clean container e.g. washed in warm soapy water and rinsed well
- encourage the milk ejection reflex by applying warm compresses or gently massaging 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, with the nipple in line with the thumb and fingers
- gently press inward towards the centre of the breast and rhythmically squeeze the breast with a rolling movement between the thumb and fingers (try about twice per second)
- drops of milk form on the nipple, and with the letdown reflex, milk may spray
- when the flow slows, move thumb and fingers around the areola so that all the milk ducts are emptied
- change hands or breasts when you get tired



Shutterstock.com/ravipat

Videoclips **Hand Expressing** - ABA <https://www.breastfeeding.asn.au/bfinfo/hand-expressing>

Using a pump (hand or electric)

- follow the set up directions that come with the pump
- follow the preparation steps above, it is also sometimes 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. The nipple should move freely in the funnel, with no rubbing
- start the electric suction at a low strength and increase according to comfort, with the aim to utilise at the maximum vacuum that is comfortable



Shutterstock.com/Asian foto

- breast massage and compression may be used during pumping to enhance milk flow (*see Practice tips: Supporting a mother with breast compression pg. 123*)
- when using a single kit, alternate between each breast (every 5 minutes or so, up to a total of 20-30mins). A hospital grade electric breast pump with double collection kit may be of benefit for increased efficiency and effectiveness



Videoclips Expressing – ABA

<https://www.breastfeeding.asn.au/bfinfo/expressing>

Storing expressed breastmilk ^{55, 56, 60, 161}

Pour the collected milk into a clean, closed container or a special breastmilk storage bag, and put it in the refrigerator or into the freezer.

Breastmilk can be:

- refrigerated for up to 72 hours at the back of the refrigerator, not in the door
- stored without refrigeration (if no fridge available) for 6 -8 hours if the temperature is below 26°C
- 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 3 months
- frozen in the deep freeze for 6-12 months
- transported in a cooler with an ice brick and placed in the refrigerator (or freezer if still frozen) immediately upon arrival. If some milk has thawed it should be used within 4 hours – do not refreeze it.

Other tips for managing expressed breastmilk include:

- label with date and time before freezing
- use oldest milk first
- freshly expressed milk should be cooled in the fridge before being 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
- if thawed in refrigerator, use within 24 hours
- if thawed outside refrigerator, use within 4 hours
- never refreeze or reheat breastmilk
- leftover expressed milk from feeding should be discarded
- should not thaw or heat breastmilk in a microwave oven

Cleaning expressing equipment ^{55, 60, 161}

A mother's own expressing equipment:

- Storage containers, expressing equipment and feeding devices do not need to be sterilised if used ^{60, 161}:
 - for human milk
 - for home use
 - for a healthy infant

- Feeding devices:
 - Containers and feeding devices used to feed the infant should be cleaned with soap and water and air dried before/after every use. They do not need to be sterilised for a healthy infant⁶¹.
- Expressing equipment:
 - Should be rinsed well between uses and stored in a clean, closed container. Unrinsed expressing equipment may be stored in a clean, closed container in the fridge between uses⁶⁰.
 - Must be cleaned thoroughly at least every 24 hours⁶⁰:
 - › Take apart all containers and the breast pump so that every part can be cleaned well. Rinse in cold water to remove milk from all the parts.
 - › Take care to remove all traces of grease, milk and dirt with a small amount of dishwashing liquid and hot water. Use a brush kept just for this purpose.
 - › Rinse at least twice in hot water.
 - › Drain bottles and containers upside-down on clean paper towel or a clean cloth towel. Cover while they air dry. Before putting away, ensure no water droplets remain in the containers or on any parts. If any water remains, dry carefully with paper towel.
 - › Store the dry kit in a clean, covered container until next use.
- In areas where there are different water supplies for drinking and washing, use drinking water to wash and rinse the pump equipment.
- Breast infections or conditions, unwell infants or non-home environments (e.g. hospital) may require more stringent cleaning practices.



Raising Children's Network

<https://raisingchildren.net.au/newborns/breastfeeding-bottle-feeding>

Australian Breastfeeding Association

Expressing and Storing breastmilk

<https://www.breastfeeding.asn.au/bf-info/breastfeeding-and-work/expressing-and-storing-breastmilk>

CHQ Fact Sheets

Breastfeeding – expressing breastmilk for your baby

<https://www.childrens.health.qld.gov.au/chq/health-professionals/fact-sheets/>

ABA Videoclips

Links to expressing and storing breast milk

<https://www.breastfeeding.asn.au/bf-info/breastfeeding-information-other-organisations/links-expressing-including-hand-and-storing-clips>

Management of milk supply

A common concern of a new mother is whether her infant is getting enough milk. There are a number of ways the health professional can assess and support the management of milk supply.

The Global Health Media video “Not enough milk” shows how to tell whether the an infant is feeding well and how to increase milk intake. <https://globalhealthmedia.org/portfolio-items/not-enough-milk/>

Breast compression

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

The technique may be useful for ¹⁶²:

- premature infants
- poor weight gain in the infant
- fussy infants
- 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



Practice tips: Supporting a mother with breast compression ¹⁶²

Instruct the mother to:

- Hold the infant with one arm.
- Hold her breast with the other hand, thumb on one side of the breast (thumb on the upper side of the breast is easiest), with other fingers on the other side, fairly far back from the nipple.
- **Watch for the infant's drinking.**
- The infant gets substantial amounts of milk when he is attached well and is nutritively sucking, i.e. swallowing can be observed.
- Use compression only while the infant is sucking but not drinking i.e. *only during non-nutritive suck pattern*.
- When the infant is only using a non-nutritive sucking pattern at the breast, compress the breast by applying gentle pressure with the flat of the hand against the breast.
- Do not roll fingers along the breast toward the infant, just squeeze the breast gently.
 - This should not be painful, and the shape of the areola should not change during compression.
 - With the compression, the infant should start drinking again with the “open mouth wide.... pause... then close mouth” type of suck i.e. a nutritive sucking pattern.
- 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 before compressing again.
- Repeat compression whenever the infant is only sucking in a non-nutritive pattern
- Continue on the first side until the infant does not drink even with the compression.
 - Infant should remain on that side for a short time longer, as another letdown reflex (milk ejection reflex) may occur. In that case, the infant will start drinking again, on his own.
- Offer the other side as indicated by feeding cues and repeat the compression process as needed.
- **Remember, compress as the infant sucks but does not drink.** If the infant is drinking/swallowing well, there is no need for breast compression



Global Health Media videos

Increasing your milk supply

<https://globalhealthmedia.org/videos/>

*Information obtained from The International Breastfeeding Centre factsheet – Breast Compression.
<https://ibconline.ca/information-sheets/breast-compression/>

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 imperative⁵⁶.

Insufficient milk production, either perceived or real, remains the most frequent reason for discontinuation of breastfeeding⁵⁸.

- Considerations:
 - If infant weight is low, breast milk production is typically also low, either as the primary problem or secondary to ineffective milk removal¹⁵⁹.
 - An infant with poor feeding skills may not be able to transfer milk well even when abundant milk supply is present.
 - Problems with the feeding process (attachment difficulties / low milk supply) are a more common cause of poor weight gain than organic illnesses in the first month of life¹⁵⁹.
- **Adequate intake** in the exclusively breastfed baby, after 5 days of age is characterised by^{60, 158}:
 - at least five heavily wet disposable, or six to eight heavily wet cloth nappies in 24 hours
 - pale yellow, in-offensive smelling urine
 - 3 or more easily passed mustard-yellow bowel motions each day in the first 1-2 months (although colour and frequency variations can be normal in a healthy breastfed infant). Less frequent stools may be passed from around 6 weeks reflecting the change in the whey: casein ratio in breastmilk.
 - infant is active and alert when awake
 - firm skin turgor, moist mucus membranes and clear, bright eyes
 - infant waking and demanding feeds
 - infant is reasonably content after most breastfeeds
 - normal increase of length, head circumference and weight gain (*see Growth page 87*)
 - reaching milestones

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.

Signs of insufficient milk intake^{56, 60, 158}:

- infant lethargy, not waking to feed, feeding infrequently, sleeping for long periods
- infant who wants to feed continuously but not effectively – i.e. sleepy/non-nutritive sucking at breast
- infrequent stools
- scant urine output
- suboptimal growth pattern e.g. not regaining birth weight by two weeks, weight plateauing or tracking downwards on the percentile growth chart (*see Growth page 87*)

Management strategies^{56, 58, 60, 158, 159, 163, 164}:

- Ascertain maternal goals for breastfeeding, current supports, work in partnership with the family and acknowledge maternal concern at an anxiety-provoking time.

- Conduct a comprehensive history and physical assessment for both mother and infant:
 - Maternal risk factors include lack of breast changes during pregnancy, thyroid dysfunction, endocrine disorders, polycystic ovary syndrome, postpartum haemorrhage, retained products of conception, breast hypoplasia, breast surgery and some maternal medications.
 - Infant assessment - consider the late-preterm infant (low energy/ less capacity), assess for oro-motor dysfunction, illness, neurological status, assess feeding reflexes.
- Conduct a thorough, systematic assessment of a full breastfeed:
 - presentation and behaviour of mother and infant during feed e.g. tense, painful, infant sleepy or restless
 - assess breasts e.g. any red or painful areas, feelings of fullness, nipple damage, nipple shape, held/shaped incorrectly during feed
 - assess infant - tone, oral anatomy and feeding reflexes
 - assess and correct positioning and attachment (*see previous - Practice tips: Promoting optimal positioning of the infant at the breast pg. 117*)
 - assess sucking pattern for nutritive sucking and milk transfer
 - › during nutritive sucking, when there is active fluid flow, the infant's sucking rate is slow, approximately one suck per second, to accommodate swallowing
 - › during non-nutritive sucking (quicker sucking) the tongue does not lower to the extent it does during nutritive sucking and therefore does not result in milk entering the oral cavity
- Discuss feeding cues and encourage parents to offer feeds at the first sign of early feeding cues.
- Assess the number of feeds in 24 hours and discuss typical breastfeeding patterns, ensuring 8-12 breastfeeds per 24 hours.
- Ensure the mother is offering both breasts at each feed.
- Provide education on the appearance of effective feeding (nutritive sucking) in the infant when breastfeeding.
- Guide mother to use breast compression when infant is sucking but no longer swallowing.
- Move infant to second breast when infant stops sucking effectively.
- Allow retries by offering both breasts again at each feed i.e. swap breasts when the infant stops suckling effectively and use both breasts twice at each feed.
- Offer extra feedings, ensuring that nutritive sucking is occurring.
- Provide infant with frequent skin-to-skin contact.
- Express after feedings (see 'Expressing Breastmilk' on pg 119).
- If supplementation is indicated, preferably use mother's expressed breastmilk. Provide education regarding options for delivery of supplementation e.g. Supplemental Nursing System, cup, finger feeding and paced bottle feeding.
- Supplementation should be given according to baby's cues for hunger and satiety. Plan to reduce then cease supplementation as breastfeeding improves. Monitor growth while supplementation is withdrawn.
- Encourage woman to rest and relax, eat a healthy diet and drink according to thirst.
- Discourage smoking and alcohol intake; limit caffeine intake.
- Develop plan that includes protection of maternal breastmilk production and increased infant intake.
- Include follow up planning for ongoing growth monitoring and breastfeeding support.
- Document plan in client record and also in PHR so that other health professionals are aware.

- If maternal milk production does not increase as expected, infant does not gain weight as expected consider referral for medical review. A galactagogue may be prescribed.

Refer family to the information

- Australian Breastfeeding Association [Common concerns – mum](#)
- CHQ Fact Sheets [Increasing your breastmilk supply](#)
- CHQ Fact Sheets [Medicines information – Domperidone for improving breastmilk supply](#)



Galactagogues

Consideration may be given to informing the mother about the use of galactagogues – a medication or other substance that may increase maternal milk synthesis ¹⁶³. Due to the inconclusive research findings specific to pharmaceutical galactagogues (such as domperidone), and the lack of regulation around herbal galactagogues (e.g. fenugreek), the health care professional should use caution in delivering this information ¹⁶³. The health care professional should be guided by their scope of practice framework and local Hospital and Health Service protocols.

Supplementary feeds ^{56, 60, 164}

Supplementary feeds 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, maintenance and duration of lactation ⁵⁶.

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 in a number of ways e.g. via a nursing supplementer (supply line), bottle, spoon or cup. An optimal supplemental feeding device has not yet been identified and may vary from one infant to another ¹⁶⁴. No method is without potential risk or benefit, but it is well known that 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 breastmilk 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.
- Gradually reduce the amount of supplement as the milk supply increases.
- Increase the number of breastfeeds per day.
- Express after breastfeeds to increase milk supply and to use as a supplement when available.

- Clients should be informed of the potential outcomes for supplementary feeding and this needs to be documented in the client's record. The infant may begin to prefer the bottle and milk supply may decrease if measures aren't taken to maintain or increase supply.



Practice tips: Lactation Aids in Breastfeeding Support

See page 128

Oversupply

Oversupply is often a temporary difficulty during the early stage of lactation, prior to the 'supply- demand' process becoming established through the body's local autocrine controls ⁵⁶. 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	Symptoms of fast flow
<ul style="list-style-type: none"> • uncomfortably full breasts • unsettled, colicky infant, frothy stools • feeding frequently 	<ul style="list-style-type: none"> • fussing • choking • gulping during feeds • pulling off breast

Management

The health professionals can provide reassurance to the family that this will resolve over time.

Given that oversupply can mask an infant problem, child health professionals should investigate the infant's ability to feed before attempting to alter milk production.

However, if the oversupply continues the following can be recommended ^{56, 58, 60}:

- express a little milk until the milk ejection reflex commences and the areola softens
- pace the feed - by allowing infant to detach from the breast during periods of high milk flow
- *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 for a certain block of time, commonly referred to as 'block feeding'. **Continuing block feeding longer than is necessary to settle an oversupply can lead to a low milk supply** ⁶⁰
- express just enough to be comfortable 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 breasts. Child health professionals should provide education on preventing and recognising mastitis

Refer family to the information:

- Child Health Information booklet: [Breastfeeding: Is My Infant Getting Enough Milk?](#) ⁹⁴
- Australian Breastfeeding Association: [Breastfeeding Information: Too much milk](#)



Practice tips: Lactation Aids in Breastfeeding Support



Using a lactation aid may impact on a loss of maternal confidence to breastfeed.

Most lactation aids are used after exploring other options and for short periods only.

Cleaning of feeding devices used with breastmilk: Containers, expressing equipment and feeding devices used to feed the infant breastmilk, should be cleaned and stored as per the instructions for cleaning expressing equipment. They do not need to be sterilised for a healthy infant ^{60, 161}.



Expressing breastmilk

See page 119

Nipple Shield ⁶⁰

A nipple shield is a thin flexible silicone cover that comes in different shapes and sizes which the mother places over her nipple prior to breastfeeding. A well fitted nipple shield is when the mother is pain free, the infant is observed to be feeding nutritively and milk transfer is optimal.



Nipple shields may benefit mothers whose infants are observed to have difficulty attaching to the breast due to:

- flat or inverted nipples
- sore, cracked nipples
- prematurity

Tips for using a nipple shield

- Encourage the mother to express a few drops breastmilk onto the inner aspect of the nipple shield. This may prevent chafing and improve the seal of the shield to the breast.
- Encourage the mother to express a few drops of breastmilk into the tip of the nipple shield. This may encourage the infant to attach.
- Place the nipple shield over your nipple and hold it in place with fingers at the outer edge.
- The “cut-out” areas on the brim need to be positioned where the baby’s chin and nose will touch the breast. When there is only one cut-out section this needs to point in the direction of the infants’ nose.

Note: Some manufacturers recommend sterilising nipple shields *before first use*. Child health professionals should follow local procedures.



Australian Breastfeeding Association

Breastfeeding Information “Nipple Shields”

<https://www.breastfeeding.asn.au/bfinfo/nipple-shields>

CHQ Fact Sheets

Breastfeeding – nipple shields for breastfeeding

<https://www.childrens.health.qld.gov.au/chq/health-professionals/fact-sheets/>

Nursing supplementer / supply line ^{60, 154, 164}

A device that allows an infant to receive additional milk while at the breast rather than by bottle and teat. May be used to supplement low milk supply in the mother or may support sucking in an infant with diminished endurance and/or weak suck.



The system involves a container that may be worn on a cord around the mother's neck. Fine tubing carries expressed breastmilk, donor milk or infant formula from the container to the nipple. The tubes are taped to the mothers' breasts. The tip of the tubing should extend slightly beyond the nipple to prevent blocking of the tube opening during feeding.

- It is suitable for infants who can attach and suck at the breast but need additional supplementation during breastfeeding.
- Supports more feeding from the breast and breast stimulation, thus assisting milk supply and reducing issues relating to nipple confusion.
- The supply line may not suit all mothers. Mothers must be individually counselled so that they can make an informed decision regarding the options available.

Management

- Ensure tubing and bottle placement provides flow rate that is manageable for the infant to coordinate sucking, swallowing and breathing.
- 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 supply line and gradually reduce the reliance on the supply line. Some mothers may have a long term need for supplementing their infant e.g. impaired glucose tolerance.

Disadvantages

- Mothers may find it awkward to use especially if they are having difficulties with basic breastfeeding 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 supply line.
- 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 supply line and it's cleaning. When commencing the use of a supply line 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.



Australian Breastfeeding Association

Breastfeeding Information - Using a breastfeeding supplementer

<https://www.breastfeeding.asn.au/bf-info/using-breastfeeding-supplementer>

Cup

A small, thin rimmed cup can be a short-term effective way of administering small amounts of expressed breastmilk, donor milk or infant formula when feeding at the breast is not possible.



- Cup feeding has been shown safe for both term and preterm infants and may help preserve breastfeeding duration among those who require multiple supplemental feedings ¹⁶⁴.
- Parents need to be educated and supported on how to use this method by a health professional who is skilled in this technique.

Finger Feeding

Finger feeding involves an infant receiving breastmilk, donor milk or infant formula via a fine feeding tube or small syringe while they suck on an adult finger. As the infant sucks on the finger milk is drawn up the feeding tube from a container or from the syringe.



Finger feeding

- Finger feeding reduces the requirement to introduce an artificial teat and the motion of the tongue and jaw is like the function of feeding at the breast.
- This method is not recommended if hygiene is suboptimal ¹⁶⁴.
- Parents need to be educated and supported on how to use this method by a health professional who is skilled in this technique.

Spoon

The use of a small smooth sided spoon may be an effective short-term option for providing an infant with expressed breastmilk in the early postnatal period.

Paced Bottle Feeding

Paced bottle feeding is a method of bottle feeding that by responding to infant cues reduces the risk of overfeeding. This method can be appropriate when the breastfeeding mother and infant are separated, or the infant requires supplementary feeding. Expressed breastmilk, donor breastmilk or infant formula may be used.



Practice tips: Supporting a mother to formula feed her infant for tips on paced bottle feeding

See page 138

Mastitis is defined as an inflammation of the breast, which may or may not involve a bacterial infection¹⁶⁵. Ten to 25% of breastfeeding women will experience at least one episode of mastitis and although it occurs most commonly in the first 4 – 6 weeks of breast feeding, it can occur at any time during lactation. There appears to be a continuum from engorgement to noninfective mastitis to infective mastitis to breast abscess¹⁶⁵.

Causes

- Nipple trauma and infection.
- Inadequate breast drainage:
 - blocked ducts
 - poor infant latch
 - oversupply
 - sudden changes in feeding pattern (e.g. infant sleeping through the night)

Signs and symptoms

- Tender/hot/reddened/swollen area in the breast.
- Flu-like symptoms.
- Fever and rigors.

Complications

- Early cessation of breastfeeding.
- Untreated and unresolved mastitis may develop into a breast abscess.

Management

- Effective removal of milk from the breast:
 - 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 or nose is 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 breast is not drained after feeding, consider expressing.
- Supportive measures
 - Encourage rest, nutritious diet and adequate fluids.
 - Apply a warm cloth to the affected area before / during the feed.
 - Apply cold packs after the feed to reduce pain and swelling.
- If symptoms persist, refer to a medical officer for antibiotics, analgesia and if severe, hospitalization may be required.

Refer family to the information:

- **Child Health Information booklet:** '[Common Breastfeeding Concerns: Common Early Problems – Swollen Breasts, Blocked Ducts, Mastitis](#)'

- **Australian Breastfeeding Association:** [Breastfeeding Information: Mastitis](#)
- **Videoclip:** Australian Breastfeeding Association [Mastitis](#)

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.
- It is particularly important for women already taking psychotropic medication to be encouraged to seek specialist advice before decisions about ceasing breastfeeding and/or the prescribed medication.
- Smoking while breastfeeding can have a direct negative impact on milk quality and quantity, as infants are exposed to tobacco compounds in breastmilk.
- Infants and children exposed to tobacco smoke are at higher risk of SIDS; respiratory infections; middle ear disease.
- Alcohol concentration in breastmilk mirrors the concentration in the bloodstream.
- Consumption of more than two standard drinks a day during lactation can lower lactational performance, suppressing the action of oxytocin and leading to early cessation of breastfeeding.

Refer family to the information:

- **Child Health Information booklet:** '[Common Breastfeeding Concerns: Drugs and Breastfeeding](#)'
- **Australian Breastfeeding Association:** [Alcohol and Breastfeeding](#)
- **Australian Breastfeeding Association:** [Breastfeeding and smoking](#)
- **Smoke-free Families program - Quitline:** www.qld.gov.au/quitthq
- **Australian Government Department of Health Topics:** <https://www.health.gov.au/health-topics>



Drugs and Lactation Database (LactMed)

<https://www.ncbi.nlm.nih.gov/books/NBK501922/>

Tobacco in Australia - Child health and maternal smoking

Summarises research on perinatal smoking

<https://www.tobaccoinaustralia.org.au/chapter-3-health-effects/3-8-child-health-and-maternal-smoking>

Alcohol, tobacco and other drugs

Queensland Health

<https://www.health.qld.gov.au/public-health/topics/atod>

Insight

Centre for alcohol and other drug training and workforce development

<https://insight.qld.edu.au/>

Queensland Drug Information Centre

Royal Brisbane & Women's Hospital

Tel: 3636 7098 / 3636 7599

NPS Medicines Line

After hours and on weekends, contact local public hospital, GP or pharmacy

Tel: 1300 633 424 (1300 MEDICINE)

Multiple births ⁶⁰

- 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 clean floor so one infant can easily be put down without disturbing the other.



Freepik.com

Feeding through pregnancy and tandem feeding ⁶⁰

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 supply may decrease as pregnancy progresses due to pregnancy hormones
- milk may revert to colostrum
- some women feel nauseous
- maternal fatigue
- need for adequate nutrition for the mother is important



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

- When breastfeeding an infant and toddler:
 - it is important that the infant has priority at the breast
 - 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



Australian Breastfeeding Association

<https://www.breastfeeding.asn.au/bf-info/breastfeeding-through-pregnancy-and-beyond>

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 lingual frenulum.



Image courtesy of Roberta Martinelli 'Lingual Frenulum Protocol for Infants'.

- This tethering can restrict the tongue from elevating and extending past the lower gum and may result in an ineffective latch, inefficient milk transfer, and increased maternal discomfort during breastfeeding^{166, 167}.
- It is important to note, that tongue-ties may be present without impacting the breastfeeding, with a reported incidence of breastfeeding difficulties in 25% to 80% of tongue-tied infants^{166, 167}. Shorter breastfeeding duration in infants with a tongue-tie has also been reported¹⁶⁶.

There has been much debate among experts about upper lip-ties in infants and their effect on feeding:

- Some discussions suggest this tethering of the upper lip may restrict flanging of the lip during breastfeeding or bottle feeding, resulting in a poor latch^{166, 168}.
- In 2017, the Australian Collaboration For Infant Oral Research (ACIOR) released a position statement on upper lip ties advising there was a wide range of anatomic variation in labial frenulums which do not impact on lip function during breastfeeding because it is not essential that the lip flanges to form an effective seal¹⁶⁹.

Similarly, there is limited literature on posterior tongue-tie:

- Some studies identify an improvement in symptoms with surgical intervention to release a posterior tongue-tie¹⁶⁸, while other experts argue that described feeding difficulties can be attributable to other causes of impaired tongue function and that using this term can result in a normal frenulum being classified as abnormal^{170, 171}.
- The Australian Dental Association's consensus statement recommends that this term not be used as a medical diagnosis¹⁷¹.

Potential signs of ankyloglossia:

- Poor attachment e.g. clicking noises, milk leakage during attempted latch, unable to maintain latch.
- Poor weight gain, infant tires quickly during feeds, unsettled infant.
- Tongue tip may appear heart or square shaped.
- Poor tongue function – including extension, elevation and lateralisation.
- Maternal pain during breastfeed, nipple trauma, pinching or creasing, low milk supply.

If the child health professional suspects an oral anomaly or tongue restriction that is impacting on breastfeeding:

- Conduct a comprehensive breastfeeding and lactation assessment, including feed observation, feeding history, infant and maternal assessment.
- Support mother with advice on positioning and attachment, latch optimization, feed frequency, milk production and other devices such as nipple shields or supplementary nursing systems if required.
- Some child health professionals with additional training may undertake additional observation using tools to assess the function of the tongue, such as the Lingual Frenulum Protocol or the Hazelbaker Assessment Tool for Lingual Frenulum Function.
- Referral to GP/ Medical Officer with experience in this area to facilitate diagnosis and treatment options for families to consider, such as frenotomy.

- Consider offering referral to: Feeding Clinic, Early Parenting Service, LANCZ, GP, MO, Ellen Barron Family Centre.
- Provide ongoing support and review of progress through follow up visits.



Sometimes tongue-tie may be present without having an impact on the breastfeeding dyad, 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.



Tongue-tie and breastfeeding – Includes videoclip by Dr Lisa Amir

Australian Breastfeeding Association

<https://www.breastfeeding.asn.au/bf-info/tongue-tie>

Tongue-tie: Information for families Factsheet

The Royal Women's Hospital (Victoria)

<https://thewomens.r.worldssl.net/images/uploads/fact-sheets/Tongue-tie-010219.pdf>

Tongue-tie in babies

Children's Health Queensland factsheets

<https://www.childrens.health.qld.gov.au/chq/information-for-families/fact-sheets/>

Weaning

- Weaning may be infant-led, mother-led or mutual and can be sudden or gradual ⁶⁰.
- 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 breastmilk 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.
 - It is suggested to start by dropping the feed the infant is least interested in, then reduce another feed every few days depending on the individual situation ⁶⁰.
- Some situations may result in a mother weaning suddenly e.g. maternal illness or 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 ⁶⁰. In this situation:
 - A mother should be advised to express for comfort only, until lactation diminishes.
 - Some women with a large milk supply may require additional assessment and support by their child health professional or support service during this time ⁶⁰.
- 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 family to the information:

- **Child Health Information booklet** : Common Breastfeeding Concerns: When Do I Stop Breastfeeding?
- **Australian Breastfeeding Association**: Weaning and introducing solids



Eat for Health – Australian Dietary Guidelines

www.eatforhealth.gov.au

Raising Children Network

<http://raisingchildren.net.au>

Australian Breastfeeding Association

Breastfeeding Information “Weaning”

<https://www.breastfeeding.asn.au/bf-info/weaning-and-introducing-solids/weaning>



Refer to the Chronic Conditions Manual

<https://www.publications.qld.gov.au/dataset/chronic-conditions-manual-2nd-edition-2020>

Safe use of infant formula

Health workers have a responsibility to promote breastfeeding first, but when women are unable to, or have made an informed decision not to breastfeed, providing individual education around the safe use of infant formula is indicated.

A mother’s informed decision not to breastfeed should be respected and any feelings of grief or loss should be acknowledged, and appropriate support provided⁵⁶.

Under the WHO International Code of Marketing of Breast-milk Substitutes:

- Feeding with infant formula should only be demonstrated by health workers, or other community workers if necessary, and only to the mothers or family members who need to use it.
- The information given should include a clear explanation of the hazards of improper preparation and storage.
- These one-to-one sessions may include⁵⁶:
 - 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 feeding

- 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 infant/child, for example:
 - putting babies/toddlers to bed with a bottle increases their risk of ear infections, dental caries and is a choking risk ⁵⁶
 - not holding and cuddling the infant while feeding may disrupt the development of the maternal-infant relationship⁵⁶
 - propping the bottle and leaving the infant to feed unattended is a hazard for choking as the milk flow is unregulated ⁵⁶
 - 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 ¹⁷²
 - chronic use of infant 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 ¹⁷²



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Practice tips: Supporting a mother to formula feed her infant

Infant formula requirements ⁵⁶

- As with breastfeeding, formula-fed infants should be fed according to need i.e. fed in response to their hunger cues and the feed stopped in response to cues of satiety ¹⁷².
- Each infant is unique, and needs vary from day to day. A holistic assessment for signs that an infant is thriving should be explained to parents, rather than focusing on the quantity of infant formula consumed.

Refer the family to the “*Is my infant getting enough*” section of the [Child Health Information booklet](#) if concerned about how much their infant is drinking.

- As a *guide*:
 - Day 1-4: 30-60ml/kg/day
 - Day 5- 3 months: 150ml/kg/day
 - 3 – 6 months: 120ml/kg/day
 - 6- 12 months: 100ml/kg/day.

Some infants, especially those preterm, may require up to 180-200 ml/kg/day.

- It is important that infant formula is made up according to the directions and is not too diluted or over concentrated. Too diluted may result in faltering growth, while over concentrated infant formula may result in constipation in the infant.
- It is recommended that infant formula, be reconstituted with cooled boiled tap 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.
- Unlike breastfeeding, formula fed infants may require additional cooled boiled water to maintain adequate levels of hydration during times of potential heat stress (e.g. due to hot weather or fever) ⁴⁹.

Choosing infant formula ⁵⁶

There are many different infant formulas available in Australia. Despite being marketed differently, there is minimal difference between the composition of most infant formulas, and all must comply with regulations defined by Food Standards Australia New Zealand (FSANZ) ¹⁵⁷.

Specialised formula should only be used where there is a diagnosed, indicated use and should be done so in consultation with a Dietitian or medical officer.

- Standard infant formula – labelled ‘suitable from birth’, this is for babies up to 12 months of age. Standard cow’s milk based infant formula, with a lower protein level is the recommended choice.
- Follow-on infant 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.
- Toddler milks - designed for children 1 – 3 years. Pasteurized, full cream cow’s milk is recommended to be introduced as a drink from 12 months, and as such, toddler milk formulas are not considered nutritionally necessary.
- Thickened infant formula – thickened formula is available and often recommended for the treatment of Gastro oesophageal reflux disease (GORD). A recent Cochrane systematic review concluded that feed thickeners should be considered if regurgitation symptoms persist in otherwise healthy, full term

bottle-fed infants. Moderate evidence points to a decrease in the number of reflux episodes, which is likely to be of significance to caregivers¹⁷³, and thus may be recommended by the GP/MO^{174, 175}.

- Extensively hydrolysed or soymilk-based formulas may be used under medical supervision for infants who cannot take cow's milk-based products. Other allergy formulas also are available but require a medical prescription. Goats milk formula is not a suitable alternative for infants with allergies to cow's milk-based formula.
- Premature infant formula – is specifically designed for the nutritional needs of a premature infant. This is not suitable for healthy term babies.

Making the formula⁵⁶

- 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 sakazadaii*⁵⁶. 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 tap water that has been cooled to body temperature when preparing infant formula⁵⁶.
- 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 after each use:
 - › 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 formula feeding equipment.
- Care should be taken to ensure formula is made up according to manufacturer's instructions, including:
 - Pour the correct amount of cooled, previously boiled water into a sterilised bottle.
 - Always add water to the bottle first, then powder.
 - Measure the formula carefully using the scoop from the container (do not to mix up scoops from other containers).
 - Level scoops with a knife.
 - Add the correct number of scoops. Using the wrong strength of formula (i.e. too much or too little powder) may harm the infant.
 - Place the teat and cap on the bottle and shake it until the powder is completely dissolved.
- 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.

How to bottle feed ⁵⁶

- 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 deformational 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 unsafe, 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 and not mixed well. Check teats often.
- Paced bottle feeding is a method of bottle feeding that, by responding to infant cues, assists the infant to coordinate their sucking and breathing during a bottle feed.

Tips for Paced Bottle Feeding:

- Hold the infant in an upright position with the bottle almost vertically against infant's lips.
- Tip the bottle horizontally into the infant's opening mouth, allowing the infant to draw the teat in. Ensure the infant's lips enclose the wide aspect of the teat, not just the narrow end.
- Maintain the infant in a semi upright position, so that the bottle is nearly horizontal in the infant's mouth. This will prevent the milk overwhelming the infant with a fast flow and allows the infant some control over the pace.
- Alternate the holding position of the infant from one arm to the other during the feed.
- In the event of the infant becoming unsettled or gulping, tilt the infant and bottle slightly forward so the milk drains away. This supports the infant to learn to pause on their own.
- Follow the infant's cues, pause, and take breaks as the infant indicates.
- Even when fed properly, an infant will swallow 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, do not 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 the infant is satiated, i.e. lack of interest in the feed, easily distracted, stops sucking, pushes the teat out of the mouth, turns the head away).
- Discard any leftover milk.
- Any formula that has been at room temperature for longer than 1 hour should be discarded.



Raising Children Network

How to bottle feed your infant

<http://raisingchildren.net.au>

Introduction of solid foods ^{52, 55, 56, 176, 177}

- 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 ⁵⁶.
- Parents should be advised to introduce solid foods to their infant at around 6 months⁵⁶, 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
 - tongue extrusion reflex has diminished
 - infant watches with interest when others are eating, may reach out for food
 - seems hungry between milk feeds
 - opens mouth when offered a spoon
- Introducing solid food too soon (before 4 months) may impact infant gut health and increases the risk of developing food allergy.
- Delaying the introduction of first foods *beyond* 6 months may increase the risk of developing allergies, faltering growth and micronutrient deficiencies.
- Premature babies have different nutrition needs to babies born at term. Queensland Health recommends starting solids when premature infants are around 5 – 7 months of their actual age, but not before 3 months of their corrected age¹⁷⁸.
- First foods should be offered after breastmilk or infant formula and should be high in iron and zinc as infant stores are declining at this time.
- 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.
- By twelve months of age infants should be being offered 5 small meals per day and enjoying a variety of nutritious family foods in addition to breastmilk where possible. By 12 months, breastmilk should be offered after meals.
- Introduce a cup from 6 months of water.
- From 12 months, tap water and pasteurised full-cream milk are preferred drinks and should be offered in a cup rather than a feeding bottle.
- Sweetened fluids, e.g. juice, are not recommended and are associated with increased dental caries.

Foods to avoid

- Nutrient poor foods with high levels of saturated fat, sugar, salt.
- Whole nuts or similar hard foods under three years to reduce the risk of choking.
- Honey (may contain *Clostridium botulinum* and cause illness in the infant under 12 months).
- Uncooked eggs (may contain bacteria that could be harmful for infants under 12 months).
- Unpasteurised milk.
- Low fat or reduced fat milk products are not recommended for infants and children under the age of two years.
- Milk as the main drink before the age of 12 months (small amounts can be added to food).
- Teas, herbal teas, coffee, sugar sweetened drinks.



Health Promotion: Introducing Solids

See page 200

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 ^{32, 56, 92}.



Raising Children Network

<http://raisingchildren.net.au>



Refer to the Pathways to Rural and Remote Orientation and Training

<https://ilearncatalogue.health.qld.gov.au/program/17/parrot-primary-care>

Health concerns

Unsettled or persistent crying

- Crying is a normal physiological behaviour in young infants. Crying time peaks at around 6-8 weeks of age, when, on average, infants will cry for 2-3 hours a day. Some infants will cry much more than this while others will cry less^{179, 180}.
- Parents often present as distressed, exhausted, and confused, often having received conflicting advice.
- Excessive crying is a risk factor for abusive head trauma ('shaken baby syndrome') and has been linked to postnatal depression and early cessation of breastfeeding^{179, 181, 182}.
- 'Colic' is an older term that is still sometimes used to describe this common period of persistent crying¹⁷⁹.
- Characteristics of normal crying / unsettled periods:
 - starts around 2 weeks, peaks at 6 -8 weeks and usually settles around 3-4 months of age
 - commonly worse in the late afternoon/evening, but it may occur at any time
 - may last several hours
 - infants often draw their legs up or scrunch up their face as if in pain
 - infants can be difficult to console during these periods
- Infant temperament, sleep requirements and feeding patterns are thought to be the common non-pathological causes of persistent crying¹⁸⁰.
- All infants with persistent crying should have a complete medical assessment to rule out underlying medical conditions for example: cow's milk protein allergy, otitis media, inguinal hernia, urinary tract infection, injury, raised intracranial pressure and intussusception^{32, 179}.
- When an organic cause has been excluded, supportive strategies are recommended to help the parents manage the infant's crying¹⁸⁰.
- Whilst there are numerous suggested remedies/treatments/medications for infant 'colic', there are none that have a strong evidence base and assure infant safety. This includes anti-reflux medications, 'colic' mixtures, changing formulas (except in diagnosed cow's milk protein allergy) or spinal manipulation therapies^{179, 183, 184}.
- Emerging research is drawing possible links between unsettled crying and low numbers of, and less diversity in, the intestinal microbiota. Evidence is mounting in the effectiveness of probiotics in the prevention of persistent crying, with some studies showing a decrease in daily cry time with the use of a probiotic (*Lactobacillus Reuteri*), but conflicting study results have prevented a consensus on whether it is truly effective¹⁸⁵.

Management

- Conduct a comprehensive 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 and coping 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 persistent crying and the increased rate of abusive head trauma in relation to peak infant crying¹⁸²

- Exploration and discussion around parent supports 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. ParentLine Queensland, I3HEALTH safety plan (See *Practice tips: Developing a safety plan* pg.319)
 - self-care promotion
 - attend parenting groups or other support networks
- Discuss options that may assist in soothing unsettled infants, for example¹⁸⁶:
 - checking infant for hunger and comfort (dry nappy, not hot or cold)
 - gentle rocking movements
 - going for a walk in the pram
 - a warm bath
 - gentle touch and massage
 - decreasing stimulation e.g. dimming the lights
 - non-nutritive sucking (at the breast or pacifier if used)
- Additional breastfeeding 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 ^{32, 56, 174}.
- Some infants may be reported to be a 'happy spitter' with simple, recurrent 'spills' and most infants will have no relationship between GOR and the disease – GORD (see below)¹⁷⁵.
- Often the amount posseted appears to be large and is worrying for the parents, but, as long as the infant is continuing to gain weight and is contented, it is of no concern.
- GOR can cause considerable parental distress, and requires reassurance, support and anticipatory guidance. General measures may minimize symptoms, for example parents may be advised re^{175, 187}:
 - use of bibs (remembering safety)
 - holding the infant upright after feeds
 - continue to sleep the infant on his back
 - observe infant through regular health surveillance
- 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 umbilicus. This condition requires immediate medical intervention ³².

Gastro oesophageal reflux disease

- Gastro oesophageal reflux disease (GORD) occurs when GOR causes complications such as: Oesophagitis, weight faltering, aspiration, respiratory symptoms including chronic cough, wheeze or apnoea, haematemesis ¹⁷⁵.
- Symptoms include pronounced infant irritability, excessive crying with arching of the back and neck extension particularly with feeding, refusal to feed, poor growth ^{32, 175}.
- Conduct a comprehensive 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 breastfeeding support may be required with supporting the mother to continue to breast feed during the infant's unsettled periods.
- Additional support may be required around bottle feeding for example ¹⁷⁵:
 - avoid aerophagia (swallowing of excessive air) by keeping bottle horizontal, paced feeding and using the appropriate flow teat
 - avoid overfeeding
 - avoid change of formula unless recommended by GP/MO
- Keeping the baby upright during and immediately after a feed may be helpful ^{32, 174, 175}.
- Discussion with family about infant cues relating to feeding and tiredness.



Full examination should include observation for non-accidental injury and abusive head trauma, e.g. bruises, petechiae due to the high rates of parental stress often associated with peak infant crying ¹⁸²

- Exploration and discussion around parent supports 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. ParentLine Queensland, I3HEALTH
 - safety plan (*See Practice tips: Developing a safety plan pg. 319*)
 - self-care promotion
 - attend parenting groups or other support networks
- 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.
 - Use EPDS / DASS / Attachment Assessment Tools.
- If symptoms of GORD are present the health care professional should refer the infant for a medical review ¹⁷⁵.
- Medical officers may consider the following ^{174, 175}:
 - **Differential diagnosis:** Normal infant crying (see page 113), persistent crying 'colic', cow's milk protein allergy (*see page 293*), lactose overload.
 - Other medical conditions, e.g. infection, injury, inguinal hernia, pyloric stenosis, intussusception.

- **Conservative management** may be suggested when infant is thriving, this may include positional measures, e.g. holding infant upright after feeds; avoid overfeeding.

- **Medication:** Proton pump inhibitors (PPI) e.g. Omeprazole are recommended as the first line medication in erosive GORD.¹⁷⁴

Antacid suspensions e.g. Gaviscon can lead to excessive ingestion of aluminum⁵⁶ and are not recommended¹⁷⁴.

- **Thickening of infant feeds:** A recent Cochrane systematic review concluded that feed thickeners should be considered if regurgitation symptoms persist in otherwise healthy, full term bottle-fed infants. Moderate evidence points to a decrease in the number of reflux episodes, which is likely to be of significance to caregivers¹⁷³, and thus may be recommended by the GP/MO ^{174, 175}.

- Provide ongoing support and review of progress through follow up visits.



Gastroesophageal reflux disease in infants and Unsettled or crying babies

The Royal Children's Hospital Melbourne

https://www.rch.org.au/clinicalguide/guideline_index/Gastroesophageal_reflux_disease_in_infants/

Raising Children Network

<http://raisingchildren.net.au>



Refer to Primary Clinical Care Manual

<https://www.health.qld.gov.au/rscsu/html/PCCM>



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Introduction
Section 1: Antenatal
Section 2: Birth to five years
Section 3: Five to twelve years
Section 4: 12 to 18 years
Appendix & References

Developmental surveillance and health monitoring

Developmental assessment (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 childcare, kindergartens and other settings³².
- 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 ³².
- 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 caregivers¹. Promotion and monitoring of immunisation can also be undertaken at this time.

The schedule of well child health checks 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		93

* An Aboriginal and Torres Strait Islander child and youth health worker may undertake the health checks if appropriately trained

- For staff working in school settings work in partnership with Department of Education, 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 pg. 323 *Practice tips: Working within school settings*
- Parents may wish to access additional services to complement well child health checks, such as:
 - self-weigh facilities (e.g. at child health clinics)
 - drop-in, open plan clinics
 - reputable 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.
- 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 child¹.

Other health checks

- Additional population screening through health checks are offered to rural and remote populations as part of the Chronic Conditions Manual recommendations⁹⁵.
 - 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 diseases⁹⁵.
 - Additional screening/assessments are recommended, for example annual body measurements from 4 years; additional ear and hearing assessments; additional clinical measurements e.g. Red eye reflex, heart sounds and haemoglobin; annual BMI from 2 years of age.
- Aboriginal and Torres Strait Islander children are eligible for a health assessment by a GP/Practice Nurse/Aboriginal health worker/practitioner every 9 months as part of the 'Aboriginal and Torres Strait Islander Peoples Health Assessment'⁹⁶



Refer to the Chronic Conditions Manual

<https://www.publications.qld.gov.au/dataset/chronic-conditions-manual-2nd-edition-2020>



Refer to the Pathways to Rural and Remote Orientation and Training

<https://ilearncatalogue.health.qld.gov.au/program/17/parrot-primary-care>

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 child¹.

- Family structures are varied including^{7, 38}:
 - extended families e.g. grandparents, aunts and uncles, Elders and kinship carers
 - foster families
 - single parent, step and blended families
 - lesbian, gay, bisexual transgender, intersex, queer, asexual, gender diverse, and questioning (LGBTIQ+) parents
- Understanding and respecting different child-rearing practices is important for planning and delivering services that reflect individual parenting choices and styles⁷.
- 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 whole³⁹.
- It is recommended that services facilitate greater involvement of fathers/partners/extended family by considering a range of strategies⁴⁰.

- 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 and offering telehealth options for fathers who are away^{39, 41}.
 - 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^{39, 42}.
 - 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 practices⁴³.
 - Discuss transition to parenthood issues including parenthood roles, lifestyle and relationships changes⁴⁰.
 - 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, consideration of offering single gender (dads) groups^{39, 44}.
 - Use a strengths-based approach when working with fathers⁴¹.
- Family members are encouraged to attend appointments with the child and attendance at group-based parenting programs is also encouraged. Parenting groups (e.g. Triple P, Circle of Security) 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^{44, 45}.
- Aboriginal and Torres Strait Islander families should be supported with access and engagement with child health primary care services.
 - Having Aboriginal and Torres Strait Islander staff, who are well respected and well connected to the community, and a culturally welcoming environment, facilitates inclusiveness of Aboriginal and Torres Strait Islander families^{39, 40, 42}.
 - There may be barriers for families in attending an in-person appointment, which may be overcome with the use of telehealth services. Therefore, it is important to⁴⁶:
 - › Raise awareness with families about the availability of telehealth.
 - › Help with resourcing at the clients end if needed.
 - › Provide cultural support to arrange the telehealth appointment and during the appointment.
 - › Support the attendance of family.



Aboriginal and Torres Strait Islander families

See page 262



Webinar: Refining the task of father-inclusive practice

Child Family Community Australia (CFCA)

<https://aifs.gov.au/cfca/events/refining-task-father-inclusive-practice>

Family Action Centre, Newcastle University

Resources and education for staff on father-inclusive practice

<https://www.newcastle.edu.au/research-and-innovation/centre/fac/about-us>

Raising Children Network

Resources (video and fact sheets) on a variety of topics.

<http://raisingchildren.net.au>

PANDA

Resources for paternal perinatal anxiety and depression

<https://www.panda.org.au/info-support/how-is-dad-going>

Family health assessment

All families are unique and come from diverse backgrounds. There are many biological, psychological and social factors that may influence a person's ability to parent. Completing a family health assessment provides an opportunity to get to know the family. It enables the child health professional to develop a relationship with the family, whilst identifying the family's strengths and complexities³⁸. This is vitally important as the evidence suggests a child's family and the environment in which they live and grow can have a profound lifelong impact on the trajectory and outcomes of their health, well-being and development^{8, 97}. Nurturing an infant in the early years impacts how children develop, their capacity to learn, their behaviour and ability to regulate their emotions, and their risks for disease in later life⁸.

- There is no universal standard of what 'good' parenting is, however, there are characteristics that appear to enrich the parenting role such as^{37, 98-100}:
 - 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.
 - Consistent, kind and positive parent-child interactions (e.g. warm, responsive and supportive parenting).
 - The ability to be consistent yet flexible when necessary, in response to the changing demands within family life.
 - An ability to delight in their child and understand that getting it right most of the time is good enough.
- The purpose of family health assessment is to^{1, 38, 101}:
 - Gain a clear understanding of the factors relating to the health and wellbeing of the child that may potentially impact upon family functioning.
 - Engage with the family using a partnership approach, develop a therapeutic relationship and work from a strengths-based perspective to build upon their parenting capacity and skills.
 - Identify family strengths, resources and needs to support formulation of an individualised plan of care with the family.
- A comprehensive family health assessment is foundational to child health surveillance and health monitoring^{37, 38}. Identification of family needs enables appropriate interventions and referral to appropriate services and supports. Child health professionals utilise advanced communication skills to engage with families and address sensitive issues, including domestic and family violence and mental health issues, and work in partnership with the family to negotiate, plan, implement and evaluate the most appropriate, culturally responsive care for the child and their family.
- If available, Aboriginal and Torres Strait Islander Advanced Health Workers should be involved in the family health assessment conversation and in developing the cultural aspects of the care plan for Indigenous families.

- Social determinants and family functioning also impact on the health outcomes of children. Population groups where additional needs may be identified include: ^{1, 38, 75, 76}
 - Families where drug and alcohol misuse is a problem.
 - Families with low incomes; unstable housing.
 - Family structured with single parents, parents with multiple re-partnering experiences, blended families, teenage parents.
 - 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.
 - Aboriginal and Torres Strait Islander families.
 - Refugee Families.
 - Families with CALD backgrounds.
 - Critical Events (e.g. loss of employment, illness, disability or death of a family member).



When risk factors are identified additional care may be required.

See relevant area in Responding to Need pg. 288 and Early Identification pg. 260 sections



Practice tips: Conducting a family health assessment

See page 64

Sample template of a Family Health Assessment

See Appendix 3



Family Health Assessment – A guide for child health clinicians practicing within the primary health care setting

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

AIDET and SBAR toolkit

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



Assessing Mother-Infant interaction

Centre of Perinatal Excellence (COPE)

<https://www.cope.org.au/wp-content/uploads/2018/07/Assessing-Mother-infant-Interaction.pdf>

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 assessment of the individual health status of a child. The extent of examination varies depending on the circumstances of each health contact ⁹².
- Ongoing physical assessments are undertaken by the child health professional according to the well child checks schedule in the PHR and at additional contacts at the discretion of the child health professional ¹⁰².
- Physical growth is best assessed by measuring weight, height and BMI and comparing these measures with a growth reference^{49, 92}. (See section on *Growth* pg. 169)
- Oral health and lift the lip assessment:
 - Decay in deciduous teeth is a predictor of decay in permanent teeth. If identified early, preventive measures can be undertaken to prevent the progress of decay¹⁸⁸.
 - Queensland's children have one of the highest rates of dental decay in Australia⁸⁰. One of the foundational areas of Australia's National Oral Health Plan 2015 – 2024 ¹²¹ includes recommending relevant health and wellbeing checks incorporate oral health components.
 - Oral health risk assessments, including checking for healthy mouths, should be included in the routine physical examination of all infants and children. See pg. 156 *Practice tips: Conducting a lift the lip / oral health screen*.
- Ear Health and hearing surveillance:
 - Ensure that universal hearing checks have been completed in the child's first year and if any follow up is required ¹¹³.
 - Aboriginal and Torres Strait Islander children currently have one of the highest rates of otitis media in the world. In 2016, *Deadly Kids, Deadly Futures*, Queensland's Aboriginal and Torres Strait Islander ear and hearing health policy. recommended ear health and hearing surveillance be embedded as a routine component of all age child health services¹¹⁹.
 - In addition to ear health questions completed at each health check and otoscopy/ tympanometry completed for Aboriginal and Torres Strait Islander children, from 4 years otoscopy, tympanometry and audiometry should be attempted on all children ^{93, 95}. See table below
- Eye health and vision screening
 - 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 include¹⁸⁹:
 - › Amblyopia or 'lazy' eye (decreased/blurry vision in one or both eyes)
 - › Strabismus or 'cross-eyed' (misalignment of the eyes)
 - › Refractive error – short or far sightedness or astigmatism
 - In addition to eye appearance, fixing and following, corneal light reflex and red eye reflex assessments completed at each health check, cover tests and visual acuity screening should be performed from 4 years^{93, 95}. See table below
- An overview of the full head to toe physical assessment is contained in the Appendix of the Guideline Assessing infant / child nutrition, growth and development within the Queensland Health, primary health care setting.
- Additional assessment / screening is recommended for infants and children living in rural and remote Queensland populations. See the Chronic Conditions Manual – Section 2: Child Health Checks.



Practice tips: Conducting a lift the lip / healthy mouth screen

See page 156

Practice tips: Conducting visual screening

See page 158

Practice tips: Conducting a hearing and ear health check

See page 161

Aboriginal and Torres Strait Islander families

See page 262

Physical assessment specifics (one to five years)

Age	Physical characteristics ^{32,95}
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 lift the lip / oral health assessment (see below).Complete a visual screen (see below):<ul style="list-style-type: none">fixing and followingcorneal light reflexred eye reflexAboriginal and Torres Strait Islander children:<ul style="list-style-type: none">Complete Otoscopy and Tympanometry (see below)
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 172).Complete a lift the lip / oral health assessment (see below).Complete a visual screen (see below):<ul style="list-style-type: none">fixing and followingcorneal light reflexred eye reflexnear cover testAboriginal and Torres Strait Islander children:<ul style="list-style-type: none">Complete Otoscopy and Tympanometry (see below)

Age	Physical characteristics ^{32,95}
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 lift the lip/oral health assessment (see below). • Complete a visual screen (see below): <ul style="list-style-type: none"> ○ fixing and following ○ corneal light reflex ○ red eye reflex ○ near and far cover tests ○ visual acuity • Hearing and ear health check (see below): <ul style="list-style-type: none"> ○ otoscopy ○ tympanometry ○ audiometry • Immunisation – is the child immunised as per recommendations?



Guideline: Assessing infant / child nutrition, growth and development within the Queensland Health, primary health care setting.

Queensland Child and Youth Clinical Network

<https://www.childrens.health.qld.gov.au/wp-content/uploads/PDF/qcycn/growth-guideline.pdf>



Refer to the Pathways to Rural and Remote Orientation and Training

<https://ilearncatalogue.health.qld.gov.au/program/17/parrot-primary-care>



Refer to the Chronic Conditions Manual

<https://www.publications.qld.gov.au/dataset/chronic-conditions-manual-2nd-edition-2020>



Refer to Primary Clinical Care Manual

<https://www.health.qld.gov.au/rccsu/html/PCCM>



Practice tips: Conducting a lift the lip / oral health screen

The Lift the Lip program aims to improve children's oral health through early access to oral health care as evidence shows the progress of tooth decay can be prevented if it is identified early¹⁸⁸.

- It consists of:
 - screening
 - risk assessment and health promotion
 - early referral and engagement with dental services

Screening

- The primary purpose is to identify tooth decay early so that preventive measures can be implemented to prevent further progress of decay. This decay is easy to recognize as it generally always starts on the outer surfaces of the upper front teeth near the gum line.
- Position the infant/child in a position that will allow reasonable view of the mouth e.g. lying on an examination table or sitting on parent's lap in front of you.
- Examiner lifts the upper lip or requests parent/older child to lift the upper lip. Do not put your fingers into the infant's or child's mouth.
- Inspect the inside of the mouth looking for:
 - pink moist mucous membranes
 - pink firm gums (not red or swollen)
 - presence of teeth, number of teeth
 - teeth should be whitish, smooth and free from plaque
 - there should be no chalky white spots or patches, or yellow/brown discolouration
 - presence of any visible dental caries (holes)
 - presence of unusual lumps, sores, infections or abscesses
 - presence of pain



"Adapted from original concept developed by South Australia Dental Services and Oral Health Services Tasmania with permission"

Risk assessment and health promotion

- Oral health promotion and oral disease prevention should be explored and discussed with parents/ carers during key age health checks (see *Oral Health Promotion* pg. 219 and pg. 237)
- Identify potentially harmful factors that may adversely affect the infant/child's oral health. For example high consumption of sugary foods or drinks, frequent unhealthy snacking between meals, low rates of tooth brushing, no fluoride, parent with active/visible decay, unhealthy dummy practices (e.g. cleaning in parents mouth, dipping in something sweet, extended use into childhood), going to bed with a bottle of formula or sugary drink.
- Offer brief intervention and anticipatory guidance as indicated.
- Discuss general oral health messages for the whole family.
 - Brush Well – twice a day with fluoride toothpaste.
 - Eat well – choose healthy foods, lower sugar intake.
 - Drink well – tap water, limit sugary drinks, preferably from a cup after 12 months.
 - Play well – protect teeth from injury, cessation of smoking.

- Stay well – regular dental checkups for the family, regular ‘lifting their child’s lip’.
- see *Oral Health Promotion* pg. 219 and pg. 237 (0-12 months or 1-5years)

Early referral and engagement with dental services

- Regular dental checkups play an integral part in prevention of decay.
- Refer to public sector Oral Health Services (if eligible) or encourage engagement with a private dental practice for the whole family.

Documentation

Detail findings of the examination and any actions taken in the child’s medical record.

Referral

Any abnormalities should be referred to an oral health professional for assessment and treatment. Early decay (white spot lesions/lines) are reversible if treated early. Advanced decay or abscesses require immediate referral and treatment.



Oral Health Promotion

See page 219 and 237



Refer to the Chronic Conditions Manual

<https://www.publications.qld.gov.au/dataset/chronic-conditions-manual-2nd-edition-2020>



Refer to the Pathways to Rural and Remote Orientation and Training

<https://ilearncatalogue.health.qld.gov.au/program/17/parrot-primary-care>



Practice tips: Conducting vision screening ^{95, 189}

- Ask the parent/carer 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/carers to be aware of the need for follow-up with their eye specialist.
- **Fixation and following objects:** use an interesting toy to slowly track in a 'H' pattern about 30cm 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.
- From 6 months a child should be able to track the object without any abnormal eye movements.
- **Corneal light reflex:**
 - Child 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 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, central part of each cornea. It is normal for the light reflex to be slightly nasal to dead centre (positive angle Kappa).
 - Observe for is asymmetry of the corneal light reflexes.
 - Document findings (e.g. corneal light reflexes R = L or equal).
- **Red eye reflex: completed by trained staff.** 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.
- **Cover tests**
 - The far cover test is completed first, followed by the near cover test
 - › Far cover test – vision tested to 6 metres
 - › Near cover test – vision tested to approximately 30cm
 - Explain the steps to the child using an eye cover (e.g. hand-held eye occluder or a piece of card).
 - Ask the child to look at an object e.g. toy, finger puppet, whilst keeping their eyes still.



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 focused on the object due to age.

- Document findings such as 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)

- The recommended tools to assess visual acuity in this age group that may be used for vision testing include:
 - The Parr 4m Letter Matching Vision Test (for younger children).
 - Snellen Chart (for older children).
- Children do not have to be literate to have their vision assessed. Reassure parents that this is a 'matching game' and not unlike asking a child to match a square or circle when asked.
- Establish a routine of testing the right eye first, as results of the right eye are usually recorded first.
- Use a cover such as an eye patch to occlude the eye not being tested.
- Make sure the child is not facing a window or other bright light source that could make it difficult for them to see (be aware of any glare or reflection on the key card).
- At no time is a child to be forced to cooperate.
- Cleaning and infection control measures are used between children.

Parr 4m Letter Matching Vision Test:

- The screening is to be conducted exactly 4 metres from the child and at the same level as the child's eyes. Measure 4 metres from where the child will be positioned with a tape measure and mark the floor at both ends with a piece of masking tape.
- Ensure that you match the screening booklet to the key card (both have confusion bars).
- Explain the procedure accurately and at an appropriate level for the individual child and give the child the opportunity to 'practice'. For example, at close distance ask the child to point to the same 'shape' on their keycard that the assessor is pointing to on their booklet. When the child is able to match a number of 'shapes' correctly then the assessor can commence assessment at the 4 metre distance.
- Start with the largest letters and show the child progressively smaller letters from each level and continue this until the child has difficulty identifying the letters. Make sure not to obscure any part of a letter.
- Allow the child adequate time to respond to each size being tested.
- Observe the behaviour of the child during testing e.g. holding head forward, squinting, blinking or frowning. These behaviours may indicate that the child is having some difficulty seeing the letters.
- Although the screen is performed at 4 metres, the results are written as though the test was undertaken at 6 metres (i.e., 6/30, 6/18, 6/12, 6/9, 6/6). The conversion table is on the back of the booklet.
- 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. R=6/6; L=6/9
 - Normal vision is 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.

- If the child makes one mistake the result is written as e.g. 6/9-1.
- Allow two attempts at any one failure.
- One mistake per size is considered a pass (i.e. 2 out of 3 correct is a pass for that size).

Snellen 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.
- Point clearly to letters being tested, (e.g. use a red coloured pencil/pen or pointer). Make sure not to obscure any part of a letter. If the child is uncertain as to which letter requires a response, circle the letter with the pointer.
- 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.
- 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 size read successfully. e.g. R=6/6; L=6/9
 - Normal vision is 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.

Referral:

- Any abnormalities should be referred to Optometrist/GP/Medical Officer, this will include:
 - any clinical concerns
 - less than acceptable visual acuity for age i.e. visual acuity of 6/9 -2 or worse in either eye for a 4- 6 year old child
 - unequal visual acuity that is outside normal parameters if there is a difference of one size or more between the eyes

Note: In children, visual acuity could be slightly different in each eye as the eye develops. If both eyes are 6/9 -1 or better, this is considered a pass. For example, R=6/6 L=6/9 is considered a pass in a 4 - 6 year old child.



For young children do not test single letters on a bland background as you may miss some amblyopes. Instead test single letters with confusion bars or single letters in a line. 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: Conducting a hearing and ear health check ⁹⁵

- Hearing surveillance aims to identify those children most likely to have hearing loss that may interfere with their speech and language, education, health and development. Surveillance 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.
- An **appropriately trained** Registered Nurse or Health Worker/Practitioner may undertake an ear and hearing health check. Training in ear and hearing health assessments, together with the use of the PLUM and HATS resources, is funded by the Australian Government and delivered across Australia by NSW TAFE <https://www.tafensw.edu.au/eartrain>
- All equipment should be handled with care and maintained according to the manufacturer's instructions; this includes annual calibration (at a minimum) for tympanometers and audiometers.
- Maintain strict infection control recommendations to reduce contamination and spread of disease.
- For Aboriginal and Torres Strait Islander children, the Parent-evaluated Listening and Understanding Measure (PLUM) and the Hearing and Talking Scale (HATS) are validated checklists that assess how a child's hearing and communication skills are developing. They are recommended for use in Aboriginal and Torres Strait Islander children 6 months to 6 years of age and scoring assists clinicians determine appropriate referral pathways. The PLUM screens for hearing and listening concerns and the HATS screens for communication concerns. Further information can be found on the website, including step by step guides, information for parents and both online and downloadable versions of the tools. Child health professionals should follow local HHS process decisions. <https://plumandhats.nal.gov.au/download-plum-and-hats/>



Do not proceed with the ear health and hearing check if there is ear pain, notable discharge or the skin is broken or inflamed. These children should be referred to MO/GP/ Nurse Practitioner or refer to the guidelines in the Primary Clinical Care Manual ¹²⁰.

- Ask the parent if they have any concerns, or if any other people have expressed concerns (e.g. educators, extended family) about their child's hearing, ear health, speech and language development and developmental/academic progress.
- Always start with the right ear as a point of reference.
- Conduct 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.

- 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 surveillance 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 hearing e.g. recognizes own name? • Do you have any concerns about how your child understands what you say e.g. understands instructions? 	Otoscopy Tympanometry
4 years 5 years	<ul style="list-style-type: none"> • Has your child been free of ear infections or discharge? • Do you have any concerns about how your child makes speech sounds e.g. can most people understand what your child says? • Do you have any concerns about how your child understands what you say e.g. follows instructions? 	Otoscopy Tympanometry Audiometry

* Refer to other sections for recommendations less than 12 months (page 82) and over 5 years (page 329).

- If using screening audiometry with otoscopy and tympanometry then the sequencing of tests will be:
 - otoscopy
 - tympanometry
 - audiometry
- Encourage and acknowledge the child's efforts during the procedures in an age-appropriate manner.
- A hearing check for the child with grommets should be within normal limits.

Otoscopy

- The otoscopy assessment is a visual examination of the ear canal and ear drum and is used to check for obvious signs of ear disease.
- Explain the steps of the procedure to the child and show the child the otoscope, while testing the light against the hand to check the brightness.
- Position yourself in a comfortable position at the level of the child's ear and ask the child to hold their head still. 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.
- Choose an otoscope earpiece with a tip size that fits comfortably in the child's ear canal.
- Hold the otoscope with pistol/ pencil grip and then straighten ear canal by pulling the pinna gently backwards.
- Brace with fingers against the child's head to anchor the otoscope if the child suddenly moves.

- Three parts of the ear should be checked with an otoscope:
 - pinna – check for swelling, inflammation and/or discharge
 - ear canal – check for:
 - › inflammation/redness/swelling
 - › discharge
 - › wax
 - › fungal infections
 - › foreign body (if a foreign body is visible, do not proceed with examination - refer for removal and reschedule assessment post removal)
 - tympanic membrane (eardrum) – observe:
 - › colour - shiny and transparent is normal; brown can indicate fluid behind the eardrum; white spots can indicate scarring or fungal infection
 - › cone of light
 - right ear at 5 o'clock and left ear at 7 o'clock
 - reflections elsewhere may indicate bulging of the membrane
 - › the handle of malleus
 - › perforation or grommets
 - › tympanosclerosis (scarring)
- Document findings e.g. Otoscopy: normal; eardrums intact and free of bulging; ear canals clean and free of debris.



Do not proceed with tympanometry if there is a history of ear surgery in the past 4 weeks, if there is ear pain, discharge or the skin is broken or inflamed.

Referral / follow up

- 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, foreign body, discharge, tympanic membrane is bulging or perforated, 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 results are within normal ranges, a 6 month follow up check is recommended.
- If there are no concerns or referral, place the child on a recall register and schedule the next appointment according to the recommendations above.



Refer to the Chronic Conditions Manual

<https://www.publications.qld.gov.au/dataset/chronic-conditions-manual-2nd-edition-2020>

Tympanometry

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

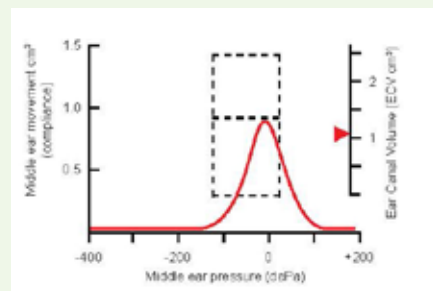


Do not proceed with tympanometry if there is a history of ear surgery in the past 4 weeks, if there is ear pain, discharge or the skin is broken or inflamed.

- The tympanometer creates a graph – a tympanogram which may 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:

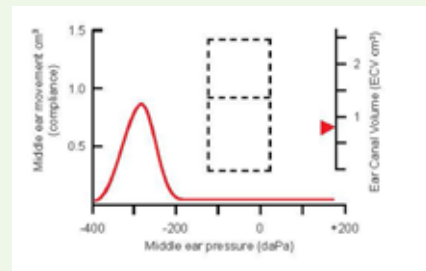
- **Type A - normal peak**

- › 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)



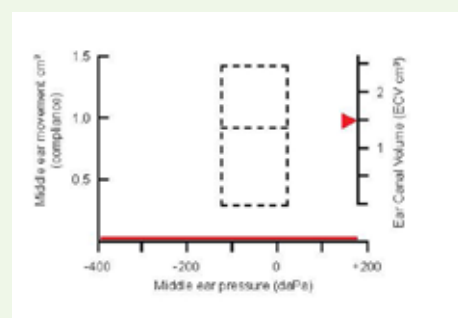
- **Type C - peak to left**

- › Normal ear canal volume
- › Normal middle ear movement
- › Negative middle ear pressure
- › Possible causes:
 - Eustachian tube dysfunction
 - URTI
 - Fluid within middle ear



- **Type B - no peak**

- › No middle ear movement
- › No middle ear pressure
- › Possible causes:
 - Usually Otitis Media
 - Otosclerosis
 - significant scarring of tympanic membrane
 - Eardrum perforation (hole)
 - Grommet
 - Ear canal blockage



- If a leak or blockage occurs during the tympanometry, try a different sized probe tip or changing the angle of the tympanometer probe. Inspect the probe tip to ensure it is clear of wax or debris.
- Document results in the clinical record under the classifications of Type A, B or C.

Referral / follow up

- Refer children to GP/MO/Nurse Practitioner.
- This may include:
 - ear pain
 - ear discharge
 - tympanogram results Type B or Type C – except when tympanometry is followed by
 - audiometry – then follow “Referral and follow up” in Audiometry section below.
 - 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 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 the recommendations above.



Refer to the Chronic Conditions Manual

<https://www.publications.qld.gov.au/dataset/chronic-conditions-manual-2nd-edition-2020>



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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 with minimal distractions.
- 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 (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 earmuffs 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 (never increase 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.
- Document the lowest screened decibel for each frequency (4000Hz; 2000Hz; 1000Hz) for each ear.
- To pass the child needs to respond twice at 25dB at 4000Hz; 2000Hz and 1000Hz in both ears.



If a child does not pass audiometry, discuss with the parents the need for follow-up and referral for further investigation. It is not a finding of a hearing impairment; this may be a temporary condition.

A hearing impairment cannot be determined by a screening test alone.

Referral / follow up

- When an initial check results in:
 - Tympanogram: Type B or C and Audiometry: **pass**
 - › Follow up at 3 months, then refer if no improvement
 - Tympanogram: Type B or C and Audiometry: **refer**
 - › Follow up at 3 months
- When a follow up check results in:
 - Tympanogram: Type A in both ears and Audiometry: **pass**
 - › Follow up in 6 months
 - Tympanogram: Type B or C and Audiometry: **refer**
 - › Refer to GP/MO/nurse practitioner/audiologist
- When there is a history of otitis media and the 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 is not a pass
 - there is ear pain or discharge
 - audiometry result: > 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 the Chronic Conditions Manual

<https://www.publications.qld.gov.au/dataset/chronic-conditions-manual-2nd-edition-2020>

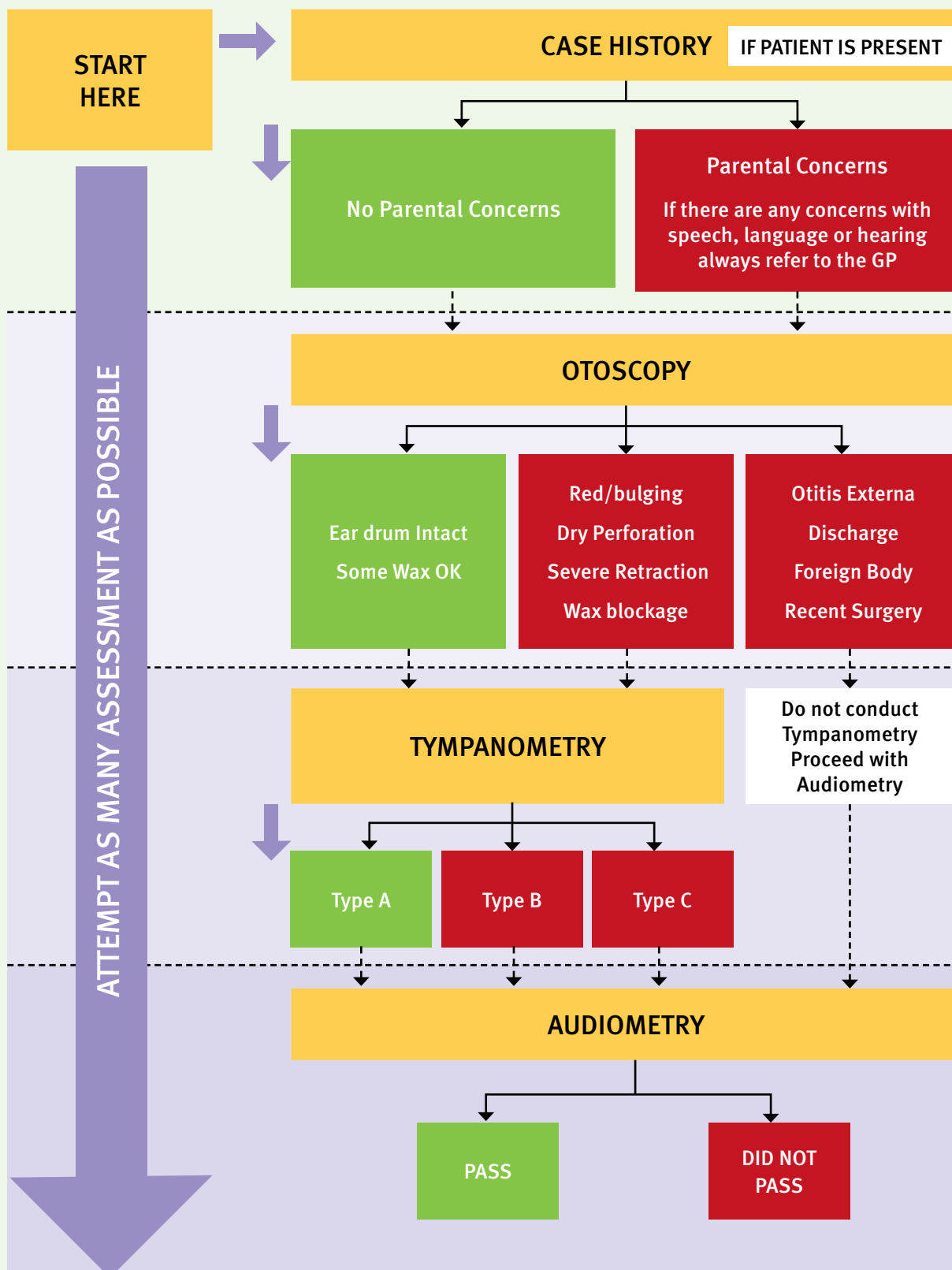


Otitis Media Guidelines

Australian Government Department of Health

<https://otitismediaguidelines.com/#/start-main>

Ear and Hearing Health Check Flowchart



PASSED ASSESSMENT

Review at next Child Health Check, School Screening opportunistically

DID NOT PASS ASSESSMENT

Report and Refer appropriately and/or arrange follow-up with the family

If you have concerns at any point in the pathway REFER to the GP

Developed by Deadly Ears

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 level ⁴⁹. 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^{49, 92}. A series of measurements over time are needed to assess a child's growth. One-off measurements show a child's size but not their growth.
- Accuracy is crucial in obtaining all physical measurements. Components of accurate measuring:
 - Technique that is standardised, e.g. bare weigh children less than two years old.
 - Equipment that is accurate. Regular calibration and checking before use is essential.
 - Examiners that are trained so they are accurate and reliable.
 - Use the same scales whenever possible.
 - Follow manufacturer's instructions on transportation of portable scales.

Growth charts ^{56, 92, 124}

- Growth charts are used as a reference to critically analyse growth measurements of weight, length or height and head circumference.
- There are currently several 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 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.
- Growth charts are monitoring or screening tools, not diagnostic instruments. The pattern of the infant's growth is used in conjunction with a clinical assessment in determining satisfactory growth.
- Factors that influence a child's growth can include gender, genetics, health, environmental factors. (e.g. nutrition)
- Children who are not following the shape of the curve over several readings are referred for further assessment according to recognised referral guidelines
- Always ensure the correct chart is being used e.g. gender.
- Growth charts contain several lines representing average growth trajectories of infants and children. By definition, 50% of the population will fall below the 50th percentile and 3% of the population will be below the 3rd percentile etc. ⁵⁶.
- Health professionals need to ensure parents understand the importance of the pattern of growth following a trajectory along the percentiles, more so than the specific percentile.



Centre for Disease and Prevention

Website includes the WHO Growth Charts for 0-2 years
www.cdc.gov/growthcharts

Top 10 things you need to know about growth charts

Royal Children's Hospital, Melbourne

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



Child growth e-Learning

Royal Children's Hospital, Melbourne

https://www.rch.org.au/childgrowth/Child_growth_e-learning/

Allowance for gestational age

- Allowance for gestational age for growth and development is made for children born before 37 completed weeks gestation until 2 years of age ^{124, 125}
 - Correction beyond two years may be required as directed by a tertiary specialist ¹²⁶.
- To correct age for prematurity, subtract the number of weeks the infant was born prematurely from the chronological age (in weeks) and assess the child's growth and development for the corrected age.

Corrected age = Actual age - number of weeks premature

- 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.



Prematurity

See page 291



Corrected Age for Assessment of Preterm Infants

Children's Health Queensland

https://qheps.health.qld.gov.au/__data/assets/pdf_file/0026/711179/proc_00199.pdf

Weight ^{56, 92, 95, 123, 124}

- 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)⁴⁹.
- Growth monitoring, particularly weighing activities, 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.
- Health professionals need to critically analyse growth patterns deviating from an individual child's previous growth pattern. 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:
 - The rising rates of obesity in children and teens in Australia^{128, 129}
 - The unacceptable rates of Diabetic Ketoacidosis at diagnosis of Type 1 diabetes in Queensland¹³⁰. Recent weight loss can be a sign of Type 1 diabetes.
 - Population groups such as Aboriginal and Torres Strait Islander families who have a higher prevalence of ^{1, 131, 132}:
 - › weight faltering
 - › obesity
 - › early onset type 2 diabetes and other chronic diseases

Indicators of poor growth

- Weight and/or length tracking downwards on the percentile growth chart ^{124, 127}.

Indicators of excessive growth ¹²⁴

- Weight and/or length for age tracking upwards on the percentile growth chart.
- If measuring BMI for children over 2 years of age, a BMI above the 85th percentile.

Documentation

Should include the child health professional's assessment of the weight measurement.

Referral

- Referral for further investigation will be required if ¹²⁴:
 - any sudden or unexplained weight loss, weight plateau or weight not re-gained following acute illness
 - growth chart patterns indicate poor or excessive growth
 - BMI increasing or decreasing percentiles on the growth chart, or a BMI greater than the 85th percentile or less than 5th percentile
- Monitor weight or length/height for age less than the 3rd percentile or greater than the 97th percentile. (There will always be a bottom and top 3% and that these measures do not necessarily indicate a growth problem.)

Length/height ^{32, 92, 124}

- 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 2 years 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.
- Generally, weight and height should follow similar percentiles with variations among children from different cultural backgrounds. Children who are not following the shape of the curve over several readings are referred for further assessment according to recognised referral guidelines.

Indicators of poor growth

- Weight and/or length tracking downwards on the percentile growth chart. ^{124, 127}

Indicators of excessive growth

- Weight and/or length for age tracking upwards on the percentile growth chart. ¹²⁴

Documentation

Documentation should include the child health professional's assessment of the length/height measurement.

Referral

Referral for further investigation will be required if growth chart patterns indicate poor or excessive growth.

Head circumference ^{32, 92, 93, 95, 133}

- Head measurement should be undertaken at universal child health checks during the first two years of life because changes in head circumference during this period may be predictive of later developmental outcomes.
- A routine measurement of head circumference is intended to identify deviations in head growth and brain development and 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. Not all infants with micro or macrocephaly will have morbidity associated with the condition.

Documentation

Documentation should include the child health professional's assessment of the head circumference measurement.

Referral

- Referral for further investigation will be required if:
 - head circumference above the 97th percentile or below the 3rd percentile
 - head circumference growth line crosses 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.

Body Mass Index (BMI) ^{95, 190}

- BMI is a useful screening tool to identify when a child weight is within the underweight, overweight or obese weight categories.
- It is recommended that the BMI is plotted from 2 years of age on CDC BMI-for-age growth charts.

$$\text{BMI} = \frac{\text{weight in kg}}{(\text{height in meters})^2}$$

- CDC BMI-for-age charts classify:
 - underweight - under 5th percentile
 - overweight - between 85 – 95th percentile
 - obese - 95th percentile or above

- Approximately 1 in 4 children are overweight or obese in Australia. An elevated BMI in childhood is associated with obesity in adulthood¹²⁹.
- The Health and Wellbeing Strategic Framework 2017 to 2026 sets targets for reducing overweight and obesity in children and recommends growth monitoring, promotion of healthy lifestyle choices and early intervention as being vital to improve the health and wellbeing of Australians.
- Child health professionals should identify underweight, overweight and obesity, explore and promote healthy lifestyle choices with the family and refer to GP/MO or other early intervention programs¹⁹⁰
- *Health and Wellbeing Queensland* have developed the [Clinician Hub](#) – a central hub that houses a variety of clinical tools, resources and training to support clinicians to identify, prevent and manage childhood obesity, including:
 - The [Clinical Toolkit](#) which has links to many resources from antenatal through breastfeeding, first foods, early identification and intervention for childhood obesity.
 - Education and Training resources including
 - › Weight4KIDS – online learning program
 - › Project ECHO education
 - › Brief interventions for a healthy lifestyle and Motivational interviewing techniques
 - **Referral Pathway:** a quick reference guide that supports primary health care providers to monitor and assess child growth, refer patients to appropriate services, and deliver interventions.

Referral

- Referral for further investigation will be required if:
 - BMI result indicates underweight, overweight or obese classification



Obesity in childhood

See page 297



Child growth e-Learning

Royal Children's Hospital, Melbourne

https://www.rch.org.au/childgrowth/Child_growth_e-learning/



WHO Growth Standards

<https://www.who.int/childgrowth/en/>



Guideline - Assessing infant / child nutrition, growth and development within the Queensland Health, primary health care setting

QCYCN Child Health Sub Network

<https://www.childrens.health.qld.gov.au/wp-content/uploads/PDF/qcycn/growth-guideline.pdf>



Refer to the Pathways to Rural and Remote Orientation and Training

<https://ilearncatalogue.health.qld.gov.au/program/17/parrot-primary-care>



Refer to the Chronic Conditions Manual

<https://www.publications.qld.gov.au/dataset/chronic-conditions-manual-2nd-edition-2020>

Developmental assessment (one to five years)



Practice tip: Conducting a developmental assessment

See page 102

- Early childhood provides a vital opportunity to shape long term trajectories given the development occurring on the first 3 years of life³⁷. This incorporates not only growing in physical size, but also in the ability to perform tasks and develop social relationships ^{32, 92}.
- It is a period of significant vulnerability for a child's development, growth, health and general well-being, all of which are affected by a complex interaction of biological, psycho-social, and environmental factors¹. It is well recognised that children with these vulnerabilities would benefit from early identification of developmental concerns, particularly in the pre-school years when the benefits of early intervention is maximised ³⁷.
- 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 and informs the development of a care plan linked to the child's needs and risk factors ³⁷.
- 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.
- Gathering information from the child's parent/carer reliably informs the clinician about the child's development, as research suggests that parents are very accurate observers of their child's developmental strengths and weaknesses ¹³⁶.
- 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 child ^{1, 32, 92}.
- Developmental delays, disorders and differences ¹³⁷:
 - Developmental delay: describes a lag in the acquisition of a skill/developmental milestone.
 - Developmental disorder: used when a child's developmental trajectory is significantly impacted, and some milestones may not be achieved.
 - Developmental differences: can simply reflect the different / unique experiences each child has in their lives, rather than reflecting a developmental delay or disorder.
- Early and accurate identification of children with developmental delays, disorders and differences 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 outcome^{1, 37}.

Congenital Heart Disease

- Children undergoing open heart surgery for congenital heart disease (CHD) under 12 months of age are known to be at higher risk for neurodevelopmental deficits, including ¹³⁸:
 - motor, cognitive, visual perceptual, social and language impairments
 - behaviour difficulties such as inattention, hyperactivity and impulsivity and impaired executive functioning

- These difficulties can be very subtle in infants and young children, and the extent of impairment can be overlooked or not fully recognised until more complex developmental skills are expected, such as at entry to formal schooling^{138, 139}. Accurate identification through assessment and referral for early intervention is known to improve health outcomes^{1, 37}.
- A statewide, developmental long-term care pathway has been developed to support these children and their families. It recommends¹⁴⁰:
 - Growth and development surveillance and parenting support:
 - › All families are encouraged to access services within their community that support growth and development e.g. child health services, Indigenous health services, GP. Rural and remote families may access services through alternative providers as available within the HHS.
 - Secondary level developmental screening:
 - › Targeted secondary level screening through the Ages and Stages Questionnaire (ASQ-3) is recommended at developmental health checks.
 - › Key time points for screening/assessment: 6mths, 12mths, 18mths, 2-3yrs, 4-5yrs, 11-12yrs, 15+yrs
 - › Secondary level developmental screening should continue even if no concerns were identified at the previous health check
 - Documentation
 - › Screening and assessment results should be documented and scanned into leMR (where available).
 - › If no leMR and with parental consent, local providers may be contacted to provide clinical information to Queensland Paediatric Cardiac Service's CHD LIFE (Long-term Improvement in Functional Health) Program database.
- Families of infants eligible for the pathway receive education about the care pathway prior to hospital discharge.
 - An education resource will be placed in the front cover of the child's PHR.
 - An 'I need an Ages and Stages' sticker on the front of the PHR.
 - An Alert is placed in leMR: 'Cardiac Developmental Long-term Care Pathway'.
 - A referral is sent to relevant child health service upon discharge. Referral will identify the care pathway and the need for secondary level developmental screening.
 - Clinical Nurse Consultant CHD LIFE Program at Queensland Children's Hospital is available for any queries.



CHD LIFE Program Pathway

Long-term care pathway for children with congenital heart disease following open heart surgery before 12 months

<https://www.childrens.health.qld.gov.au/wp-content/uploads/PDF/qcycn/Long-Term-Care-Pathway-Congenital-Heart-Disease.pdf>

CHD LIFE Program

Supporting the long-term developmental needs of children with congenital heart disease and their families (the Pink Book)

<https://www.childrens.health.qld.gov.au/chq/health-professionals/qcyc-network/resources/>

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 ^{143,145}	'Red Flags' - Signs for referral ^{143,145}
12 months	Postural control and stability develops with pre-walking activities e.g. stands well with support / walks around furniture	Unable to crawl or move around the floor Not pulling to stand and standing holding onto furniture items
18 months	Characteristic gait – wide based gait with 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	Not able to walk independently Not able to walk up and down stairs holding on
3 years	Hopping usually attained about two years after walking. Children can usually walk in a straight line	Not able to run or jump (two feet together) Not able to walk up & down stairs independently
4 years	Arms held by child's side and move reciprocally when they walk	Not able to walk, run, climb, jump and use stairs confidently Unable to catch, throw or kick a ball
5 years	Children can usually stand on one foot	Not able to hop five times on one leg and stand on one leg for five seconds

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 ¹⁴⁵.

If these activities are not established by three years then referral is recommended ¹⁴³. 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 ¹⁴³.

- 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^{143, 145}:
 - 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
- Length of sleep is one of the most common topics discussed by parents at well child checks. 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^{32, 191}.
- The following table offers a guide only to an average child's sleep patterns and behaviours and identifies some common conditions whereby referral is recommended^{32, 191}:

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 209, 229) 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</p>

Age	Total hours of sleep/day	Common behaviours	Considerations for referral
		<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>	<p>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; night-time 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>

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 factors ⁹⁹. 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 them ¹⁴⁵.
- 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 play ¹⁴⁵. 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 task ¹⁴⁵. Parent-child interaction may also be observed.

Examples of observations may include:

Age	Typical developmental pattern ^{143,145}	'Red Flags' - Signs for referral ^{143,145}
3 years	Follows simple game rules Takes turns	No interest in 'pretend' play Lack of social interaction Difficulty noticing and understanding feelings of self or 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

- Children are more likely to experience speech delay when they have ^{99, 146-148}:
 - hearing loss, including both sensorineural and early fluctuating conductive hearing loss
 - a family history (including parents and siblings) of speech and/or language delays
 - socio-demographic vulnerabilities
 - low birth weight, birth asphyxia, prematurity
 - impaired parenting e.g. lack of social stimulation and interaction
 - other developmental impairments e.g. autism
 - when a child has multiple risk factors there is an increased risk of developmental delay
- 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^{143, 146}.
- Children who show signs of communication delay or difficulty such as table below, should be referred for further assessment and early intervention:

Age	'Red Flags' - Signs for referral ¹⁴³
12 months	Not babbling in phrases; No response to familiar words (e.g. bottle, daddy).
18 months	No clear words; Not able to understand short requests (e.g. 'Where is the ball?').
2 years	Not putting words together; Not learning new words.
3 years	Not using simple sentences; Speech difficult for familiar people to understand.
4 years	Speech is difficult to understand; Unable to follow a direction with two steps.
5 years	Has difficulty expressing 'what is wrong' to their parent; Unable to answer simple questions within a conversation.

Parent – child interaction

Should be observed during appointments.

- Consider:
 - How the parent describes their child e.g. in a positive or negative way.
 - The tone of voice, affect, and facial expression of the parent when they are talking to and about their child, and their feelings for the child.
 - How satisfied the caregiver is with their role.
 - The child's reaction to their caregiver e.g. emotional expression on the child's face or whether they seek closeness to them.
- Observe:
 - Is there eye contact, touch, and does the caregiver talk to their child?
 - Do the child and caregiver mirror one another e.g. one smiles and the other smiles?
 - Does the caregiver respond to their child in a timely and appropriate way?
- In an emotionally healthy relationship, delight between caregiver and child is evident.

Examples of positive and problem indicators of parent-child interaction^{17, 99}

Postitive indicators	Problem indicators
Parent <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 	Parent <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 • Unable to cope with their child's distress • Unable to delight in the child or enjoy activities with the child • Does not ensure the child is safe or is overprotective / excessively worried about the child • 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
Child <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 	Child <ul style="list-style-type: none"> Has difficulty communicating needs to the parent Overly friendly/overly fearful with strangers Avoids looking at/towards the parent Does not seek out the parent for comfort Appears apprehensive around the parent Does not explore its environment Flat affect or emotionally under-responsive Lack of crying, limited vocalizing Irritable, constant crying, extremely difficult to settle Difficulty separating from parent (age-dependent)

- Concerns should be referred for early intervention, such as parental negativity toward the child or apportioning blame to the child for their own feelings. e.g. "He just does that to annoy me".



Health Promotion

See page 205 and 227



Laying the Foundations e-Learning

Centre for Community Child Health, RCH Melbourne

https://www.rch.org.au/ccch/training-dev/Laying_the_Foundations_eLearning/

Ready Together

Online learning for health workers on child development and school readiness, for the six stages of development from pregnancy to 5yr

<https://learningplace.eq.edu.au/cx/resources>



Assessing Mother-Infant interaction

Centre of Perinatal Excellence (COPE)

<https://www.cope.org.au/wp-content/uploads/2018/07/Assessing-Mother-infant-Interaction.pdf>

ZERO to THREE website

<https://www.zerotothree.org/>



From birth to five years: Practical developmental examination Sharma & Cockerill ¹⁴⁴

From birth to five years: Children's developmental progress Sheridan et al ¹⁴⁵

Wong's Essentials of Pediatric Nursing (11th ed.) Hockenberry et al ³²

Validated screening tools

- There are a number of tools that are available for developmental assessment in the primary care setting.
- The Parents Evaluation of Developmental Status (PEDS) and the Ages and stages questionnaire (ASQ-3) are the developmental screening tools recommended for use in the community child health practice setting¹⁴¹.
- All Child health professionals utilising the PEDS and ASQ-3 developmental screening tools must be appropriately trained in their use¹⁴¹.
- The PEDS screening tool is utilised as the primary developmental screening tool and is recommended to be universally administered in child health settings from 6 months.

○ **Parents Evaluation of Developmental Status (PEDS)**

Age: 0 – 8 years

Why is it used: To detect developmental and behavioural issues.

When is it used: All universal well-child health checks from 6 months.

Completed by:

- › The PEDS questions are in the PHR from 6 months. The parents can complete the questions in the PHR before their appointment or at the time of their appointment.
- › The PEDS questions are used to facilitate a conversation between the parent and child health professional about the infant/child's development and behaviour. It is intended to guide the developmental assessment consultation.

Scoring and interpretation: Completed by the child health professional at the appointment and discussed with the parent/s.

Documentation:

- › The outcome of the PEDS will be documented in the child's medical record.
- › Should also include examples of the developmental milestones which the child has achieved across each of the PEDS developmental domains i.e. Receptive language, fine motor, gross motor, behaviour, expressive language, social-emotional, self-help and school/pre-school skills. For example: Gross motor – rolls from front to back.

Resources:

- › **e-Learning** http://www.rch.org.au/ccch/training-dev/PEDS_training/
- › **PEDS developmental milestone checklist** <https://qheps.health.qld.gov.au/ccyfhs/html/resources>
- › If child development concerns are identified through the PEDS screen, an additional secondary screen may be indicated¹⁴¹. The ASQ-3 is the recommended secondary developmental screening tool

○ **Ages and stages questionnaire (ASQ-3)**

Age: 3 months – 5 years

Why it is used: To identify developmental delays.

When is it used: As the secondary screen if concerns are identified through primary screening.

Completed by:

- › Parents and explored with child health professionals during the follow-up developmental assessment appointments.

Scoring and interpretation:

- › Completed by the child health professional at the appointment. Outcomes explained and follow up discussed with the parent.

Documentation:

- › Outcomes, interventions and follow up plans should be documented in the child's medical record. Appropriate referrals should be submitted.

Resources:

- › **Screening tools and user guides** <https://agesandstages.com/>
- › **Ages and stages parent information sheets** <https://www.childrens.health.qld.gov.au/chq/our-services/community-health-services/child-health-service/>
- **ASQ-TRAK** is a developmental screening tool, based on the ASQ, adapted to create more culturally appropriate questionnaires. For observing and monitoring the developmental progress of Australian Aboriginal children at 2 months, 6 months, 12 months, 18 months, 24 months, 36 months and 48 months of age. It is available in multiple languages.
<https://asq-trak.education.unimelb.edu.au/>
- Various other validated tools for assessing development are available, including the Brigance Screens and the Child Development Inventory (CDI). There are also validated tools that assess child socioemotional wellbeing, for example the Strengths and Difficulties Questionnaire (SDQ) and the Modified Checklist for Autism in Toddlers (M-CHAT). Child health professionals should follow local HHS process decisions. <https://www1.health.gov.au/internet/publications/publishing.nsf/Content/nat-fram-ucfhs-html~appendices~appendix3>

Referral

- When concerns are raised following a thorough developmental assessment, a referral is recommended.
 - PEDS pathways¹⁴²:
 - › Pathway A: 2 or more predictive concerns - use secondary screen (ASQ-3) to support and inform the referral.
 - › Pathway B: 1 predictive concern only – use secondary screen (ASQ-3)
 - ASQ-3¹²⁵:
 - Children whose scores indicate a need for monitoring:
 - › Provide learning activities and follow up/monitor
 - › Refer for further assessment as per clinical judgement or if no progress
 - Children whose scores indicate a need for further assessment:
 - › Total scores that fall below the cut-off values require referral for further assessment
- 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 Developmental Service/Infant-Mental Health Service. Use local referral pathways.

The Red Flag Early Identification Guide (for children birth to five years)¹⁴³ can be used as a guide.



Knowledge of typical infant/child development is required to undertake developmental assessment and screening.



Laying the Foundations eLearning

Centre for Community Child Health, RCH Melbourne

https://www.rch.org.au/ccch/training-dev/Laying_the_Foundations_eLearning/



Center on the Developing Child - Harvard University

Brain Architecture

<https://developingchild.harvard.edu/science/key-concepts/brain-architecture/>



PEDS developmental milestone checklist

CHQ Staff Resources

<http://qheps.health.qld.gov.au/ccyfhs/html/resources.htm>

QCYCN Child Health Sub Network Guideline - Assessing infant / child nutrition, growth and development within the Queensland Health, primary health care setting

QCYCN Child Health Sub Network

<https://www.childrens.health.qld.gov.au/wp-content/uploads/PDF/qcycn/growth-guideline.pdf>

The Red Flags Early Identification Guide (for children birth to five years)

Queensland Health

<https://qheps.health.qld.gov.au/ccyfhs/html/resources>



From birth to five years: Practical developmental examination Sharma & Cockerill ¹⁴⁴

From birth to five years: Children's developmental progress Sheridan et al ¹⁴⁵

Wong's Essentials of Pediatric Nursing (11th ed.) Hockenberry et al ³²



Refer to the Chronic Conditions Manual

<https://www.publications.qld.gov.au/dataset/chronic-conditions-manual-2nd-edition-2020>



Refer to the Pathways to Rural and Remote Orientation and Training

<https://ilearncatalogue.health.qld.gov.au/program/17/parrot-primary-care>

Assessment of nutrition



Also see Health Promotion - Promotion of optimal nutrition

See page 222

Nutritional assessment is an opportune time for discussion and anticipatory guidance around healthy eating within the family. Considerations of the social determinants of health, environmental and cultural factors are important during these discussions ¹⁻⁷. Other considerations include⁴⁹:

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

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 ³².



Guideline - Assessing infant / child nutrition, growth and development within the Queensland Health, primary health care setting

QCYCN Child Health Sub Network

<https://www.childrens.health.qld.gov.au/wp-content/uploads/PDF/qcycn/growth-guideline.pdf>

Breastfeeding

- Breastfeeding is the physiological normal way for a child to feed 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 ^{56, 59, 156}
- 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. telehealth, clinic visits, home visiting, group sessions¹.
- Use culturally appropriate tools for education on breastfeeding and infant nutrition such as:
 - Growing Strong - feeding you and your baby resources ⁵². This is a resource developed to assist health staff talk with Aboriginal and Torres Strait Islander families about nutrition for mothers, babies and young children. There are a range of resources available.
<https://www.health.qld.gov.au/nutrition/patients#>
 - The Good Start Program has a range of culturally tailored resources for Maori and Pacific Islander families and communities ⁵³.
<https://www.childrens.health.qld.gov.au/service-good-start-resources/>
 - Multicultural nutrition resources - including Infant feeding for African communities, a suite of resources designed in partnership with African women covering all aspects of feeding and nutrition⁵⁴. <https://metrosouth.health.qld.gov.au/multicultural-nutrition-resources>
 - Raising Children Network has articles, videos and picture guides translated into multiple languages⁵⁵. <https://raisingchildren.net.au/for-professionals>
 - The Global Health Media breastfeeding videoclips are available in multiple languages ⁶¹
<https://globalhealthmedia.org/videos/>
 - The Australian Breastfeeding Association has a range of multicultural breastfeeding factsheets are available in a number of different languages⁶⁰
<https://www.breastfeeding.asn.au/bf-info/other-languages>
- Health professionals empower mothers to breastfeed for as long as the mother and child desire by ^{56, 57, 59, 60}:
 - informing families of the benefits of ongoing breastfeeding
 - supporting partners and other family members, recognising the importance of their role in encouraging and maintaining breastfeeding
 - promoting maternal self-care
 - exploring support networks and strategies to overcome challenges
 - encouraging the family to use expressed breastmilk when the mother and infant are separated including returning to work

- providing information on the range of support services available, e.g. Australian Breastfeeding Association (ABA); Pregnancy, Birth and Baby website and the Raising Children website
- supporting the principles of the Baby Friendly Health Initiative (see *Health Promotion – Breastfeeding* pg.195)



Clinician Assessment of Breastfeeding & Lactation

See Appendix 6

Health Promotion - Breastfeeding

See page 195

Feeding through pregnancy and tandem feeding ⁶⁰

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 supply may decrease as pregnancy progresses due to pregnancy hormones
- milk may revert to colostrum
- some women feel nauseous
- maternal fatigue
- need for adequate nutrition for the mother is important



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

- When breastfeeding an infant and toddler:
 - it is important that the infant has priority at the breast
 - 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



Australian Breastfeeding Association

<https://www.breastfeeding.asn.au/bf-info/breastfeeding-through-pregnancy-and-beyond>

Weaning

- Weaning may be infant-led, mother-led or mutual and can be sudden or gradual ⁶⁰.
- 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 breastmilk 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.
 - It is suggested to start by dropping the feed the infant is least interested in, then reduce another feed every few days depending on the individual situation ⁶⁰.
- Some situations may result in a mother weaning suddenly e.g. maternal illness or 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 ⁶⁰. In this situation:
 - A mother should be advised to express for comfort only, until lactation diminishes.
 - Some women with a large milk supply may require additional assessment and support by their child health professional or support service during this time ⁶⁰.
- 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 family to the information:

- **Child Health Information booklet :** Common Breastfeeding Concerns: When Do I Stop Breastfeeding?
- **Australian Breastfeeding Association:** Weaning and introducing solids



Eat for Health – Australian Dietary Guidelines

www.eatforhealth.gov.au

Raising Children Network

<http://raisingchildren.net.au>

Australian Breastfeeding Association

Breastfeeding Information “Weaning”

<https://www.breastfeeding.asn.au/bf-info/weaning-and-introducing-solids/weaning>



Refer to the Chronic Conditions Manual

<https://www.publications.qld.gov.au/dataset/chronic-conditions-manual-2nd-edition-2020>



Freepik.com

Health promotion

Health promotion strategies are designed to improve child and family health by enabling parents to increase health awareness and health literacy, 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 primary health practice¹⁹². The National Action Plan for the Health of Children and Young People: 2020-2030⁷⁴ was developed to ensure that Australian children and young people, from all backgrounds and all walks of life, have the same opportunities to fulfil their potential, and are healthy, safe and thriving.

A best practice population health care model for parents with children is one that aims to ensure universal access to health promotion and prevention services, with targeted services available for those that are most vulnerable^{1, 37}.

Structured universal health services aim to arm parents with practical information and knowledge by:

- Working in partnership with families to provide health promotion that builds on parent capacity, developing skills and competence to make informed decisions for the health and wellbeing of themselves and their infant /child.
- Provide parents with health promotion messages that are congruent with national and state health policies and guidelines, and, appropriate for the infant/child's age and stage of development.
- Provide parents with relevant evidenced-based, contemporary anticipatory guidance and health promotion information and resources on illness and safety prevention.

Working within a strengths based approach, health promotion and illness prevention increases the opportunity for positive family experiences and improved family wellbeing^{1, 192}.

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, 6}.

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, 6}. 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-judgmental, culturally respectful manner
 - content meets the WHO International Code of Marketing of Breastmilk 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.



The personal health record (PHR) 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.

It is also a guide for information sharing between parents and health care professionals by providing: 'Questions for parents' or 'Parents' Evaluation of Development Status (PEDS)' from 6 months, 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.

A schedule of visits – 'Well Child Health Checks' are part of the PHR⁹³.

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 safety⁹⁴. Health care professionals are recommended to encourage families to use this resource.



Personal Health Record



Child Health Information booklet

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 child¹.

- Family structures are varied including^{7, 38}:
 - extended families e.g. grandparents, aunts and uncles, Elders and kinship carers
 - foster families
 - single parent, step and blended families
 - lesbian, gay, bisexual transgender, intersex, queer, asexual, gender diverse and questioning (LGBTIQ+) parents

- Understanding and respecting different child-rearing practices is important for planning and delivering services that reflect individual parenting choices and styles⁷.
- 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 whole³⁹.
- It is recommended that services facilitate greater involvement of fathers/partners/extended family by considering a range of strategies⁴⁰. 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 and offering telehealth options for partners who are away ^{39, 41}.
 - Recognise father/ partner/extended family 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^{39, 42}.
 - Involve father/ partner/extended family 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 practices⁴³.
 - Discuss transition to parenthood issues including parenthood roles, lifestyle and relationships changes⁴⁰.
 - Change service environments to account for possible barriers that prohibit father/ partner/ 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, consideration of offering single gender (dads) groups ^{39, 44}.
 - Use a strengths-based approach when working with fathers⁴¹.
- Family members are encouraged to attend appointments with the child and attendance at group-based parenting programs is also encouraged. Parenting groups (e.g. Triple P; Circle of Security) 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^{44, 45}.
- Aboriginal and Torres Strait Islander families should be supported with access and engagement with child health primary care services.
 - Having Aboriginal and Torres Strait Islander staff, who are well respected and well connected to the community, and a culturally welcoming environment, facilitates inclusiveness of Aboriginal and Torres Strait Islander families^{39, 40, 42}.
 - There may be barriers for families in attending an in-person appointment, which may be overcome with the use of telehealth services. Therefore, it is important to⁴⁶:
 - › Raise awareness with families about the availability of telehealth.
 - › Help with resourcing at the clients end if needed.
 - › Provide cultural support to arrange the telehealth appointment and during the appointment.
 - › Support the attendance of family.



Aboriginal and Torres Strait Islander families

See page 262



Webinar - Refining the task of father-inclusive practice

Child Family Community Australia (CFCA)

<https://aifs.gov.au/cfca/events/refining-task-father-inclusive-practice>

Family Action Centre, Newcastle University

Resources and education for staff on father-inclusive practice

<https://www.newcastle.edu.au/research-and-innovation/centre/fac/about-us>

Raising Children Network

Resources (video and fact sheets) on a variety of topics.

<http://raisingchildren.net.au>

PANDA

Resources for paternal perinatal anxiety and depression

<https://www.panda.org.au/info-support/how-is-dad-going>

At all contacts with families, child health professionals are recommended to opportunistically educate and provide anticipatory guidance and parenting support to promote optimal family health¹.

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. New parent groups, Triple P, Circle of Security.

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 term⁴⁵.



Ray Cash for Children's Health Queensland



Practice tips: Facilitating a group parenting session ^{193, 194}

- 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?
 - Does the client want to engage with other people?
- Facilitating a parenting group, requires an understanding of the specific needs and attributes of adult learners. For example, adult learners:
 - are highly motivated to learn in areas relevant to their current needs
 - inclusion and consultation enhance their learning experience
 - learn well through experiential techniques (e.g. discussion and problem solving)
 - need to be respected, valued and acknowledge for their past experience and
 - need to have the opportunity to apply this experience to their current learning
- Facilitators need a number of skills to facilitate learning in a group setting such as:
 - effective communication, especially active listening and advanced questioning techniques
 - an ability to generate discussion e.g. ask open ended questions; use eye contact to include everyone; redirecting responses back to the group e.g. 'what do others think about that?'; acknowledge and use responses to build further discussion
 - knowledge and enthusiasm for topic being discussed
 - managing challenging group behaviours e.g. side conversations, quiet group
- Prior to the group, facilitators need to consider how to create an optimal learning environment for the participants. For example:
 - set up and check the physical environment – location; room temperature; seating configuration; audio-visual equipment, background noise/distractions
 - be prepared - 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
 - ensure that the parents feel welcomed and included - involve everyone in discussions, acknowledge input
- 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 '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.
- Managing group behaviours can be challenging. Some strategies include:

Challenging Behaviour	Potential Strategies
Side conversation	<ul style="list-style-type: none"> • ask them to share their idea with the group • remind people of the group rules – only one person talks at a time • call on someone who is sitting next to one of them
The quiet group or quiet participant	<ul style="list-style-type: none"> • ask open-ended questions, re-direct questions from group, facilitate discussion • be enthusiastic, show genuine interest in participants comments, acknowledge and thank participants when they engage • reduce frequency of your comments (facilitator may be talking too much) • ice breakers and ‘getting to know you’ games to build trust and comfort within the group participants • direct questions to specific people to encourage inclusion and engagement
One person dominating the conversation	<ul style="list-style-type: none"> • when they pause, thank them/acknowledge their comment and direct questions to the rest of the group e.g. ‘what do others think about’ or ‘does anyone have a different experience?’ • if necessary, invite further discussion outside of the group session e.g. ‘we need to move on due to time constraints, but we could continue this discussion in an appointment if you like’ • always remain respectful and acknowledge their participation

As a professional, it is important to have the ability to listen and take on a broad range of perspectives, 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.

Health Promotion

o 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 environment ³².

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

Parents / carers 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^{56, 177}:

- Encourage families to create an environment whereby mealtime is a pleasurable time spent with other family members.
- Encourage parents to offer a range of nutritious food options and flavours to establish an infant's sense of taste and acceptance of variety.
- Encourage families to demonstrate healthy eating habits and choices to their infants that can inform lifelong healthy eating patterns.
- 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 include³²:
 - regularly consuming large meal sizes
 - a family culture of admonishing children for leaving food on their plates
 - types of foods eaten by the family
- Use culturally appropriate tools for education on breastfeeding and infant nutrition such as:
 - Growing Strong - feeding you and your baby resources ⁵². This is a resource developed to assist health staff talk with Aboriginal and Torres Strait Islander families about nutrition for mothers, babies and young children. There are a range of resources available.
<https://www.health.qld.gov.au/nutrition/patients#>
 - The Good Start Program has a range of culturally tailored resources for Maori and Pacific Islander families and communities ⁵³.
<https://www.childrens.health.qld.gov.au/service-good-start-resources/>
 - Multicultural nutrition resources - including *Infant feeding for African communities*, a suite of resources designed in partnership with African women covering all aspects of feeding and nutrition⁵⁴.
<https://metrosouth.health.qld.gov.au/multicultural-nutrition-resources>

- Raising Children Network has articles, videos and picture guides translated into multiple languages⁵⁵. <https://raisingchildren.net.au/for-professionals>
- The Global Health Media breastfeeding videoclips are available in multiple languages⁶¹. <https://globalhealthmedia.org/videos/>
- The Australian Breastfeeding Association has a range of multicultural breastfeeding factsheets available in a number of different languages⁶⁰. <https://www.breastfeeding.asn.au/bf-info/other-languages>
- Identify community partnerships and opportunities for services to work together on promoting optimal nutrition including local hospitals, GPs, birthing units and postnatal services, local support organisations (e.g. ABA, LANCZ), dietitians, speech pathologists, pharmacies and oral health services¹.



Breastfeeding Position Statement

QCYCN Child Health Sub Network

<https://www.childrens.health.qld.gov.au/chq/health-professionals/qcyc-network/resources/>

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 (solid) foods are added with continued breastfeeding up to 2 years of age or beyond, for as long as the mother and child desire^{56, 59, 156}.

- Not breastfeeding increases the risks of major long-term effects on the child's health, nutrition and development, and also effects maternal health. For example⁵⁹:
 - Infants who are not breastfed have an increased risk of SIDS; respiratory and gastrointestinal infections; acute ear infections; asthma, type 1 and type 2 diabetes; overweight and obesity and leukemia.
 - Mothers who breastfeed have a decreased risk of breast cancer; ovarian cancer; hypertension; cardiovascular disease, type 2 diabetes, depression.
 - Breastfeeding influences the proper priming and development of the infant's microbiome as it contains probiotics and prebiotics and elements of mothers' immunity, which is integral to immune and metabolic health of the infant.
 - Breastfeeding also encourages skin to skin contact, early mother-child social exchanges and calms the infant by triggering their natural sucking reflex.
 - Breastfeeding has been associated with higher intelligence, school achievement and adult earnings, and it is environmentally friendly.
- The Baby Friendly Health Initiative (BFHI) is a joint World Health Organisation (WHO) and UNICEF initiative that aims to create a healthcare environment where breastfeeding is the norm, and practices known to promote the well-being of all mothers and infants are promoted⁶². It provides an accreditation framework that assists facilities to implement *The Ten Steps to Successful Breastfeeding* (maternity services) and the *Seven-point Plan for Community Health Centres*.

The BHFI seven-point plan for community health centres 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 possess⁶²:

- 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

The BHFI seven-point plan for community health centre

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: <http://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 Breastmilk 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 through the appropriate marketing and distribution of breastmilk substitutes ¹⁹⁵.

WHO Code summary of main points:

- No advertising of breastmilk substitutes, teats and bottles
- No donations of breastmilk substitutes, teats and bottles
- No free samples of breastmilk substitutes, teats and bottles to mothers
- No promotion of breastmilk substitutes, teats and bottles in the health services
- No infant formula company personnel to advise mothers
- No gifts or personal samples from infant formula companies to health workers
- No use of space, equipment or educational materials sponsored or produced by infant formula companies when teaching mothers about infant feeding
- No pictures of infants or other pictures idealising artificial feeding
- Information to health workers about artificial feeding should be scientific and factual
- Information on artificial feeding, including labels, should explain the benefits of exclusive breastfeeding and the costs and risks associated with artificial feeding
- No promotion of products unsuitable for infant feeding, such as condensed milk or evaporated milk
- Promotion of optimal maternal nutrition during breastfeeding is important to maintain maternal health and enhance the micronutrient and fatty acid make up of breastmilk. The child health professional should encourage the mother to consume a healthy diet during breastfeeding ^{56, 196}.

- Supplements:
 - Breastfeeding mothers are recommended to have iodine supplements as it is difficult to obtain enough dietary iodine daily. Generally, it is recommended to take 150µg of iodine per day ^{48, 56}.
 - Women from specific population groups may require other supplements when breastfeeding for example, vegan breastfeeding women.
 - Queensland Health's Nutrition Education Materials Online (NEMO) has a range of factsheets for parents, including "Healthy eating for breastfeeding mothers" and "Healthy eating for vegetarian or vegan mothers" <https://www.health.qld.gov.au/nutrition/patients#>
- Identify community partnerships and opportunities for services to work together on promoting optimal nutrition including local hospitals, GPs, birthing units and postnatal services, local support organisations (e.g. ABA, LANCZ), dietitian/nutritionists, speech pathologists, pharmacies and oral health services ¹.
- 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
 - supporting families if they have specific breastfeeding concerns, e.g. perceived milk supply concerns, painful breasts, inverted nipples
 - normal newborn behaviour including feeding cues
 - supporting partners and other family members, recognising the importance of their role in encouraging and maintaining breastfeeding
 - promoting maternal self-care
 - encouraging the family to avoid the use of teats and pacifiers until breastfeeding is well established
 - encouraging the family to use expressed breastmilk when the mother and infant are separated including information on returning to work and breastfeeding
 - exploring support networks and strategies to overcome challenges
 - information sources and support agencies specific to feeding, e.g. local child health services, Australian Breastfeeding Association, LANCZ (Lactation Consultants), Raising Children website



Assessing infant nutrition

See page 104



Nutrition Education Materials Online (NEMO)

<https://www.health.qld.gov.au/nutrition/patients>

'Growing Strong: Feeding You and Your Baby' suite of resources

Queensland Government

<https://www.health.qld.gov.au/nutrition/patients#>

Multicultural Nutrition Resources, Metro South Health

A suite of resources designed in partnership with local communities covering all aspects of feeding and nutrition

<https://metrosouth.health.qld.gov.au/multicultural-nutrition-resources>

Global Health Media| Breastfeeding videos

Available in multiple languages

<https://globalhealthmedia.org/>

Raising Children Network

<http://raisingchildren.net.au>

Australian Breastfeeding Association

www.breastfeeding.asn.au

Queensland Health

Breastfeeding resources for multicultural families

<https://www.health.qld.gov.au/clinical-practice/guidelines-procedures/clinical-staff/maternity/nutrition/breastfeeding/multicultural>

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 working¹⁹⁷.
- Employment policies that ensure a supportive workplace culture, access to lactation breaks with suitable facilities to express and store EBM and flexible working hours are associated with improved breastfeeding practices^{59, 197}.
- By law, employers must make reasonable attempts to meet the needs of breastfeeding mothers. The child health professional should encourage mothers to discuss options with their employer regarding supporting their breastfeeding needs¹⁹⁸.
- The child health professional should discuss preparation for returning to work, e.g. expressing and storing breastmilk; options to support ongoing breastfeeding¹⁹⁷.



Expressing breastmilk

See page 119



Australian Breastfeeding Association

Breastfeeding Friendly Workplace – Your rights at work

<https://www.breastfeeding.asn.au/workplace/working-mothers>

Formula feeding

Health workers have a responsibility to promote breastfeeding first, but when women are unable to, or have made an informed decision not to breastfeed, providing individual education around the safe use of infant formula is indicated.

A mother's informed decision not to breastfeed should be respected and any feelings of grief or loss should be acknowledged, and appropriate support provided⁵⁶.

Under the **WHO International code of marketing of breast-milk substitutes**:

- feeding with infant formula should only be demonstrated by health workers, or other community workers if necessary, and only to the mothers or family members who need to use it
- the information given should include a clear explanation of the hazards of improper preparation and storage.
- These one-to-one sessions may include⁵⁶: (*See Practice Tips: Supporting a mother to formula feed her infant pg.138*)
 - 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 feeding
- 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 infant/child, for example:
 - putting babies/toddlers to bed with a bottle increases their risk of ear infections, dental caries and is a choking risk;
 - not holding and cuddling the infant while feeding may disrupt the development of the maternal-infant relationship;
 - propping the bottle and leaving the infant to feed unattended is a hazard for choking as the milk flow is unregulated;⁵⁶
 - 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 infant 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.¹⁷²



Practice tips: Supporting a mother to formula feed her infant

See page 138

Supplementation: fluoride^{50, 56, 176}

- Fluoride helps to protect teeth in three ways: it helps make teeth more decay resistant, helps get rid of early decay before it becomes permanent and helps stop bacteria in the mouth producing acids, which leads to tooth decay.
- Fluoride can be obtained through fluoride toothpaste, fluoridated water and fluoride supplements.
- Fluoride supplements do not provide the same benefit as fluoridated water.
- Most tap water is fortified with fluoride and this water should be used in preparing infant formula and as a drink for infants from 6 months.
- If local water supply is not fluoridated, seek advice on your options from a dental professional.
- Certain 'at risk' groups of infants may require supplementation (e.g. premature infants are often prescribed iron and vitamin supplements).

Introducing a feeding cup^{56, 176}

- 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.

Introducing solids^{52, 55, 56, 176, 177}

- 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.
 - Tongue extrusion reflex has diminished.
 - Infant watches with interest when others are eating, may reach out for food.
 - Seems hungry between milk feeds.
 - Opens mouth when offered a spoon.
- Introducing solid food too soon (before 4 months) may impact infant gut health and increases the risk of developing food allergy.
- Delaying the introduction of first foods beyond 6 months may increase the risk of developing allergies, faltering growth and micronutrient deficiencies.
- Premature babies have different nutrition needs to babies born at term. Queensland Health recommends starting solids when premature infants are around 5 – 7 months of their actual age, but not before 3 months of their corrected age¹⁷⁸.
- 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 and 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.

- Introducing a range of food flavours and textures between six to nine months reduces the risk of later feeding difficulties. For example: infants kept on pureed foods and not offered lumpy foods prior to 10 months were found to be fussier at eating at three years of age¹⁹⁹.
- New foods may need to be offered repeatedly before the infant gets accustomed to the taste.
- 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

- Infants should not be coerced, or force fed ¹⁷².
- Encourage families to create an environment whereby mealtime is a pleasurable time spent with other family members.
- Encourage families to demonstrate healthy eating habits and choices to their children that can inform lifelong healthy eating patterns.
- Use culturally appropriate tools for education on infant nutrition such as:
 - Growing Strong - feeding you and your baby resources⁵². This is a resource developed to assist health staff talk with Aboriginal and Torres Strait Islander families about nutrition for mothers, babies and young children. There are a range of resources available.
<https://www.health.qld.gov.au/nutrition/patients#>
 - The Good Start Program has a range of culturally tailored resources for Maori and Pacific Islander families and communities⁵³.
<https://www.childrens.health.qld.gov.au/service-good-start-resources/>
 - Multicultural nutrition resources - including *Infant feeding for African communities*, a suite of resources designed in partnership with African women covering all aspects of feeding and nutrition⁵⁴.
<https://metrosouth.health.qld.gov.au/multicultural-nutrition-resources>
 - Raising Children Network has articles, videos and picture guides translated into multiple languages⁵⁵. <https://raisingchildren.net.au/for-professionals>
- 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.

Foods to avoid

- Honey should not be given to infants less than one year as it can contain *Clostridium botulinum* and cause illness in the infant.
- Uncooked eggs may contain bacteria that could be harmful for babies under 12 months of age.
- Avoid foods poor in nutrient value or high in salt, saturated 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 and 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 or grated carrot).

Beverages to avoid

- 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 organisms.
- 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.

Infants with a family history of allergy

- Breastfeed.
- Follow normal introduction of foods process.
- Delaying the introduction of the common allergy causing foods (e.g. egg, peanut, dairy, tree nuts, soy, sesame, wheat, fish, and other seafood)²⁰⁰:
 - does not prevent food allergy
 - can actually increase the risk of developing an allergy to that food
- Research supports introducing common allergy foods before 12 months, and once introduced, to continue to include these foods regularly as part of a varied diet, to maintain tolerance²⁰⁰.
- A small number of babies will still develop a food allergy even if common allergy causing foods are introduced before one year of age²⁰⁰.

Vegetarian or vegan diets

- Micronutrient stores, especially iron, zinc and Vitamin B12 are likely to become depleted if appropriate foods are not provided⁵⁶.
- Iron deficiency is the most common and widespread nutritional disorder in the world. As well as affecting a large number of children and women in developing countries, it is the only nutrient deficiency, which is also significantly prevalent in industrialized countries, including Australia. Impacts on infants and children include alteration in brain function, increased risk of infection and mortality, poor exercise tolerance and poor school performance²⁰¹.
- Parents using a vegetarian/vegan diet need to ensure that supplies of iron and zinc and B12 are adequate to meet the needs of a growing child. They should be encouraged to ⁵⁶:
 - continue breastfeeding for as long as possible, e.g. > 2 years
 - seek dietetic advice (this may include use of soy-based formula if not breastfeeding)
 - nutritional supplements may be required



Nutrition Education Materials Online (NEMO)

<https://www.health.qld.gov.au/nutrition/patients>

'Growing Strong: Feeding You and Your Baby' suite of resources

Queensland Government

<https://www.health.qld.gov.au/nutrition/patients#>

Growing good habits

Queensland Health

<https://www.growinggoodhabits.health.qld.gov.au/babies-and-toddlers/>

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

Australasian Society of Clinical Immunology and Allergy (ASCIA)
Information for health professionals and parents
<https://www.allergy.org.au/hp/papers/infant-feeding-allergy-prevention>

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 around two weeks of age⁵⁶.
 - Double their birth weight by six months with an average gain of 150 grams/week^{32, 56}.
 - Triple their birth weight by the first birthday with weight gain on average of approximately 80 grams/week^{32, 56}.
- Child health professionals can explain and educate parents about the use of growth charts and the factors influencing growth. For example^{32, 124}:
 - The importance of the pattern of growth following a trajectory along the percentiles, more so than any specific percentile. By definition, 50% of the population will fall below the 50th percentile and 3% of the population will be below the 3rd percentile etc.⁵⁶
 - Growth charts are monitoring or screening tools, not diagnostic instruments. The pattern of the infant's growth is used in conjunction with other clinical signs in determining satisfactory growth.
 - Factors that influence a child's growth can include gender, genetics, health, environmental factors (e.g. nutrition).
- Parents can be informed that in general that³²:
 - 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.
- 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 as³²:
 - The brain weight increased by 2.5 times during the first year of life.
 - The posterior fontanelle closes between 6 – 8 weeks.
 - The anterior fontanelle closes between 12 – 18 months.

Cognitive development

- Child health professionals offer information to families about³⁷:
 - how the infant brain grows faster in the first three years of life than at any other time (from approximately 25% to 90% of its adult size)
 - how brain development (neural pathways) are shaped by life experiences
 - 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
- 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 ⁹⁴.
- During the period of birth to one year the infant progresses cognitively from³²
 - reflexive behaviours to
 - simple repetition to
 - imitating activities
- As cognitive pathways develop, infants apply their learning to their environment.

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 ³²:

- 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
 - infant sucks 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 stops 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.

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 around 6 of age, object permanence develops in infants. This means that the infant has learnt that an object (or a person) still exists even when they are not within the visual field³².
- From around 8 months of age, separation anxiety develops after the infant gains an understanding of object permanence. Peaks around 12 – 18months⁵⁵.
- The infant cries in response to their parent leaving their sight because they know that the parent still exists beyond their visual field, and it leaves them feeling unsettled. That is, they know they are separated, and this causes upset. Prior to object permanence, when the infant could not see the caregiver, it was quite literally 'out of sight out of mind'.
- 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 it has significantly influenced policy development with the incorporation of services that promote parent-infant relationships and parenting skill development ^{37, 99}.

- 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 Red Flags Early Identification Guide (for children birth to five years)¹⁴³.



Brain Builders video

Centre for Community Child Health, Royal Children's Hospital

<https://www.rch.org.au/ccch/publications-resources/videos/>

Centre on the Developing Child, Harvard University

<https://developingchild.harvard.edu/science/key-concepts/serve-and-return/>

Raising Children Network

<http://raisingchildren.net.au>

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 interactions³².
- 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 giver³².
- The early infant-caregiver relationship provides the building blocks for future social, emotional and cognitive development, and promotes optimal infant mental health. Absence of, or disruption to, this primary relationship is a common cause of infant mental health difficulties³⁷.
- Promoting the development of healthy parent-infant relationships is seen as one of the best ways to promote infant emotional wellbeing and positive mental health⁹⁹. A secure attachment where caregivers respond in a consistent, caring and timely manner has been shown to enhance developmental outcomes later in life in self-reliance, self-efficacy, empathy and social competence⁸.



Freepik.com

- In an emotionally healthy relationship, delight between caregiver and infant is evident.

Examples of positive and problem indicators of parent-child interaction^{17, 99}

Positive indicators	Problem indicators
Parent <ul style="list-style-type: none"> • Responsive to the infant'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 infant appropriately, e.g. welcomes the infant, encourages the infant to explore, comforts the infant when it's needed • Appears to enjoy 'being with' the infant • Provides practical support to the infant as needed 	Parent <ul style="list-style-type: none"> • Unable to identify the infant's communication cues • Unable to respond consistently and appropriately • Unable to cope with their child's distress • Unable to delight in the infant or enjoy activities with the infant • Does not ensure the infant is safe or is overprotective / excessively worried about the infant • Uses hostile, rejecting language • Rough handling of the infant • Inappropriate representations of infant's behaviours, e.g. manipulative, rejecting, trying to make me angry

Positive indicators	Problem indicators
Infant <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 	Infant <ul style="list-style-type: none"> • Does not seek out the parent for comfort • Appears apprehensive around the parent • Does not explore its environment • Flat affect or emotionally under-responsive • Lack of crying, limited vocalizing • Irritable, constant crying, extremely difficult to settle • Difficulty separating from parent (age-dependent)

- 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^{32, 55}:
 - making eye contact, smiling and talking to the infant
 - skin to skin contact, cuddle with baby
 - baby massage
 - going for a walk with use of a parent facing pram
 - spending time playing games, e.g. 'peek a boo'

- The child health professional can share information to increase the parent's awareness and sensitivity to the infant's attachment behaviours and body language cues such as^{32, 55}:
 - smiling and vocalisation to the primary care giver more than anyone else
 - looking more at the primary care giver
 - crying if they leave the room
 - looking back at the primary care giver for reassurance when exploring
- 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^{32, 55}:
 - eye contact, facial expression and voice modulation
 - talking, reading, singing, smiling, stroking, kissing
 - rocking, using soothing measures
 - how they are expressing their feelings and emotions toward their infant
- 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^{55, 202}.
- An infant's ability to develop self-regulation, i.e. regulate his/her own emotions and behaviours, are enhanced by positive parent-infant interactions⁹⁹.
- Parents are encouraged to discuss any concerns about their infant's development with their child health professionals and/or GP.
- Refer to resources to raise the family's awareness of delays in development such as [The Red Flags Early Identification Guide \(for children birth to five years\)](#)¹⁴³.



The development of infant communication and interaction may also be impacted by difficulties with parent-infant relationship, such as^{17, 99}:

- The parent/carer does not respond to the infant's communication, e.g. does not respond consistently to cues, does not soothe when distressed, does not pay attention to reactions, is not in tune with the infant.
- The parent/carer has limited interactions, e.g. does not make eye contact, smile or talk to the infant, or may use a harsh or negative communication style.

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 Service / Early Intervention (Parenting) Clinician as appropriate for further assessment.



Building Healthy Brains – The Eleven Key Messages
See Appendix 2



Assessing Mother-Infant interaction

Centre of Perinatal Excellence (COPE)

<https://www.cope.org.au/wp-content/uploads/2018/07/Assessing-Mother-infant-Interaction.pdf>

Circle of Security videos

Circle of Security – Good Enough; Connection; Being with and shark music

<https://www.circleofsecurityinternational.com/resources-for-parents/>

ZERO to THREE website

<https://www.zerotothree.org/>

Connected Parenting

Circle of Security in the context of Aboriginal and Torres Strait Islander families - eLearning

<https://www.sjog.org.au/for-medical-professionals/connected-parenting/e-learning-resource>

Health Promotion

0 TO 12 MONTHS

Normal infant behaviour

Patterns of sleep

Infant sleep is a common issue raised by parents with child health professionals. Providing early accurate evidence-based information around normal sleep patterns and development, may be reassuring for parents and could prevent the need for intervention³².

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 states³².

It is important for health care professionals to have a basic understanding of these concepts to assist parents in understanding an infant's behaviour, such as feeding and sleeping cues.

Behavioural state	Description	Implications
Deep sleep (quiet)	Closed eye lids Eyeballs still Regular breathing Body still, with occasional twitch	Baby sound asleep, limited response to external environmental factors
Light sleep (active)	Eyeballs 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	<p>Eyes wide open and bright</p> <p>Active body movements in response to the environment</p> <p>Stares at close range objects</p> <p>Focuses attention on stimuli</p> <p>Regular breathing</p>	<p>Seeks to satisfy hunger and enjoys non-nutritive sucking</p> <p>Best time to position baby at the breast for feeding</p> <p>Displays cues to communicate with caregiver</p> <p>Ideal time to interact with infant and be in close view of infant</p> <p>Plays with developmentally appropriate toys</p>
Active alert	<p>Eyes open</p> <p>Irregular breathing</p> <p>May whimper / whine</p> <p>Restless body movements</p>	<p>Infant sensitive to an external or internal stimulus</p> <p>Parent can adjust environment, anticipate infant needs</p> <p>Soothe the infant</p>
Crying	<p>Eyes open or tightly closed</p> <p>Irregular breathing</p> <p>Grimaces</p> <p>Strong cry</p> <p>Uncoordinated movements of the extremities</p>	<p>Intervene to provide comfort / relieve hunger</p> <p>Soothing measures used in active alert state usually no longer work – try rocking, swaddling, shushing, warm bath.</p> <p>Crying is part of normal infant development.</p> <ul style="list-style-type: none"> 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

32, 56

- The newborn baby does not distinguish day from night; however, as the infant experiences more activity, sound, and interaction with carers during daytime hours and less interactions 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 ³².
- These individual differences are normal and should be anticipated by parents.
- Child health professionals should provide education around the wide range of what is 'normal' to support parents in understanding their infant.

The following offers a guide to an average infant's sleep-wake pattern:

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

55, 191

- 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 the development of a parent-infant relationship in which the infant feels physically and emotionally safe, which can lead to improved sleeping patterns²⁰³
- There is an enormous variation in the amount of sleep and activity among infants and sleep needs will change throughout life. Many factors influence infant sleep, some examples include²⁰⁴:
 - infant temperament
 - developmental stage (e.g. separation anxiety)
 - physical reasons (e.g. hunger or illness)
 - parental influence (e.g. sleeping environment and associations)
 - responsiveness to infant cues (e.g. misinterpreting tired signs)
- Sleep disturbance that impacts on the parent and infant may have profound negative consequences for both. There is evidence that it may increase the likelihood of behavioural problems, impact the parent-infant relationship and parental wellbeing ^{204, 205}.

Sleep ^{32, 51, 55, 92, 204}

Infant behaviour

- Infants are recommended to have 14 to 17 hours (for those aged 0-3 months) and 12 to 16 hours (for those aged 4-11 months) of good quality sleep, including naps during the 24 hour period⁵¹.
- An infant's behaviour changes as they become tired. Tired signs include:
 - Newborns – Closed fists, fluttering eye lids, grimacing, glazed stare, jerky limb movements, whining, yawning, seeking comfort by sucking, crying, screaming.
 - 3-12 months – 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 are 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 infant'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 infant has been awake.
- Check that the infant's physical needs have been met e.g. is not hungry, dry nappy.
- 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'.
- 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 "*Sudden unexpected death in infants (SUDI)*" in Safety and injury section [page 255](#)



Raising Children Network

Resources in both video and fact sheets

<http://raisingchildren.net.au>

Ellen Barron Family Centre

Responsive settling videos

<https://www.childrens.health.qld.gov.au/chq/our-services/community-health-services/ellen-barron-family-centre/responsive-settling/>

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 or soothing cuddle, discomfort e.g. too cold and often for unknown reasons.
- Characteristics of normal crying / unsettled periods:
 - starts around 2 weeks, peaks at 6 -8 weeks and usually settles around 3-4 months of age
 - commonly worse in the late afternoon/evening, but it may occur at any time
 - may last several hours. The average crying time for an infant at six weeks of age is around three hours/day
 - infants often draw their legs up or scrunch up their face as if in pain
 - infants can be difficult to console during these periods
- 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 ⁵⁶.
- When parents respond to crying, they are assisting their infants to manage their difficult feelings. As infants grow and develop, they learn healthy self-regulation - how to manage their own feelings. This is true even if the crying persists whilst the parent is comforting them²⁰³.
- Although timely response to infant crying is recommended, parents should be reassured that occasional / incidental delays won't cause harm (e.g. caught in traffic while infant crying)²⁰³

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.
- Discuss options that may assist in soothing unsettled infants, for example:
 - checking infant for hunger and comfort (dry nappy, not hot or cold)
 - gentle rocking movements
 - going for a walk in the pram
 - a warm bath
 - gentle touch and massage
 - decreasing stimulation e.g. dimming the lights
 - non-nutritive sucking (at the breast or pacifier if used)
- Provide information to families on how to tell if their baby is sick, e.g. temperature, rash, decreased intake, decreased output.
- 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/persistent crying should be investigated to rule out underlying medical conditions for example: cow's milk protein allergy, otitis media, inguinal hernia, urinary tract infection, injury, raised intracranial pressure and intussusception ^{32, 179}.
- Ensure that dummy-sucking does not 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

Resources in both video and fact sheets

<http://raisingchildren.net.au>

Physical activity / play ^{20, 32, 51, 55, 143}

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.
- Physical activity particularly through supervised interactive floor-based play should be encouraged from birth. For those not yet mobile, 30 minutes of tummy time spread throughout the day during awake periods is encouraged ⁵¹.
- Infants should not be restrained for more than 1 hour at a time (e.g. in a stroller or highchair). Infants should also not spend any time watching television or using other electronic media and instead, when sedentary, the caregiver is encouraged to engage with them through activities such as reading, singing, puzzles and storytelling.
- Parent-child play builds connection, sense of self and emotional resilience in children²⁰⁶

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 deformational/positional plagiocephaly are simple and effective. All parents should receive information on prevention strategies, for example:
 - Alternating head position:
 - › alternate the sides and positions for holding and carrying the infant, so as to offer them a variety of movement opportunities
 - › alternate the head position on the right and left occiput during sleep
 - › when feeding the infant swap sides to alternate positions during the feed time
 - Tummy time: Back to sleep, tummy to play. When the baby is awake tummy time helps to builds neck, head and upper body strength.
 - › can be done on any safe surface, including on the parent's chest, over their arm, on the carpet or on a play mat.
 - › begin with short sessions (1-2 mins), two to three times a day and build up to 10-15 minutes, several times a day
 - › make tummy time interesting, fun and safe e.g. toys, non-breakable mirror in front of baby, different places like outside
 - › Infants respond better to tummy time if they are interacting with the caregiver whilst on their tummy. Tummy time is an opportunity for building connections through play.
 - 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, looking through picture books, placing toys just in reach of the infant, encouraging the infant to hold and play with toys.
- As the infant develops use tunnels for fun, crawling activities, push and pull toys and clear away dangerous things.

Cautions and things to avoid

- Routine baby checks should include examination for plagiocephaly and torticollis which is often associated with plagiocephaly. See *"Practice tips: Conducting a 'head-to-toe' assessment"* page 76
- Avoid use of infant walkers as these do not enhance development and increase the rates of infant injury.



Raising Children Network

Resources in both video and fact sheets

<http://raisingchildren.net.au>

Infant behaviour

- Infants learn social skills and interaction by observing those around them and by their own experiences of social interaction with caregivers.
- Cultural, social, physiological factors can impact on emotional development e.g. wellness / illness of the infant or parent.
- An infant innately seeks to develop an attachment with a primary carer. They use facial expressions, vocalisations and body language to communicate their feelings (for example joy, delight, discomfort and distress) and to communicate their physical and emotional needs. A secure attachment develops when timely and sensitive care is offered to the infant in response to their communication cues.
- Having a relationship in which an infant feels secure and connected to a primary carer promotes healthy social and emotional wellbeing for the future e.g. healthy self-esteem, good mental health, coping with stress, fewer behavioural problems.

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’.
- 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 sensitive way to their infant’s communication i.e. comfort when upset, delight in their babble.
- Discuss that responding to an infant will never ‘spoil’ them.
- Use ‘mirroring’ language e.g. Smile at the infant when they smile at you, copy sounds and babble.
- 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 months).
- Expose the infant to a range of positive experiences and activities.
- 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

Cautions and things to avoid

- Avoid screen time e.g. watching TV
- A full family assessment is recommended and referral to the EIPS/EIC/ GP/Infant-Mental Health Service if a child health professional identifies signs of disruption to the parent-infant relationship, 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 manner.
- See “Parent-infant interaction” on page 205 for examples of positive and problem indicators of parent-child interaction



Emerging Minds

<https://emergingminds.com.au/resources/toolkits/>

Raising Children NetwoK

Resources in both video and fact sheets

<http://raisingchildren.net.au>

ZERO to THREE website

<https://www.zerotothree.org/>

Circle of Security videos

Circle of Security – Good Enough; Connection; Being with and shark music

<https://www.circleofsecurityinternational.com/resources-for-parents/>

Beyond Blue - Healthy Families

Resources on emotional and mental health for the whole family

<https://healthyfamilies.beyondblue.org.au/>



Connected Parenting

Circle of Security in the context of Aboriginal and Torres Strait Islander families - eLearning

<https://www.sjog.org.au/for-medical-professionals/connected-parenting/e-learning-resource>



Australian Family Strengths Nursing Assessment Guide

See Appendix 1

Building Healthy Brains – The Eleven Key Messages

See Appendix 2

Speech and language ^{20, 32, 55, 143}

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.
- 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.
- 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.
- Problematic hearing can affect speech development.
- 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

- Responsive communication, that is interactions that consist of back and forth communication (turn taking), is how children build their early language skills.
- 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'.
 - Parents encouraged to follow their infant's gaze as they look towards an object or noise and naming what they have seen or heard; e.g. 'oh you can hear the bird' or 'oh you can see the puppy/light/fan'.
 - 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

Resources in both video and fact sheets

<http://raisingchildren.net.au>



The Red Flags Early Identification Guide (for children birth to five years)

Queensland Health

<https://qheps.health.qld.gov.au/ccyfh/html/resources>

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 on average between 6-10 months of age with all 20 baby teeth usually appearing by the time the infant is three years. See *Child Health Information Booklet* for further information about teething and eruption timing.
- Good oral health is an essential part of general health and well-being and early childhood is the time when most lifelong habits are established. Oral diseases are among the most common and costly chronic diseases in Queensland⁸⁰.
- The deciduous teeth are important for young children's development - eating, speech and facial appearance. They also guide the eruption and position of the permanent teeth.
- Decay in deciduous teeth is a predictor of decay in permanent teeth. If identified early, preventive measures can be undertaken to prevent the progress of decay¹⁸⁸.
- Queensland's children have one of the highest rates of dental decay in Australia^{80,207}.

Parenting tips / Skills to support infant development

- Parents can be encouraged to:
 - Keep the infant's skin clean and dry by using bibs when drooling is excessive.
 - Use firm, cool items for baby to suck/chew on e.g. teething ring, sugar-free rusk.
 - Rubbing the gums with a clean finger or applying a small amount of teething gel may also help.
- Dental caries is highly preventable and is related to both dietary issues and the build-up and retention of plaque through infrequent, substandard tooth cleaning.
- Decay can start in teeth soon after they appear in the mouth and it progresses quickly. Parents should be informed about the signs of decay, prevention of decay and the importance of regular dental checks.
- Parents should be advised that newborn infants do not have the bacteria in their mouth that can cause tooth decay. Bacteria are passed to the infant/child through sharing of spoons or 'cleaning' the dummy / bottle teat in the adult mouth.
- It is important for parents, other family members and carers to have good oral hygiene - brushing twice a day with a small soft head toothbrush and fluoride toothpaste - to reduce the chance of bacterial transmission.
- Taking care of teeth:
 - Infant's teeth should be brushed with a small soft-head, child sized toothbrush as soon as they appear
 - Introduce a small, pea-size smear of low fluoride toothpaste after 18 months in areas with fluoridated tap water and after six months in non-fluoridated areas¹⁷⁶. Low fluoride toothpastes are created especially for children under six years of age and are available in most supermarkets or pharmacies. Children only require a small amount of fluoride toothpaste and should not be allowed to dispense toothpaste without supervision

- Ensure all family members have good oral health
 - Parents should assist with brushing of teeth until children are about eight years of age.
 - Dietary discussion should focus on healthy food options to reduce consumption of sugars, and should include:
 - Promotion of breast feeding
 - Reduction of the quantity and frequency of high sugar drinks, foods and snacks
 - Offering only breastmilk, formula or cool boiled tap water in a bottle
 - The Australian Dental Association recommends that children have their first dental visit when the first tooth becomes visible or they reach 12 months of age²⁰⁸. A dental check-up at this early age will:
 - allow the infant/toddler to become familiar with the sights, sounds and smells of the dentist.
 - allow early detection of tooth decay and other dental conditions
 - enable dental staff to give advice and instruction on toothbrushing and on good eating habits
- Holders of a Health Care Card or Pension Card, and all children 4 years old until end of Year 10, are eligible for free dental care at public dental clinics located throughout Queensland.
- Use culturally appropriate resources for oral health education where possible:
 - *Looking after Young Mouths* pictorial flipchart is a health education tool aimed to prevent oral disease in Aboriginal and Torres Strait Islander communities.
 - *Building Strong Teeth* is aimed at children and can be used by early childhood educators

Cautions and things to avoid

- Avoid leaving an infant with a bottle when going to bed.
- Only put breastmilk, formula or cool boiled tap water in a bottle.
- Do not dip pacifiers or bottle teats in sugar, jam, honey or other sugary substance.
- Do not put anything in an infant's mouth if it has been in another person's mouth to avoid spreading bacteria that cause tooth decay.
- It is important for parents, other family members and carers to have good oral hygiene - brushing twice a day with a small soft head toothbrush and fluoride toothpaste - to reduce the chance of transferring bacteria to the infant.



Raising Children Network

Resources in both video and fact sheets

<http://raisingchildren.net.au>

Child Health Information Booklet

Queensland Health

<https://www.childrens.health.qld.gov.au/chq/information-for-families/personal-health-record/>

Happy Teeth Program

Queensland Health

https://www.health.qld.gov.au/oralhealth/promo_programs/happy_teeth

Looking after Young Mouths:

Queensland health: Pictorial flipchart for Aboriginal and Torres Strait Islander families

https://www.health.qld.gov.au/__data/assets/pdf_file/0021/143094/YoungMouths_updated.pdf



Refer to the Chronic Conditions Manual

<https://www.publications.qld.gov.au/dataset/chronic-conditions-manual-2nd-edition-2020>



Refer to the Pathways to Rural and Remote Orientation and Training

<https://ilearncatalogue.health.qld.gov.au/program/17/parrot-primary-care>



Freepik.com

Health Promotion

One - 5 years

Needs of the child

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

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

Promotion of optimal nutrition

Parents / carers 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^{56, 177}:

- Encourage families to create an environment whereby mealtime is a pleasurable time spent with other family members.
- Encourage parents to offer a range of nutritious food options and flavours to establish a child's sense of taste and acceptance of variety.
- Encourage families to demonstrate healthy eating habits and choices to their children that can inform lifelong healthy eating patterns.
- 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

- Children should not be force fed¹⁷⁷.
- From 12 months, milk and water should be offered from a cup rather than a bottle and families should be encouraged to wean children from bottle feeds⁵⁶.
- Pasteurised cow's milk offers a rich source of protein and calcium and can be added as a drink from one year onwards. However, offering pasteurised cow's milk should be limited to around 500mls / day to avoid the risk of reducing the variety of food intake best for a child⁵⁶.
- Toddler milks or special complementary foods are not considered nutritionally necessary for healthy children⁵⁶.
- 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 family⁵⁶.

- 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 include³²:
 - regularly consuming large meal sizes
 - a family culture of admonishing children for leaving food on their plates
- Families should avoid⁵⁶
 - Foods poor in nutrient value or high in salt, fat or sugar.
 - Hard foods e.g. whole nuts, seeds, raw carrot, celery and apple should be avoided for the first three years due to the risk of choking. All these foods can be given to a child in a suitable consistency e.g. nuts in a paste form, cooked or grated carrot.
 - Unpasteurised milks are to be avoided altogether as they may cause the child illness due to possible infective organisms.
 - Juice drinks, sweet beverages, tea or caffeinated drinks.
- Micronutrient stores, especially iron, zinc and Vitamin B12 are likely to become depleted if appropriate foods are not provided⁵⁶.
- Iron deficiency is the most common and widespread nutritional disorder in the world. As well as affecting a large number of children and women in developing countries, it is the only nutrient deficiency, which is also significantly prevalent in industrialized countries, including Australia. Impacts on infants and children include alteration in brain function, increased risk of infection and mortality, poor exercise tolerance and poor school performance²⁰¹.
- Parents using a vegetarian/vegan diet need to ensure that supplies of iron and zinc and B12 are adequate to meet the needs of a growing child. They should be encouraged to⁵⁶:
 - continue breastfeeding for as long as possible e.g. > 2 years
 - seek dietetic advice and assessment
 - nutritional supplements may be required
- Use culturally appropriate tools for education on breastfeeding and infant nutrition such as:
 - Growing Strong - feeding you and your baby resources⁵². This is a resource developed to assist health staff talk with Aboriginal and Torres Strait Islander families about nutrition for mothers, babies and young children. There are a range of resources available.
<https://www.health.qld.gov.au/nutrition/patients%23>
 - The Good Start Program has a range of culturally tailored resources for Maori and Pacific Islander families and communities⁵³.
<https://www.childrens.health.qld.gov.au/service-good-start-resources/>
 - Multicultural nutrition resources - including *Infant feeding for African communities*, a suite of resources designed in partnership with African women covering all aspects of feeding and nutrition⁵⁴.
<https://metrosouth.health.qld.gov.au/multicultural-nutrition-resources>
 - Raising Children Network has articles, videos and picture guides translated into multiple languages⁵⁵.
<https://raisingchildren.net.au/for-professionals>
- Identify community partnerships and opportunities for services to work together on promoting optimal nutrition including local hospitals, GPs, birthing units and postnatal services, local support organisations (e.g. ABA, LANCZ), dietitians, speech pathologists, pharmacies and oral health services¹.

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 ^{56, 59, 156}.

- Promotion of optimal maternal nutrition during breastfeeding is important to maintain maternal health and enhance the micronutrient and fatty acid make up of breastmilk. The child health professional should encourage the mother to consume a healthy diet during breastfeeding ¹⁹⁶.
- Breastfeeding supplements:
 - Breastfeeding mothers are recommended to have iodine supplements as it is difficult to obtain enough dietary iodine daily. Generally, it is recommended to take 150µg of iodine per day ¹⁹⁶.
 - Women from specific population groups may require other supplements when breastfeeding for example, vegan breastfeeding women.
 - Queensland Health's Nutrition Education Materials Online (NEMO) has a range of factsheets for parents, including "Healthy eating for breastfeeding mothers" and "Healthy eating for vegetarian or vegan mothers" <https://www.health.qld.gov.au/nutrition/patients#>
- The Marketing in Australia of Infant Formula (MAIF) Agreement is Australia's response to the WHO International Code of Marketing Breastmilk 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 through the appropriate marketing and distribution of breastmilk substitutes ¹⁹⁵.
- During the 1 -5 year period, discussion with families about breastfeeding may include:
 - the benefits of breastfeeding and the risks of not breastfeeding
 - extended breastfeeding
 - promoting maternal self-care
 - information sources and support agencies specific to feeding, e.g. local child health services, Australian Breastfeeding Association, LANCZ (Lactation Consultant), Raising Children website
 - returning to work and breastfeeding



Assessment of nutrition

See page 184



Nutrition Education Materials Online (NEMO)

<https://www.health.qld.gov.au/nutrition/patients>

'Growing Strong: Feeding You and Your Baby' suite of resources

Queensland Government

<https://www.health.qld.gov.au/nutrition/patients#>

Multicultural Nutrition Resources, Metro South Health

A suite of resources designed in partnership with local communities covering all aspects of feeding and nutrition

<https://metrosouth.health.qld.gov.au/multicultural-nutrition-resources>

Raising Children Network

<http://raisingchildren.net.au>

Australian Breastfeeding Association

www.breastfeeding.asn.au

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 time¹⁹⁷.
 - 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 working¹⁹⁷.
 - Employment policies that ensure a supportive workplace culture, access to lactation breaks with suitable facilities to express and store EBM and flexible working hours are associated with improved breastfeeding practices^{59, 197}.
- By law, employers must make reasonable attempts to meet the needs of breastfeeding mothers. The child health professional should encourage mothers to discuss options with their employer regarding supporting their breastfeeding needs¹⁹⁸.
- Discuss preparation for returning to work, e.g. expressing and storing breastmilk; options to support ongoing breastfeeding¹⁹⁷.



Expressing breastmilk

See page 119



Breastfeeding Friendly Workplace – Your rights at work

Australian Breastfeeding Association

www.breastfeeding.asn.au

Extended breastfeeding

There is no public health recommendation of when a mother and child should cease breastfeeding.

- Mothers who continue to breastfeed past infancy are often exposed to society constraints, with some women describing a negative shift in approval for continued breastfeeding as their child transitioned from ‘baby’ to ‘toddler’. Many women feel the need to hide breastfeeding of the older child and are reluctant to seek advice from healthcare professionals for fear of being judged negatively²⁰⁹.
- 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.
- Child health professionals may advocate for breast feeding information to include pictures of children breastfeeding, rather than just babies breastfeeding to assist in addressing societal barriers²⁰⁹.



Raising Children Network

<http://raisingchildren.net.au>

Australian Breastfeeding Association

www.breastfeeding.asn.au

National Health and Medical Research Council

Infant Feeding Guidelines – Information for Health Workers

<https://www.nhmrc.gov.au/about-us/publications/infant-feeding-guidelines-information-health-workers>

Australian National Breastfeeding Strategy: 2019 and Beyond

COAG Health Council

<https://www1.health.gov.au/internet/main/publishing.nsf/Content/health-pubhlth-strateg-brfeed-index.htm>

Queensland Health – Baby Friendly Health Initiative

<https://www.health.qld.gov.au/clinical-practice/guidelines-procedures/clinical-staff/maternity/nutrition/bfhi>

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 ³²
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 fontanelle closes 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.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.
4 to 5 years	<ul style="list-style-type: none">Growth on average:length increase of 7.5 cm/yearaverage weight 16.5-19 kgsHead 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 example³²:

- Myelination of the spinal cord becomes complete, resulting in an opportunity for the child to develop bladder and bowel control, with daytime toilet training often being achieved around the age of 2.5 -4 years.
- The child begins to incorporate previous learning with new skills including intellectual reasoning, such as turning on a light switch.
- 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.
- As their sense of autonomy and language skills advance, power and control is explored and their self-identity is expressed through behaviours such as willfulness, possessiveness, developing rituals.

- 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.

Parent-child interaction

- The relationships developed in the early years provide the building blocks for future social, emotional and cognitive development, and promotes optimal infant/child mental health. Absence of, or disruption to this primary relationship is a common cause of mental health difficulties¹⁷. 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 themselves⁹⁹.
- 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.
- In an emotionally healthy relationship, delight between caregiver and child is evident.

Examples of positive and problem indicators of parent-child interaction^{17, 99}

Postitive indicators	Problem indicators
Parent <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 	Parent <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 • Unable to cope with their child's distress • Unable to delight in the child or enjoy activities with the child • Does not ensure the child is safe or is overprotective / excessively worried about the child • 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
Child <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 	Child <ul style="list-style-type: none"> Has difficulty communicating needs to the parent Overly friendly/overly fearful with strangers Avoids looking at/towards the parent Does not seek out the parent for comfort Appears apprehensive around the parent Does not explore its environment Flat affect or emotionally under-responsive Lack of crying, limited vocalizing Irritable, constant crying, extremely difficult to settle Difficulty separating from parent (age-dependent)

- Parents are informed that a child's brain development is enhanced when the child feels nurtured, loved and secure and when their care-givers respond to their needs ^{55, 202}.
- A child's ability to develop self-regulation, i.e. regulate his/her own emotions and behaviours, are enhanced by positive parent-child interactions ⁹⁹.
- Parents are encouraged to discuss any concerns about their infant's development with their child health professionals and/or GP.
- Refer to resources to raise the family's awareness of delays in development such as The Red Flags Early Identification Guide (for children birth to five years) ¹⁴³.

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 Service / Early Intervention Parenting Clinician as appropriate for further assessment.



Building Healthy Brains – The Eleven Key Messages

See Appendix 2



Assessing Mother-Infant interaction

Centre of Perinatal Excellence (COPE)

<https://www.cope.org.au/wp-content/uploads/2018/07/Assessing-Mother-infant-Interaction.pdf>

Circle of Security videos

Circle of Security – Good Enough; Connection; Being with and shark music

<https://www.circleofsecurityinternational.com/resources-for-parents/>

ZERO to THREE website

<https://www.zerotothree.org/>



Connected Parenting

Circle of Security in the context of Aboriginal and Torres Strait Islander families - eLearning

<https://www.sjog.org.au/for-medical-professionals/connected-parenting/e-learning-resource>

Health Promotion

One - 5 years

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

- Children's sleep pattern is a common issue raised by parents with child health professionals. Providing early accurate evidence-based information around normal sleep patterns and development, may be reassuring for parents and could prevent the need for intervention³².
- There is an enormous variation in the amount of sleep and activity among children and sleep needs will change throughout life. Many factors influence sleep, some examples include²⁰⁴:
 - temperament;
 - developmental stage (e.g. separation anxiety);
 - physical reasons (e.g. hunger or illness);
 - parental influence (e.g. sleeping environment, technology use and associations).
- Sleep disturbance that impacts on the parent and child may have profound negative consequences for both. There is evidence that it may increase the likelihood of behavioural problems, impact the parent-child relationship, parent-parent relationship and parental wellbeing.^{204, 205}
- The following tables offer a guide to a child's behaviours patterns and activities and offers strategies and tips that may enhance their child's development

Sleep ^{32, 51, 55, 92, 191, 204}

Child behaviour

- A child's behaviour changes as they become tired.
- Children can become overtired quickly. Some tired signs include:
 - clumsiness
 - clinginess
 - grizzling or crying
 - demands for attention
 - boredom with toys
 - fussiness with food
- **1 - 3 years:**
 - Average total sleep/day: 11-14 hours.
 - One nap a day for most children at 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:**

- Average total sleep/day: 10-13 hours.
- Gradual transition to no naps in the day.
- Increase of fears during sleep e.g. monsters.
- Nightmares occur in 10- 50% of children
 - › children remember the event
 - › usually occurs in the second half of sleep
- Confusional arousals are common ('sleep drunkenness')
 - › child has slurred speech, disorientated behaviour
 - › 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
- 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
- Electronic devices emit an artificial blue light that engages the brain and can suppress the release of melatonin, causing sleep disruptions –difficulty with both falling asleep and also staying asleep. Interactive technological devices e.g. cell phones/tablets, computers and electronic games, are most strongly associated with sleep disturbance²¹⁰.

Parenting tips / Skills to support development

- Work towards prevention of behavioural insomnia by encouraging techniques supporting self-settling and regular sleep routines for example:
 - Develop a regular bedtime routine (e.g. quiet time, reading, no stimulation).
 - Establish a bedtime and wake up time.
 - Encourage daytime naps according to the child's tired signs.
 - Avoid scary TV shows, books etc. if your child is developing bedtime 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
- Restrict screen time during the day, but particularly within 1 – 2 hours before bedtime.
- 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.

Cautions and things to avoid

- Avoid overstimulation e.g. screen time before bed.
- 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 pg.255](#).



Raising Children Network

Resources in both video and fact sheets on a variety of topics

<http://raisingchildren.net.au>

Ellen Barron Family Centre

Responsive settling videos

<https://www.childrens.health.qld.gov.au/chq/our-services/community-health-services/ellen-barron-family-centre/responsive-settling/>

Promoting Optimal Sleep in Infants and Young Children

Child and Youth Community Health Service

https://qheps.health.qld.gov.au/__data/assets/pdf_file/0024/2130909/promoting-optimal-sleep-infants-children.pdf

Physical activity: exercise and play ^{20, 32, 51, 55}

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.
- Parent-child play builds connection, sense of self and emotional resilience in children²⁰⁶.
- Children should have limited inactivity/sedentary time, with no more than one hour at a time (excepting sleep) throughout the day be spent sitting completing quiet sitting activities i.e. reading / drawing / restrained in a stroller⁵¹.

Parenting tips / Skills to support 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.
 - 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 day⁵¹
 - Avoid having TV on the background within the family home.
- If a parent reports their child is not interested in physical activity:
 - Explore barriers and obstacles e.g. screen time, lack of opportunity.
 - Assess for other symptoms of hyperglycaemia: weight loss despite usual appetite, excessive thirst, polyuria and any return to enuresis (classic 4T symptoms – Tired, Thin, Thirst, Toilet.) Refer for same day blood glucose finger prick test. See *Type 1 Diabetes* page 419.



Raising Children Network

Resources in both video and fact sheets on a variety of topics

<http://raisingchildren.net.au>

Toilet training^{32, 55, 92, 211}

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 can also have an 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.
- Most children are day trained between 2 .5 years and 4 years.
- Nighttime 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, but normal variance can be up to 8 years old.

Parenting tips / Skills to support development

- Do not rush toilet training. The child and the parent need to be ready.
- It is time to start when the child is showing signs of readiness e.g. indicating when they are soiled or wet; show an interest in the toilet; undress or pull down their own pants; longer periods between wet nappies and regular bowel movements.
- Talk to the child about the toilet/potty, what it is for, let the child play and sit on it.
- 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 e.g. birth of another baby, moving to a new house, or when the child is unwell.
- Nocturnal enuresis is often reported as the first sign of Type 1 diabetes.
 - Child health professionals should have a high index of suspicion of Type 1 diabetes with a relapse to enuresis in a previously toilet trained child.
 - Polyuria (a symptom of Type 1 diabetes) can be masked by the use of disposable nappies. If any of the other classic signs (4T's - Tired, Thin, Thirst and Toilet) are present, parents should be referred for same day blood glucose fingerpick test. *See Type 1 Diabetes page 419.*
- If parents are worried about toilet training progress, they should discuss this with the Child Health Professional / GP.



Raising Children Network

Resources in both video and fact sheets on a variety of topics

<http://raisingchildren.net.au>

Child behaviour

- Generally, by 1 year, children can be eating the same foods as the rest of the family.
- It is common for children to be inconsistent (sometimes referred to as ‘fussy’) with their food intake. Many parents find this inconsistency difficult.
 - Children experience decreases in appetite as their growth slows, and growth spurts can result in hunger bursts.
 - It is part of normal development for children to be at times fussy with their foods, to not like the taste, texture or colour of particular foods.
 - It is also common for children to like something one day but dislike it the next and to refuse new foods.
 - Children are very interested in the world around them and can be easily distracted away from eating.
 - It is more helpful to look at what a child eats over a week rather than across a single day.
- Establishing healthy eating patterns and attitudes early in life can protect a child from developing later physical and mental health concerns.
 - The way a child feels about their body starts to develop as early as three years.
 - A child’s body image may be influenced by a number of personal factors (e.g. biology, temperament) and environmental factors that may be outside the family (e.g. exposure to certain media).
 - Promoting the development of positive body image involves promoting healthy eating patterns and attitudes towards food.
- Healthy eating refers to eating a balance and variety of foods, including nutritious (‘everyday’) foods from the five food groups.
 The [Australian Guide to Healthy Eating](#) ²¹³ is a food selection guide which visually represents the five food groups recommended for consumption each day.

Parenting tips / Skills to support development

- Parents can be encouraged to:
 - Establish family routines around mealtimes e.g. hand washing before eating, modelling healthy mealtime behaviours, making healthy choices for the entire family.
 - Eat together as a family when possible. Family meals can promote healthy attitudes towards food and eating when they occur in a positive and relaxed environment. They also allow opportunities to discuss personal difficulties, provide parental support, and family bonding time.
 - Create a happy social environment for mealtime with few distractions e.g. no television.
 - Offer small serves and 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, get child involved in preparation e.g. washing fruit and vegetables or picking the recipe.
 - 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 and avoid snacking before mealtimes.
- Provide 3 nutritious meals and 2 healthy snacks each day.
- Parents are advised to use the Australian Guide to Healthy Eating and role model consuming and providing a balanced variety and amount of nutritious foods and drinks.
- Read labels to choose lower sodium options ('reduced-salt' or 'low-salt' foods). A useful resource is the Nutrition Education Materials Online (NEMO) *tip sheet on label reading*, available at: https://www.health.qld.gov.au/__data/assets/pdf_file/0027/145476/diab_labels.pdf
- 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 plates
 - using foods for reward; giving foods as a form of comfort to a child
 - types of foods and fluids consumed or cooking methods utilised e.g. deep frying
- Describe the concept of 'often' foods and 'sometimes' foods and encourage parents to teach children about groups of foods that are healthy.
- Promote an increase in physical activity and reduction in sedentary activities (*See Physical activity: exercise and play pg. 131*).
- Encourage children to drink tap water and limit cordials, soft and sports drinks and flavoured milks.
- Encourage children to eat whole fruits and limit juices
- Pack interesting healthy lunch boxes for children, choosing food and snacks from the 5 food groups. If children are involved with choosing and preparing their lunch box, they are more likely to eat it. Many healthy snacks and foods can be pre-prepared and frozen.
- Support parents to promote "body satisfaction" e.g.
 - Parents should discourage their children from "dieting" behaviours.
 - Parents should avoid talking about dieting, calories, weight and appearance, as this may encourage similar behaviours in their children.
 - Discourage appearance-based teasing and avoid endorsing a preference for thinness in front of your child/ren.
 - Promote the importance of a fit and healthy body, rather than a thin or ideal body.
- Use culturally appropriate tools for education on infant nutrition such as:
 - Growing Strong - feeding you and your baby resources⁵². This is a resource developed to assist health staff talk with Aboriginal and Torres Strait Islander families about nutrition for mothers, babies and young children. There are a range of resources available. <https://www.health.qld.gov.au/nutrition/patients#>
 - The Good Start Program has a range of culturally tailored resources for Maori and Pacific Islander families and communities⁵³. <https://www.childrens.health.qld.gov.au/service-good-start-resources/>
 - Multicultural nutrition resources - including *Infant feeding for African communities*, a suite of resources designed in partnership with African women covering all aspects of feeding and nutrition⁵⁴. <https://metrosouth.health.qld.gov.au/multicultural-nutrition-resources>

- Healthy Eating Samoan Nutrition Resources – resources, including example recipes tailored for this community ⁵⁴.
<https://metrosouth.health.qld.gov.au/multicultural-nutrition-resources>
- Raising Children Network has articles, videos and picture guides translated into multiple languages⁵⁵. <https://raisingchildren.net.au/for-professional>

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

Resources in both video and fact sheets on a variety of topics

<http://raisingchildren.net.au>

Diet and Eating Factsheets

Including Fun not Fuss with Foods, Introducing complementary foods, food allergy
Queensland Government

<http://conditions.health.qld.gov.au/HealthCondition/home/topic/8/78/diet-and-eating>

Confident Body Confident Child

A guide for healthy eating and helping children grow up feeling good about their body

<https://www.confidentbody.net/>

Growing Good Habits

<https://www.growinggoodhabits.health.qld.gov.au/>

Multicultural Nutrition Resources, Metro South Health

A suite of resources designed in partnership with local communities covering all aspects of feeding and nutrition

<https://metrosouth.health.qld.gov.au/multicultural-nutrition-resources>



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Child behaviour

- Whilst teeth erupt at different times from one child to another, all 20 deciduous (baby) teeth usually appear 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 an essential part of general health and well-being and early childhood is the time when most lifelong habits are established. Oral diseases are among the most common and costly chronic diseases in Queensland⁸⁰. Tooth decay is a mostly preventable disease and is associated with significant long-term health problems e.g. periodontitis has been associated with heart disease.
- The deciduous teeth are important for young children's development - eating, speech and facial appearance. They also guide the eruption and position of the permanent teeth.
- Decay in deciduous teeth is a predictor of decay in permanent teeth. If identified early, preventive measures can be undertaken to prevent the progress of decay.
- Queensland's children have one of the highest rates of dental decay in Australia.

Parenting tips / Skills to support development

- Dental caries is highly preventable and is related to both dietary issues and the build-up and retention of plaque through infrequent, substandard tooth cleaning.
- Decay can start in teeth soon after they appear in the mouth and it progresses quickly. Parents should be informed about the signs of decay, prevention of decay and the importance of regular dental checks.
- Parents can be encouraged to:
 - Set up a routine of dental hygiene at least twice a day.
 - Teeth should be brushed with a small soft-head, child sized toothbrush as soon as they appear.
 - Introduce a small, pea-size smear of low fluoride toothpaste after 18 months in areas with fluoridated tap water and after six months in non-fluoridated areas¹⁷⁶.
 - › Low fluoride toothpastes are created especially for children under six years of age and are available in most supermarkets or pharmacies.
 - › Children only require a small amount of fluoride toothpaste and should not be allowed to dispense toothpaste without supervision.
 - Ensure all family members have good oral health.
- For young children the most effective method of cleaning the teeth is cleaning by brushing and flossing by the parents.
 - Parents can support the child to learn to brush their teeth from about two years but should assist with brushing of teeth until children are about eight years of age.
 - 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' gives access to the front teeth.

- Dietary discussion should focus on healthy food options to reduce consumption of sugars, and should include:
 - Promotion of breast feeding.
 - Reduction of the quantity and frequency of high sugar drinks, foods and snacks.
- Offering only breastmilk, cow's milk or cool boiled tap water as a drink after 12 months, preferably from a cup not a bottle.
- The Australian Dental Association recommends that children have their first dental visit when the first tooth becomes visible or they reach 12 months of age²⁰⁸. A dental check-up at this early age will:
 - allow the toddler to become familiar with the sights, sounds and smells of the dentist
 - allow early detection of tooth decay and other dental conditions
 - enable dental staff to give advice and instruction on toothbrushing and on good eating habits

Holders of a Health Care Card or Pension Card, and all children 4 years old until end of Year 10, are eligible for free dental care at public dental clinics located throughout Queensland.
- Use culturally appropriate resources for oral health education where possible:
 - Looking after Young Mouths pictorial flipchart is a health education tool aimed to prevent oral disease in Aboriginal and Torres Strait Islander communities.
 - Building Strong Teeth is aimed at children and can be used by early childhood educators.

Cautions and things to avoid

- Avoid putting your child to sleep with a bottle, leaving the milk on your child's teeth can increase the risk of decay.
- Only put breastmilk, formula or cool boiled tap water in a bottle.
- Do not put anything in a child's mouth if it has been in another person's mouth to avoid spreading bacteria that cause tooth decay.
- Do not dip pacifiers or bottle teats in sugar, jam, honey or other sugary substance.
- Encourage children to 'let go' of their dummies or sucking their thumb or fingers. This usually happens by 2 – 4 years of age.



Raising Children Network

Resources in both video and fact sheets

<http://raisingchildren.net.au>

Child Health Information Booklet

Queensland Health

<https://www.childrens.health.qld.gov.au/chq/information-for-families/personal-health-record/>

Happy Teeth Program

Queensland Health

https://www.health.qld.gov.au/oralhealth/promo_programs/happy_teeth

Queensland Government

Pictorial flipcharts for Aboriginal and Torres Strait Islander parents, families, teachers

- **Looking after Young Mouths**

https://www.health.qld.gov.au/__data/assets/pdf_file/0021/143094/YoungMouths_updated.pdf

- **Building Strong Teeth**

https://www.health.qld.gov.au/__data/assets/pdf_file/0036/154899/StrongTeeth_updated.pdf



Refer to the Chronic Conditions Manual

<https://www.publications.qld.gov.au/dataset/chronic-conditions-manual-2nd-edition-2020>



Refer to the Pathways to Rural and Remote Orientation and Training

<https://ilearncatalogue.health.qld.gov.au/program/17/parrot-primary-care>



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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 i.e. stammering, stuttering may be common during this time.
- Problematic hearing can affect speech development.
- Communication Milestones²¹⁴:
 - 12 Months: Understands around 10 words, responds to their name and can recognise gestures e.g. waves bye, can say a few words, constant babble and copies different sounds.
 - 18 months: Understands around 50 words and short phrases and can say 6-12 single words. Follows simple instructions e.g. throw the ball and can sometimes name a few body parts.
 - 3 Years: Can follow two-part instructions, recognise basic colors, understands some concepts like 'same' and 'different'. Says 4 – 5 words in a sentence, asks a lot of questions and can have a conversation although may not stay on topic.
 - 5 years: Follows a three-part instruction, understands time related words e.g. before, now, later. Begins to recognise some words and letters, uses sentences and can be understood by most people. May still have some difficulty with certain speech sounds e.g. s, r, l and th.
 - See Speech Pathology Australia's *Communication Milestones* for more information <https://www.speechpathologyaustralia.org.au/>

Parenting tips / Skills to support development

- Responsive communication, that is interactions that consist of back and forth communication (turn taking), is how children build their early language skills.
- Parents can be encouraged to:
 - Read stories aloud – discussing the pictures not just reading the words.
 - Sing songs, recite rhymes together.
 - React, praise their child's efforts to communicate.
 - Name objects or give the child the words when they are gesturing e.g. say 'cup' when giving the sippy cup, or 'thirsty' if indicating they would like a drink.
 - Follow the child's lead, focusing on things that have caught his interest, not persisting when he is showing disinterest or other cues e.g. tired, hungry.
 - Pause, allow the child time to respond, allow time for 'turn taking'.
- If stammering occurs, encourage child to slow and relax. Parent should resist completing sentence, slow and relax themselves and 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

Resources in both video and fact sheets on a variety of topic

<http://raisingchildren.net.au>

Communication Milestones

Speech Pathology Australia

<https://www.speechpathologyaustralia.org.au/>



The Red Flags Early Identification Guide (for children birth to five years)

Queensland Health

<https://qheps.health.qld.gov.au/ccyfhs/html/resources>

Emotional wellbeing ^{20, 32, 55, 143, 203, 215}

Child behaviour

- Children continue to learn social skills and interaction by observing those around them and by their own experiences of social interaction.
- Exposure to adverse childhood events may impact on emotional wellbeing, the more events the more likelihood there will be an impact.
- Family stressors (e.g. job loss, parental mental health, domestic violence) and broader environmental stressors (e.g. natural disasters resulting in forced isolation or major changes to routine) are challenging to children and, if not addressed, potentially can develop into long-term emotional mental health issues.
- In times of stress, it is common for children to seek more attention.
- Having a relationship in which a child feels secure and connected to a primary carer promotes healthy social and emotional wellbeing for the future e.g. healthy self-esteem, good mental health, coping with stress, fewer behavioural problems.
- At around 18 months of age the toddler recognises him/herself as an individual person. Physically aggressive behaviours e.g. biting, hitting, kicking is 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 wrongdoing 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 gender awareness of basic anatomical differences and stereotypes becomes evident through curiosity and play.
- Common parenting issues include eating, tantrums and bedtime problems and disobedience.

Parenting tips / Skills to support development

The child health professional can promote positive relationships, parenting behaviours and a parenting style that supports healthy parent-child relationships.

- Using a strengths-based, partnership approach can build positive behaviours and skills that enhance a child's coping skills and self-regulation.
- Parents can be encouraged to:
 - Respond in a sensitive, caring way to their child's communication i.e. comfort when upset, delight in their play.
 - 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.
 - Instill positive body image messages.
 - Maintain familiar routines as much as possible, limit screen time and encourage physical activity.
 - Discuss major changes in an open honest way using age appropriate language.
 - Talk about their worries and fears, manage exposure to media coverage.
 - 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 EIC / EIPC within the multidisciplinary team.
- See “[Parent-infant interaction](#)” on page 227 for examples of positive and problem indicators of parent-child interaction



Emerging Minds

<https://emergingminds.com.au/resources/toolkits/>

Raising Children Network

Resources in both video and fact sheets

<http://raisingchildren.net.au>

ZERO to THREE website

<https://www.zerotothree.org/>

Beyond Blue - Healthy Families

Resources on emotional and mental health for the whole family

<https://healthyfamilies.beyondblue.org.au/>

Circle of Security videos

Circle of Security – Good Enough; Connection; Being with and shark music

<https://www.circleofsecurityinternational.com/resources-for-parents/>



Connected Parenting

Circle of Security in the context of Aboriginal and Torres Strait Islander families – eLearning

<https://www.sjog.org.au/for-medical-professionals/connected-parenting/e-learning-resource>



No-Drama Discipline: The Whole-Brain Way to Calm the Chaos and Nurture Your Child's Developing Mind Dr Daniel Siegel and Tina Bryson ²¹⁶

Raising a Secure Child Hoffman, Cooper and Powell ²¹⁷



Australian Family Strengths Nursing Assessment Guide

See Appendix 1

Building Healthy Brains – The Eleven Key Messages

See Appendix 2

Health Promotion

0 - 5 years

Immunisation

- 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 diseases⁷¹. Immunisation is important for everyone, adults as well as children.
- For the best protection, vaccinations need to occur on time - on (or as close as possible to) the due date in accordance with the National Immunisation Program Schedule Queensland (NIPS). The schedule outlines the ages at which children should be vaccinated to get the earliest and best protection against vaccine-preventable disease²¹⁸.
- As at March 2020, the rate of immunisation for Queensland's 2 year olds was 91.84%. The goal is 95%. This means that around one in ten Queensland children are at risk of contracting vaccine preventable diseases²¹⁹. Meeting population health goals for immunisation rates involves collaborative practice with a range of service providers across government and non-government sectors.
- When families visit a Child Health professional, it provides an opportunity to:
 - assess the child's immunisation record against the current NIPS
 - validate the immunisation status where possible and
 - encourage vaccination when it is due⁷²
- Identified medically at risk children and some population groups require additional vaccinations e.g. children born <28 weeks gestation or Aboriginal and Torres Strait Islander families⁷¹. There are also other funded disease prevention programs⁷³ for example, Bubba Jabs on Time is a state-wide immunisation initiative that follows up Aboriginal and Torres Strait Islander children under 5 years of age who are identified as overdue for their immunisation²²⁰.
- Some family assistance payments are also now directly linked to children being fully vaccinated and if a child is not up to date with their immunisation, childcare providers have options to refuse or cancel enrolments or attendance²²¹.
- 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 Queensland Health Drug Therapy Protocol – Immunisation Program without doctor's prescription.
- Any Registered Nurse may administer vaccines prescribed by a medical officer. All immunisations administered are recorded on the Australian immunisation Register (AIR).
- The Australian Immunisation Handbook (online) provides clinical recommendations that are based on the best scientific evidence available at the time of publication from published and unpublished literature. Where specific empirical evidence was unavailable, recommendations were formulated using the best available expert opinion relevant to Australia⁷¹.
- Parents, families and carers are also able to contact 13HEALH, where they can receive immunisation advice from a Child Health Nurse or a specialist immunisation nurse over the phone.



Australian Government Department of Health

Immunisation

<https://www.health.gov.au/health-topics/immunisation>

Queensland Specialist Immunisation Service

<https://www.childrens.health.qld.gov.au/service-qsis-info-for-health-professionals/>

Immunisation Schedule Queensland

<https://www.health.qld.gov.au/clinical-practice/guidelines-procedures/diseases-infection/immunisation>

The Australian Immunisation Handbook (online)

<https://immunisationhandbook.health.gov.au/>

Translated Immunisation factsheets

<https://www.qld.gov.au/health/conditions/immunisation/translated-fact-sheets>

Immunisation – Information for families

- **National Centre for Immunisation Research and Surveillance**
<http://www.ncirs.org.au/public>
- **Sharing Knowledge About Immunisation (SKAI)**
<http://www.talkingaboutimmunisation.org.au/>
- **Queensland Government**
<https://www.qld.gov.au/health/conditions/immunisation>



Refer to the Pathways to Rural and Remote Orientation and Training

<https://ilearncatalogue.health.qld.gov.au/program/17/parrot-primary-care>



Refer to Primary Clinical Care Manual

<https://www.health.qld.gov.au/rrcsu/html/PCCM>



Shutterstock.com/First Glimpse Photography

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 management ¹⁵¹

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

<https://www.health.gov.au/resources/publications/national-vaccine-storage-guidelines-strive-for-5>

Safety, illness and injury prevention

This section discusses injury prevention and safety promotion to reduce the risk of morbidity and mortality relating to injuries and death for children aged 0-5 years.

- A sudden unexpected death in infancy (SUDI) is a category of deaths where an infant (aged under one year) dies suddenly, usually during sleep, and with no immediately obvious cause²²².
- Injury is the leading cause of child deaths in Australia²²³ with children aged 1-4 years having the highest rate at 6.1 per 100,000. Across Australia in 2016-2017, approximately 1500 children aged 0-4 year were hospitalised due to injury, with boys 1.3 times as likely to be hospitalised for injury than girls⁷⁵.
- Injury death rates for children increased with remoteness. In outer regional, remote and very remote areas the rate was 3 times as high as for major cities. The injury death rate for children living in the lowest socioeconomic areas was also higher and differences are also evident between Indigenous and non-Indigenous children⁷⁵.
- In the age group of zero to five, safety and injury prevention require more than just supervision. Successful strategies to reduce injuries are often referred to as the three 'E's' which include education, enforcement and engineering²²⁴ 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

- The most common injury death groups that occur in the 0-4 years age group between 2015-2017 were land traffic accidents, accidental drowning and assault⁷⁵.
- These are listed in the tables below along with other common injuries, with recommendations for parents regarding injury prevention. Examples of resources that can be accessed are also provided.

General information

- In Australia, falls are the most common cause of injuries in every age group.
- Falls occur commonly from prams, strollers, cots, highchairs, 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 2016-2017:
 - An injury following a fall was the leading cause of hospitalisation for injured children.
 - Falls from furniture were the most common cause, followed by fall from tripping.
- There are three important things that can influence the seriousness of a fall:
 - The height children can fall from: the lower the height, the lower the danger. Children under five years should not have access to heights over 1.5 m.
 - What children fall onto: hard surfaces like concrete, ceramic tiles and even compacted sand are more hazardous to fall onto than softer surfaces. Soft-fall or a bed of pine mulch under play equipment provides a softer landing. These beds must be at least 30 cm deep.
 - What children might hit as they fall: put sharp-edged furniture, like coffee tables and bedside tables, in areas where a child is unlikely to fall on them.

Recommendations for parents

- Ensure all infant/child equipment and furniture items comply with Australian mandatory standards.
- Always follow the manufacturer's instructions when assembling nursery furniture.
- Secure heavy pieces of furniture e.g. bookshelves, stove, television.
- Never leave an infant unattended on a change table, lounge, bench, beds, in a highchair or in a bath.
- Always use a 5-point harness to restrain a child in a stroller or highchair and provide constant supervision. 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.
- Use safety gates at the top and bottom of stairs.
- Avoid baby walkers. These are not recommended as they can be unstable and enable a child to move quickly into danger areas.
- Provide a soft surface when children are learning to walk e.g. a carpet square rather than hard floorboards or tiles.
- Keep sharp corners covered especially coffee tables with "corner bumpers".
- 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.
- Parents are advised to learn basic first aid and resuscitation.



Kidsafe Queensland

Multiple resources, factsheets and brochures on Home Safety, Including Falls prevention
<https://kidsafeqld.com.au/programs/home-program/>

Raising Children Network

Multiple safet resources for Babies, Toddlers, preschoolers
<http://raisingchildren.net.au>

Product Safety Australia

<https://www.productsafety.gov.au/product-safety-laws/safety-standards-bans/mandatory-standards>

CPR videos

How to perform CPR on adults, children and infants
<https://www.healthdirect.gov.au/how-to-perform-cpr>

Drowning / near drowning ^{55, 75, 226, 227}

General information

- 19 children aged 0-4years died as a result of drowning in Queensland in 2018/19. This is a 12% increase on the previous year although still less than the 10 year average of 27.
- Accidental drowning risk triples when a child turns 1 year. Data shows that infants and young children (aged 1–4) have the highest accidental drowning death rates.
- Accidental falls into water remain the leading activity prior to drowning among this age group, accounting for 84% of all deaths. This includes swimming pools, rivers, dams and bathtubs.
- As with fatal drowning, non-fatal drowning incidents occur in all aquatic locations and among people of all ages. For every toddler drowning death, approximately eight children are admitted to hospital as a result of non-fatal drowning.
- On average, two children under the age of five, drown in farm dams every year.

Recommendations for parents

- **Supervise** - Active supervision means focusing all of attention on the children all the time, when they are in, on or around the water.
 - A responsible adult should always be in the water and within arms' reach.
 - Older children are not always equipped to deal with the responsibility of being the supervisor around water – an adult should always hold this responsibility.
 - Have a designated supervisor – this responsibility can be rotated.

- **Restrict Access** - Place a barrier between the child and the water. This may include:
 - placing a barrier around the water by fencing a pool or spa, closing the door to a bathroom. Inflatable pools with a depth greater than 300mm also need to be fenced by law.
 - placing a barrier around the child by creating a child safe play area that can be used inside or outside of the home. This can be effective in areas such as dams on farms.
- **Water Awareness** – strategies and activities to your child safe when in or around water include:
 - water familiarisation
 - checking for and removing water hazards
 - setting rules around water
 - discussing water safety with your child.
- **Resuscitate** - Everyone learns CPR.



Kidsafe Queensland

Multiple resources, factsheets and brochures on Home Safety, including Drownings and Farm Safety

<https://kidsafeqld.com.au/programs/home-program/>

Raising Children Network

Multiple safety resources for Babies, Toddlers, preschoolers: e.g. Water safety for children, CPR and first aid

<http://raisingchildren.net.au>

Royal Life Saving Australia

<https://www.royallifesaving.com.au/stay-safe-active>

CPR videos

How to perform CPR on adults, children and infants

<https://www.healthdirect.gov.au/how-to-perform-cpr>

General information

- Despite there being a noticeable decline in deaths among children aged 0–4, which has decreased by 68% since 2009, land transport accidents remain the leading cause of death overall for children 0–14 years. 59% of those children who died were passengers and 29% were pedestrians.
- Regional areas have the highest numbers transport-related deaths in children, with males numbering more than twice the number of females.
- 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.
- The majority of low-speed accidents occur at or near a child's home with the driver of the vehicle often their parent.

Recommendations for parents

- **Supervise** - When moving vehicles, know where children are. Keep them close, in sight, or in the car. Never leave children unattended in cars. Never leave motors of any kind switched on and unsupervised when children are around. Turn off and lock a car or vehicle; take the key out of the ignition; and always know where your children are around cars.
- **Separate** - Use fences and self-closing gates to keep garages and driveways separate from play areas - create safe play spaces for your children by fencing off the driveway from play areas. Always keep car doors locked. Make access to the driveway from the house difficult for young children, by using security doors, fencing or gates.
- **See** - Every driver should walk around their car before driving. Keep children in mind when using your reversing mirrors, sensors and cameras.
- **On farms:**
 - Keep young children well away from tractors and farm machinery.
 - Know where children are. Dress them in bright colours so they are easy to see.
 - Remove all keys from farm vehicles and machinery when not in use.
- **Car restraints:**
 - Babies up to 6 months of age must be in an approved rear-facing restraint that is properly fastened and adjusted. It is recommended that babies stay in a rear-facing restraint for as long as their size allows.
 - Babies and children from 6 months and up to 4 years must be in an approved child restraint that is properly adjusted and fastened. The child restraint may be rear-facing or forward-facing with a built-in harness. However, it is recommended that babies and children stay in a rear-facing restraint for as long as their size allows.
 - Ensure infant restraint meets the Australian/New Zealand Standard and are correctly fitted.
 - The Royal Automobile Club Queensland (RACQ) (<https://www.racq.com.au/cars-and-driving/safety-on-the-road/driving-with-children/child-restraints>), Queensland Ambulance Service (<https://ambulance.qld.gov.au/index.html>) and Kidsafe (<http://www.kidsafeqld.com.au>) can assist parents/carers with hiring baby capsules and installation advice for child restraints.
- Parents are advised to learn basic first aid and resuscitation.



Kidsafe Queensland

Resources: Road Safety

www.kidsafeqld.com.au

Raising Children Network

Resources: Child car restraints and booster seats

<http://raisingchildren.net.au>

Royal Life Saving Australia

<https://www.royallifesaving.com.au/stay-safe-active>

CPR videos

How to perform CPR on adults, children and infants

<https://www.healthdirect.gov.au/how-to-perform-cpr>

Choking / suffocations / poisoning ^{55, 64, 225}

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.
- The greatest number of accidental poisoning cases are seen in the 0-4 year age group, with about 1600 children under 4 years presenting to hospitals across Australia in 2016/17.
- Poisoning often occurs as a result of incorrect use/dosage of medication, herbal remedies.

Recommendations for parents

- Never prop feed your baby.
- Sit and supervise your infant/child when feeding/eating.
- Keep food pieces small.
- Cook, grate or mash hard foods, particularly hard fruit and vegetables like carrots and apples.
- Avoid foods that are hard and small e.g. whole nuts, seeds, whole grapes, popcorn, lollies as these can be a choking hazard.
- 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 small objects out of reach.
- Keep your infant's play area free from small items that may be a choking hazard.
- Ensure toys are solid and sturdy, and avoid toys with small parts, breakable parts or brittle surfaces. Check toys for exposed stuffing and loose screws and buttons.
- Avoid buying toys with button batteries.
- Keep toys for small children and older siblings in separate boxes. Encourage older siblings to keep their little toys out of reach.
- Before your child starts moving and climbing, make sure all small or dangerous items are out of 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.
- Leave all chemicals, medicines and cleaning products in their original containers. Never transfer poisons into food or drink containers. Don't put chemicals like detergents, paint thinners and weed killers into empty soft drink or juice bottles.
- Clean out chemical's cupboard regularly. Get rid of unwanted chemicals and cleaning products. Rinse empty chemical containers with water before throwing them out.
- Mothers should keep their handbag out of reach.
- Never refer to medicines or vitamins as "lollies".
- Before giving medicines always read the label, dosage and instructions carefully.
- Purchase products in child resistant containers and make sure the lids are on properly after use.
- Parents are advised to learn basic first aid and resuscitation.
- Advise parents of poisons information centre phone number on 13 11 26 – providing support seven days a week / 24hrs a day.



Kidsafe Queensland

Home Safety Resources: Choking and suffocation, Toys, Poisoning

<https://kidsafeqld.com.au/programs/home-program/>

Raising Children Network

Multiple safety resources for Babies, Toddlers, preschoolers

<http://raisingchildren.net.au>

CPR videos

How to perform CPR on adults, children and infants

<https://www.healthdirect.gov.au/how-to-perform-cpr>

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.
- Scalds were the most common cause of burns in children followed by contact and flame burns, with the kitchen being the location for 50% of the cases.
- It takes at least 20 mins of active cooling (immersion or irrigation with cool running water) for to sufficiently cool a burn to prevent progression.
- Children can get sunburnt in as little as ten minutes, and depending on the severity, it can take a few days or weeks to heal. Signs of severe sunburn include blisters, swollen skin and severe pain and should be seen by a GP.

Recommendations for parents

- Kitchen
 - Keep hot food and liquids out of reach of children.
 - Avoid consuming hot drinks / hot foods while holding infants.
 - Stove guards and cordless kettles help prevent children pulling hot liquids down. Use back elements on the stove, turn handles backwards and ensure free-standing stoves are firmly attached to the floor or wall.
 - Microwave ovens heat fluid / foods unevenly – avoid heating bottles in the microwave, stir food thoroughly and test the temperature.
 - Use place mats instead of tablecloths.
- Bathroom
 - Bath temperature should be around 38°C (adults usually have their baths around 41°C).
 - When running a bath, turn the cold water on first and off last and only put the child in once the water is finished running and has been tested. 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).
- Keep children away from hot objects (e.g. heater, BBQ, candles).
- Use safety plugs in power sockets.
- Choose clothing labelled ‘low-fire danger’.
- Develop a home fire escape plan with your family. Practice this plan to ensure all family members know what to do and where to go. Teach children to “Stop, Drop, Cover and Roll” if their clothes catch fire and “Get down Low and Go” in case of a house fire.
- Adopt the “Slip, Slop, Slap, Seek, Slide” message as a simple and effective way to reduce the risk of burns and skin cancer.
- Parents are also advised to learn basic first aid for burns ensure their home has smoke detectors.



Kidsafe Queensland

Resources: *Burns factsheet, plus access to The Australian & New Zealand Burn Association (ANZBA) resources*

<https://kidsafeqld.com.au/programs/home-program/>

Raising Children Network

Resources: *Bathing your baby, Scalds prevention and first aid*

<http://raisingchildren.net.au>

The Royal Children's Hospital Melbourne

Resources: *Sun protection*

www.rch.org.au/kidsinfo/fact_sheets/Safety_Sun_protection/

Sudden unexpected death in infancy (SUDI) 55, 64, 65, 222, 232

General information

- Cases of SUDI with an official cause of death are grouped broadly into two categories:
 - Explained SUDI—infant deaths for which a cause was not immediately obvious; but for which post-mortem examinations were able to identify a specific reason (including unrecognised infant illnesses, sleep accidents and non-accidental injury).
 - Unexplained SUDI—those infant deaths for which a cause could not be determined (including sudden infant death syndrome and undetermined causes).
- On average over the past 15 years, there have been 41 SUDI deaths per year, with male rates higher than female.
- In 2017-18, the leading cause of death for post-neonatal infants (aged from 28 days to 1 year) was unexplained SUDI (SIDS and undetermined), with the majority of deaths occurring in the under 6 months age group.
- Risk factors for SUDI:
 - Infant factors: Prematurity and low birth weight, male, multiple gestation, neonatal health problems and recent history of minor viral respiratory infections or gastrointestinal illness.
 - Sleep environment factors: Prone and side sleeping positions, sleeping on soft surfaces and loose bedding, some forms of shared sleeping and overwrapping or overheating.
 - Family factors: Cigarette smoking, young maternal age (≤ 20 years), single marital status, high parity and short intervals between pregnancies, high-risk lifestyles including alcohol and illicit drug abuse, social disadvantage and poverty.

Recommendations for parents

Health professionals continue to promote safe sleeping guidelines, such as:

- **Sleep the infant on the back** from birth (not on their side or tummy). Wrapping the infant firmly (but not tightly) may help them settle and sleep on their back. Discontinue wrapping as soon as infant starts showing signs of rolling.
- **Keep the head and face uncovered** when asleep. Position the infant so that the feet are at the bottom of the cot, blankets are firmly tucked in or use a baby sleeping bag with fitted armholes and neck and with no hood.
- Maintain a **smoke-free environment before and after birth.**

- Provide a **safe sleeping environment night and day**. Cot should meet Australian Standards for safety, mattress is firm and correct size for cot. Do not use bumpers, pillows, soft toys, doonas.
- Sleep the infant in their **own safe sleeping place in the same room** as a parent for the first six to 12 months.
- **Breastfeed.**
- Avoid overheating infant by using a light, cotton fabric e.g. muslin and ensuring the infant isn't overdressed under the wrap.
- Remove any items that are around the infant's neck e.g. bibs, teething necklaces.

Shared Sleeping

Shared sleeping is a common and valued infant care practice for many families and may occur as a planned event or an unplanned event.

- Shared sleeping increases the risk of SUDI in certain circumstances:
 - Antenatal and postnatal exposure to tobacco smoke.
 - Prone sleep position.
 - Caregiver use of alcohol, medicine or drugs causing a sedative effect.
 - Soft sleep surfaces e.g. pillows, doonas.
 - Environments with entrapment hazards (e.g. sofas/couches and armchairs).
 - Multiple bed-sharers.
 - Obesity of person sharing the sleep surface.
 - Infant movement is restricted, e.g. infant wrapped.
- Shared sleeping should be avoided when:
 - Caregivers or family member smoke tobacco (even if they don't smoke in the bedroom).
 - Caregivers have recently consumed alcohol prior to sleep.
 - Caregivers have taken any medicines or drugs that have a sedative effect.
 - Caregivers who are extremely tired or unwell.
 - For infants born prematurely (<37 weeks) and small for gestational age (≤2500g).
 - › Increased risk due to the young infant's limited ability to maintain airway patency.
 - › Avoid until infant age at least equal to term-corrected, and weight at least 2500g.
 - › If shared sleeping is likely to occur, implementing all other safe sleep advice is especially important for these small infants.
 - Sleeping on a sofa or armchair with an infant is not recommended in any circumstances as this environment greatly increases the risk of entrapment and/or suffocation.
- Communication with parents about shared sleeping:
 - Ask caregivers about their plans for infant sleeping.
 - Ask caregivers what they know/understand about shared infant sleeping.
 - Ask caregivers about their experiences with shared infant sleeping.
 - Provide clear and impartial information about the benefits and risks of sharing a sleep surface with their infant.

- Discuss strategies for shared sleeping, anticipating that shared sleeping may occur, whether intended or not.
- Offer caregivers the opportunity to ask questions.
- Set goals for minimising risk and ensure follow up.
- Risk Minimisation strategies for safer shared sleeping:
 - Risk Minimisation strategies for safer shared sleeping:
 - Sleep infant on back.
 - Ensure mattress is firm and flat.
 - Ensure adult bedding cannot cover infant's face.
 - Keep pillows and adult bedding away from infant.
 - Avoid use of doonas and duvets (greatly increased risk of accidental head covering).
 - Ideally use an infant sleep suit or sleeping bag to keep infant warm to reduce need for additional bedding.
 - Place infant to the side of one parent – avoid placing infant between parents, avoid placing next to other children or pets.
 - Ensure infant cannot fall off the bed (place infant far enough away from the edge) or place mattress on the floor.
 - Move bed or mattress away from the wall so infant cannot get trapped/wedged between the bed and the wall.
 - Do not wrap the infant if sharing a sleep surface with an adult as this restricts arm and leg movement.
 - › Falling asleep holding an infant on a couch or chair is a major risk for infant suffocation through entrapment.
 - Advise parents to move themselves and their infant to a safer sleep environment if they think they might fall asleep.
 - Shared sleep should not occur on a bean bag, waterbed or sagging mattress.
 - Consider the size of the sleep surface in relation to the people sharing the space.
 - › Is there enough room to create a clear space for the infant to sleep safely?



Red Nose Australia

Multiple resources and information statements, in multiple languages regarding all aspects of safe infant sleeping

<https://rednose.org.au/resources/education>

Kidsafe Queensland

<https://kidsafeqld.com.au/programs/home-program/>

Raising Children Network

<http://raisingchildren.net.au>

Queensland Clinical Guidelines

Shared Sleeping with Infants Guide

<https://www.health.qld.gov.au/qcg>

Assault / witnessing violence ^{25, 55, 75, 222, 233}

General information

- Over 600 children across Australia each year are hospitalised due to assault.
- Seven child deaths were recorded as a result of probable or confirmed assault and neglect in Queensland during 2018–19. The majority of assault deaths are classified as intra-familial.
- Among infants under 1 year, the rate of assault death was almost 8 times higher than children aged 1–14 years.
- Relationship issues and / or domestic and family violence may impact on the child in numerous ways including children being injured by their care givers e.g. shaken baby syndrome.
- Witnessing violence is also known to be harmful to children. Children who witness violence are impacted in a variety of ways and have poorer outcomes both in childhood and later in life than children who have not witnessed violence.
- Children are acutely aware of their environment and can react either outwardly or inwardly, when those around them experience tension, fear, anxiety, depression and aggression.
- 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.
- Under s13E of the Child Protection Act 1999 Registered Nurses are mandated to report where there is reasonable suspicion of significant harm to a child. Under s13A, other health professionals have a duty of care to report where there is reasonable suspicion of significant harm to a child.

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.
- Discuss with all parents / care givers what to do if they are finding parenting challenging or feel themselves becoming frustrated. This may be developed into a ‘safety plan’ for the parents to keep with them. Focus the parent on calming themselves down. For example:
 - put the baby in a safe place and walk away, checking on the baby every 5 to 10 minutes
 - call a friend, relative, neighbour, or contact a 24-hour parent helpline
- Never leave a baby with a person who is easily irritated, has a temper, or a history of violence.
- 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 and engage with community support and health services to improve psychosocial health and parental functioning.



Australian Family Strengths Nursing Assessment Guide

See Appendix 1

Building Healthy Brains – The Eleven Key Messages

See Appendix 2

Child Protection

See page 311

Introduction

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Birth to five years

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Appendix & References



Raising Children Network

Resources: Parent helplines and hotlines

<http://raisingchildren.net.au>

Queensland Centre for Domestic and Family Violence Research

<https://noviolence.org.au/factsheets/>



Queensland Health DFV Toolkit

Information, resources and training and including the Online Portal link for Queensland families impacted by DFV

<https://www.health.qld.gov.au/clinical-practice/guidelines-procedures/patient-safety/duty-of-care/domestic-family-violence>

Illness prevention ^{55, 73}

General information

- Whilst prevention of communicable diseases if 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.
- Good hygiene practices, staying home when unwell and physical distancing are proven ways to slow the spread of disease.
- Some illness will have a recommended minimum exclusion periods from school, pre-schools and childcare centres.

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 i.e. 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.
- Keep children home when unwell.
- Discourage sharing of eating and drinking utensils.



Raising Children Network

Resources: Preschooler hygiene; Personal hygiene for children – in pictures; Bottle feedings – cleaning and sterilising equipment

<http://raisingchildren.net.au>



Refer to the Chronic Conditions Manual

<https://www.publications.qld.gov.au/dataset/chronic-conditions-manual-2nd-edition-2020>

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
- 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

- 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 primary health care 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 into the service ¹.
- Depending on local resources, this may include extended home visiting, group programs (e.g. culturally 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).

Social determinants of health and wellbeing

There are many biological, psychological and social factors that may influence a person's ability to parent. The environment in which a child lives and grows can have a profound lifelong impact on the trajectory and outcomes of their health, well-being and development⁸.

The National Action Plan for the Health of Children and Young People: 2020-2030⁷⁴ was developed to ensure that all Australian children and young people, have the same opportunities to fulfil their potential, and are healthy, safe and thriving.

- Population groups where additional needs may be identified include ^{1, 38, 75, 76}:
 - Socioeconomically disadvantaged children and families.
 - Single parents, parents with multiple re-partnering experiences, stepfamilies and blended families, young parents.
 - 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 experiencing substance use issues: smoking, alcohol and other substance misuse.
 - Families with chronic illnesses and / or disability.
 - Isolated families e.g. living in remote areas.
 - Families with current violence, past abuse, or where a parent has experienced abuse as a child.
 - Aboriginal and Torres Strait Islander families.
 - Refugee Families.
 - Families from a culturally and linguistically diverse (CALD) background.

For more information and supporting literature for these vulnerabilities, see [Family Health Assessment Guide](#).

- A comprehensive family health assessment will provide a foundation for engaging families and will assist in identification of family strengths and needs, enabling appropriate interventions and referral. 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 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 example¹:
 - universal service provision with brief structured interventions and/or
 - referral to additional support services within or external to the service
- The child health professional uses a strength based, partnership approach to build on parent capacities and skills, focusing on ^{1, 101}:
 - providing evidence based, culturally respectful, 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
- If the child identifies as being of Aboriginal or Torres Strait Islander decent, Aboriginal and Torres Strait Islander Advanced Health Workers (where available) should be involved in the family health assessment conversation and in developing the cultural aspects of the care plan.



Refer to the Chronic Conditions Manual

<https://www.publications.qld.gov.au/dataset/chronic-conditions-manual-2nd-edition-2020>



Family Health Assessment – A guide for child health clinicians practicing within the primary health care setting

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

Aboriginal and Torres Strait Islander families

- In 2016, the National Framework for Health Services for Aboriginal and Torres Strait Islander Children and Families identified that the child and family health system was not meeting the needs of all Aboriginal and Torres Strait Islander children and their families. It identified that a more holistic approach to health and wellbeing that draws on the strengths of Aboriginal and Torres Strait Islander peoples and cultures must inform how high quality, evidence-based child and family health services are delivered to Aboriginal and Torres Strait Islander people⁷.
- Health in the context of an Aboriginal and Torres Strait Islander person is a holistic concept, encompassing body, mind, spirit, land, environment, custom and socio-economic status of the child as well as their community²³⁴.
- It is important to ask a family at first contact if they identify their child as being of Aboriginal and/or Torres Strait Islander origin so culturally capable healthcare can be provided to the family²³⁵. It is the starting point for the delivery of appropriate care and therefore should occur early in the healthcare journey.



See **Queensland Health's Indigenous Identification Module** available on iLearn

<https://ilearncatalogue.health.qld.gov.au/course/611/queensland-health-indigenous-identification-module>



Artwork produced for Queensland Health by Gilimbaa

- Culturally competent and capable care for Aboriginal and Torres Strait Islander families, is care that is⁷:
 - family centered
 - relationship-based
 - includes a focus on social and emotional wellbeing
 - builds on family strengths and resilience
 - considers the pervasive nature of trauma, and promotes environments of healing and recovery rather than practices that may inadvertently re-traumatize (trauma informed care)
- Key elements have been identified which enhance the quality of services for Aboriginal and Torres Strait Islander children and families^{7, 236}. These include:
 - Working within a primary health, family centred model, prioritising the relational dimensions of care.
 - Utilising a multi-disciplinary, collaborative approach, building partnerships with other services.
 - Capacity building to ensure a highly skilled, and culturally capable workforce.
 - Continuity of care models.
 - Conducting a comprehensive, holistic assessment that informs the identification of individual family needs and care planning, and supporting families to access appropriate services that meet their needs
 - Accessible, acceptable and flexible service delivery
- Each individual family will have their own parenting practices, beliefs and needs, influenced by differing cultural practices between communities across urban, rural and remote areas of Australia.
- Generally, however
 - men's and women's business remain a fundamental cultural practice within Aboriginal and Torres Strait Islander families, and
 - kinship and family responsibilities hold a higher priority than personal health needs e.g. a child's needs are always put before the parents' health needs.
- These concepts, along with communication barriers and cultural differences, often create obstacles to accessing and staying engaged with mainstream health care agencies²³⁷.
- Aboriginal and Torres Strait Islander Health Workers/Practitioners provide an important link between health services and the community. They are able to develop the required connection and relationship with Elders and families, overcoming barriers and improving engagement with the service.

Cultural needs

Culture is of fundamental importance to health and wellbeing for Aboriginal and Torres Strait Islander children and families. It is the source of strength and resilience for many families⁷.

Why there may be additional need

- Cultural processes and parenting practices differ between Aboriginal and Torres Strait Islander individuals, families and communities. Unfortunately, stereotyping of cultural needs and cultural misunderstanding continues to exist²³⁸.

- Culture can influence Aboriginal and Torres Strait Islander people's decisions about when and why they should seek health services, their acceptance of treatment, the likelihood of adherence to treatment and follow up, and the likely success of prevention and health promotion strategies²³⁹.
 - Aboriginal and Torres Strait Islander people may be mistrusting or fearful of health care services due to the traumatic history of mistreatment and disadvantage that has occurred in Australia²³⁹.
 - Other cultural barriers to accessing health care may include health service provider attitudes and practice, communication issues, poor cultural understanding and racism²³⁵.
- 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, fear of the unknown or of being judged.
- Appropriate, holistic care should address all these aspects, as well as their physical health care needs.

Recommendations specific to Aboriginal and Torres Strait Islander families

- Wherever available, involve Aboriginal and Torres Strait Islander Health workers / practitioners as early as possible in engaging families, and the assessment and planning of health care.
- Understanding and respecting different parenting practices is important for planning and delivering services that are culturally responsive, reflecting individual family choices and styles.
 - Collaborate and reflect with Aboriginal and Torres Strait Islander Health Workers/ Practitioners to enhance cultural knowledge.
 - Cultural Practice Programs are available for Queensland Health Staff, for more information see <https://www.health.qld.gov.au/public-health/groups/atsihealth/cultural-capability>
- A person's cultural identity does not automatically mean the child or family require a form of care that is stereotypical of that culture. Care should be family centered and strengths based ^{238, 240}.
- Create an inclusive welcoming environment in consultation with Aboriginal and Torres Strait Islander Health Workers/Practitioners and community Elders. Use colours, artwork, 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.
- Continuity of carer models assist with establishing and maintaining a therapeutic relationship and engagement have shown improved outcomes for women, infants and the workforce³⁶. Use strategies such as:
 - Spread assessment over a number of sessions to enable rapport to be built when possible.
 - Build rapport by asking where their people are from, share stories about yourself or find other topics of interest.
 - Use a casual discussion process and indirect questioning to illicit information rather than a formal interview process or direct questions.
 - Use a suitable environment for the family whereby naturalistic observation may be used to gather information e.g. playground, home.
 - Work with the family to strengthen supports and develop strategies that align with their own belief system.
 - 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.

- 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.
- Use culturally appropriate and safe resources when providing education to families.
- Communicating effectively with Aboriginal and Torres Strait Islander families requires knowledge and respect of cultural communication differences. For example²⁴¹:
 - Some non-verbal communication cues e.g. hand gestures have different meanings.
 - Extended periods of silence during conversations are considered normal and are valued.
 - Narrative communication and indirect questioning styles are preferred.
 - Avoidance of eye contact is customarily a gesture of respect.
 - Many Aboriginal and Torres Strait Islander people do not speak English as their first language.
- Aboriginal and Torres Strait Islander Health Workers/Practitioners may be able to assist with overcoming these communication barriers and interpreting information provided from families.

Health needs

Why there may be additional need

- A complex interplay of factors influence the health and wellbeing of Aboriginal and Torres Strait Islander families, including socioeconomic factors, housing, education, health literacy, social justice and health equity⁷. The consequences of historical trauma have been profound, creating disadvantage that has been passed from one generation to the next²³⁹.
- These circumstances can negatively impact on people's capacity to parent especially when these factors occur in multiple combinations²³⁶.
- Aboriginal and Torres Strait Islander children's wellbeing includes safety, health, culture and connections, mental health and emotional wellbeing, home and environment, learning and skills, empowerment and economic wellbeing²³⁶.
 - These wellbeing domains are interrelated.
 - Consideration of these social determinants of health is necessary when providing holistic, family-centered care to Aboriginal and Torres Strait Islander children and their families.
- Pregnancy and early childhood is a critical stage at which the foundation for future health and wellbeing is established⁹⁰.
- While some health gains are being realised, Aboriginal and Torres Strait Islander children still face large disparities in many health outcomes including^{76, 242}:
 - birthweight
 - mortality rate for children aged 0-4 years
 - ear disease
 - oral health
 - general nutrition

Clinical practice points for these health needs are covered in the relevant section elsewhere in this manual.

- Aboriginal and Torres Strait Islander children are not only more likely to be exposed to a range of health-related conditions as children, but are also less likely to have access to resources and preventative health services⁷.

- While most Aboriginal and Torres Strait Islander children and families thrive, there remains a proportion who continue to experience extreme disadvantage and vulnerability.
 - In Australia, Aboriginal and Torres Strait Islander children are over-represented in the child protection system and are far more likely than non-Indigenous children to be notified, investigated, substantiated and/or placed on a protection order, and to reside in out-of-home care²⁴³. These disparities between Aboriginal and Torres Strait Islander children and non-Indigenous children have continued to increase in recent years²³⁶.
 - Inequity trajectories start early, and early childhood provides a vital opportunity for child health professionals to develop a relationship with the family, identify the family's strengths and complexities, and support the development of a plan of care that meets their needs.

Recommendations specific to Aboriginal and Torres Strait Islander families

- The provision of health care to Aboriginal and Torres Strait Islander children and their families should be multi-disciplinary, and involve a collaborative partnership approach⁷:
 - utilise the knowledge and expertise of Aboriginal and Torres Strait Islander Health Workers/ Practitioners in the assessment and care planning discussions where ever possible.
 - liaise with local Aboriginal and Torres Strait Island medical and community services, establishing links and local referral pathways to enable holistic, coordinated care that meets the family's needs.
 - › Family Wellbeing Services: Aboriginal & Torres Strait Islander, are delivered throughout Queensland to reduce the over representation of Aboriginal and Torres Strait Islander children in the child protection systems.
 - › Aboriginal Medical Services are located throughout Queensland and offer case management, social health services, counselling and psychology support service. Referrals are through the AMS doctor.
- Due to family kinship structures and relationships, health care decisions often involve input by other family members²⁴¹. Health professionals should not only work with children and their parent/ carers, but also recognise the importance and influence of kinship, and the wider community, on the health of a child. Aboriginal and Torres Strait Islander Health Workers/ Practitioners are well connected to the community, and are able to facilitate inclusiveness of Aboriginal and Torres Strait Islander kinship systems^{39, 40, 42}.
- Aboriginal and Torres Strait Islander children and families should have access to appropriate, close to community, comprehensive primary health care services⁷. Flexible, responsive home visiting programs or local community clinics should be considered when planning care.
- Complete a comprehensive, family health assessment. This allows the child health professional to develop a relationship with the family, whilst identifying the individual family's strengths and complexities³⁸.
- Provide anticipatory guidance and health education that is appropriate and relevant, paying attention to both the content and delivery of messages ⁷. Tools and resources used should be culturally acceptable.
- Adopt a strengths-based approach that supports parents and carers to reduce exposure to environmental stressors, supports the development of strong parent/child relationships and promotes ongoing engagement with health services ⁷.
- Promote breastfeeding as a primary prevention activity. Breastfeeding has positive effects on nutritional, physical and psychological wellbeing of infants and where environmental conditions may be less than ideal, breastfeeding provides optimum protection against infection and under-nutrition ⁷.

- Encourage antenatal engagement early in pregnancy so that optimal level and type of care can be planned according to individual needs¹⁰.
- Promote 'On time' vaccinations
- Include an ear health assessment, and ear health education with health checks where able.
 - Aboriginal and Torres Strait Islander children have a significantly different experience of middle ear disease in that it has an earlier onset; higher frequency; greater severity and persists for longer than most non-Indigenous children¹¹⁹.
 - The impacts of middle ear disease and associated hearing loss has a significant impact on child development, with far-reaching social and economic consequences into adulthood¹¹⁹.
 - Ear health assessment involves exploring hearing and speech and language development, and conducting otoscopy, tympanometry and audiometry as appropriate. (See *Practice tips: Conducting a hearing and ear health check* page 161)
 - Provide health information and education as appropriate for example:
 - › children need to hear well to be able to talk well
 - › runny ears' and ear pain are not normal and that the children should be seen as soon as possible at a health centre
 - › regular 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 and nose blowing if children are unwell
 - › encourage healthy living e.g. eating fresh fruit and vegetables, a smoke free environment, breastfeed for as long as possible
- Aboriginal and Torres Strait Islander children are eligible for a health assessment by a GP/Practice Nurse/Aboriginal health worker/practitioner every 9 months as part of the 'Aboriginal and Torres Strait Islander Peoples Health Assessment'⁹⁶.



iStock.com/kerriekerr

Resources for use with families



Australian Indigenous HealthInfoNet

Links to multiple resources specific to Aboriginal and Torres Strait Islander peoples

<https://healthinfonet.ecu.edu.au/key-resources/resources/>

Raising Children Network

Videos and factsheets designed for Aboriginal & Torres Strait Islander parents

<https://raisingchildren.net.au/>

Beyond Blue

Beyond Blue has a range of resources for families including information specific to Aboriginal and Torres Strait Islander families

www.beyondblue.org.au

Queensland Health

Aboriginal and Torres Strait Islander peoples

<https://www.qld.gov.au/atsi/health>

Queensland Centre for Perinatal and Infant Mental Health (QCPIMH)

Resources for families

<https://www.childrens.health.qld.gov.au/chq/our-services/mental-health-services/qcpimh/for-families/>

Care for Kids Ears

www.careforkidsears.health.gov.au

Information for health professionals

General



Working with First Nations Families and Children - A Framework for Understanding Emerging Minds

<https://emergingminds.com.au/resources/toolkits>



Australian Indigenous HealthInfoNet

Links to multiple resources specific to Aboriginal and Torres Strait Islander peoples

<https://healthinfonet.ecu.edu.au/key-resources/resources/>

Queensland Health - Aboriginal and Torres Strait Islander Health Unit

Resources for health professionals

<https://www.health.qld.gov.au/atsihealth>

Queensland Centre for Perinatal and Infant Mental Health (QCPIMH)

Aboriginal and Torres Strait Islander Resources

<https://www.childrens.health.qld.gov.au/chq/our-services/mental-health-services>

Specific health topics



Connected Parenting

Circle of Security in the context of Aboriginal and Torres Strait Islander families

<https://www.sjog.org.au/for-medical-professionals/connected-parenting/e-learning-resource>



Yarning about mental health: an easy guide to mental health assessment

HealthInfoNet Flipchart

<https://healthinonet.ecu.edu.au/key-resources/resources/?id=19702>

Recommendations for clinical care guidelines on the management of Otitis Media in Aboriginal and Torres Strait Islander Populations

Australian Government Department of Health

<https://www1.health.gov.au/internet/publications>

Breastfeeding video guide for health workers

<https://www.health.qld.gov.au/clinical-practice/guidelines-procedures/clinical-staff/maternity/nutrition/breastfeeding/how-to/video>

Growing Strong: Feeding You and Your Baby

Suite of resources on nutrition

<https://www.health.qld.gov.au/nutrition/patients#>

Looking after Young Mouths

https://www.health.qld.gov.au/__data/assets/pdf_file/0021/143094/YoungMouths_updated.pdf

Centre for Excellence in Indigenous Tobacco Control

<http://www.ceitc.org.au/>



Family Health Assessment – A guide for child health clinicians practicing within the primary health care setting

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



Refer to the Chronic Conditions Manual

<https://www.publications.qld.gov.au/dataset/chronic-conditions-manual-2nd-edition-2020>

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Appendix & References

Children from culturally and linguistically diverse (CALD) or refugee backgrounds ^{32, 75, 104, 244-246}

Identified risks / additional needs

- Australia has a culturally and linguistically diverse (CALD) population. The 2016 census identified that in Queensland 11.2 % of the population speak a language other than English at home, and that 9% of children were born overseas.
- Cultural factors and belief systems will vary according to the family's background.
- Children from (CALD) backgrounds are more vulnerable due to cultural and linguistic barriers, poor health literacy, lack of awareness and capacity to access available services. They may also be impacted by relocation and disjointed health care issues.
- Common social issues to CALD families include:
 - 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.
- Refugees and CALD families with a background of trauma will often have significant language and cultural barriers to obtaining services.
 - Refugees are a highly vulnerable population with common health issues including incomplete immunisation coverage, nutritional deficiencies (e.g. iron, vitamin D), diabetic ketoacidosis at diagnosis of Type 1 diabetes; 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.
- Many children from CALD backgrounds starting their first year of school are developmentally vulnerable, as they have not acquired the necessary language, self-help, socio-emotional, cognitive, motor and/or behavioural skills they need to achieve in school.
- 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.
- Supported playgroups for parents from CALD backgrounds are a key source of social support for refugee and migrant mothers, facilitating development of informal support networks²⁴⁵.

Principles to underpin good clinical practice

- Welcoming cultural diversity as a strength helps eliminate discrimination and strengthens community cohesion. Encourage families to share their cultural beliefs. Recognise that everyone will view other cultures through their own 'cultural lens'.
- Ensure that interpreter services are used routinely and are culturally and linguistically acceptable by considering gender and ethnicity preferences (including dialect). Avoid using family members as interpreters as this may breach confidentiality and information may be inaccurate.
- Families will benefit from engaging with multicultural health workers who have a better understanding of families' cultural perspectives.
- 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'.
- 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 afterhours breastfeeding 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 i.e. 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.
- Emphasise with families the value of play between adults and young children in activities that are relevant to their cultures.
- Provide multicultural health resources and information in appropriate language, if available.



Queensland Transcultural Mental Health Centre

Multilingual resources relating to mental health issues

<https://metrosouth.health.qld.gov.au/transcultural-mental-health?provider=168>

Multicultural Nutrition Resources, Metro South Health.

Food and cultural profiles

Information about the food and food practices of selected communities, background on their country and their health profile in Australia

<https://metrosouth.health.qld.gov.au/multicultural-nutrition-resources>

Raising Children Network

Articles, videos and picture guides translated into multiple languages

<http://raisingchildren.net.au>

Global Health Media videoclips

<https://globalhealthmedia.org/>

Refugee Health Network

Translated Resources

<http://www.refugeehealthnetworkqld.org.au/translated-resources/>

Immunisation factsheets

Translated into nine languages

<https://www.qld.gov.au/health/conditions/immunisation/translated-fact-sheets>

Queensland Program of Assistance to Survivors of Torture and Trauma (QPASTT)

Resources for those who have suffered trauma prior to arriving in Australia.

www.qpastt.org.au

National Child Traumatic Stress Network (NCTSN)

Trauma informed care

<https://www.nctsn.org/trauma-informed-care>



Family Health Assessment – A guide for child health clinicians practicing within the primary health care setting

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



Freepik.com

Low family income / unstable housing / low parental education level ^{1, 32, 38, 75, 101, 247-250}

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.
- Poverty is an established risk factor for behaviour problems across development.
- The impact of housing on health is multidimensional. Factors which impact negatively on family and child health and wellbeing include poor quality housing, overcrowding, lack of space for recreation and privacy, an unsafe physical environment within the home and/or neighbourhood, lack of access to services and amenities, homelessness.
- When multiple risk factors are present, there is a higher risk of child abuse and neglect²⁴⁸. Infant mortality rates are 1.2 times higher in families with low income than with infants in higher income families and children have twice the number of decayed teeth by the time they are six years old.
- Often children have a lack of opportunity to access activities outside of the home due to lack of income or 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. The risk for diabetic ketoacidosis at diagnosis of Type 1 diabetes, is higher in children whose parents report an education level lower than 9 years.

Principles to underpin good clinical practice

- Home visiting programs have proven effective in improving health outcomes.
- For low income families promoting and supporting breastfeeding will result in improved health outcomes as well as lessening the financial burden e.g. formula costs, less health costs due to reduced rate of illness.
- Ensure families have information for afterhours breastfeeding support services / help lines.
- Conduct a comprehensive family health assessment to identify specific needs of family.
- If the child identifies as being of Aboriginal or Torres Strait Islander decent, Aboriginal and Torres Strait Islander Advanced Health Workers (if available) should be involved as early as possible in the engagement of families, family health assessment conversation and in developing the cultural aspects of the care plan.
- Work in partnership with the family to develop an ongoing plan for care.
- Review immunisation history and promote a catch-up schedule if necessary. 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, type 1 diabetes.
- Promote oral health care in children. See *Oral Health* pg. 237 in 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 i.e. empathetic, parent centred discussion, with a focus on listening, 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

Articles, videos and picture guides translated into multiple languages

<http://raisingchildren.net.au>



Family Health Assessment – A guide for child health clinicians practicing within the primary health care setting

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

Family structure: young, single, same sex attracted, re-partnering parents, step and blended families ^{38, 101, 251-253}

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 (a parent with children from multiple partners), stepfamilies, blended families and families with same-sex parents.
- The quality of parenting the child receives has more impact on the child's development than the diversity of the family structure. For example, children raised in same-sex parented families do as well emotionally, socially and educationally as children raised by heterosexual couple parents when parenting practices are satisfactory. Discrimination and perceived stigma is negatively associated with mental health.
- Young maternal age on its own is not a risk factor for poorer child outcomes, however young mothers are more likely to have cumulative risk e.g. financial stress, lower educational level, higher levels of perinatal depression and an increased risk of performing unresponsive parenting practices and having repeat pregnancies. Their children are also at greater risk of maltreatment, child abuse and being developmentally delayed.
- Single parent families can face substantial difficulties with income, housing, and employment.
- 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.
- Non-nuclear families with stepparents or defacto partners are over-represented in child safety statistics.
- Multiple re-partnering can place children at risk of abuse, especially if a number of partners enter the home.

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 improve emotional wellbeing for the family, therefore linking parents into suitable networks is important e.g. Young Parents Program.
- 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.
- Often young parenthood and 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 costs, less health costs due to reduced rate of illness. Ensure families have information for after-hours breastfeeding support services / help lines.
- Parents raising children on their own may have greater difficulty in accessing services and have poor social connectedness. Parents identify home visits, connecting with other parents and child care as their key support needs in this situation ²⁵⁴.
- Discuss 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 i.e. empathetic, parent centred discussion, with a focus on listening, 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.



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<http://raisingchildren.net.au>

ReachOut.com

A non-government organisation for youth providing information about mental fitness, alcohol and drugs.

<http://au.reachout.com>



Family Health Assessment – A guide for child health clinicians practicing within the primary health care setting

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

Children living in non-parental or out of home care environments^{75, 101, 243, 255, 256}

Identified risks / additional needs

- The majority of children in Australia live with at least one of their biological parents, but as at 30 June 2019, approximately 44,900 children were in out-of-home care. Of those living in non-parental care, 52% are placed with relatives and kin.
- This group of children have many vulnerabilities including a higher incidence of:
 - acute and chronic illness
 - poor growth and development delay
 - emotional and behavioural issues
 - poor social relationships
 - incomplete immunisation
- May have experienced abuse or neglect, trauma from the loss of a parent, or relationship conflict and breakdown.
- Queensland Health's Statement of Intent²⁵⁷ outlines the commitment to addressing the health needs of vulnerable children and young people including those who are:
 - at risk of entering the child protection system (0 – 18 years of age);
 - currently in out of home care (OOHC) (0 – 18 years of age);
 - transitioning to independence following a care experience (15 – 21 years of age).

Queensland Health's commitment to these vulnerable children and young people is demonstrated by prioritising access to health services wherever possible.

Principles to underpin good clinical practice

- Providing support for the foster parents/carers is key in promoting the ongoing placement of the child which will provide greater stability and improved health outcomes.
- Conduct a comprehensive family health assessment to identify specific needs of the foster/kinship family and child.
- If the child identifies as being of Aboriginal or Torres Strait Islander decent, Aboriginal and Torres Strait Islander Advanced Health Workers (if available) should be involved as early as possible in the engagement, family health assessment conversation and in developing the cultural aspects of the care plan.
- Work in partnership with the family to develop an ongoing plan for care.
- Review immunisation history and promote a catch-up schedule if necessary. Encourage ongoing immunisations on time.
- Coordinate referrals for any identified concerns e.g. EIC/EIPC 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 i.e. empathetic, parent centred discussion, with a focus on listening, summarising and supporting the carer 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.



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Children of parents with a disability / physical illness 75, 101, 258, 259

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.
- Limited or impaired capacity or mobility of parents to meet their child's emotional, developmental or physical needs places the child potentially at risk of physical illness, psychological issues, developmental delay and/or behavioural problems.
- 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, dependency on others, social stigmatisation, isolation for the whole family. Under these conditions' children may be emotionally or physically compromised with some children needing to adopt the carer role to the parent or developing behavioural problems.
- Epilepsy during pregnancy is associated with increased risks of adverse pregnancy and perinatal outcomes, for example preterm birth, low Apgar scores, congenital malformations.

Breastfeeding is recommended for mothers with epilepsy taking antiepileptic drugs as evidence suggests there is no adverse effects on infants.

Principles to underpin good clinical practice

- Child health professionals are well placed to assist parents to access information, self-help and professional support on-line and in the community e.g. Life Tec for assisted technology and modified equipment, Qld Government disability website <https://www.qld.gov.au/disability>
- Promote ongoing engagement with child health services to enable assessment of children's adjustment and socio-emotional needs, and appropriate referral where required.
- Families with disability often have an associated low income. Promoting and supporting breastfeeding will result in improved health outcomes as well as lessening the financial burden, e.g. formula costs, less health costs due to reduced rate of illness. Ensure families have appropriate information for after-hours breastfeeding support, services / help lines.
- Provide psycho-education appropriate to the education level of the parent, demonstrate unfamiliar activities and use picture pamphlets where possible.
- Develop a safety plan, as appropriate, in collaboration with the parent to reduce risk of harm to the parent and child during an adverse health episode 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 i.e. empathetic, parent centred discussion, with a focus on listening, 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.



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Healthy Start

Parenting Research Centre

Resources for health professionals supporting parents who have learning difficulties

<https://www.parentingrc.org.au/programs/healthy-start/>

Epilepsy Australia

www.epilepsyaustralia.net

Qld Government Disability website

<https://www.qld.gov.au/disability>



e-Learning - Diabetic Ketoacidosis

Primary prevention and early identification of hyperglycaemia in children to reduce the rate of DKA at diagnosis

<https://ilearncatalogue.health.qld.gov.au/course/1581/preventing-dka-at-diagnosis-of-type-1-diabetes-mellitus-in-children-under-16>



Isolated families (e.g. living in remote areas) 75, 131, 207, 222, 256, 260

Identified risks / additional needs

- Three per cent of Australian children aged 0-14yrs live in remote and very remote areas, 38% of these children identified as Aboriginal and Torres Strait Islander people.
- In 2017, mortality rates for children were more than double in remote areas compared to metropolitan areas.
- Children living in remote areas have 1.5 times higher incidence of decayed teeth as those in metropolitan areas.
- Obesity in remote areas is a greater risk with 38% of Aboriginal or Torres Strait Islander children being overweight or obese, up from 31% in 2012.
- Social isolation and loneliness can impact on parental mental health and wellbeing.
- Regional areas have the highest numbers transport-related deaths in children, with males numbering more than twice the number of females.

Principles to underpin good clinical practice

- Services can be offered via telehealth if appropriate.
- If the child identifies as being of Aboriginal or Torres Strait Islander descent, Aboriginal and Torres Strait Islander Advanced Health Workers (if available) should be involved as early as possible in the engagement, family health assessment conversation and in developing the cultural aspects of the care plan.
- 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. parent groups/playgroups (online if living remote), conversations with family and friends.
 - Provide non-directive counselling in partnership with the parent i.e. empathetic, parent centred discussion, with a focus on listening, 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.
- Provide health promotion and anticipatory guidance to address common health issues and risk factors e.g. oral health screening and education; nutrition and physical activity; safe sleeping and injury prevention.



Raising Children Network

Factsheet: How to make new friends and keep old ones. Also offers online discussion forums where parents can chat to other parents.

<http://raisingchildren.net.au>

Emerging Minds Podcasts

Rural children's voices episode 8

Evidence-informed wisdom from experts in the field

<https://emergingminds.com.au/resources/podcast/>



Family Health Assessment – A guide for child health clinicians practicing within the primary health care setting

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

Smoking, alcohol and substance misuse ^{60, 79, 261, 262}

Identified risks / additional needs

- The consumption of alcohol, tobacco and other drugs is a major cause of preventable disease and illness in Australia.
- In 2017, mothers living remotely had higher rates of smoking than metropolitan mothers, whereas the opposite is true for rates of alcohol consumption, with metropolitan mothers having higher rates of alcohol consumption during pregnancy.
- 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 SUDI, respiratory illness, asthma. Tobacco use is the risk factor associated with the highest disease burden in Australia.
- In Queensland, 27% of children aged 0-14 lived in a household with a daily smoker, with Indigenous Queenslanders 2.4 times more likely to live in a household with a smoker. Smoking also continues to be prevalent in people living in remote and very remote areas, single parent households, unemployed people and those in lower socio-economic circumstances.
- 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; miscarriage, premature birth, still birth and a range of abnormalities included under the umbrella term Foetal Alcohol Spectrum Disorders (FASD).
- FASD is a diagnostic term for the range of physical, cognitive, behavioural and neurodevelopmental abnormalities which can result from maternal drinking during pregnancy³⁴.
 - Alcohol crosses the placenta and may irreparably damage the brain of the developing fetus.
 - No safe level for alcohol consumption in pregnancy has been established.
 - FASD has lifelong consequences and can lead to significant secondary impairments, such as difficulties accessing education services, substance use, mental ill-health, difficulties living independently, problems obtaining and maintaining employment and early contact with the justice system³⁴. A recent study on the prevalence of FASD within the juvenile justice system found that 36% of 10-18 year olds in Banksia Hill Detention Centre (WA) were diagnosed with FASD³⁵.

- All child health professionals who have concerns about neurodevelopmental delay on screening, should refer to a GP or to specialised FASD assessment clinic if alcohol is considered as a possible cause for the delays experienced³⁴.
- Most women cease or reduce alcohol consumption during pregnancy; however, many recommence drinking postpartum and while breastfeeding and most seek guidance about safely consuming alcohol whilst breastfeeding (e.g. timing, quantity).
- Consumption of more than two standard drinks a day during lactation can lower lactational performance, suppressing the action of oxytocin and leading to early cessation of breastfeeding.
- 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.
- When parents use illicit substances, their priorities frequently shift to the supply and consumption of these substances, parenting is often inconsistent and inefficient with tendencies for harsh and punitive parental behaviour.

Principles to underpin good clinical practice

- Build a professional, trusting and empathetic relationship that encourages a continuation of health care.
- If the child identifies as being of Aboriginal or Torres Strait Islander decent, Aboriginal and Torres Strait Islander Advanced Health Workers (where available) should be involved as early as possible in the engagement, family health assessment conversation and in developing the cultural aspects of the care plan.
- 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 socioeconomic areas, 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 **3 'A's** (example for smoking):
 - Ask: Ask all families about smoking as part of the assessment.
 - › Start with 'We ask all families about smoking'
 - › Does anyone living or visiting at home smoke?
 - › If they answer yes, ask them 'How many cigarettes a day do you usually smoke?'
 - Assess: Assess client's relationship with smoking by asking a couple of simple questions.
 - › 'How do you feel about your smoking?'
 - › 'Have you tried to quit before?'
 - › 'How might you keep your baby in a smoke free environment when you smoke?'

- Assist: begin with acknowledging that it's not easy to quit, but the outcome is worth it.
 - › 'Quitting smoking is one of the most important things you can do for both you and your child/children. It's not easy and you don't have to do it alone. How would you feel about getting some extra support to quit?'
 - › 'Queensland Health's Quitline service has a free quit smoking program for parents/carers of babies and young children. The staff at Quitline are friendly and will support you on your quit journey. The program includes a 12-week supply of nicotine replacement products. All you need to do is call 13 7848 and mention Smoke-free Families'.
- 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 in partnership with the parent i.e. empathetic, parent centred discussion, with a focus on listening, 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, specialised FASD assessment clinic, GP.
- Assess risk of harm to infant /child and take appropriate action.



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<http://raisingchildren.net.au>

Queensland Health

Alcohol, tobacco and other drugs

<https://www.health.qld.gov.au/public-health/topics/atod>

Australian Government Department of Health

Health Topics

<https://www.health.gov.au/health-topics>

Smoke-free Families program - Quitline

www.qld.gov.au/quithq

Alcohol and Drug Information Service (ADIS)

www.adis.health.qld.gov.au



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

Domestic and Family violence / past abuse / parent abused as a child ^{23, 25, 26, 28, 38, 91, 101}

Identified risks / additional needs

- More than one million Australian children are affected by domestic and family violence and 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 living in a violent home.
- DFV has serious impacts on women's health. These impacts can include injuries, homicide, poor mental health and reproductive health problems. In Australia DFV is the leading preventable contributor to death and illness for women aged 18-44 years.
- While some children are subjects of physical violence, many children living in a home where there is domestic and family violence are 'silent' victims. Experiencing, hearing or seeing the impact of family violence can impact on infants and children in a wide range of physical, emotional and behavioural ways.
- Particular populations groups, including women, children, Aboriginal and Torres Strait Islander people, people from culturally and linguistically diverse backgrounds (CALD), the elderly, people with a disability, people in rural and remote communities and people who identify LGBTQ+, are all at significantly higher risk from the incidences and impacts of domestic and family violence.
- Parents who were abused as children may carry with them residual, multidimensional effects which can impact on parenting and family functioning.
- Routine screening has been widely introduced in health care setting for intimate partner violence, although some barriers remain such as lack of privacy and limited confidentiality.
- It is recommended that a domestic and family violence screen is undertaken at the first visit as part of the family health assessment.
- Past or current history of abuse increases the risk of parental depression, anxiety and post-traumatic stress disorder.



Practice tips: Conducting the domestic violence screen

See page 71

DVI Assessment Form

See Appendix 4

Principles to underpin good clinical practice

- Home-visiting programs for these families has proven to be effective in improving health outcomes. Child health professionals should follow local home visiting risk screening processes and undertake strategies to reduce risk to staff as per HHS procedures.
- Work in partnership with the family to establish a professional, trusting and empathetic relationship that encourages an ongoing plan for health care.
- If the child identifies as being of Aboriginal or Torres Strait Islander decent, Aboriginal and Torres Strait Islander Advanced Health Workers (where available) should be involved in the family health assessment conversation and in developing the cultural aspects of the care plan.
- Conduct a comprehensive family health assessment to identify specific needs of the individual family.

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Appendix & References

- Undertake a Domestic Violence Screen at the first face to face contact with all women using the Domestic Violence Inventory tool. It is important that the Domestic Violence Inventory (DVI) is introduced with sensitivity, in privacy and not in the presence of a partner or others (including children over the age of 3 years).
- All responses to a disclosure of DFV should include consideration of the safety of any children including an unborn child.
- 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 breastfeeding support services / help lines.
- 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 i.e. 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'** pg. 311.



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>

DV Alert

Training for health professionals

www.dvalert.org.au/

Domestic and Family Violence Online Portal

Queensland Government

Information, services and support for people impacted by domestic and family violence

<https://www.qld.gov.au/community/getting-support-health-social-issue/support-victims-abuse/domestic-family-violence>

DFV Toolkit

Queensland Health

Information, resources and training

<https://www.health.qld.gov.au/clinical-practice/guidelines-procedures/patient-safety/duty-of-care/domestic-family-violence>



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

Child safety (QHEPS) factsheets

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

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Parental mental health and wellbeing ^{8, 17, 38, 45, 99, 101, 252}

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.
- Potential risks for perinatal depression include a previous mental health illness, stressful life events such as: family problems, poor marital relationship, isolation (including from culture), intimate partner violence, lack of social support, history of abuse or neglect and unplanned pregnancy. Negative birthing experiences may result in psychological trauma, which may present as postnatal depression/anxiety, post-traumatic stress disorder or other mental health issue.
- 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.
- Untreated mental illness may impact on a parent's availability to their child as well as their consistency in parenting behaviours that support child-parental attachment. Children with parents suffering from untreated mental illness are more likely to have an altered attachment, socio-emotional and behavioural problems.
- Every contact with the family provides an opportunity to explore maternal emotional well-being.
- 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.
- If the child identifies as being of Aboriginal or Torres Strait Islander decent, Aboriginal and Torres Strait Islander Advanced Health Workers (where available) should be involved as early as possible in the engagement of families, in the assessment conversation and in developing the cultural aspects of the care plan.
- Holistic assessment facilitates early detection of symptoms of mental illness, identifying parental strengths and functioning and referral to appropriate mental health services where required. The Edinburgh Postnatal Depression Scale (EPDS) is an evidence-based tool that may be used as a component of the assessment. *See Practice Tips: Conducting an EPDS pg. 68.*
- The negative effects of postnatal depression are not restricted to the mother but can also impact on marital and social relationships and have significant adverse implications for the parent – infant relationship, making it imperative to assess the interaction between mother and child.

- Promote parental wellbeing by offering psychosocial support strategies including:
 - 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 i.e. 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 Practice tips: Developing a safety plan pg. 319.*
- 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. Circle of Security, Triple P, Postnatal Wellbeing groups.
- 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 breastmilk. Ensure families have information for after-hours breastfeeding support services / help lines. see previous section.



If assessment identifies altered attachment models, refer to EIC / EIPC.



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' pg.311.



Postnatal Depression (PND) in Responding to Need (next section)
See page 304

Practice Tips: Conducting an EPDS
See page 68

See Practice tips: Developing a safety plan
See page 319



eMHprac

Directory of Australian, evidence-based, free (or low-cost) digital mental health programs and resources

<https://www.emhprac.org.au/>

Children of Parents with Mental Illness (COPMI)

<http://www.copmi.net.au/parents>

Beyond Blue

Resources for women, men, young people and carers, as well as resources for professionals

www.beyondblue.org.au

Black Dog Institute

<https://www.blackdoginstitute.org.au/>

Yarning about mental health: an easy guide to mental health assessment

HealthInfoNet Flipchart

<https://healthinonet.ecu.edu.au/key-resources/resources/?id=19702>



Keeping Well During Pregnancy and Beyond Booklet

https://metrosouth.health.qld.gov.au/sites/default/files/keeping_well_booklet_web.pdf

Family Health Assessment – A guide for child health clinicians practicing within the primary health care setting

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

Queensland Transcultural Mental Health Centre

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

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 need ²⁶³. 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 if 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 and family 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 intervention by the specialty services and in consultation with other primary care providers such as the GP.



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^{84, 85}. Sustained home visiting programs have shown trends of improved health outcomes specific to breastfeeding, warm parenting, parent-child interaction, play opportunities and safety in the home^{84, 85}.

Child health professionals should follow home visiting risk screening as per HHS procedures.

Care Coordination

- To manage and coordinate service provision for families with identified needs where a number of health care providers are involved, a care coordinator 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 and improving outcomes for vulnerable children²⁶⁴.
- Key elements of care coordination include:
 - family partnership
 - comprehensive and ongoing family assessment
 - holistic, family focused, keeping the child at the center
 - working from a strengths base supports parental capacity building
 - ensures multidisciplinary coordination, planning and collaboration
 - reflective practice
 - working with and utilising community resources (it is important for the care coordinator to be aware of local services available, to meet additional needs of families outside of child health professional's scope)
 - monitoring and evaluating client and service delivery outcomes
 - advocating on behalf of family with identified need
 - documenting client encounters, activities and care plan 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'²⁶³. 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
- 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 family²⁶³.
 - ideally a care plan will be developed in partnership with the family across the continuum of care
 - good communication is integral to all these processes

- 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, residential, specialist child health service, for families living in Queensland, northern New South Wales, and the Northern Territory. The Statewide health service provides education and support to families with children aged from birth to three years, who require assistance with building practical skills and confidence in parenting.
- Offers multiple inpatient programs including:
 - The Parenting Education Program (PEP) – a medium stay program for families 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 for families with complex needs, for example: parents with mental illness, disability, complex feeding issues requiring tertiary centre support and education.
 - Telehealth Parenting Education Program. A short stay multi-disciplinary program offering support, education and guidance through telehealth.
- Provides education and support in the following areas:
 - responsive settling
 - responsive feeding – Breast feeding, bottle feeding and mealtime management, child development and behaviour
 - general parenting
- EBFC Referral Process
To be admitted to EBFC, families will need a referral from one of the following health professionals:
 - Child and Youth Community Health Service professionals e.g. child health nurses
 - General Practitioners
 - Paediatricians
 - Allied health professionals e.g. psychologists, social workers, occupational therapist, speech therapist, dietitian.
 - Other health/community service professionals/NGO's
- Ongoing support and intervention from local community services (i.e. Child health services) is encouraged prior to admission to EBFC. An EBFC referral template must be completed and is available at: https://qheps.health.qld.gov.au/_data/assets/pdf_file/0028/714808/700020.pdf
- Resources:
There are a range of resources available for families e.g. Responsive Settling and Responsive Feeding vodcasts available on the website.
- Discharge planning endeavours to link families back into primary health care providers and local resources within their own community.



Ellen Barron Family Centre

<http://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 ^{32, 49, 73, 80, 152}

General information

- In 2016, Queensland had 5821 infants born premature. 1% (599) were born before 28 weeks gestation. The prevalence of premature births has increased by 5% over the past decade.
- 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 should not 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, i.e. the infant's body should be supported behind the shoulders and the head should have freedom of movement.
 - Use paced bottle-feeding method if infant is being fed using a bottle. Paced bottle feeding is a method of bottle feeding that, by responding to infant cues, assists the infant to coordinate their sucking and breathing during a bottle feed. See Practice tips: Supporting a mother to bottle feed her infant page 140.

- Allowance for gestational age for growth and development is made for infants born before 37 completed weeks gestation until 2 years of age. Infants born at 37 weeks, or beyond, do not require age correction.
 - Correction beyond two years may be required as directed by a tertiary specialist.
 - To correct age for prematurity, subtract the number of weeks the infant was born prematurely from the chronological age (in weeks) and assess the child's growth and development for the corrected age.

Corrected age = Chronological age in weeks - Number of weeks premature

- For example, if an infant is born at 34 weeks gestation visits a child health center 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).
- A formula fed premature infant may be initially prescribed a formula specific for the additional nutritional needs of a premature infant.
- Premature infants may require supplementation e.g. iron and vitamin supplements.
- Premature infants are at greater risk of SIDS - health promotion strategies are important for parents.
- The immunisation schedule aligns with the infant's actual birth date (chronological age). Additional vaccination may be prescribed depending on the degree of prematurity e.g. children born <28 weeks gestation.

Clinical practice points

- Management strategies may include:
 - Additional breastfeeding support may be required with supporting the mother and infant to transition to fully breast feeding.
 - For infants signaling feeding resistance e.g. turning the head away from the nipple, gagging:
 - › refer 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 of 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
- GP
- EIC / EIPC
- Speech / Occupational Therapist
- Ellen Barron Family Centre
- Specific support groups e.g. PIPA (Preterm Infants Parents Association – www.pipa.org.au) and Miracle Babies Foundation (helpline and playgroups)



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

Cow's milk protein allergy (CMPA) 32, 200, 265

General information

- CMPA is a common food allergy in infants (approximately 2% or 1 in 50). Most 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.
- Rapid onset (usually present 15 minutes to 2 hours following consumption)
 - Mild or moderate – hives (urticaria), swelling of the lips, face or eyes, stomach (abdominal pain) vomiting and diarrhoea.
 - Severe allergic reactions (anaphylaxis) – noisy breathing or wheeze, tongue swelling, throat swelling or tightness, hoarse voice, loss of consciousness and floppiness in babies or young children. Anaphylaxis should always be treated as a medical emergency.
- Delayed reactions (usually 2 hours or more following consumption)
 - Increase in eczema or delayed vomiting and/or diarrhoea, constipation, blood or mucus in stools, faltering growth, food refusal.
- Confirmed CMPA is treated with diet, by excluding dairy foods.
- 10% of children allergic to cow's milk protein are also allergic to soy.
- Most people who are allergic to cow's milk protein will be allergic to other animal milks e.g. goat, sheep milks, including infant formula made from these milks.
- In confirmed CMPA, there is growing evidence that use of probiotics is associated with higher rate of acquisition of tolerance to CMP by 3 years of age.
- Breastmilk remains the first choice for all infants including those with food allergy.

Clinical practice points

- Additional parental support may be required due to the ongoing stressors of parenting an unsettled infant.
- Additional breastfeeding 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 dairy foods
- Education for parents should include:
 - Exclusive breastfeeding for the first 6 months minimises severe allergic reactions during early childhood.
 - Elimination of all dairy foods 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) 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 medical specialist/Dietitian.

Higher level services

- 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
- Dietitian
- EIC / EIPC
- 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
<https://www.health.qld.gov.au/rscsu/html/PCCM>

General information

- Weight faltering describes a pattern of growth rather than a diagnosis and may include normal variations of growth. Faltering (slow) growth is observed when weight (and subsequently length) plateau or drop centiles.
- Referral for further investigation will be required if:
 - any sudden or unexplained weight loss, weight plateau or weight not re-gained following acute illness
 - where the weight has dropped percentiles, indicating poor growth
- Child health professionals monitor weight for age less than the 3rd percentile. (There will always be a bottom and top 3% and that these measures do not necessarily indicate a growth problem).
- Adequacy of growth is best evaluated by measuring weight, length / height and head circumference and plotting accurately on centile charts. It is recommended infants/children are weighed and regular intervals, as per the Personal Health Record.
- 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 (for example type 1 diabetes) 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:
 - Oral intake, what and how much, how often.
 - Food preferences, texture preferences, swallowing, drooling, chewing issues.
 - Parental mental health.
 - Cultural and social context of mealtimes.
 - Impact of family budget on foods.
 - Impact of rural environment on food choices.
 - Any of the classic 4 symptoms of hyperglycaemia: polyuria, polydipsia, lethargy, weight loss (The 4Ts – Tired, Thin, Thirst, Toilet. [See Type 1 diabetes page 419](#)).
 - 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.

- Discussions with parents about child feeding and growth always requires a sensitive approach:
 - Show and explain the centile lines on the growth charts.
 - Demonstrate how their child is progressing, discuss the trend in child's weight compared with previous measurements and explain the need for intervention.
 - Ask the parent / carer can they think of anything which may have contributed to the change.
 - Promote and support ongoing breastfeeding – complete a breastfeeding assessment to ensure child is being fed according to the child's feeding cues; assess breastmilk supply; ensure families have information for after-hours breastfeeding support services / help lines. See *Promotion of optimal infant nutrition* page 195.
 - Talk about the importance of nutrition and promote oral intake of solids from around six months based on the Australian Dietary Guidelines. See *Promotion of optimal infant nutrition* page 200.

Higher level services

Management strategies may include:

- Work in partnership with other health care professionals (e.g. GP and Dietitian), to implement a feeding plan.
- Targeted home visiting according to need.
- 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)
- Dietitian
- EIC / EIPC
- Ellen Barron Family Centre



Child growth e -Learning

Royal Children's Hospital, Melbourne

https://www.rch.org.au/childgrowth/Child_growth_e-learning/



Raising Children Network

<http://raisingchildren.net.au>

Eat for Health – Australian Dietary Guidelines

www.eatforhealth.gov.au



Refer to the Pathways to Rural and Remote Orientation and Training

<https://ilearncatalogue.health.qld.gov.au/program/17/parrot-primary-care>



Refer to the Chronic Conditions Manual

<https://www.publications.qld.gov.au/dataset/chronic-conditions-manual-2nd-edition-2020>

Obesity in childhood ^{80, 128, 129, 131, 190, 266-268}

General information

- More than one in four Queensland children are overweight or obese. The effects of which can have significant negative impact on children's physical and psycho-social health and wellbeing.
- Overweight is classified as a BMI above the 85th percentile and obesity is classified as a BMI over 97th percentile on the CDC or WHO growth charts. Child health professionals should refer for further investigation if the BMI is increasing on percentiles (excessive growth) or is above the 85th percentile.
- Childhood obesity is now considered a chronic disease and increases the risk of developing life-threatening conditions 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.
- Parents are the primary influence on the development of child eating, physical activity behaviours and healthy lifestyles.
- Obesity occurs because of an imbalance between energy intake from the diet and energy expenditure. The causes of this imbalance 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 an elevated BMI in infancy and childhood is associated with obesity in adulthood. Effective weight management in childhood and adolescence will minimise the risk of overweight or obesity persisting into adulthood.
- Exclusive breastfeeding for the first 6 months is known to reduce the risk of obesity.
- Children are more at risk of becoming obese if their family is:
 - experiencing socio-economic disadvantage
 - living in rural and regional areas.

- Aboriginal and Torres Strait Islander children face health disparities in terms of obesity and type 2 diabetes when compared with non-Indigenous children¹³¹
 - In 2018–19, according to data from the National Aboriginal and Torres Strait Islander Health Survey, 38% of Aboriginal and Torres Strait Islander children and adolescents aged 2–17 were overweight or obese. This is an increase of 7% in the previous five years.
 - The prevalence of overweight and obesity was significantly higher across all age groups. The biggest disparity being the 10-14 age group, at almost twice as high for Aboriginal and Torres Strait Islander children and adolescents.
 - The largest increase was in the 5-9-year age group (11% increase in the previous five years).
- **Health and Wellbeing Queensland** have developed the [Clinicians Hub](#) – a central hub that houses a variety of clinical tools, resources and training to support clinicians to identify, prevent and manage childhood obesity, including:
 - The Clinical Toolkit, which has links to many resources from antenatal through breastfeeding, first foods, early identification and intervention for childhood obesity.
 - Education and Training resources including
 - › Weight4KIDS – online learning program
 - › Project ECHO education
 - › Brief interventions for a healthy lifestyle and Motivational interviewing techniques
 - [Referral Pathway](#): a quick reference guide that supports primary health care providers to monitor and assess child growth, refer patients to appropriate services, and deliver interventions.

Clinical practice points

- Prevention, health promotion and early intervention are key to reducing childhood obesity. Child health professionals should:
 - identify overweight and obesity
 - explore and promote healthy lifestyle choices with the family
 - refer to GP or other early intervention programs
- Engage and utilise the knowledge and expertise of Aboriginal and Torres Strait Islander Health Workers/Practitioners early and where ever possible.
- 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 mealtimes.
 - Impact of family budget on foods.
 - Impact of rural environment on food choices.
 - Child activity assessment e.g. play time activities, screen time.
 - Parental mental health.
 - Child sleep patterns (poor sleep can disturb metabolic processes and disrupt appetite control).
 - Parental- child interaction particularly during feeding and play.
 - The family readiness and ability to make and sustain behavioural changes.

- Discussions with parents about child feeding and growth always requires a sensitive approach:
 - Demonstrate how their child is progressing on the percentile charts and explain high rates of obesity in the Australian population. Explain that obesity weight range increases the risk of associated lifestyle disease later in life (e.g. hypertension and other cardiovascular diseases, type 2 diabetes, orthopedic complications as well as emotional/mental health risks).
 - Promote and support breast feeding and explain improved health outcomes including lessening the risk of obesity. Ensure families have information for after-hours breastfeeding support services / help lines (*See Breastfeeding pg. 195*).
 - Talk about the importance of nutrition and promote food intake based on the Australian Dietary Guidelines (*See Nutrition and Mealtimes pg. 234*).
 - Describe the concept of 'often' foods and 'sometimes' foods.
 - Encourage drinking plain tap water rather than other sweetened drinks e.g. cordial, juices, soft drinks, sports drinks or flavoured milk.
 - Promote an increase in physical activity and reduction in sedentary activities (*See Physical activity: exercise and play pg. 231*).
- Work in partnership with the family to develop an ongoing plan of care to promote responsive feeding practices and sustainable family lifestyle habits e.g.
 - Provide food that is developmentally suitable, nutritional, and fresh when possible.
 - Pleasant environment with few distractions e.g. no television.
 - Choose foods that promote healthy eating.
 - Avoid foods poor in nutrient value or 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.
 - Establish family routines around mealtimes e.g. hand washing before eating, modelling healthy mealtime behaviours, making healthy choices for the entire family.
- 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 plates
 - using foods for reward; giving foods as a form of comfort to a child
 - types of foods and fluids consumed or cooking methods utilised e.g. deep frying
- Parents are advised to role model healthy eating behaviours, using the Australian Guide to Healthy Eating to consume and provide a balanced variety and amount of nutritious foods and drinks.
- Provide ongoing support and review of progress through follow up visits.

- Use culturally appropriate tools for education on infant nutrition such as:
 - Growing Strong - feeding you and your baby resources⁵². This is a resource developed to assist health staff talk with Aboriginal and Torres Strait Islander families about nutrition for mothers, babies and young children. There are a range of resources available. <https://www.health.qld.gov.au/nutrition/patients#>
 - The Good Start Program has a range of culturally tailored resources for Maori and Pacific Islander families and communities⁵³. <https://www.childrens.health.qld.gov.au/service-good-start-resources/>
 - Multicultural nutrition resources - including Infant feeding for African communities, a suite of resources designed in partnership with African women covering all aspects of feeding and nutrition⁵⁴. <https://metrosouth.health.qld.gov.au/multicultural-nutrition-resources>
 - Raising Children Network has articles, videos and picture guides translated into multiple languages⁵⁵. <https://raisingchildren.net.au/for-professionals>
 - Global Health Media videoclips are available in multiple languages⁶¹. <https://globalhealthmedia.org/videos/>

Higher level services

Management strategies may include:

- Additional breastfeeding support may be required.
- Have a multidisciplinary team approach with the involvement of health professionals and workers with varied specialties. The management strategy should include:
 - Monitoring of growth and nutritional status.
 - Behavioural change strategies e.g. healthy food choices, mealtimes.
 - Active parental involvement.
 - Lifestyle interventions (e.g. nutrition, physical activity, sedentary behaviour).
 - Assist children with disordered eating, poor body image, depression and anxiety and weight-related bullying where these are present.
 - Identification of cultural needs and appropriate supports.
- Consider risk of impaired parenting.
- Observe parent-child interaction and emotional health - EPDS / DASS / Attachment Assessment Tools.
- Encourage engagement with local targeted groups or weight management clinics as appropriate.

Referral

- Referral for further investigation will be required:
 - where the weight has increased percentiles, indicating excessive growth
 - BMI increasing percentiles on the growth chart, or a BMI greater than the 85th percentile
- Child health professionals monitor weight for age greater than the 97th percentile. (There will always be a bottom and top 3% and that these measures do not necessarily indicate a growth problem).
- Referral Options
 - GP
 - Ellen Barron Family Centre
 - Specialist clinics or services (e.g. a feeding clinic, weight management clinics)
 - EIC / EIPC
 - Dietitian



Clinicians Hub

Health & Wellbeing Queensland

A variety of clinical tools, resources and training to support clinicians to identify, prevent and manage childhood obesity

<https://hw.qld.gov.au/hub/>

Eat for Health – Australian Dietary Guidelines

www.eatforhealth.gov.au

Australian 24-Hour Movement Guidelines for the Early Years (Birth to 5 years)

Australian Government

<https://www1.health.gov.au/internet/main/publishing.nsf/Content/npra-o-5yrs-brochure>

Growing Good Habits

<https://www.growinggoodhabits.health.qld.gov.au/>

Australian Indigenous HealthInfoNet

Links to multiple resources specific to Aboriginal and Torres Strait Islander peoples

<https://healthinonet.ecu.edu.au/key-resources/resources/>

Framework - An integrated approach for tackling childhood overweight and obesity in Queensland

Queensland Child and Youth Clinical Network

<https://www.growinggoodhabits.health.qld.gov.au/health-professionals/clinical-resources-and-tools/>

Confident Body Confident child

<https://www.confidentbody.net/about.html>



Refer to the Chronic Conditions Manual

<https://www.publications.qld.gov.au/dataset/chronic-conditions-manual-2nd-edition-2020>

General information

- Infant sleep plays a critical and positive role in cognition and physical growth. Sleep development is a highly dynamic process particularly in the first 2 years of life, and occurs parallel to, and in interaction with, cognitive and physical growth. (See *Sleep patterns* pg. 209).
- There is an enormous variation in the amount of sleep and activity among infants and sleep needs will change throughout life. Many factors influence infant sleep, some examples include:
 - infant temperament;
 - developmental stage (e.g. separation anxiety);
 - physical reasons (e.g. hunger or illness);
 - parental influence (e.g. sleeping environment and associations);
 - responsiveness to infant cues (e.g. misinterpreting tired signs).
- Infant and child sleep disruptions may result in an increased likelihood of behaviour problems and emotional regulation, compromised development, increased body weight, parental perceived difficult temperament and chronic sleep loss has been linked to neuronal damage and cognitive loss in children.
- When a child does not sleep well this increases risk of parenting exhaustion and fatigue which has its own consequences - impacting on parenting stress levels, optimal parenting behaviours, the child-parent relationship and the parent-parent relationship.
- Electronic devices emit an artificial blue light that engages the brain and can suppress the release of melatonin, causing sleep disruptions –difficulty with both falling asleep and also staying asleep. Interactive technological devices e.g. cell phones/tablets, computers and electronic games, are most strongly associated with sleep disturbance²¹⁰.

Clinical practice points

- Conduct a comprehensive family health assessment to identify specific needs of the individual child / family, this should include:
 - Child sleep patterns, including activities and objects that may be associated with sleep.
 - Child's feeding history i.e. child feeding and dietary intake, what, how, how much.
 - Growth assessment to ensure there is not an underlying feeding issue.
 - Cultural and social context of the family and sleep environment.
 - Child activity assessment e.g. play time activities, screen time.
 - Parental- child interaction.
- Parental psychoeducation, in particular:
 - Child tired signs and cues.
 - Provide information about evidence-based techniques that may enhance child settling and sleep e.g. Responsive Settling, avoidance of screen time before bed.
 - Provide information on strategies that may reduce parenting fatigue e.g. 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

- 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

Responsive settling videos

<https://www.childrens.health.qld.gov.au/chq/our-services/community-health-services/ellen-barron-family-centre/responsive-settling/>



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General information

- Postnatal depression is a common disorder with approximately 1 in 5 women and 1 in 10 men experiencing PND. For those women with a past history of PND, 20-40% will have a relapse in subsequent perinatal periods.
- Puerperal psychosis is uncommon, occurring in 1-2/1000 births, and usually manifests 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 and family violence.
- Potential risks for postnatal depression include a previous mental health illness, stressful life events such as: family problems, poor marital relationship, isolation (including from culture), intimate partner violence, lack of social support, history of abuse or neglect and unplanned pregnancy. Birth trauma may result in postnatal depression/anxiety, post-traumatic stress disorder or other mental health issue.
- Mothers with a history of schizophrenia, bipolar affective disorder, depression and anxiety are at a heightened risk of relapse postpartum.
- 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
 - child neglect or abuse
 - while rare, suicide and infanticide

Clinical practice points

- Every contact with the family provides an opportunity to explore maternal emotional well-being.
- 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.
- If the child identifies as being of Aboriginal or Torres Strait Islander decent, Aboriginal and Torres Strait Islander Advanced Health Workers (where available) should be involved in the family health assessment conversation and in developing the cultural aspects of the care plan.
- Administer EPDS / DASS / Attachment assessment tools following an informed consent process (See *Practice tips: Conducting and scoring the EPDS* pg. 68).

- 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 the current safety of the parent and children, according to clinical judgement seek advice and mental health assessment.
- 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.



The child health professional may identify child safety concerns and be required to complete a 'Report of Suspected Child in Need of Protection' pg. 311.



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.



If assessment identifies altered attachment models, refer to EIC / EIPC.

- Maintain a therapeutic relationship by:
 - encourage expression of feelings
 - effective listening
 - maintaining a non-judgmental, family-centred approach
- Self-care promotion.
- Information about perinatal mental health:
 - BeyondBlue has a range of resources for families including information specific to Aboriginal and Torres Strait Islander families, multicultural people (information translated into other languages), lesbian, gay bisexual and transgender (LGBTIQ+) parents.
 - Centre of Perinatal Excellence (COPE) has a range of resources for families including newsletters families can subscribe to, a video series promoting perinatal and infant mental health and fact sheets.
 - Perinatal Anxiety and Depression Australia (PANDA) has resources for families, including a hotline, handouts and mental health checklists to identify mental health difficulties.
 - PANDA also have a website dedicated to perinatal mental health for new dads.
 - Queensland Centre for Perinatal and Infant Mental Health (QCPIMH) has resources for families, including handouts and a telepsychiatry service for remote areas.

- Lavender Mother and Baby Unit is a state-wide, acute mental health facility for admission of mothers with significant mental health problems and her baby under one year old.
 - › The Unit has four adult beds located at Gold Coast University Hospital.
 - › A referral for the service must be made by medical practitioners and local mental health services. The referral form is located on the Lavender Mother and Baby Unit Website.
- Additional parental support may be required. This may include:
 - Targeted parenting groups e.g. Post-natal wellbeing group, Circle of Security group.
 - Development of a safety plan with the parents, including provision of crisis service information, e.g. hotlines through PANDA (1300 726 306) and Gidget Foundation (1300 851 758) . *See Practice tips: Developing a safety plan pg. 319.*
 - Additional breastfeeding 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

- Management strategies may include:
 - Targeted home visiting according to need/risk
 - EIC / EIPC
 - Mental health groups e.g. postnatal depression support groups and services
 - Consider risk of impaired parenting

Referral options

- GP
- Acute mental health facility
- Perinatal mental health services
- Infant mental health services
- Drug and alcohol support services
- EBFC – (for parenting support)



Centre of Perinatal Excellence

Free online training and national clinical guidelines for health professionals, resources for families

<https://www.cope.org.au/training/>

eMHprac

Directory of Australian, evidence-based, free (or low-cost) digital mental health programs and resources

<https://www.emhprac.org.au/>

Keeping Well During Pregnancy and Beyond Booklet

https://metrosouth.health.qld.gov.au/sites/default/files/keeping_well_booklet_web.pdf

Queensland Centre for Perinatal and Infant Mental Health (QCPIMH)

State-wide service promoting perinatal and infant mental health

<https://www.childrens.health.qld.gov.au/chq/our-services/mental-health-services/qcpimh/>

Children of Parents with Mental Illness (COPMI)

<http://www.copmi.net.au/parents>

Yarning about mental health: an easy guide to mental health assessment

HealthInfoNet Flipchart

<https://healthinfonet.ecu.edu.au/key-resources/resources/?id=19702>

Beyond Blue

www.beyondblue.org.au

Black Dog Institute

<https://www.blackdoginstitute.org.au/>

PANDA Perinatal Anxiety & Depression Australia

<https://www.howisdadgoing.org.au/>

Gidget Foundation

<https://gidgetfoundation.org.au/get-support/start-talking-telehealth/>

Queensland Transcultural Mental Health Centre

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



Refer to the Chronic Conditions Manual

<https://www.publications.qld.gov.au/dataset/chronic-conditions-manual-2nd-edition-2020>

Disruptive behaviour / aggression / regulatory disorders ^{32, 55, 272}

General information

- 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.
- 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. During the preschool years, most children learn how to demonstrate their sense of autonomy in a socially acceptable manner.
- Some children however will display ongoing disruptive behaviours, aggression and regulatory disorders. Parents may 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, parenting and family factors

Clinical practice points

- Conduct a comprehensive family health assessment to identify specific needs of the individual child / family, this should include:
 - Child's feeding, sleeping and developmental history.
 - Assessment of growth and development.
 - 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 psychoeducation, 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; Raising Children's Network and Circle of Security program.
 - 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.
 - Spending quality time with children, descriptive praise, talking with children, having interesting activities, giving attention and tuning in to the child, giving children the opportunity to take the lead, support their exploration, support their emotions.
- Encourage parents to enroll in a group parenting program e.g. Triple P, Circle of Security.
- Use DASS / Parenting Attachment Assessment Tools.
- Provide ongoing support and review of progress through follow up visits.

Higher level services

- Management strategies may include:
 - Targeted parenting groups e.g. Circle of Security and Triple P Parenting
 - EIC / EIPC
 - Consider risk of impaired parenting

Referral options

- GP/MO
- Infant – mental health worker
- Ellen Barron Family Centre (*see Ellen Barron Family Centre page 293*)
- Family and Child Connect



Raising Children Network

<https://raisingchildren.net.au/preschoolers/behaviour>

Family and Child Connect

<http://familychildconnect.org.au/>

Kids Health info Fact Sheet - challenging behaviour Toddlers and young Children

Royal Children's Hospital Melbourne

https://www.rch.org.au/kidsinfo/fact_sheets/Challenging_behaviour_toddlers_and_young_children/

Parental grief and loss ^{32, 75, 113, 273}

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 (death rate in the first year of life) is 3.2 infant deaths to every 1000 births. The overall infant mortality rate in Australia is 2.6.
- In 2015, around 7% of Australian children aged 0-14 have a level of disability. The proportion was slightly higher among boys than girls (9.4% compared with 5.4%). The most common types were intellectual (4%) and sensory/speech (3%).

Clinical practice points

- When facing unexpected events, parents generally want:
 - A clear simple explanation regarding the diagnosis.
 - Information on 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:
 - Focus on what the child can do and build from there.
 - 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 child with extra health needs, 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 family's emotional health.
- Provide ongoing support and review of progress through follow up visits.

Referral options

- GP
- Specialty agencies specific to need, such as:
 - Down Syndrome Australia <https://www.downsyndrome.org.au/qld/>
 - SANDS Queensland (miscarriage, stillbirth and newborn death support) <https://www.sands.org.au/>
 - Cleftpals Queensland <http://www.cleftpalsqld.org.au>



Department of Communities, Disability Services and Seniors

Queensland Government

<https://www.communities.qld.gov.au/disability-connect-queensland>

Raising Children Network

Grief after stillbirth or neonatal death

<http://raisingchildren.net.au>



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Child Protection

- 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^{2, 274}. Child Health practice is based on purposefully engaging in effective therapeutic relationships with parents and carers. The child health professional undertakes assessments of children including the physical and psychological assessments to identify strengths, risks and vulnerabilities²⁷⁵.
- While most children in Australia are healthy, happy and safe there are still many children who experience disadvantage, abuse and neglect. During 2018-19, over 170000 Australian children received child protection services (investigation, care and protection order and/or were in out-of-home care), which represents an increase of approximately 25% over the previous five years²⁴³.
- Medical professionals (doctors/nurses) have both mandatory and nonmandatory obligations under the Child Protection Act 1999 to report a reasonable/reportable suspicion of child abuse and neglect⁸⁶.
 - Under s13E of the Child Protection Act 1999, they are mandated to report where there is reasonable suspicion that a child has suffered, is suffering, or is at unacceptable risk of suffering, significant harm caused by physical or sexual abuse and may not have a parent able and willing to protect the child from the harm.
 - Medical professionals have a duty of care to report other types of harm (emotional, neglect).
- Other health professionals (social workers/psychologists/advanced health workers) have a duty of care to inform Department of Child Safety, Youth and Women (CSYW) in accordance with s13A of the Child Protection Act 1999 where the staff member reasonably suspects a child may be in need of protection⁸⁶.
- Harm to a child is defined in the Child Protection Act 1999 (section 9) as: any detrimental effect of a significant nature on the child's physical, psychological or emotional wellbeing²³³.
- All health professionals are expected to be aware of their responsibilities in relation to child protection and the legal framework (the Child Protection Act 1999) for sharing information about child protection concerns.
- Initial orientation to local child protection processes, information on child protection and the reporting of suspected child abuse and neglect and contacts should be part of onboarding and annual updating requirements²⁷⁶.



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The following tables outline factors that may increase the risk of child abuse or neglect:

Developmental considerations 0 – 2 years ^{88, 277}	
<ul style="list-style-type: none"> • No mobility or limited mobility e.g. young age, disability • High dependency on others to meet basic needs e.g. unable to seek food for themselves • Unable to alert others e.g. young age, does not attend childcare/school 	
Child factors	Family Characteristics
<ul style="list-style-type: none"> • Prematurity • Feeding difficulties • Sleep difficulties • Developmental delay, disability • Difficult temperament • Disruptive / challenging behaviour • Disordered attachment • Repeat exposure to safety hazards 	<ul style="list-style-type: none"> • History of previous harm to this child or a sibling • Family violence • Parental mental illness • Parental criminality • Isolated, single parent • First time parent • Financial stress • Coercive family practices or family lifestyle • Substance abuse • Poor parental role modelling including past abuse as a child • Social isolation • Behaviours, such as the inability to manage stress or anger



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- Child is mobile, therefore able to injure themselves accidentally
- High dependency on others to meet basic needs e.g. developmental delay, disability
- Unable to alert others e.g. does not attend childcare/school

Child factors	Family Characteristics
<ul style="list-style-type: none"> • significant developmental delay • exposure to multiple forms of child abuse • repeat accidents, injury, poisoning • disordered attachment • difficult temperament, early onset of hyperactivity or disruptive/challenging behaviour, inadequate behaviour management • exposure to family violence • exposure to community violence • learning difficulties • low self-esteem • impulsivity • poor peer relationship building • low social skills and problem solving 	<ul style="list-style-type: none"> • History of previous harm to this child or a sibling • Family violence • Parental mental illness • Parental criminality • Isolated, single parent • First time parent • Financial stress • Coercive family practices or family lifestyle • Substance abuse • Poor parental role modelling including past abuse as a child • Social isolation • Behaviours, such as the inability to manage stress or anger

Clinical findings of significant harm, especially when a suitable explanation is not provided, may include (list not exhaustive)²⁷⁷:

Physical abuse

- Human bite marks, multiple bruises, bruising of any part of a baby, pinch marks
- Abusive head trauma e.g. shaken baby syndrome.
 - presentation can be relatively mild, such as poor feeding and irritability, or severe such as coma, seizures and apnoea)
 - typical intracranial injury is subdural hematoma, but other types of brain injury can occur
 - serious brain injury can occur without external signs such as bruises
 - may be associated with retinal haemorrhages, rib fractures and other injuries
- Fabricated or induced illness (medical child abuse)
- Thermal injury
 - may present as cigarette burns or scalds from immersion in very hot water particularly feet, buttocks and hands (e.g. glove and stocking distribution)
- Fractures
 - all fractures in the first year of life must be viewed with suspicion, particularly limbs, skull and rib

Sexual abuse

- Presentation behaviours - soiling or wetting, poor sleep, anxiety, fear, behavioural problems
- Petechiae at back of throat
- Genital injury – anal and or vaginal bleeding, penile injury

Emotional abuse

- Significant behaviour problems
- Associated neglect and failure to thrive with developmental delay
- Significant relationship issues between parent and child and family
- Disorders of attachment

Neglect – emotional, physical, medical

- Growth faltering
- Fabricated or induced illness (medical child abuse)
- Depression/withdrawal presentation of infant
- Disorders of attachment
- Delayed medical presentations resulting in detrimental outcome/s to health and wellbeing
- Presentation with poor hygiene (which has a detrimental impact on the child's functioning/ wellbeing) including:
 - oral hygiene
 - lack of appropriate clothing/equipment (important to differentiate from economic disadvantage)

- 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 limitations. It is likely that many cases are not reported or identified¹⁸².

Shaken baby syndrome occurs most commonly in infants under 12 months correlating with the normal peaks of infant crying ¹⁸².

- Factitious disorder imposed on another (previously known as 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.
- Factitious disorder imposed on another is difficult to identify because the fabrications are usually denied and are often intricate and believable²⁷⁹. 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 their diagnostic evidence?
- Have treatments been commenced due to caregiver's insistence?
- 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 risk^{32, 89}. See below for an example of a *Risk and Protective Framework* pg. 317.
- **Information sharing:** Informing a reasonable suspicion of child abuse and neglect, health professionals can 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 Child Safety Youth and Women)²⁸⁰.
 - See the *Information sharing in child protection - Key Messages*, which summarizes the purpose for information sharing, consent, documentation and includes links to the key overarching guideline documents.
- As part of the child protection reform program, community-based intake and referral services provide an additional pathway for referring concerns about children and their families²⁸¹
 - If concerns do not reach the threshold for a report to Child Safety, but the family would benefit from a support service, consider referral with consent to:
 - › Family and Child Connect
 - › An Intensive Family Support service
 - › Other support service specific to family need



- **When a child health professional forms a reasonable suspicion of harm, they must immediately report their concerns directly to Child Safety Regional Intake Service using a 'Report of suspected child in need of protection' form**
- **When a child health professional suspects a child has been physically harmed, follow local policy and guidelines to:**
 - facilitate immediate access for acute medical assessment of the child
 - make a report to Child Safety Regional Intake Service if the harm is significant and there is no parent able and willing to protect the child.
 - notify their supervisor/s
 - forward a copy of the report to your local CPLO / CPA.

Child Protection Resources

- The **Child Safety QHEPS site** provides all Queensland Health staff with information on individuals' responsibilities regarding child protection, how to recognise child abuse and neglect and how to report reasonable suspicions of child abuse and neglect. Education modules, online support tools, factsheets and support services can be found on the site. <https://qheps.health.qld.gov.au/csu>
- The **Child Protection Guide** provides guidance and support in decision making for staff who have concerns for the safety and/or wellbeing of a child/young person. The guide is intended to complement, not replace, clinical judgement, expertise or critical thinking. <https://www.csyw.qld.gov.au/about-us/partners/child-family/our-government-partners/queensland-child-protection-guide>
- The **Reporting and Referring Child Protection Concerns flowchart** is a useful tool to inform of the process regarding reporting and referring child protection concerns. https://qheps.health.qld.gov.au/_data/assets/pdf_file/0019/408430/qhreportreferflowchart_facc.pdf
- **Child Protection Guidelines** <https://qheps.health.qld.gov.au/csu/policy>
 - Reporting and responding to a reasonable suspicion of child abuse and neglect
 - Health professionals child protection capability requirements
 - Prioritisation of health services for children and young people in the child protection system
- The Child Protection **Reporting Tips** and **Reporting forms**, support staff to understand the reporting processes for health professionals. <https://qheps.health.qld.gov.au/csu/reportingforms>
- **Child Protection Liaison Officers** (CPLO) and **Child Protection Advisors** (CPA) provide support to local HHS staff when managing child protection issues. Contact lists can be found on the [Child Safety QHEPS site](#).
- The **Information sharing in child protection - Key Messages** summarizes the purpose for information sharing, consent, documentation etc. https://qheps.health.qld.gov.au/_data/assets/pdf_file/0026/2239361/ISCP_keymessagesfactsheet.pdf
- There are multiple **factsheets** available on the Child Safety QHEPS page. Some examples include:
 - Presenting characteristics of child abuse and neglect
 - Clinical risk factors and indicators (for Physical abuse; Emotional abuse; Sexual abuse and Neglect)
 - Clinical risk factors and indicators for harm in children (0-2 years; 3-5 years; 6-13 years; 14-18 years)
 - Risk versus protective factor assessment framework
 - Female genital mutilation
 - Documentation in child protection
 - High risk population groups
- The Queensland Family and Child Commission has produced an **Information Kit on Child Protection for Professionals**, which provides key facts about the Queensland child protection system for anyone who works with children or families. <https://www.qfcc.qld.gov.au/>

Sample framework of protective and risk factors

	Protective factors	Risk factors
Infant/child factors	<ul style="list-style-type: none"> • Easy to soothe • Calm temperament • Positive and warm child- parent interaction • Sleep patterns developmentally appropriate • Feeding well for age • Social and emotional competence 	<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
Famiy factors	<ul style="list-style-type: none"> • Good physical and emotional health of parents • Positive parent-child attachment • Stable family structure • Positive relationships with extended family • Parental self-esteem • Family cohesion • Two-parent household • High level of parental education • Self-efficacy • Knowledge of parenting and child development • Parental resilience 	<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 / environment 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 • Socio-economically advantaged neighbourhood • Access to health and social services 	<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 domestic and family violence

Introduction

Section 1:
Antenatal

Section 2:
Birth to five years

Section 3:
Five to twelve years

Section 4:
12 to 18 years

Appendix & References

Safety plans

Safety of the child always remains a key focus for the child health professional. In planning for safety child health professionals aim to work with the family to develop a 'safety plan' that is appropriate to their individual family context. See next page Practice Tips: Developing a safety plan.

For the purpose of this manual a safety plan refers to a plan:

- for the family to refer to and use during challenging times
- developed by the family with support of the health care professional outlining agreed specific actions that the parent will undertake during challenging times

Dealing with requests for information from Queensland Police Service

- Child health professionals 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.



Practice tips: Developing a safety plan

- 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 parent 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"
 - › The **trigger** is "when the baby is crying constantly"
 - These words can then be used within the safety plan, such as:

"I am more likely to get frustrated when the baby is crying constantly"
- Formulate strategies to address the parent risk/trigger statement:
 - *Strategies that I can put into place to reduce this occurring will be to 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 Jane for support on _____
 - › If Jane doesn't answer I will ring Lifeline on 13 11 14
 - Include external agencies that are available for 24-hour support e.g. Lifeline, Parentline, I3Health.
- 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.



Section 3:

Five to twelve years

3

Section 3: Five to twelve years

The ‘middle’ childhood years are characterised by more gradual physical growth and social and emotional development ³². 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 ³².



Please note: Some children in this stage of the continuum may also experience issues discussed in Section 4: 12 – 18 years

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)



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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 or in greater need ⁶.
- 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, telehealth, group work^{1, 6}.

Primary School Nurse Health Readiness Program (PSNHRP)

- In Queensland, school health nursing has been identified as an important innovation in public health nursing, however, the context of health care for children in their primary school years has changed over time. The PSNHRP is a state-wide service, established in 2015, and provides vision screening to all prep aged children in state, catholic and independent schools ¹⁸⁹.
- Registered Nurses in the PSNHRP use two vision screening tools to identify children who have vision outside of normal limits. The PARR 4m Letter Matching Vision Test with confusion bars is used to perform the subjective visual acuity assessment. The Welch Allyn automated Spot Vision Screening Device is the objective assessment, and uses infrared light to capture measurements of the child's eyes to compare against normal parameters for that age group.
- Registered Nurses are employed in the PSNHR program, and work in all hospital and health services across Queensland. They are supported by the PSNHRP Hub, based in Brisbane, to ensure consistent service delivery¹⁸⁹. 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.
- Child health services may also be provided at a targeted level by early intervention (parenting) clinicians (EIC / EIPC) . 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 and promote 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 ^{282, 283}. For more information about the *HPS framework*, see page 394.



Practice tips: Working within school settings

- Staff working in school settings work in partnership with the Department of Education (DoE), 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 visitor's book when attending the school and be aware of scheduled lockdown or fire drills etc. .
- In many instances, formal licence agreements exist between DoE and Catholic Education Dioceses and some HHS's. These agreements outline the mutual responsibilities of each party in relation to the provision of health care services in schools
- Once an agreement has been reached between an 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 staff are primarily responsible for the administration of first aid services on the school campus as they are provided with training and tools in various health areas, for example CPR and Diabetes in Schools program.

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

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, other caregivers e.g. teachers etc.¹ Promotion and monitoring of immunisation can also be undertaken at this time.

- The final recommended well child health check is the 4 – 5 year check, which includes the addition of vision and hearing screening for all children⁹³.
- Additional population screening through health checks are offered to for rural and remote populations as part of the Chronic Conditions Manual recommendations⁹⁵.
 - 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 diseases⁹⁵.
 - Additional screening/assessments are recommended, for example annual body measurements from 4 years; additional ear and hearing assessments; additional clinical measurements e.g. Red eye reflex, heart sounds and haemoglobin; annual BMI from 2 years of age.
- Aboriginal and Torres Strait Islander children are eligible for a health assessment by a GP/Practice Nurse/Aboriginal health worker/practitioner every 9 months as part of the 'Aboriginal and Torres Strait Islander Peoples Health Assessment'⁹⁶.



Children's Health Queensland

4-5 year old Health Check Work Instruction

https://qheps.health.qld.gov.au/__data/assets/pdf_file/0026/718109/wi-19915.pdf



Refer to the Chronic Conditions Manual

<https://www.publications.qld.gov.au/dataset/chronic-conditions-manual-2nd-edition-2020>

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. The extent of examination varies depending on the circumstances of each health contact ⁹².
- Accuracy is crucial in obtaining all physical measurements. Components of accurate measuring:
 - technique that is standardised, e.g. bare weigh children less than two years old
 - equipment that is accurate. Regular calibration and checking before use is essential
 - measurers that are trained so they are accurate and reliable
 - use the same scales whenever possible
 - follow manufacturer's instructions on transportation of portable scales
- Growth during childhood is an important indicator of nutritional and health status and remains the best method of assessment at the primary care level ⁴⁹. 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/year ³².

- Factors that influence a child's growth can include gender, genetics, health, environmental factors, e.g. nutrition⁹². 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 group³². 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^{49, 92}. A series of measurements over time are needed to assess a child's growth. One-off measurements show a child's size but not their growth.

The CDC growth charts are used for this age range. Always ensure the correct chart is being used, e.g. gender¹³⁴.

- Referral for further investigation will be required if growth chart patterns indicate poor or excessive growth; unexplained weight loss or weight not re-gained following acute illness¹²⁴.

- **Indicators of poor growth**

- › Weight and/or length plateauing or tracking downwards on the percentile growth chart

- **Indicators of excessive growth**

- › Weight and/or length for age tracking upwards on the percentile growth chart.
 - › BMI above the 85th percentile.

- Oral health and lift the lip assessment

- Queensland's children have one of the highest rates of dental decay in Australia⁸⁰. As such, oral health risk assessments, including checking for healthy mouths, should be included in the routine physical examination of all infants and children. *See Practice tips: Conducting a lift the lip / healthy mouth screen pg. 156.*

- Ensure that recommended hearing screens have been completed and enquire if any follow up appointments are required¹¹⁹.

- Eye health and vision screening

- 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 include¹⁸⁹:
 - › Amblyopia or 'lazy' eye (decreased/blurry vision in one or both eyes)
 - › Strabismus or 'cross-eyed' (misalignment of the eyes)
 - › Refractive error – short or far sightedness or astigmatism
 - In addition to eye appearance, fixing and following, corneal light reflex and red eye reflex assessments completed at each health check, cover tests and visual acuity screening should be performed from 4 years^{93, 95}.

- Additional assessment / screening is recommended for infants and children living in rural and remote Queensland populations. See the Chronic Conditions Manual – Section 2: Child Health Checks.



Practice tips: Conducting a lift the lip / healthy mouth screen

See page 156

Practice tips: Conducting visual screening

See page 327

Practice tips: Conducting a hearing and ear health check

See page 161



Centre for Disease and Prevention

Growth charts

https://www.cdc.gov/growthcharts/cdc_charts.htm

The Royal Children's Hospital, Melbourne

<https://www.rch.org.au/childgrowth/>



Refer to the Pathways to Rural and Remote Orientation and Training

<https://ilearncatalogue.health.qld.gov.au/program/17/parrot-primary-care>



Refer to the Chronic Conditions Manual

<https://www.publications.qld.gov.au/dataset/chronic-conditions-manual-2nd-edition-2020>



Refer to Primary Clinical Care Manual

<https://www.health.qld.gov.au/rccsu/html/PCCM>



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Practice tips: Visual acuity screening (5 to 12 years) ^{95, 189}

- The recommended tools to assess visual acuity in this age group that may be used for vision testing include:
 - The Parr 4m Letter Matching Vision Test (for younger children)
 - Snellen Chart (for older children)
- Children do not have to be literate to have their vision assessed. Reassure children that this is a 'matching game'.
- Establish a routine of testing the right eye first, as results of the right eye are usually recorded first.
- Use a cover such as an eye patch to occlude the eye not being tested.
- Make sure the child is not facing a window or other bright light source that could make it difficult for them to see (be aware of any glare or reflection on the key card).
- At no time is a child to be forced to cooperate.
- Cleaning and infection control measures are used between children.

Parr 4m Letter Matching Vision Test:

- The screening is to be conducted exactly 4 meters from the child and at the same level as the child's eyes. Measure 4 meters from where the child will be positioned with a tape measure and mark the floor at both ends with a piece of masking tape.
- Ensure that you match the screening booklet to the key card (both have confusion bars).
- Explain the procedure accurately and at an appropriate level for the individual child and give the child the opportunity to 'practice'. For example, at close distance ask the child to point to the same 'shape' on their keycard that the assessor is pointing to on their booklet. When the child is able to match a number of 'shapes' correctly then the assessor can commence assessment at the 4-meter distance.
- Start with the largest letters and show the child progressively smaller letters from each level and continue this until the child has difficulty identifying the letters. Make sure not to obscure any part of a letter.
- Allow the child adequate time to respond to each size being tested.
- Observe the behaviour of the child during testing e.g. holding head forward, squinting, blinking or frowning. These behaviours may indicate that the child is having some difficulty seeing the letters.
- Although the screen is performed at 4 meters, the results are written as though the test was undertaken at 6 meters (i.e., 6/30, 6/18, 6/12, 6/9, 6/6). The conversion table is on the back of the booklet.
- 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. R=6/6; L=6/9
 - Normal vision is 6/6
 - › Acceptable visual acuity for the 4 – 6 year old child is 6/9
 - › Acceptable visual acuity for the 7 + year old child is 6/6
 - If the child makes one mistake the result is written as 6/9-1.
 - Allow two attempts at any one failure.
 - One mistake per size is considered a pass (i.e. 2 out of 3 correct is a pass for that size).

Snellen 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.
- Point clearly to letters being tested, (e.g. use a red coloured pencil/pen or pointer). Make sure not to obscure any part of a letter. If the child is uncertain as to which letter requires a response, circle the letter with the pointer.
- 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.
- 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 size read successfully. e.g. R=6/6; L=6/9
 - Normal vision is 6/6
 - › Acceptable visual acuity for the 4 – 6 year old child is 6/9
 - › Acceptable visual acuity for the 7 + year old child is 6/6
- **Refer** any abnormalities detected to Optometrist/GP/Medical Officer, this will include:
 - Any clinical concerns.
 - Less than acceptable visual acuity for age i.e. visual acuity of 6/9 -2 or worse in either eye for a 4-6-year-old child.
 - Unequal visual acuity that is outside normal parameters if there is a difference of one size 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.

Note: In children, visual acuity could be slightly different in each eye as the eye develops. If both eyes are 6/9 -1 or better, this is considered a pass. For example, R=6/6 L=6/9 is considered a pass in a 4 -6 year old child.



For young children do not test single letters on a bland background as you may miss some amblyopes. Instead test single letters with confusion bars or single letters in a line. 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: Ears and hearing check: 5 to 12 years⁹⁵

- Hearing surveillance aims to identify those children most likely to have hearing loss that may interfere with their speech and language, education, health and development. Surveillance 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.
- An appropriately trained Registered Nurse or Health Worker/Practitioner may undertake an ear and hearing health check ⁹⁵.
- Do not proceed with ear health and hearing check if there is ear pain, notable discharge or the skin is broken or inflamed. These children should be referred to MO/GP/Nurse Practitioner or refer to the guidelines in the Primary Clinical Care Manual ¹²⁰.
- Ask the child/parent/carer if they have any concerns, or if any other people have expressed concerns (e.g. educators, extended family) about the child's hearing, ear health, speech and language development and developmental/academic 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 recommendations (5 – 12 years) ⁹⁵

Age	Questions to ask	Proceudre
5 years 12 years	<ul style="list-style-type: none"> • Has your child been free of ear infections or discharge? • Do you have any concerns about how your child makes speech sounds? • Do you have any concerns about how your child understands what you say? 	<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



Practice tips: Conducting a hearing and ear health check

See page 161

Developmental assessment

- 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 and informs the development of a care plan linked to the child's needs and risk factors ³⁷.
- 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.
- The child's development is significantly affected by the family environment and experience of the child within this environment ⁹¹, with the parent/carer-child attachment relationship being a pivotal factor influencing child development ^{99, 203}.
- 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 child ^{1, 32, 92}.
- Developmental delays, disorders and differences ¹³⁷:
 - Developmental delay often describes a lag in the acquisition of a skill/developmental milestone.
 - Developmental disorder is used when a child's developmental trajectory is significantly impacted, and some milestones may not be achieved.
 - Developmental differences can simply reflect the different / unique experiences each child has in their lives, rather than reflecting a developmental delay or disorder.
- Developmental surveillance is designed to identify risk factors and detect early delay which enables the implementation of early intervention strategies. Concerns raised by parents, teachers and other school staff, once the child is integrated into the school setting should also be considered in developmental surveillance ¹⁴⁷.
- 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 ³².
 - **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 ³².
 - **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. Gender 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 ³².

- **Developing a self-concept.** As children grow and mature, a conscious awareness of themselves forms, e.g. their physical appearance, abilities and 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 ³².
- Children's social and emotional wellbeing—how they think and feel about themselves and others, and deal with daily challenges—is one component of mental health and wellbeing. Socially and emotionally competent children⁷⁵:
 - are confident
 - have good relationships
 - communicate well
 - do better at school
 - take on and persist with challenging tasks
 - develop the necessary relationships to succeed in life

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.

Common screening tools include¹:

- **Parents Evaluation of Developmental Status (PEDS)**

Age: 0– 8 years

When it is used: Detecting developmental and behavioural issues needing further evaluation. May be useful as a surveillance tool.

Completed by: Parents and incorporated into a child health monitoring program.

Resources:

- **e-Learning** http://www.rch.org.au/ccch/training-dev/PEDS_training/
- **PEDS developmental milestone checklist**
<http://qheps.health.qld.gov.au/ccyfh/html/resources.htm>

- **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.

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.



Practice tips: Conducting a developmental assessment

See page 102



e -Learning

Centre for Community Child Health, RCH Melbourne

Laying the Foundations eLearning

www.rch.org.au/ccch/resources_and_publications/Monitoring_Child_Development/



The Red Flags School-aged Guide

Queensland Health

<https://qheps.health.qld.gov.au/ccyfhs/html/resources>

PEDS developmental milestone checklist

<http://qheps.health.qld.gov.au/ccyfhs/html/resources.htm>



Refer to the Pathways to Rural and Remote Orientation and Training

<https://ilearncatalogue.health.qld.gov.au/program/17/parrot-primary-care>



Refer to the Chronic Conditions Manual

<https://www.publications.qld.gov.au/dataset/chronic-conditions-manual-2nd-edition-2020>

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 *Nutrition and healthy eating pattern* pg. 343 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^{32, 55, 146-148}

- 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 able to be formed by the lips, are common up to approximately five years.
 - Encourage the child to relax and speak slowly.
 - Parents should resist completing sentences, slow and relax themselves and take time to listen.
- 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 Department of Education, 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 <https://qed.qld.gov.au/about-us/department-apps/speak>

Cautions and things to avoid

- Avoid finishing words/sentences for children.
- Avoid pressuring a child to produce a particular sound.
- Do not criticize or mock the child for speaking differently.
- Limit screen time.

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, being understood when speaking
 - answering simple questions within a conversation, taking turns in a conversation, understanding jokes
 - following directions with a number of steps, finishing tasks
 - loss of previously acquired skills
- The [Red Flags School-aged Guide](#) can be used as a guide²⁸⁴.

- Daytime bladder control and coordination usually occurs by 4 years of age; however night-time bladder control typically takes longer and is not expected until a child is 5–8 years old.
- Attaining nighttime dryness is a normal developmental process, with significant age variation. Almost a third of four-year-olds wet the bed, 1 in 10 six-year olds and 1 in 20 ten-year olds. Bedwetting can sometimes continue into adolescence.
- There is a strong genetic tendency to bedwetting. Other exacerbating factors include fluid intake, behavioural or psychological issues, parenting capacity and socioeconomic vulnerability, medical history such as diabetes, sleep apnoea and constipation.
- ‘Wetting the bed’ may result in embarrassment and increased anxiety, and can interfere with child’s normal psychosocial development.
- For most children, enuresis is only seen as a problem when it interferes with their ability to socialise with friends (for example overnight stays or school camps). If the enuresis is infrequent and/or not distressing to the child or parents, treatment is not indicated.
- Typically, treatment is not started before age 6 years, as there is a high rate of spontaneous resolution.
- A return to bedwetting after a dry period of longer than 6 months, is not normal and requires further investigation. Nocturnal enuresis is often reported as the first sign of type 1 diabetes and parents should be asked about the presence of symptoms such as polyuria, polydipsia, weight loss and tiredness. The child should have a same day fingerpick blood glucose check to exclude type 1 diabetes.
- Sometimes children experience daytime symptoms as well (e.g. frequency, urgency, polyuria, recurrent UTI, leakage etc.). These children should be referred to their GP/MO.

Parenting tips / Skills to support child development

All children with urinary symptoms or a return to nighttime bedwetting 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 can be helpful.
- Provide reassurance to the child and caregivers about the condition, e.g. not the child’s fault, skills will develop in time.
- It is important that parents and siblings are patient and encouraging, and do not tease or punish the child.
- Provide encouragement and appropriate rewards specific to behaviours that the child can control, e.g. regular toileting through the day, toilet attempt prior to bedtime and first thing in the morning, participating in changing clothing and wet linen, being ‘in charge’ of any enuresis alarms.
- A child is less likely to stop wetting the bed if they are in a nighttime nappy/pull-up. Mattress protection pads or covers are available.
- 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. Advise against fluid restriction but eliminate caffeinated beverages and excessive fluid intake in the evening.

- 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 alarm therapy is considered the most useful and successful initial way to treat bedwetting in children older than 6 years of age, with good long-term success and fewer relapses than medication. It requires motivation of both child and parent and may take 6–8 weeks to work. 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, criticizing or teasing a child for not getting to the toilet on time.

Referral

- Children with a return to nocturnal enuresis, daytime wetting or urinary symptoms should be referred to their GP/MO for review to exclude secondary causes of symptomology, for example onset of type 1 diabetes.
- Refer to a Continence Nurse/Clinic.
- Consider referral to EIC/EIPC if emotional or behavioural issues are observed or parenting difficulties are noticed.



Continence Foundation of Australia

Factsheets: Bedwetting, Day wetting, Soiling, Tips for Bedwetting Children Who Want to Enjoy A Sleepover

Free helpline: 1800 33 00 66

Raising Children Network

Assorted fact sheets and video resources

<http://raisingchildren.net.au>

The Royal Children's Hospital Melbourne

Factsheets for parents

https://www.rch.org.au/kidsinfo/fact_sheets/Bedwetting/

Information for health professionals

https://www.rch.org.au/clinicalguide/guideline_index/Enuresis_-_Bed_wetting_and_Monosymptomatic_Enuresis/



Freepik.com

- There is great variation in patterns from one child to the next with some children passing 1-2 stools per day and other children defaecating every 2–3 days.
- 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.
- Constipation frequently occurs during the introduction of solid foods, toilet training and school.
- The Rome III symptom-base defines constipation as follows:
 - When the child is under four years old, and there are more than two of 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 dehydrates - 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 or encopresis 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 [Nutrition and healthy eating patterns](#) page 343.*

- 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 for up to 5 minutes, three times a day, preferably after meals
 - 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
- Review toilet access e.g. investigate barriers to using school toilets.
- 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, criticizing or teasing 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

Fact sheets and video resources, including Constipation and Soiling (encopresis)

<http://raisingchildren.net.au>

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

<https://www.publications.qld.gov.au/dataset/chronic-conditions-manual-2nd-edition-2020>

Pediculus Capitis (head lice) ²⁸⁷

- 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 up to two days 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 and do not carry disease.
- Treatment should only be applied when live lice are found on the head. There are two methods of treatment - Conditioner & Combing technique and Chemical treatment products.
- 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:
 - Pyrethrin
 - Synthetic Pyrethroids
 - Organophosphates
 - Combinations of herbal and essential oils
- 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 or a nit comb.
- 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-insecticidal treatment may be used on all children and is just 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 retreating in 7 days to kill any lice that have hatched from eggs that were not removed. No chemical treatments kill the eggs.
- Pillowcases 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-insecticidal 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)

<http://conditions.health.qld.gov.au/HealthCondition/condition/14/165/351/head-lice>



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Health promotion

Health promotion strategies are designed to improve child and family health by enabling parents to increase health awareness and health literacy, build 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 primary health practice¹⁹². A best practice population health care model for parents with children is one that aims to ensure universal access to health promotion and prevention services, with targeted services available for those that are most vulnerable^{1, 37}.

Working within a strengths based approach, health promotion and illness prevention increases the opportunity for positive family experiences and improved family wellbeing^{1, 192}. 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, 6}.

The health promotion framework for 5 – 12 year old's 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^{282, 283}:

- curriculum, teaching and learning
- school, organisation, ethos and environment
- partnerships and services

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^{282, 283}.



Health Promoting Schools Framework

See page 394

Practice tips: Working within school settings

See page 323

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 child¹.

- Family structures are varied including^{7, 38}:
 - extended families e.g. grandparents, aunts and uncles, Elders and kinship carers
 - foster families
 - single parent, step and blended families
 - lesbian, gay, bisexual transgender, intersex, queer, asexual , gender diverse and questioning (LGBTIQ+) parents

Understanding and respecting different child-rearing practices is important for planning and delivering services that reflect individual parenting choices and styles⁷. 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 whole³⁹.

It is recommended that services facilitate greater involvement of fathers/partners/extended family by considering a range of strategies⁴⁰. 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 and offering telehealth options for fathers who are away ^{39, 41}.
- Discuss parenthood roles and the impact on family lifestyle and relationships⁴⁰.
- Change service environments to account for possible barriers that prohibit father/ partner/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, consideration of offering single gender (dads) groups ^{39, 44}.

Aboriginal and Torres Strait Islander families should be supported with access and engagement with child health primary care services.

- Having Aboriginal and Torres Strait Islander staff, who are well respected and well connected to the community, and a culturally welcoming environment, facilitates inclusiveness of Aboriginal and Torres Strait Islander families^{39, 40, 42}.
- There may be barriers for families in attending an in-person appointment, which may be overcome with the use of telehealth services. Therefore, it is important to⁴⁶:
 - Raise awareness with families about the availability of telehealth.
 - Help with resourcing at the clients end if needed.
 - Provide cultural support to arrange the telehealth appointment and during the appointment.
 - Support the attendance of family.



Aboriginal and Torres Strait Islander families

See page 262



Webinar: Refining the task of father-inclusive practice

Child Family Community Australia (CFCA)

<https://aifs.gov.au/cfca/events/refining-task-father-inclusive-practice>

Family Action Centre, Newcastle University

Resources and education for staff on father-inclusive practice

<https://www.newcastle.edu.au/research-and-innovation/centre/fac/about-us>

Raising Children Network

Resources (video and fact sheets) on a variety of topics

<http://raisingchildren.net.au>

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.

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, 6}.

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-judgmental, culturally respectful manner
 - content meets the WHO International Code of Marketing of Breastmilk 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.

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.



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

- Queensland children aged 5-17 years are not meeting their targets (from healthy food sources) for the five food groups:
 - very few (0.6%) children met the recommendation for daily vegetable intake
 - 35% met the recommendation for daily fruit intake
 - 9% met the recommendation for lean meats and alternatives
- '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 and around half of children (46.4%) consume sugar sweetened drinks at least once per week²⁹⁰.
- 25% of Queensland children between 5 and 17 years were overweight or obese in 2017-18 and 10% were underweight. There are no significant differences in males and females.
- Many parents report concern about their child's eating habits and describe their child's eating as 'picky, fussy or irregular'.
- Good dietary habits in children are known to decrease physical health risks such as obesity and long-term chronic conditions heart disease and cancers.
- Establishing healthy eating patterns and attitudes early in life can protect a child from developing later mental health concerns:
 - The way a child feels about their body starts to develop as early as three years.
 - A child's body image may be influenced by a number of personal factors (e.g. biology, temperament) and environmental factors that may be outside the family (e.g. exposure to certain media).
 - Promoting the development of positive body image involves promoting healthy eating patterns and attitudes towards food.

Parenting tips / skills to support child development

- Parents are advised to use the Australian Guide to Healthy Eating and be a good role model by consuming and providing a balanced variety all the nutrients children need to grow and develop normally. Ensure to include a wide variety of 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.
 - Meat and meat alternatives: Lean meats and poultry, oily fish, eggs, tofu, nuts and seeds, and beans.
 - Dairy and dairy alternatives: Milk and dairy products such as yoghurt and cheese, calcium fortified plant-based milk (e.g. soymilk).
 - Encourage reduced fat options after the age of 2 years.
- A full family diet consists of three meals and two healthy snacks each day.
- Describe the concept of 'often' foods and 'sometimes' foods and encourage parents to teach children about groups of foods that are healthy.

- Encourage children to drink tap water and limit cordials, soft and sports drinks and flavoured milks.
- Encourage children to eat whole fruits and limit juices.
- Pack interesting healthy lunch boxes for children, choosing food and snacks from the 5 food groups. If children are involved with choosing and preparing their lunch box, they are more likely to eat it. Many healthy snacks and foods can be pre-prepared and frozen.
- 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). A useful resource is the Nutrition Education Materials Online (NEMO) tip sheet on label reading, available at https://www.health.qld.gov.au/_data/assets/pdf_file/0027/145476/diab_labels.pdf
- 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 in between mealtimes; avoid forcing of foods; provide appropriate variety and texture of foods; reward independent eating e.g. star chart.
 - Establish family routines around mealtimes e.g. hand washing before eating, model healthy mealtime behaviours, make healthy choices for the entire family.
 - Limit mealtimes to approx. 30 minutes or when the child is no longer interested.
- 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 plates.
 - Using foods for reward; giving foods as a form of comfort to a child.
 - Types of foods and fluids consumed or cooking methods utilised e.g. deep frying.
- Support parents to promote "body satisfaction" e.g.
 - Parents should discourage their children from "dieting" behaviours.
 - Parents should avoid talking about dieting, calories, weight and appearance, as this may encourage similar behaviours in their children.
 - Discourage appearance-based teasing and avoid endorsing a preference for thinness in front of your child/ren.
 - Promote the importance of a fit and healthy body, rather than a thin or ideal body.
- Promote an increase in physical activity and reduction in sedentary activities
(See *Physical activity* pg. 345)

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.
- 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.
- Avoid food and drinks containing added salt. Do not add salt to foods in cooking or at the table.
- Avoid or limit caffeine/ caffeinated drinks



Raising Children Network

Resources in both video and fact sheets on a variety of topics

<http://raisingchildren.net.au>

Confident Body Confident Child

A guide for healthy eating and helping children grow up feeling good about their body

<https://www.confidentbody.net/>

Growing Good Habits

<https://www.growinggoodhabits.health.qld.gov.au/>

Multicultural Nutrition Resources, Metro South Health

A suite of resources designed in partnership with local communities covering all aspects of feeding and nutrition, including resources on Preparing healthy school lunchboxes

<https://metrosouth.health.qld.gov.au/multicultural-nutrition-resources>

Education Queensland

Smart Choices Ready Reckoner

<https://education.qld.gov.au/student/Documents/smart-choices-ready-reckoner.pdf>

Physical activity 55, 131, 291

- Participating in regular physical activity provides many benefits for physical and mental health at all ages and reduces risk factors for future health e.g. high body weight, high blood pressure and high cholesterol. In 2017/18, 25% of Australian children between 2 and 17 years were overweight or obese.
- 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 weight gain.
 - Improves bone and muscle health.
 - Reduces risk of cardiovascular disease and type 2 diabetes.

- Children and young people should aim for at least 60 minutes of moderate to vigorous physical activity every day. This can be spread out throughout 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.
- Sedentary behaviour is considered as sitting or lying down without sleeping. Children aged 5 – 17 should have no more than 120 minutes of screen use each day and should break up long periods of sitting.
- Only 1 in 10 (12%) children aged 5–12 years meet both the physical activity and sedentary screen-based behaviour guidelines²⁹².

Parenting tips / skills to support child development

- 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 e.g. 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.
- If a parent reports their child is not interested in physical activity:
 - explore barriers and obstacles e.g. screen time, lack of opportunity.
 - assess for other symptoms of hyperglycaemia: weight loss despite usual appetite, excessive thirst, polyuria and any return to enuresis (classic 4T symptoms – Tired, Thin, Thirst, Toilet.) Refer for same day blood glucose finger prick test. See *Type 1 Diabetes* page 419.



National Physical Activity, Sedentary Behaviour, and Sleep Recommendations for Children and Young People (5-17 years)

<https://www1.health.gov.au/internet/main/publishing.nsf/Content/health-pubhlth-strateg-phys-act-guidelines>

Raising Children Network

<http://raisingchildren.net.au>

Nature Play QLD: Getting Our Kids Outdoor

www.natureplayqld.org.au

- Queensland's children have one of the highest rates of dental decay in Australia. In 2017, of 5-14 year old's:
 - 55% experienced decay.
 - 63- 65% experienced decay if they were living in rural and remote areas or in socioeconomically disadvantaged areas.
 - 70% of Indigenous Queensland children experienced decay.
- Dental caries (decay) is one of the most prevalent health issues in Australia across all age groups.
- 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.
- Decay in deciduous teeth is a predictor of decay in permanent teeth. If identified early, preventive measures can be undertaken to prevent the progress of decay.
- Dental caries is highly preventable and is related to both dietary issues and the build-up and retention of plaque 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.
- For young children the most effective method of cleaning the teeth is cleaning by brushing and flossing by the parents.
 - Parents should assist with brushing of teeth until children are about eight years of age.
- Children should brush their teeth for at least 2 minutes in the morning before breakfast and last thing before bed at night, with a soft head toothbrush and toothpaste. (Follow age recommendations on toothpastes e.g. low fluoride up to 6 years).
- Regular flossing at least daily may reduce gum disease and build-up of plaque.
- Children should be encouraged to spit not rinse after brushing.
- 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.
- All children 4 years old until end of Year 10, are eligible for free dental care at public dental clinics located throughout Queensland.
- Use culturally appropriate resources for oral health education where possible:
 - *Looking after Young Mouths* pictorial flipchart is a health education tool aimed to prevent oral disease in Aboriginal and Torres Strait Islander communities.
 - *Building Strong Teeth* is aimed at school children and can be used by teachers.

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 guard is recommended.



Practice tips: Conducting a lift the lip / healthy mouth screen

See page 156



Raising Children Network

<http://raisingchildren.net.au>

Child Health Information Booklet

Queensland Health

<https://www.childrens.health.qld.gov.au/chq/information-for-families/personal-health-record/>

Happy Teeth Program

Queensland Health

https://www.health.qld.gov.au/oralhealth/promo_programs/happy_teeth

Pictorial flipcharts for Aboriginal and Torres Strait Islander parents, families, teachers Queensland Government

- Looking after Young Mouths

https://www.health.qld.gov.au/__data/assets/pdf_file/0021/143094/YoungMouths_updated.pdf

- Building Strong Teeth

https://www.health.qld.gov.au/__data/assets/pdf_file/0036/154899/StrongTeeth_updated.pdf



Refer to the Pathways to Rural and Remote Orientation and Training

<https://ilearncatalogue.health.qld.gov.au/program/17/parrot-primary-care>



Refer to the Chronic Conditions Manual

<https://www.publications.qld.gov.au/dataset/chronic-conditions-manual-2nd-edition-2020>

- Exposure to adverse childhood events may impact on emotional wellbeing, the more events the more likelihood there will be an impact.
- Family stressors (e.g. job loss, parental mental health, domestic violence) and broader environmental stressors (e.g. natural disasters resulting in forced isolation or major changes to routine) are challenging to children and, if not addressed, potentially can develop into long-term emotional mental health issues.
- Middle childhood may be complicated by child behavioural problems, many of these do not meet criteria for clinical diagnoses. Difficulties with managing strong feelings are likely to be reflected in changes in a child's mood, social relationships and learning.
- 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.
- A child's self-image becomes increasingly distinct during this age. Mastery and competency feature strongly in children's self-image.
- Child health professionals use a strengths-based, family partnership approach to build positive behaviours and skills to enhance a child's coping and self-regulation skills and strengthen the parent-child relationship.
- Protective factors that enhance emotional wellbeing include a secure parent-child 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 interacting with their child and provide a safe physical and emotional environment.
 - 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.
 - Talk through the facts of an adverse event in a 'matter of fact' way, while using simple and easy-to-understand language.
 - During times of change, support parents to maintain as much routine and social connection as possible for their children.
 - Role model positive behaviours, e.g. by reflecting on how they express their own emotions, enhance cooperation with others, demonstrate a positive self-concept.
 - Encourage parental self-care to maximise own mental and physical health.

- 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.
 - Instill positive body image messages.
- Encourage a regular bedtime to promote sleep periods of approximately 11 hours per night at 5 years reducing to around 9 hours by 12 years of age.



Emerging Minds

<https://emergingminds.com.au/>

Reachout

<https://au.reachout.com/>

Beyond Blue - Healthy Families

Resources on emotional and mental health for the whole family

<https://healthyfamilies.beyondblue.org.au/>

Circle of Security videos

Circle of Security – Good Enough; Connection; Being with and shark music

<https://www.circleofsecurityinternational.com/resources-for-parents/>



No-Drama Discipline: The Whole-Brain Way to Calm the Chaos and Nurture Your Child's Developing Mind Dr Daniel Siegel and Tina Bryson ²¹⁶

Raising a Secure Child Hoffman, Cooper and Powell ²¹⁷



Australian Family Strengths Nursing Assessment Guide

See Appendix 1

Building Healthy Brains – The Eleven Key Messages

See Appendix 2



Freepik.com

- The prevention of communicable diseases is managed primarily through immunisation.
- 94% of Australian children at 5 years old were fully immunised as of June 2020. This has steadily increased since 2009, and is close to reaching the national target of 95%
- 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 subgroups 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 ²⁹⁶
- Parents, families and carers are able to contact 13HEALTH, where they can receive immunisation advice from a Child Health Nurse or a specialist immunisation nurse over the phone.



SKAI – Sharing Knowledge About Immunisation

National Centre for Immunisation Research and Surveillance

<http://www.ncirs.org.au/health-professionals/>

Immunisation

Australian Government Department of Health

<https://www.health.gov.au/health-topics/immunisation>

Queensland Specialist Immunisation Service

<https://www.childrens.health.qld.gov.au/service-qsis-info-for-health-professionals/>

Immunisation Schedule Queensland

<https://www.health.qld.gov.au/clinical-practice/guidelines-procedures/diseases-infection/immunisation>

The Australian Immunisation Handbook (online)

www.immunise.health.gov.au/internet/immunise/publishing.nsf/Content/Handbook10-home

Translated Immunisation factsheets

<https://www.qld.gov.au/health/conditions/immunisation/translated-fact-sheets>

- 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.
- Good hygiene practices, staying home when unwell and physical distancing are proven ways to slow the spread of diseases.
- Some illness will have a recommended minimum exclusion periods from school, pre-schools and childcare centres.
- The most common chronic conditions that particularly affect children, such as asthma, diabetes, mental illness and food allergies can have a substantial impact on a child's overall quality of life.
- **Asthma** is the most prevalent chronic illness in Australia in children less than 15 years with the incidence remaining steady at around 10% over the past decade (around 460 000 children).
 - While the underlying causes of asthma are still not well understood, a wide range of factors have been identified as triggers for asthma, prompting or exacerbating asthma symptoms.
 - Triggers differ between individuals, and can include viral infections, exposure to specific allergens, irritants, exercise, some chemical or food additives and genetic factors. Tobacco smoke (either exposure in utero or second-hand environmental smoke) is a common irritant that exacerbates asthma symptoms.
- **Type 1 diabetes** is a common childhood auto immune endocrine disorder and 60% of people diagnosed are aged under 25. The highest rate of diagnosis is among children aged 10 to 14 years and the incidence is higher in males than females²⁹⁷. There are about 11,000 school aged children living with type 1 diabetes including more than 1000 school aged children who have been diagnosed in 2019²⁹⁸.
 - In 2020, the *Diabetes in Schools* program was launched nationally to provide free specific training for school staff to meet the needs of children with type 1 diabetes so that they can learn, develop and thrive.
 - Queensland has unacceptable rates of Diabetic Ketoacidosis (DKA) at the diagnosis of type 1 diabetes. In 2017 the average rate in Queensland was 45%¹³⁰ DKA is a life threatening metabolic emergency and is preventable if the signs of hyperglycaemia in prodromal stage of the disease are recognised and treated. See *Type 1 diabetes* page 419
- In 2014, an estimated 314 000 children aged 4–11 experienced a **mental disorder**, with Attention deficit hyperactivity disorder (ADHD) being the most common disorder in boys and anxiety disorders being the most common for girls.
 - Mental health problems in childhood can have a substantial impact on wellbeing. In addition, there is strong evidence that mental disorders in childhood and adolescence predict mental illness in adulthood. Early intervention in childhood presents the greatest opportunity to lessen the long term impact²⁹⁹.
 - The Be You program provides school and educators with resources and strategies for helping school aged children achieve their best possible mental health.
- On average, Australian families living in rural and remote areas have poorer health outcomes – i.e. higher levels of disease and injury and report more barriers to accessing health services³⁰⁰.

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 i.e. 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.
- Have a high index of suspicion for Type 1 diabetes in children exhibiting any of the classic 4T symptoms of hyperglycaemia: Tired, Thin, Thirst, Toilet and should be referred to their GP/MO for review to have a same day finger prick blood glucose check.
- Linking children and parents into early intervention support services can assist with management of emotional and behavioural problems.



Asthma

See page 418

Type 1 Diabetes

See page 419

Mental health and wellbeing : Anxiety, depression

See page 406



Staying healthy: Preventing infectious diseases in early childhood education and care services

Covers a wide range of topics for preventing infectious diseases and fact sheets for many common conditions.

<https://www.nhmrc.gov.au/about-us/publications/staying-healthy-preventing-infectious-diseases-early-childhood-education-and-care-services>

Asthma Australia

Guidelines, training and resources for primary and secondary schools

<https://asthma.org.au/about-asthma/asthma-in-schools/>

Be You

Provides educators with knowledge, resources and strategies for helping children and young people achieve their best possible mental health.

<https://beyou.edu.au>

DiabetesinSchools website
Information and training resources
www.diabetesinschools.com.au

Raising Children Network
Fact sheets: Daily personal hygiene, Health concerns
<http://raisingchildren.net.au/>



Shutterstock.com/noBorders-BraydenHowie

Sun safety and skin cancer prevention 80, 301, 302

- Exposure to ultraviolet radiation (UVR) during outdoor activity and with inadequate sun protection increases a person's risk of developing skin cancer. UV radiation causes 95% of melanomas.
- Queensland's UVR levels can cause skin damage all year round, even on cooler or overcast days.
- Melanoma is the deadliest type of skin cancer with a strong causative link to sunlight exposure. Australia and New Zealand have the highest melanoma incidence rates globally, and melanoma rates in Queensland are 3 times higher than the national average - the highest of all states and territories.
- In Australia in 2019, there was 15 229 new diagnoses of melanoma - close to one every half hour.
- Eye damage and premature ageing are also effects of exposure to UVR.
- Children can get sunburnt in as little as ten minutes, and depending on the severity, it can take a few days or weeks to heal. Signs of severe sunburn include blisters, swollen skin and severe pain and should be seen by a GP.

Recommendations

- The key messages to promote to children and parents include protecting themselves from skin cancer in five ways:
 - **Slip** on a shirt - Wear sun protective clothing that covers as much of their body as possible.
 - **Slop** on broad spectrum SPF 30 or higher sunscreen – Apply liberally to clean, dry skin, at least 20 minutes before being exposed to the sun, and reapply at least every two hours when outdoors. It is suggested to make this part of the morning routine to provide protection against the harmful effects of everyday sun exposure.
 - **Slap** on a broad-brimmed hat - One that shades their face, neck and ears.
 - **Seek** shade - especially during periods when the UVR levels are highest (between 10am – 3pm).
 - **Slide** on some sunglasses – Wear sunglasses that meet Australian standards and wrap around to protect the eyes as much as possible.
- Avoid using sunscreen which has passed its use by date.
- A history of repeated episodes of sunburn and blistering, especially in childhood and adolescence, increases the risk of developing melanoma.
- 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).



Cancer Council

<https://www.cancer.org.au/about-cancer/types-of-cancer/skin-cancer.html>

QUEST

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.

<https://cancerqld.org.au/cancer-prevention/programs-resources/>

Melanoma Institute Australia

Information to support education of young people about skin checks for melanoma.

<https://www.melanoma.org.au/preventing-melanoma/>

The Royal Children's Hospital Melbourne

Resources: Sun protection

www.rch.org.au/kidsinfo/fact_sheets/Safety_Sun_protection/

- Injury is a leading cause of death for children aged 0–14 in Australia and is also a major cause of hospitalisation.
- Injuries in children aged 5 – 14 years occur in a range of settings including schools, sporting environments and their neighbourhoods.
- Hospitalised injury rates are almost twice as high for children in remote areas as for metropolitan areas.
- In Australia, falls are the most common cause of injuries in every age group, and account for close to half of hospitalised injury cases. Additionally, Aboriginal children have a high rate of injuries due to exposure to fire and flame³⁰⁴.
- In 2018-19 in Queensland²²²:
 - The leading causes of death from injuries in children 5–9 years were land transport accidents and accidental drowning.
 - Rivers, creeks and streams continue to be the location with the largest number of drowning deaths, accounting for 29% of all drowning deaths in 2018/19.
 - In children 10 – 14 years, the leading cause of death from injury was suicide. Intentional self-harm was reported more commonly in girls.
 - Injury death rates for children increased with remoteness. In outer regional, remote and very remote areas the rate was 3 times as high as for major cities. The injury death rate for children living in the lowest socioeconomic areas was also higher and differences are also evident between Indigenous and non-Indigenous children⁷⁵.

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. Older children are not always equipped to deal with the responsibility of being the supervisor around water – an adult should always hold this responsibility.
- 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 noodles 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'.
- Develop a home fire escape plan with your family. Practice this plan to ensure all family members know what to do and where to go. Teach children to "Stop, Drop, Cover and Roll" if their clothes catch fire and "Get down Low and Go" in case of a house fire.
- Parents are also advised to learn first aid for burns ensure their home has smoke detectors.
- Actively supervise children in playgrounds and on play equipment.
- Advise parents of Queensland Poisons Information Centre, Tel: 13 11 26 – which provides support and advice, seven days a week, 24 hours a day.

- Develop a safety routine before starting motor vehicles, e.g.
 - Child in an appropriate restraint, seat belt fastened.
 - When moving vehicles, know where children are, walk around car to check before driving.
 - Never leave children unattended in cars.
 - Never leave motors of any kind switched on and unsupervised when children are around.
 - Keep children well away from tractors and farm machinery when unsupervised.
- Encourage parents to seek advice on correct use of medications e.g. paracetamol, herbal preparations.
- 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.



Kidsafe Queensland

Fact sheets: Childhood drowning, Farm-related injury, Child care safety and Home safety checklist.

www.kidsafeqld.com.au

Raising Children Network

<http://raisingchildren.net.au>

CPR videos

How to perform CPR on adults, children and infants

<https://www.healthdirect.gov.au/how-to-perform-cpr>



Freepik.com

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

- The Primary Health Care (PHC) model promotes positive health outcomes for children, young people and their families through the delivery of accessible, acceptable, responsive and culturally respectful primary health care 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 into the service e.g. schools, community centres ¹.
- Depending on the local model of care, this may include:
 - Appointments for short term individual structured intervention.
 - Group programs.
 - 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.
- When screening identifies additional 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.
- The child health professional uses a strength based, partnership approach to build on parent capacities and skills, focusing on ^{1, 101}:
 - 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.

Social determinants of health and wellbeing

There are many biological, psychological and social factors that may influence a person's ability to parent. The environment in which a child lives and grows can have a profound lifelong impact on the trajectory and outcomes of their health, well-being and development⁸. The National Action Plan for the Health of Children and Young People: 2020-2030 ⁷⁴ was developed to ensure that all Australian children and young people have the same opportunities to fulfil their potential, and are healthy, safe and thriving.

For more information and supporting literature for these influencing factors, see [Family Health Assessment Guide](#).

- Population groups where additional needs may be identified include ^{1, 38, 75, 76}:
 - Socioeconomically disadvantaged children and families.
 - Single parents, parents with multiple re-partnering experiences, stepfamilies and blended families, young parents.
 - 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 experiencing substance use issues: smoking, alcohol and other substance misuse.
 - Families with chronic illnesses and / or disability.
 - Isolated families e.g. living in remote areas.
 - Aboriginal and Torres Strait Islander families.
 - Refugee Families.
 - Families from a culturally and linguistically diverse (CALD) background.
- When multiple risk factors are present, there is a higher risk of child abuse and neglect²⁴⁸.
- Children from families with low income, unstable housing and/or low level of education are known to have poorer health outcomes. For example:
 - Poverty is an established risk factor for behaviour problems across development²⁵⁰.
 - Developmental vulnerability across 1 or more of the AEDC domains (a predictor for school readiness and achievement), was twice as high for children living in the lowest socioeconomic areas as those in the highest socioeconomic areas⁷⁵.
 - Children have twice the number of decayed teeth by the time they are six years old, compared to families with higher incomes⁷⁵.
 - The impact of housing on health is multidimensional. Factors which impact negatively on family and child health and wellbeing include poor quality housing, overcrowding, lack of space for recreation and privacy, an unsafe physical environment within the home and/or neighbourhood, lack of access to services and amenities, homelessness⁷⁵.
 - Growth retardation and obesity are risks when nutritional requirements are not met and illness more common. The risk for diabetic ketoacidosis at diagnosis of type 1 diabetes, is higher in children whose parents report an education level lower than 9 years²⁴⁷.
 - Children living in low socioeconomic areas were 12 times as likely to be living in an overcrowded situation. Overcrowding has been associated with increased risk of emotional and behavioural problems and reduced school performance, likely due to disrupted sleep, lack of space to study and the impact of noise levels on concentration⁷⁵. Overcrowding can also impact children's physical health, with asthma frequently reported by families experiencing overcrowding and also results in higher incidence of communicable illnesses⁷⁵. Vaccination schedules may not be maintained due to lack of access/transportation.
- The prevalence of family structures other than two biological parents and only their mutual children, has risen dramatically and includes single parenthood, multi-partnered (a parent having children to more than one partner), stepfamilies, blended families and families with same sex parents²⁵².
 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. For example^{38, 252}:
 - Single parent families can face substantial difficulties with income, housing, and employment.
 - Non-nuclear families with stepparents or defacto partners are over-represented in child safety statistics.

- Multiple re-partnering can place children at risk of abuse, especially if a number of partners enter the home.
- Children of same-sex parent families are prone to discrimination and stigma related to parental sexual orientation which may result in negative impacts on the child's mental and emotional wellbeing²⁵¹.
- Young maternal age on its own is not a risk factor for poorer child outcomes, however young mothers are more likely to have cumulative risk e.g. financial stress, lower educational level, higher levels of perinatal depression and an increased risk of performing unresponsive parenting practices and having repeat pregnancies⁷⁵. 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.
- The majority of children in Australia live with at least one of their biological parents, but as at 30 June 2019, approximately 44,900 children were in out-of-home care. Of those living in non-parental care, 52% are placed with relatives and kin²⁴³.
 - 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, poor social relationships with parents and peers, lower education attainment ⁷⁵.
 - May have experienced abuse or neglect, trauma from the loss of a parent, or relationship conflict and breakdown ⁷⁵.
- About 1 in 6 children live with a parent with a disability⁷⁵. 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 backgrounds²⁵⁹.
 - Limited or impaired capacity of parents to meet their child's emotional, developmental or physical needs places the child potentially at risk of physical illness, psychological issues, developmental delay and/or behavioural problems. Some children may be emotionally compromised if they need to adopt the carer role to the parent⁷⁵.
- Parental mental health and wellbeing in the child's early years of life is known to have a significant impact on their health as well as the overall health of the family unit ^{17, 91}.
 - 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 ⁹⁹.
 - Untreated mental illness may impact on a parent's availability to their child as well as their consistency in parenting behaviours that support child-parental attachment. Children with parents suffering from untreated mental illness are more likely to have an altered attachment, socio-emotional and behavioural problems⁴⁵.
- 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^{45, 252}.
- Three per cent of Australian children aged 0-14yrs live in remote and very remote areas⁷⁵
 - Children living in remote areas have 1.5 times higher incidence of decayed teeth as those in metropolitan areas²⁰⁷.

- 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 areas⁴³¹.
- Regional areas have the highest numbers transport-related deaths in children, with males numbering more than twice the number of females⁷⁵.
- Social isolation and loneliness can impact on parental mental health and wellbeing²⁶⁰.
- In 2017, mortality rates for children were more than double in remote areas compared to metropolitan areas⁷⁵.



Further information on these topics can be found in
Section 2 - 'Early identification' pg. 260 and 'Responding to need' pg. 288



Raising Children Network

Video and fact sheets on a variety of topics

<http://raisingchildren.net.au>

Parenting Research Centre

Healthy Start

<https://www.parentingrc.org.au/programs/healthy-start/>

Queensland Government Disability website

Resources for health professionals supporting parents who have learning difficulties

<https://www.qld.gov.au/disability>

ReachOut.com

Resources and information about mental fitness.

<http://au.reachout.com/>



e -Learning - Diabetic Ketoacidosis

Primary prevention and early identification of hyperglycaemia in children to reduce the rate of DKA at diagnosis

<https://ilearncatalogue.health.qld.gov.au/course/1581/preventing-dka-at-diagnosis-of-type-1-diabetes-mellitus-in-children-under-16>



Family Health Assessment – A guide for child health clinicians practicing within the primary health care setting

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



Practice tips: Conducting a developmental assessment^{1, 92, 93, 102, 143}

- Welcoming diversity of family forms as a strength will reduce discrimination and enhance community cohesion.
- A comprehensive health assessment will provide a foundation for engaging children and their families and providing ongoing services^{6, 38}. 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 example¹:
 - universal service provision with brief structured interventions and/or
 - referral to additional support services within or external to the service
- 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, 101}
- Social support for parents has been shown to improve emotional wellbeing for the family with additional needs, therefore linking parents into suitable networks is important²⁴⁵.
- Coordinate referrals for any identified concerns e.g. EIC/EIPC for behavioural issues.
- Promote parental wellbeing by offering psychosocial support strategies including:
 - promoting peer support, e.g. attend parent groups / supported playgroups, support from family / friends
 - psycho-education specific to promoting self-care e.g. lifestyle activities, sleep and exercise
- Additional factors are to be considered when working with families with specific cultural needs. These are outlined in Section 2 : Birth to 5 years



Aboriginal and Torres Strait Islander families

See page 262

Children from culturally and linguistically diverse (CALD) or refugee backgrounds

See page 270

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 need²⁶³. 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 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 and family 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 (ambulance, police, acute mental health services, Royal Flying Doctors Service etc.).

Ongoing care planning will continue during intervention by the specialty services and in consultation with other primary care providers such as the GP.



Refer to Primary Clinical Care Manual

<https://www.health.qld.gov.au/rscsu/html/PCCM>

Care Coordination

To manage and coordinate service provision for families with identified needs where a number of health care providers are involved, a care coordinator 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 and improving outcomes for vulnerable children ²⁶⁴.

Key elements of care coordination include:

- family partnership
- comprehensive and ongoing family assessment
- holistic, family focused, keeping the child at the center
- working from a strengths base supports parental capacity building
- reflective practice
- multidisciplinary coordination, planning and collaboration
- working with and utilising community resources (it is important for the care coordinator to be aware of local services available to meet additional needs of families outside of child health professional's scope)
- 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' ²⁶³. 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.

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 ²⁶³.

- ideally a care plan will be developed in partnership with the family across the continuum of care
- good communication is integral to all these processes

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 32, 56, 102, 123, 127		Introduction
<ul style="list-style-type: none">Weight faltering describes a pattern of growth rather than a diagnosis and may include normal variations of growth. Faltering (slow) growth is observed when weight (and subsequently length) plateau or drop centiles.Referral for further investigation will be required if:<ul style="list-style-type: none">any sudden or unexplained weight loss, weight plateau or weight not re-gained following acute illnesswhere the weight has dropped percentiles, indicating poor growthMalnutrition 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 (for example type 1 diabetes) or excessive caloric expenditure.Prolonged, severe malnutrition can result in poor physical and cognitive development.		Section 1: Antenatal
Clinical practice points <ul style="list-style-type: none">Conduct a comprehensive family health assessment to identify specific needs of the individual child/ family, this should include:<ul style="list-style-type: none">food intake, what and how much, how oftenany of the classic four symptoms of hyperglycaemia: polyuria, polydipsia, lethargy, weight loss (the 4Ts – Tired, Thin, Thirst, Toilet).cultural and social context of mealtimesimpact of family budget on food availabilityimpact of rural environment on food choicessleep patterns (poor sleep can disturb metabolic processes and disrupt appetite control)activity assessment e.g. mealtime environment, play activitiesparental- child interaction particularly during mealtimesDiscussions with parents about child feeding and growth always requires a sensitive approach:<ul style="list-style-type: none">Show and explain the centile lines on the growth charts.Demonstrate how their child is progressing, discuss the trend in child's weight compared with previous measurements and explain the need for intervention.Ask the parent / carer can they think of anything which may have contributed to the change.Talk about the importance of nutrition and promote healthy eating habits based on the Australian Dietary Guidelines. Healthy eating refers to eating a balance and variety of foods, including nutritious ('everyday') foods and some high energy or low nutrient ('sometimes') foods.Educate parents to regard mealtimes as a period of learning and love.		Section 2: Birth to five years
		Section 3: Five to twelve years
		Section 4: 12 to 18 years
		Appendix & References

- 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.
 - Promote child's interest in food e.g. provide food predictably when child is hungry, cease mealtime 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 mealtime 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, especially in this age group, as this may cause high parental anxiety. Usually the GP / Paediatrician / Dietitian will suggest a recommended plan for reweighing.

Higher level services

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 as appropriate.

Referral options

- GP
- Specialist clinics/services e.g. speech pathologist, feeding clinic, early parenting service
- Dietitian
- EIC / EIPC



Child growth e -Learning

Royal Children's Hospital

https://www.rch.org.au/childgrowth/Child_growth_e-learning/



Raising Children Network

<http://raisingchildren.net.au>

Eat for Health – Australian Dietary Guidelines

www.eatforhealth.gov.au



Refer to the Pathways to Rural and Remote Orientation and Training

<https://ilearncatalogue.health.qld.gov.au/program/17/parrot-primary-care>



Refer to the Chronic Conditions Manual

<https://www.publications.qld.gov.au/dataset/chronic-conditions-manual-2nd-edition-2020>

- More than one in four Queensland children are overweight or obese. The effects of which can have significant negative impact on children's physical and psycho-social health and wellbeing.
- Overweight is classified as a BMI above the 85th percentile and obesity is classified as a BMI over 97th percentile on the CDC or WHO growth charts. Child health professionals should refer for further investigation if the BMI is increasing on percentiles (excessive growth) or is above the 85th percentile.
- Childhood obesity is now considered a chronic disease and increases the risk of developing life-threatening conditions 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.
- Obesity occurs because of an imbalance between energy intake from the diet and energy expenditure. The causes of this imbalance 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 an elevated BMI in infancy and childhood is associated with obesity in adulthood. Effective weight management in childhood and adolescence will minimise the risk of overweight or obesity persisting into adulthood.
- Exclusive breastfeeding for the first 6 months is known to reduce the risk of obesity.
- Children are more at risk of becoming obese if their family is:
 - experiencing socio-economic disadvantage
 - living in rural and regional areas
- Aboriginal and Torres Strait Islander children face health disparities in terms of obesity and type 2 diabetes when compared with non-Indigenous children¹³¹
 - In 2018–19, according to data from the National Aboriginal and Torres Strait Islander Health Survey, 38% of Aboriginal and Torres Strait Islander children and adolescents aged 2–17 were overweight or obese. This is an increase of 7% in the previous five years.
 - The prevalence of overweight and obesity was significantly higher across all age groups. The biggest disparity being the 10-14 age group, at almost twice as high for Aboriginal and Torres Strait Islander children and adolescents.
 - The largest increase was in the 5-9-year age group (11% increase in the previous five years).

- **Health and Wellbeing Queensland** have developed the [Clinicians Hub](#) – a central hub that houses a variety of clinical tools, resources and training to support clinicians to identify, prevent and manage childhood obesity, including:
 - The [Clinical Toolkit](#), which has links to many resources from antenatal through breastfeeding, first foods, early identification and intervention for childhood obesity.
 - Education and Training resources including
 - › Weight4KIDS – online learning program
 - › Project ECHO education
 - › Brief interventions for a healthy lifestyle and Motivational interviewing techniques
 - Referral Pathway: a quick reference clinical decision making tool, that supports primary health care providers to monitor and assess child growth, refer patients to appropriate services, and deliver interventions.

Clinical practice points

- Prevention, health promotion and early intervention are key to reducing childhood obesity. Child health professionals should identify overweight and obesity, explore and promote healthy lifestyle choices with the family and refer to GP or other early intervention programs.
- 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 mealtimes 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).
 - Child activity assessment e.g. play time activities, mealtime environment, screen time.
 - Parent- child interaction particularly during mealtimes.
 - The family readiness and ability to make and sustain behavioural changes.
- Discussions with parents about child feeding and growth always requires a sensitive approach:
 - Demonstrate how their child is progressing on the percentile charts and explain high rates of obesity in the Australian population. Explain that obesity weight range increases the risk of associated lifestyle disease later in life (e.g. hypertension and other cardiovascular diseases, type 2 diabetes, orthopedic complications as well as emotional/mental health risks).
 - Talk about the importance of nutrition and promote healthy eating habits based on the Australian Dietary Guidelines.
 - Describe the concept of ‘often’ foods and ‘sometimes’ foods and encourage parents to teach children about groups of foods that are healthy.
 - 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 or flavoured milk.
 - Promote an increase in physical activity and reduction in sedentary activities including reduced screen time.

- 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 of foods.
- Establish family routines around mealtimes e.g. hand washing before eating, modelling healthy mealtime behaviours, making healthy choices for the entire family.
- Provide three meals and two snacks each day. Have set mealtimes and avoid food craving.
- Parents are advised to role model healthy eating behaviours, using the Australian Guide to Healthy Eating²¹³ to consume and provide a balanced variety and amount of nutritious foods and drinks.
- 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 plates.
 - Types of foods and fluids consumed.
 - Cooking methods utilised e.g. deep frying.
- Support parents to promote "body satisfaction". Early weight management awareness gives children the opportunity to learn positive lifestyle behaviours.
 - Parents should discourage their children from "dieting" behaviours, rather encourage healthy food choices.
 - Discourage appearance-based teasing.
 - Promote the importance of a fit and healthy body.
- Provide ongoing support and review of progress through follow up visits

Higher level services

Management strategies may include:

- Have a multidisciplinary team approach with the involvement of health professionals with varied specialties. The management strategy should include:
 - Monitoring of growth and nutritional status.
 - Behavioural change strategies e.g. healthy food choices, mealtimes.
 - Active parental involvement.
 - Lifestyle interventions (e.g. nutrition, physical activity, sedentary behaviour).
 - 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.
- Encourage engagement with local targeted groups or weight management clinics.

Referral

- Referral for further investigation will be required if:
 - The weight has increased percentiles, indicating excessive growth.
 - BMI increasing percentiles on the growth chart, or a BMI greater than the 85th percentile.
- Referral options
 - GP
 - Specialist clinics/services e.g. weight management clinics, local health promotion programs, group programs
 - Dietitian
 - EIC / EIPC



Eat for Health – Australian Dietary Guidelines

www.eatforhealth.gov.au

Australian 24-Hour Movement Guidelines for the Early Years

Australian Government

<https://www1.health.gov.au/internet/main/publishing.nsf/Content/health-pubhlth-strateg-phys-act-guidelines>

Growing Good Habits

<https://www.growinggoodhabits.health.qld.gov.au/>

Framework - An integrated approach for tackling childhood overweight and obesity in Queensland

Queensland Child and Youth Clinical Network

<https://www.growinggoodhabits.health.qld.gov.au/health-professionals/clinical-resources-and-tools/>

Australian Institute of Health and Welfare

Overweight and obesity: an interactive insight

<https://www.aihw.gov.au/reports-data/behaviours-risk-factors/overweight-obesity/overview>

Confident Body Confident child

<https://www.confidentbody.net/about.html>



Refer to the Chronic Conditions Manual

<https://www.publications.qld.gov.au/dataset/chronic-conditions-manual-2nd-edition-2020>

- 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.
- 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 image-based abuse.
- In 2016, 7 in 10 children aged 12–13 experienced at least 1 bullying-like behaviour within a year and 1 in 5 Year 4 students experience bullying on a weekly basis⁷⁵.
- 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.
- It is important to note that a high proportion of cyberbullying victims are also cyberbullies, with almost half (46%) of children aged 12–13 who experienced at least 1 bullying-like behaviours within a year also used bullying-like behaviours against another child.
- There are further threats to young people's safety online 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. 1 in 4 children aged 8–12 who completed the eSafety Commissioner's Youth Digital Participation Survey³¹² had experienced unwanted contact and content while online.
- 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.

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. 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.
- Encourage regular conversations around school life and difficulties such as bullying.
- Encourage children 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.
- Parents should always tell their child that 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.



eSafety Commissioner

Commonwealth Government site with a variety of resources on cybersafety for parents, children, schools

<https://www.esafety.gov.au/key-issues>

Student Wellbeing Hub

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.

<https://studentwellbeinghub.edu.au/>

Bullying: No Way!

Includes a range of resources and research for students, parents and teachers.

<https://bullyingnoway.gov.au>

ThinkUKnow

An internet safety program – includes interactive training for parents, carers and teachers

<http://www.thinkuknow.org.au/>

Reachout

Useful information about cyberbullying for young people

<http://au.reachout.com/cyberbullying>



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Disruptive behaviour / aggression / regulatory disorders ^{32, 55}

- 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 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.
- Often these issues are associated with poor feeding, sleeping behaviours, parenting or family factors.

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.
- Parental psychoeducation, 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, Raising Children's Network.
 - 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.

Introduction

Section 1:
Antenatal

Section 2:
Birth to five years

Section 3:
Five to twelve years

Section 4:
12 to 18 years

Appendix & References

- 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.
 - Spending quality time with children, descriptive praise, talking with children, having interesting activities, giving attention and tuning in to the child, giving children the opportunity to take the lead, support their exploration, support their emotions.
- Encourage parents to enroll in a group parenting program e.g. Triple P.
- Provide ongoing support and review of progress through follow-up visits.

Higher level services

Management strategies may include:

- Targeted parenting groups e.g. Triple P Parenting Program.
- EIC / EIPC.
- Consider risk of impaired parenting.
- Referral to GP if they are displaying any of the four classic symptoms of hyperglycaemia – Lethargy, weight loss, polydipsia and polyuria (the 4T's Tired, Thin, Thirst, Toilet). A same day blood glucose fingerpick test is needed to prevent the possibility of diabetic ketoacidosis.

Referral

- Refer to GP/MO to rule out underlying medical condition.
- Child and Youth Mental Health Service.
- Family and Child Connect.



Raising Children Network

<https://raisingchildren.net.au/preschoolers/behaviour>

Family and Child Connect

<http://familychildconnect.org.au/>

Nature Play QLD: Getting Our Kids Outdoors

www.natureplayqld.org.au/about



The Red Flags School-aged Guide

Queensland Health

<https://qheps.health.qld.gov.au/ccyfh/html/resources>

Child Protection

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^{2, 274}. Child Health practice is based on purposefully engaging in effective therapeutic relationships with parents and carers. The child health professional undertakes assessments of children including the physical and psychological assessments to identify strengths, risks and vulnerabilities²⁷⁵.

- While most children in Australia are healthy, happy and safe there are still many children who experience disadvantage, abuse and neglect. During 2018-19, over 170 000 Australian children received child protection services (investigation, care and protection order and/or were in out-of-home care), which represents an increase of approximately 25% over the previous five years²⁴³.
- Medical professionals (doctors/nurses) have both mandatory and nonmandatory obligations under the Child Protection Act 1999 to report a reasonable/reportable suspicion of child abuse and neglect⁸⁶.
 - Under s13E of the Child Protection Act 1999, they are mandated to report where there is reasonable suspicion that a child has suffered, is suffering, or is at unacceptable risk of suffering, significant harm caused by physical or sexual abuse and may not have a parent able and willing to protect the child from the harm.
 - Medical professionals have a duty of care to report other types of harm (emotional, neglect).
- Other health professionals (social workers/psychologists/advanced health workers) have a duty of care to inform Department of Child Safety, Youth and Women (CSYW) in accordance with s13A of the Child Protection Act 1999 where the staff member reasonably suspects a child may be in need of protection⁸⁶.
- Harm to a child is defined in the Child Protection Act 1999 (section 9) as *any detrimental effect of a significant nature on the child's physical, psychological or emotional wellbeing*²³³.
- 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.



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The following are some factors that may increase the risk of child abuse or neglect²⁷⁷:

Developmental considerations	
<ul style="list-style-type: none"> with increasing age – more likely to intervene in domestic and family violence, or may be threat to self, siblings, property provocation of child may lead to exhibition of violence significant relationship issues between parent and child, or child, family and peers 	
Child factors	Family Characteristics
<ul style="list-style-type: none"> exposure to multiple forms of child abuse and neglect including non-familial and familial exposure to family violence exposure to community violence repeat accidents, injury, poisoning children with a disability disordered attachment difficult temperament, hyperactivity or disruptive behaviour, inadequate behaviour management 	<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 parental substance abuse poor parent-child interaction disordered attachment marital conflict associated with instability/ domestic and family violence children in care Parental criminality

- 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 ^{32, 89}.

See *Child Protection* pg. 311 in Section 2 (Birth – 5 years) for an example of a *Risk and Protective Framework* pg. 317

- Information sharing:** Informing a reasonable suspicion of child abuse and neglect, health professionals can 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 Child Safety Youth and Women)²⁸⁰.

See the *Information sharing in child protection - Key Messages*, which summarizes the purpose for information sharing, consent, documentation and includes links to the key overarching guideline documents.

- As part of the child protection reform program, community-based intake and referral services provide an additional pathway for referring concerns about children and their families²⁸¹
 - If concerns do not reach the threshold for a report to Child Safety, but the family would benefit from a support service, consider referral with consent to:
 - Family and Child Connect
 - An Intensive Family Support service
 - Other support service specific to family need



- **When a child health professional forms a reasonable suspicion of harm, they must immediately report their concerns directly to Child Safety Regional Intake Service using a 'Report of suspected child in need of protection' form**
- **When a child health professional suspects a child has been physically harmed, follow local policy and guidelines to:**
 - **facilitate immediate access for acute medical assessment of the child**
 - **make a report to Child Safety Regional Intake Service if the harm is significant and there is no parent able and willing to protect the child.**
 - **notify their supervisor/s.**
 - **forward a copy of the report to your local CPLO / CPA.**

Child Protection Resources

- The **Child Safety QHEPS site** provides all Queensland Health staff with information on individuals' responsibilities regarding child protection, how to recognise child abuse and neglect and how to report reasonable suspicions of child abuse and neglect. Education modules, online support tools, factsheets and support services can be found on the site. <https://qheps.health.qld.gov.au/csu>
- The **Child Protection Guide** provides guidance and support in decision making for staff who have concerns for the safety and /or wellbeing of a child/young person. The guide is intended to complement, not replace, clinical judgement, expertise or critical thinking. <https://www.csyw.qld.gov.au/about-us/partners/child-family/our-government-partners/queensland-child-protection-guide>
- The **Reporting and Referring Child Protection Concerns flowchart** is a useful tool to inform of the process regarding reporting and referring child protection concerns. https://qheps.health.qld.gov.au/__data/assets/pdf_file/0019/408430/qhreportreferflowchart_facc.pdf
- **Child Protection Guidelines** <https://qheps.health.qld.gov.au/csu/policy>
 - Reporting and responding to a reasonable suspicion of child abuse and neglect.
 - Health professionals child protection capability requirements.
 - Prioritisation of health services for children and young people in the child protection system.
- The Child Protection **Reporting Tips** and **Reporting forms**, support staff to understand the reporting processes for health professionals. <https://qheps.health.qld.gov.au/csu/reportingforms>
- **Child Protection Liaison Officers** (CPLO) and **Child Protection Advisors** (CPA) provide support to local HHS staff when managing child protection issues. Contact lists can be found on the [Child Safety QHEPS site](#).
- The **Information sharing in child protection - Key Messages** summarizes the purpose for information sharing, consent, documentation etc. https://qheps.health.qld.gov.au/__data/assets/pdf_file/0026/2239361/ISCP_keymessagesfactsheet.pdf
- There are multiple **factsheets** available on the Child Safety QHEPS page. Some examples include:
 - Presenting characteristics of child abuse and neglect.
 - Clinical risk factors and indicators (for Physical abuse; Emotional abuse; Sexual abuse and Neglect).

- Clinical risk factors and indicators for harm in children (0-2 years; 3-5 years; 6-13 years; 14-18 years).
- Risk versus protective factor assessment framework.
- Female genital mutilation.
- Documentation in child protection.
- High risk population groups.
- The Queensland Family and Child Commission has produced an **Information Kit on Child Protection for Professionals**, which provides key facts about the Queensland child protection system for anyone who works with children or families. <https://www.qfcc.qld.gov.au/>



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.



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Section 4:
**12 to 18
years**

4

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^{249, 313}. 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 Islander Advanced Health Workers.

Developmental surveillance and health monitoring

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 services.

SBYHN service provision is guided by a Memorandum of Agreement and Service Management guidelines negotiated between individual Hospital and Health Services (HHS) and the corresponding Department of Education regional office.

SBYHNs also practice in accordance with relevant professional body guidelines, such as the Standards of Practice for Children and Young Peoples Nurses² and the National School Nursing Standards for Practice: Registered Nurse³.

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 Agreement and Service Management guidelines or HHS policies/procedures.

- They constitute a general guide only and are subject to the professional judgement of the SBYHN and Aboriginal and Torres Strait Islander Advanced 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 Services¹ 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.



Australian Government

National Framework for Universal Child and Family Health Services

<https://www1.health.gov.au/internet/main/publishing.nsf/Content/nat-fram-ucfhs>

Australian College of Children and Young Peoples ACCYPN

Standards of Practice for Children and Young People's Nurses

<https://www.accypn.org.au/knowledge-centre/standards-of-practice/>

Australian Nursing & Midwifery Federation

National School Nursing Standards for Practice: Registered Nurse

<http://anmf.org.au/pages/school-nursing-standards>

Health and developmental surveillance

- The National Action Plan for the Health of Children and Young People: 2020-2030⁷⁴ was developed to ensure that Australian children and young people, from all backgrounds and all walks of life, have the same opportunities to fulfil their potential, and are healthy, safe and thriving.

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^{80, 249, 314}.
- 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 outcomes³¹⁴⁻³¹⁶.
- 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^{80, 249, 316}.
- The leading causes of injury and death for young people are transport incidents, intentional self-harm, assaults and suicide^{225, 317}.
 - Males are more likely to succumb to injury from 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 suicide and are 14 times more likely to suffer injury as a result of assault than non-Indigenous young people. The injury assault rate for Aboriginal and Torres Strait Islander females was over 29 times the rate for non-Indigenous females.
- Common health concerns for young people are^{80, 297, 317}
 - 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.
 - Oral health problems such as untreated decay.
 - Type 1 Diabetes.
- 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,^{80, 132, 318}:
 - 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 basis; and

- Although the rate of diagnosis of chlamydia for Aboriginal and Torres Strait Islander young people fell by 20%, it is still 3 times that of the non-Indigenous notification rate.
- 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^{32, 75}.

Service access barriers

- A range of barriers influence young people's access to health services³¹⁹⁻³²³:
 - limited knowledge of services available
 - 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)
 - issues relating to gender, age and culture
 - remote living
- 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 community³²¹.



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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 SBYHNs³²¹:
 - 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.
- 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).
 - 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 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 the *Immunisation* section on page 425, which addresses health promotion strategies in the school setting.
- Department of Education 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 Department of Education 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.). Department of Education is responsible for sourcing this training via other avenues.

Rapport building with young people in the school setting

Engagement with a young person is critical to being able to undertake a meaningful assessment³²⁴. To build engagement, the SBYHN builds trusting therapeutic relationships, addresses confidentiality issues and concerns and involves caregivers if possible. To build rapport, it is essential the young person feel respected, understood and perceive that their clinician is trustworthy³²⁴.

Establishing consent ³²⁵

- 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.
- 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
- 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)³²⁶. Under the Code of Conduct, nurses also have ethical and legal obligations to protect the privacy of young people⁴.
- There will at times be exceptions where disclosure is permitted under the HHB Act. 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.
- In particular, young people should be made aware of Child Safety legislation and Queensland Health Guidelines which mandate reporting of concerns regarding sexual activity causing significant harm i.e non-consensual; occurs between family members; pornographic; significant age gap or power imbalance³²⁷.
- 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-judgmental 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 ³²⁸.
- Further enablers to building rapport with young people include³²⁸:
 - 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

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 include³²³:
 - 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-judgmental environment for boys to express angry feelings and helping them to recognise the emotions and situations that may have precipitated these feelings.

Rapport building with LGBTIQ+ young people ³²⁹

- It is important to provide affirmative and inclusive health care for LGBTIQ+ people by communicating with knowledge and understanding about the health concerns, barriers to care and other common needs.
- Some young people may have experienced trauma through marginalisation or prejudice and may be hesitant to engage with health care. Many have high levels of stress caused from discrimination which may lead to unhealthy coping behaviors and mental health difficulties. Sensitive, respectful communication is required when interacting with this vulnerable group. For example:
 - When addressing new clients, avoid pronouns or gender terms
 - Politely and privately ask if you are unsure about their preferred name or pronouns
 - Use the terms they use to describe themselves
 - Only ask for information that is required
 - Apologise with sincerity if you make a mistake.

Work effectively within the cultural context

- In Australia many young people are not only experiencing the challenge of adolescence, but of growing up between two cultures.
 - 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-judgmental 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.

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 ^{319, 320} and SBYHNs should be mindful of specific cultural norms when attempting to build rapport and facilitate their engagement. Suggested strategies include ^{241, 330}:
 - It is vital that a 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 issues³³⁰.



Aboriginal and Torres Strait Islander families

See page 262



Aboriginal and Torres Strait Islander Health Branch

Information and resources for health professionals

<https://www.health.qld.gov.au/public-health/groups/atsihealth/resources-for-health-professionals>

National Aboriginal Community Controlled Health Organisation (NACCHO)

<https://www.naccho.org.au/>

Yarning about mental health: an easy guide to mental health assessment

HealthInfoNet Flipchart

<https://healthinonet.ecu.edu.au/key-resources/resources/?id=19702>

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.

HEEADSSS assessment

- The HEEADSSS adolescent psychosocial assessment is a widely applied framework consisting of a series of open-ended questions, is 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 HEEADSSS 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 factors³³¹.
- HEEADSSS is an acronym which guides assessment of relevant domains, including³³¹:

- Home
 - Education/employment
 - Eating and Exercise
 - Activities
 - Drugs (Smoking, Alcohol and other)
 - Sexuality and Relationships
 - Suicide / Low Mood
 - Safety
 - Other
- 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 HEEADSSS 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 HEEADSSS 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 HEEADSSS assessment is conducted during an initial consultation, and it may be necessary to undertake this over subsequent visit/s.

Risk and protective factors



Genogram and a HEEADSSS assessment tool.
See Appendix 11 & 12



SBYH Professional Development Course
Role of the School Based Youth Health Nurse
Learning modules available on iLearn for all SBYH nurses to complete.
Contact line manager or Nurse Manager Statewide SBYH, for enrollment details



Freepik.com

- 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 skills²³⁶.
- 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 HEEADSSS 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.



Young Person Mental Health Assessment example
See Appendix 13

Recognition of child abuse and neglect

The role of youth health professionals encompasses a range of broad multifaceted practice strategies from health education and promotion, early intervention for health issues through to complex assessment of the safety of a young person ^{2, 274}. Youth health practice is based on purposefully engaging in effective therapeutic relationships with the young person and undertake assessments that identify strengths, risks and vulnerabilities²⁷⁵.

- 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.
- Medical professionals (doctors/nurses) have both mandatory and nonmandatory obligations under the Child Protection Act 1999 to report a reasonable/reportable suspicion of child abuse and neglect ⁸⁶.
 - Under s13E of the Child Protection Act 1999, they are mandated to report where there is reasonable suspicion that a child has suffered, is suffering, or is at unacceptable risk of suffering, significant harm caused by physical or sexual abuse and may not have a parent able and willing to protect the child from the harm.
 - Medical professionals have a duty of care to report other types of harm (emotional, neglect).
- 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.
Harm to a child is defined in the Child Protection Act 1999 (section 9) as *any detrimental effect of a significant nature on the child's physical, psychological or emotional wellbeing*²³³.
- **Information sharing:** Informing a reasonable suspicion of child abuse and neglect, health professionals can 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 Child Safety Youth and Women)²⁸⁰.

See the [Information sharing in child protection - Key Messages](#), which summarizes the purpose for information sharing, consent, documentation and includes links to the key overarching guideline documents.

- The SBYHN needs to consider relevant child safety legislation and mandatory reporting requirements in regard to assessing whether there are any concerns regarding sexual activity causing significant harm in a young person. The SBYHN considers whether the young person ³²⁷:
 - is not capable of understanding the implications
 - is at risk due to the nature of the sexual encounter:
 - › is non-consensual;
 - › occurs between family members;
 - › there is a significant age gap (five years or more) between the young person and alleged offender;
 - › suggests an inappropriate power differential;
 - › involves coercion to engage in any unlawful sexual activity, including prostitution; and/or
 - › exposes them to, or uses them in, pornographic performances or material.
- As part of the child protection reform program, community-based intake and referral services provide an additional pathway for referring concerns about children and their families²⁸¹
 - If concerns do not reach the threshold for a report to Child Safety, but the family would benefit from a support service, consider referral with consent to:
 - › Family and Child Connect
 - › An Intensive Family Support service
 - › Other support service specific to family need



When a child health professional forms a reasonable suspicion of harm, they should immediately report their concerns directly to Child Safety Regional Intake Service using a 'Report of suspected child in need of protection' form

When a youth health professional suspects a child has been physically harmed, follow local policy and guidelines to:

- **facilitate immediate access for acute medical assessment of the young person**
- **make a report to Child Safety Regional Intake Service if the harm is significant and there is no parent able and willing to protect the child.**
- **notify their supervisor/s**
- **forward a copy of the report to your local CPLO / CPA**
- **file a copy into the clinical record**



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 Department of Education policies pertaining to this responsibility.

Child Protection Resources

- The **Child Safety QHEPS site** provides all Queensland Health staff with information on individuals' responsibilities regarding child protection, how to recognise child abuse and neglect and how to report reasonable suspicions of child abuse and neglect. Education modules, online support tools, factsheets and support services can be found on the site. <https://qheps.health.qld.gov.au/csu>
- The **Child Protection Guide** provides guidance and support in decision making for staff who have concerns for the safety and /or wellbeing of a child/young person. The guide is intended to complement, not replace, clinical judgement, expertise or critical thinking. <https://www.csyw.qld.gov.au/about-us/partners/child-family/our-government-partners/queensland-child-protection-guide>
- The **Reporting and Referring Child Protection Concerns flowchart** is a useful tool to inform of the process regarding reporting and referring child protection concerns. https://qheps.health.qld.gov.au/_data/assets/pdf_file/0019/408430/qhreportreferflowchart_facc.pdf
- **Child Protection Guidelines** <https://qheps.health.qld.gov.au/csu/policy>
 - Reporting and responding to a reasonable suspicion of child abuse and neglect
 - Health professionals child protection capability requirements
 - Prioritisation of health services for children and young people in the child protection system
- The Child Protection **Reporting Tips** and **Reporting forms**, support staff to understand the reporting processes for health professionals. <https://qheps.health.qld.gov.au/csu/reportingforms>
- **Child Protection Liaison Officers** (CPL) and **Child Protection Advisors** (CPA) provide support to local HHS staff when managing child protection issues. Contact lists can be found on the [Child Safety QHEPS site](#).
- The **Information sharing in child protection - Key Messages** summarizes the purpose for information sharing, consent, documentation etc. https://qheps.health.qld.gov.au/_data/assets/pdf_file/0026/2239361/ISCP_keymessagesfactsheet.pdf
- There are multiple **factsheets** available on the Child Safety QHEPS page. Some examples include:
 - Presenting characteristics of child abuse and neglect
 - Clinical risk factors and indicators (for Physical abuse; Emotional abuse; Sexual abuse and Neglect)
 - Clinical risk factors and indicators for harm in children (0-2 years; 3-5 years; **6-13 years; 14-18 years**)
 - Risk versus protective factor assessment framework
 - Female genital mutilation
 - Documentation in child protection
 - High risk population groups
- The Queensland Family and Child Commission has produced an **Information Kit on Child Protection for Professionals**, which provides key facts about the Queensland child protection system for anyone who works with children or families. <https://www.qfcc.qld.gov.au/>



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.

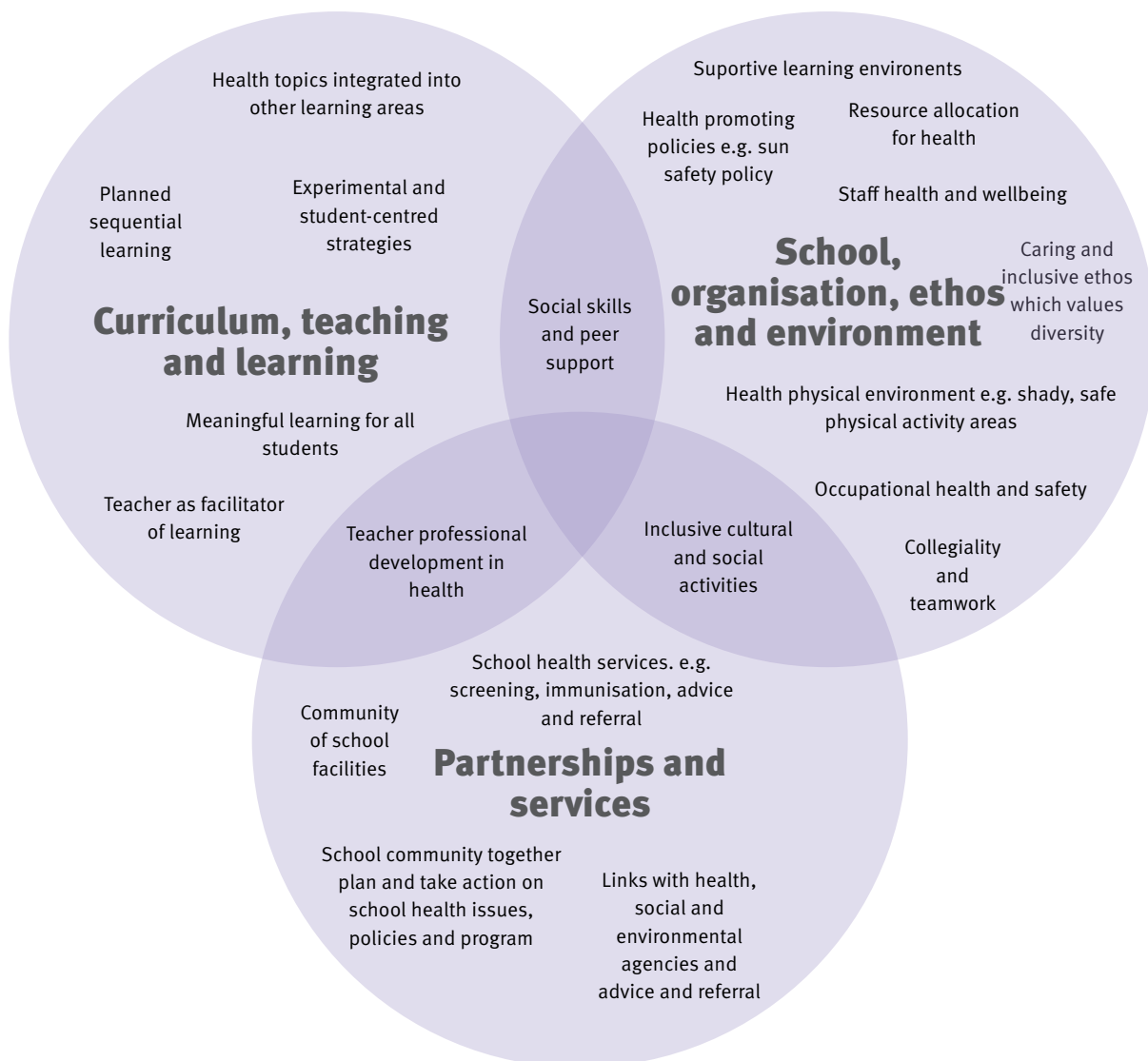
Health promotion

Health promoting schools approach

The SBYHN service is focused upon prevention, harm minimisation and early intervention. Numerous opportunities for prevention arise from a focus on risk processes that begin in or before adolescence. Health promotion at this age is extremely important as many health related behaviours developed during adolescence have implications throughout life.

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) adapted by the National Health and Medical Research Council (1996) and has been utilised in Australian schools in every state at some level since 1995. It is recognized globally as a multifaceted approach that can support health behaviours and incorporates the three interconnected domains of: curriculum, teaching and learning; school, organisation, ethos and environment; and partnerships and services ^{282, 283} (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 for the whole community²⁸³. 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^{332, 333}.
- To ensure the sustainability of health promotion strategies, the SBYHN is not the driver of health promotion within the school but should provide a facilitative role and act as a catalyst for change. By using a comprehensive, school partnership approach, SBYHNs are able to build the capacity of schools and influence positive health outcomes for individuals and school communities^{321, 334}.
- 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^{321, 335}.



Working Together for Heathier Young Queenslanders Guidelines parts 1-3

<https://qheps.health.qld.gov.au/ccyfhs/html/resources>

WA Health Promoting Schools Association

<https://wahpsa.org.au/resources/background-information/>

Student Learning and Wellbeing Framework

<https://education.qld.gov.au/student/Documents/student-learning-wellbeing-framework.pdf>

Student Wellbeing Hub

<https://studentwellbeinghub.edu.au/parents/resources/>

Capacity building

- Health Promotion is the process of enabling people to increase control over, and to improve their health and begins with capacity building¹⁹². 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.
- 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 initiatives³³².
- Building capacity for health within the school environment includes³³⁶:
 - 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.
- Institutionalising health promotion in day-to-day school processes and management is the key to building capacity towards a health-promoting school³³⁶. The SBYHN is well placed to support this process.



Working Together for Heathier Young Queenslanders Guidelines parts 1-3

<https://qheps.health.qld.gov.au/ccyfhs/html/resources>

Health and Wellbeing Queensland

<https://hw.qld.gov.au/our-approach/prevention/>

Queensland Government – Education

<https://education.qld.gov.au/students/student-health-safety-wellbeing>

School health audit

- A school health audit provides a structured way to approach capacity building 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.



WA Health Promoting Schools Association

School health audit tool

<https://wahpsa.org.au/resources/health-promoting-schools-toolkit-2/>



A toolbox for creating healthy places to learn, work and play

Booklet 7 'How to conduct a school health audit'

available on iLearn

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. Example 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 (e.g. 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 (e.g. posters, fliers, postcards, media articles etc.) in your office, on the school website, social media platforms, electronic displays 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 (e.g. information displays, special events, presentations, on-line information linked to external service providers etc.).
- Implementing awareness-raising activities for school staff surrounding health and wellbeing issues (including staff room displays; electronic staff notices; 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 [Queensland Health calendar](#)).

Partnerships and services

- Showcasing staff modelling healthy attitudes and behaviours to parents and the broader school community (e.g. via the school newsletter, online platforms 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 like-minded 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 (e.g. establishing a parents' meeting or co-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 Department of Education 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 developed in consultation with relevant teaching staff and Heads of Department prior to delivery of these lessons.

- The Australian Curriculum - Health and Physical Education, endorsed in 2015, enhances student's health and wellbeing by supporting students to develop a strong sense of self, maintain satisfying relationships and make health-enhancing decisions. See <https://australiancurriculum.edu.au/f-10-curriculum/health-and-physical-education/>
- Fitting with school curriculum and strategic priorities, balancing need and resources and excellent communication with school staff can assist with successful collaboration and partnerships³³⁷.

Health promotion resources

- It is important that all information provided to young people and school community members is contemporary and evidence based. The SBYHN is to ensure that resources used for health promotion and health education purposes meet the requirements of HHS review procedures.
 - Check the CERG Register to see if the resource is approved for use, or if the website is on the 'allowed websites' tab.
 - Education 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 not meeting the criteria outlined above should be subject to a systematic review process, utilising the [CERG Resource Review Tool](#).
 - See the CHQ Client Education Resource Group (CERG) Procedure for process and links to reviewing documents.
 - Statewide SBYH follow the Client Health Education Resource Recommendation (CHERR) Process managed through the SBYHN Clinical Collaborative.

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.
- Process and Impact evaluation results will serve to support negotiations to undertake future health promotion activities within the school community and information regarding barriers and enablers to implementation may be shared with other SBYHNs to inform their health promotion practice.
- 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 include³³⁸:
 - **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?

The following pages identify the key health issues that young people may contend with, and provides guidance to address regarding these health issues, with links to relevant health promotion activities and/or resources. Please note that this is not 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.



iStock.com/courtneyk

Nutrition, sleep and physical activity / obesity prevention ^{49, 128, 291, 339, 340}

Prevalence

- Young people should participate in a range of physical activities while maintaining good quality sleep and limiting screen time and prolonged sitting.
- In 2017-18, 22% of young people age 15–24 years were overweight or obese, with statistics showing that ages 10-17 years were significantly more likely to be overweight/obese than the same age group 20 years ago. Adult overweight or obesity rates during the same year were 67%, indicating that excess body weight is increasing with age.
- Young people (9-18 years) fell well short of the recommended daily serves of vegetables, meat and dairy, with 41% of their total energy intake coming from discretionary foods. Soft drinks, fried potato products and cakes being the main contributors.
- Less than 1 in 5 young people aged 9-18 years do the recommended amount of physical activity.
- In Australia, young women are twice as likely as boys to be inactive and they experience more barriers preventing them from being as physically active³⁴⁰.
- Sleep is essential for optimal health. Young people (14–17 years) should have 8 to 10 hours uninterrupted sleep per night. To establish and maintain healthy sleep patterns, young people should have a consistent bedtime routine, avoid screen time before sleep, and keep screens out of the bedroom.

Recommendations

- Young people need to do at least 60 minutes of moderate to vigorous physical activity every day involving mainly aerobic activities (and for additional health benefits - several hours of light physical activities 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 recreational screen time to no more than 2 hours a day and break up long periods of sitting as often as possible.
- The Girls Make Your Move campaign, developed by the Department of Health, is aimed at inspiring, energizing and empowering young women to be more active.
- 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 disease.

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 Dietitian and/or medical practitioner is recommended to ensure appropriate growth and development for overweight adolescents.



Clinicians Hub - Health & Wellbeing Queensland

A variety of clinical tools, resources and training to support clinicians to identify, prevent and manage childhood obesity

<https://hw.qld.gov.au/hub/>

Queensland Health - Youth Resources

Information and resources on a wide range of topics aimed at supporting young people

<https://www.qld.gov.au/youth>

Multicultural Nutrition Resources, Metro South Health - Food and cultural profiles.

Information about the food and food practices of selected communities, background on their country and their health profile in Australia

<https://metrosouth.health.qld.gov.au/multicultural-nutrition-resources>

Girls Make Your Move campaign

<https://campaigns.health.gov.au/girlsmove>

Make your move – Sit less, Be active for life!

Australia's physical activity and sedentary guidelines 13-17 years

<https://www.health.gov.au/health-topics/physical-activity-and-exercise/physical-activity-and-exercise-guidelines-for-all-australians>

Dietary Guidelines for Children and Adolescents in Australia and Australian Guide to Healthy Eating

Information on the nutritional and energy requirements of adolescents

<https://www1.health.gov.au/internet/publications/publishing.nsf/Content/gug-family-toc~gug-family-guidelines>

Australian Government

Australian 24-Hour Movement Guidelines for Children and Young People (5-17 years)

<https://www1.health.gov.au/internet/main/publishing.nsf/Content/health-24-hours-phys-act-guidelines>

Education Queensland – Smart Choices

Healthy food and drink choices for Queensland schools

<https://education.qld.gov.au/students/student-health-safety-wellbeing/student-health/smart-choices>

Queensland Government – Staying Healthy : Diet and Nutrition
<https://www.qld.gov.au/health/staying-healthy/diet-nutrition>

Department of Education – Student Wellbeing Hub

Multiple resources on many topics related to enhancing wellbeing and learning in the school community

<https://studentwellbeinghub.edu.au/educators/>

Mental health and wellbeing: Body image and disordered eating

341-346

Prevalence

- Body image is a person's perception of their physical self and the thoughts and feelings, positive, negative or both, which result from that perception.
- The four aspects of body image:
 - *perceptual* body image - how you see your body
 - *affective* body - the way you feel about our body
 - *cognitive* body image - the way you think about your body
 - *behavioural* body image - behaviours in which you engage as a result of your body
- 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. A survey by Mission Australia in 2013 reported body dissatisfaction as the top ranked issue for young people in Australia.
- For the eighth year in a row in 2019, young Australians rated body image issues as one of the top four concerns. This is increasing, with 26.5 % young people concerned about their body in 2015 compared with 31% in 2019³⁴⁷.
- Body dissatisfaction occurs when a person becomes fixated on trying to change their body shape which often result in unhealthy practices with food and exercise. Body dissatisfaction can influence the development of poor self-esteem and disordered eating and lead to serious mental illness including depression and eating disorders.
- 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.
- While disordered eating is more prevalent in females, it also occurs in males, with studies suggesting that males make up between one quarter to one third of young people with disordered eating. One unique difference between males and females with disordered eating is that men typically engage in compulsive exercise as a compensatory behaviour, which can be a serious health issue.
- Eating disorders are 2.5 times more common in adolescents with type 1 diabetes due to the focus on counting number of grams of carbohydrates in food as insulin therapy is matched to carbohydrates consumed.

- Weight loss along with other symptoms of hyperglycaemia can easily be overlooked in a culture that espouses thinness or lean and muscular as an ideal body shape. The four classic symptoms of hyperglycaemia are weight loss, lethargy, polyuria and polydipsia (the 4Ts – Tired, Thin, Thirst, Toilet). See Type 1 diabetes page 419.
- Significant association between disordered eating and mental health comorbidity is well documented in the literature. Anxiety, depression and substance use disorders are common, and rates of suicide are elevated amongst those with eating disorders.

Recommendations

- Early Intervention is seen as highly desirable in treatment of disordered eating and eating disorders, and referral for appropriate medical and psychological assessment can be key to uptake of treatment and successful recovery.
- 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.
 - **Personal characteristics** of the individual (including perfectionistic traits and a tendency to judge themselves according to external standards).
 - **Other high-risk factors and experiences** include puberty, young girls and women, LGBTIQ+ persons, low self-esteem, experience teasing/bullying about appearance, poor role models of restrictive eating/excessive exercise, larger body size who experience discrimination.
- 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.
- Media literacy fosters a healthy skepticism 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 change.

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. Language that uses fear or stigma as a way to motivate should be avoided.
- Further, research indicates that highlighting certain aspects of eating disorders, for example the symptoms or effects of eating disorders, may actually increase the prevalence as it could 'normalise' or glamorise the illness.
- Information about the causes, symptoms and detrimental effects are appropriate in professional development sessions with teaching and school staff to aid identification of eating disorders.



Young Person Potential Eating Disorder Assessment Tool

See Appendix 15



Queensland Health - Youth Resources

Information and resources on a wide range of topics aimed at supporting young people

<https://www.qld.gov.au/youth>

Department of Education – Student Wellbeing Hub

Multiple resources on many topics related to enhancing wellbeing and learning in the school community

<https://studentwellbeinghub.edu.au/educators/>

Eating Disorders Queensland

Support services for Qld individuals and families living with and recovering from an eating disorder, including promotion of positive body image and prevention of eating disorders.

<https://eatingdisordersqueensland.org.au/>

The National Eating Disorders Collaboration

Provides details of prevention and early intervention resources suitable for use in schools.

<https://www.nedc.com.au/research-and-resources/>

The Butterfly Foundation for Eating Disorders

A variety of fact sheets on body image and eating disorders, as well as links to curriculum resources available for purchase.

<http://thebutterflyfoundation.org.au/for-professionals/>

Eating Disorders Victoria

<https://www.eatingdisorders.org.au/eating-disorders-a-z/>

Body Image Movement

Developed for year 9 & 10 students, aligns with HPE curriculum. Includes activities, lesson plans, ideas and video clips to support teachers

<https://bodyimagemovement.com/resources/education-study-guide-australia/>

Mental health and wellbeing : Anxiety, depression, intentional non-suicidal self-harm, and suicide ideation ^{74, 317, 348-352}

Prevalence ^{317, 348, 349}

- The mental health and wellbeing of children and young people is a significant concern. Tackling mental health and risky behaviours is one of the priority areas in the National Action Plan for the Health of Children and Young People 2020-2030.
- 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 2013-14, more than 14% of young Australians aged 12 - 17 years had a mental health disorder in the preceding 12 months. This increased to 26% in the 16 – 24-year-old age group – the highest of any age groups.
- The leading specific cause of mental ill health among young people were anxiety disorders, accounting for almost half of the burden of disease in this age group. Followed by Attention Deficit Hyperactivity Disorder (ADHD) and depression.
- Females were more likely than males to have experienced mental health concerns and the prevalence of mental health conditions is also significantly higher among LGBTIQ+ young people.
- Intentional self-harm and suicide are significant public health issues in Australia. In 2013-14, adolescents had the highest rate of intentional non-suicidal self-harm among children and young people, and 41,000 young people reported attempting suicide in the previous 12 months. Suicide among young Australians (15-24 years) is at its highest level for ten years and is the leading cause of death for this age group.
- Suicide and intentional non-suicidal self-harm rates in females are almost double that of males and there is no significant difference in rates by socio-demographic characteristics.
- 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, appropriate nutrition and personal resilience.

Recommendations ^{350, 351}

- As mental health problems frequently commence in adolescence, there is a strong case for embedding mental health promotion in schools.
- 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 relevant approaches to ensure inclusivity of people from diverse backgrounds.
- With most adolescents using the internet daily, e-mental health care is an opportunistic way of supporting young people – from promotion and prevention through to treatment and recovery.

Introduction

Section 1:
Antenatal

Section 2:
Birth to five years

Section 3:
Five to twelve years

Section 4:
12 to 18 years

Appendix & References

- 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.
- 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.

Cautions / things to avoid ³⁵²

- 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.
- 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.
- Do not avoid talking to young people at risk of developing, or currently experiencing a mental health disorder, or engaging in self-harm about suicidal thoughts or behaviours. Any reports of suicidal ideation need to be thoroughly investigated using direct questioning to determine the extent of the thoughts, the presence or absence of suicidal behaviour, the presence or absence of a suicide plan, and to evaluate other psychosocial risk factors.



Be You

Provides educators with knowledge, resources and strategies for helping children and young people achieve their best possible mental health.

<https://beyou.edu.au>

ReachOut

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.

<http://au.professionals.reachout.com/>

RUOK?

Provides classroom toolboxes which address suicide prevention with secondary school students.

<https://www.ruok.org.au/education>

Headspace

Provides a range of youth-friendly information sheets to support mental health promotion in schools.

<https://headspace.org.au/schools/headspace-in-schools/>

Ed-Linq

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 at <https://www.childrens.health.qld.gov.au/service-statewide-ed-linq-program/>

eMHprac

Directory of Australian, evidence-based, free (or low-cost) digital mental health programs and resources.

<https://www.emhprac.org.au/>

Queensland Health - Youth Resources

Information and resources on a wide range of topics aimed at supporting young people

<https://www.qld.gov.au/youth>

The BRAVE Program

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

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

Yarning about mental health: an easy guide to mental health assessment

HealthInfoNet Flipchart

<https://healthinfo.net.ecu.edu.au/key-resources/resources/?id=19702>



Freepik.com

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.
- 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 image-based abuse.
- In 2017, 1 in 5 young people in Australia reported being bullied online.
- Image based abuse (IBA) occurs when an intimate image or video is shared without the consent of the person pictured. It is of growing concern, with 15% of girls aged 15-17years and 24% of 18-24years women reporting IBA in 2017.
- About three quarters of victims of cyberbullying are female, whereas the perpetrators of cyberbullying are equally likely to be male or female.
- Less than half of all cyberbullying incidents to secondary school students are reported to schools.
- Young people are being impacted by cyberbullying to the point where some engage in self-harm and suicidal ideation.
- 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.
- It is important to note that a high proportion of cyberbullying victims are also cyberbullies.

Recommendations

- As there is no easy division between 'traditional' bullying and cyberbullying, interventions and preventions should look at strategies which deal with both.
- Strategies to address 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.
- 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.
- 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.
- 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.

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.
- 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.
- 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.



Student Wellbeing Hub

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.

<https://studentwellbeinghub.edu.au/>

Queensland Health - Youth Resources

Information and resources on a wide range of topics aimed at supporting young people

<https://www.qld.gov.au/youth>

Bullying: No Way!

Includes a range of resources and research for students, parents and teachers.

<https://bullyingnoway.gov.au>

eSafety

Provides a wide range of online safety programs and resources

<https://www.esafety.gov.au/>

National Centre Against Bullying

Includes links to a series of articles addressing cyberbullying, online relationships and safe practices.

www.ncab.org.au/cyberbullyingpractices/

ThinkUKnow

An internet safety program – includes interactive training for parents, carers and teachers

<http://www.thinkuknow.org.au/>

Reachout

Useful information about cyberbullying for young people

<http://au.reachout.com/cyberbullying>

The Queensland Police Service

Information for parents on how to support their children to maintain on-line safety.

<https://www.police.qld.gov.au/safety-and-preventing-crime>

Sexuality and healthy relationships 75, 315, 317, 318, 353, 354

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 the 6th National Survey of Secondary Students and Sexual Health conducted in 2018:
 - 34.3% of year 10 and 55.8% of year 12 students reported having had sexual intercourse.
 - During their last sexual encounter, 53% reported using a condom, 41% reported using the contraceptive pill, 19% reported using the withdrawal method, and 4% reported using emergency contraception.
- 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.
- In 2017, around 6600 babies were born to teenage mothers, a decline of 40% over the last 10 years. Teenage pregnancy has been associated with poorer health outcomes for both the baby and the mother. For example, there is a higher risk of premature birth, low birth weight, stillbirth and longer-term risks such as behavioural and cognitive disadvantages for the infant. For the mother, interruption to schooling, higher risk of depression, poorer health and economic outcomes.
- Chlamydia remains the most frequently reported STI in young people, with 75% of notifications coming from the 15-29 year age group. Notification rates of gonorrhea and syphilis continue to increase in young people, with over half (gonorrhoea) and more than a third (syphilis) of new diagnoses occurring in people aged 15-29 years in 2017.
- In 2017 there were 11 notifications of new cases of HIV among young people aged 15-19 years. This increases dramatically to 256 new cases in the 20-29-year age group. Although overall population rates of new HIV notifications have remained steady over the past 10 years, male to male rates are decreasing while heterosexual notification rates are rising.
- Although the majority of 16-27 years who identify as LGBTIQ+ reported they felt good about identifying as LGBTI, 72% of them reported experiencing abuse because of their sexuality and / or gender identity and 85% report mental health problems.

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 (e.g. via policies addressing sexual harassment, marginalization of young people diverse in gender and sexuality and anti-bullying).
- SBYHNs may promote or co-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.

The Implementing Enhanced Sexual Health Services for State-wide School Based Youth Health Nurses guideline has been developed to guide the establishment and clinical processes, and associated training for SBYHNs in the safe delivery of enhanced sexual health services and is recommended for use by all HHS providing enhanced sexual health services.

- 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. SBYHNs have access to suite of resources for working with schools to improve sexual health literacy within the iLearn *True Relationships and Reproductive Health Resources* module in the SBYHN Professional Development course

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 and meet all expectations of conduct for registered health practitioners in relation to terminations as set by Queensland health in response to the Termination of Pregnancy Act 2018. <https://www.health.qld.gov.au/system-governance/legislation/specific/termination-of-pregnancy-legislation>
- Results from the National Survey of Secondary Students and Sexual Health in 2018³⁵³ found that only 1 in 3 students (37%) found the formal Relationships and Sexuality Education in schools relevant.

Students' comments said that they wanted it delivered more often, cover a wide range of content and be delivered by someone who was knowledgeable and comfortable with the topic. 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.



SBYH Professional Development Course

Role of the School Based Youth Health Nurse

Learning modules available on iLearn for all SBYH nurses to complete.

Contact line manager or Nurse Manager Statewide SBYH, for enrollment details



TRUE

Relationships & Reproductive Health

Teaching and learning resources e.g. Relationship Ready for schools. Also has a wide range of fact sheets and brochures

<https://www.true.org.au/>

Children by Choice

Offers comprehensive youth-friendly information about pregnancy options.

<https://www.childrenbychoice.org.au/>

Tune In Not Out

Provides tip sheets, stories and youth-friendly videos surrounding a wide range of health issues.

www.tuneinnotout.com

Department of Education – Student Wellbeing Hub

Multiple resources on many topics related to enhancing wellbeing and learning in the school community

<https://studentwellbeinghub.edu.au/educators/>

Queensland Health - Youth Resources

Information and resources on a wide range of topics aimed at supporting young people

<https://www.qld.gov.au/youth>

Love Bites

A school-based domestic and family violence and sexual assault prevention program.

<http://growingrespect.org.au/love-bites/about/what-is-love-bites/>

Core of Life

A 'hands on' pregnancy and parenting education program for young people.

Website also has a 'teen' section with youth friendly information and resources surrounding sexual and reproductive health.

www.coreoflife.org.au



Queensland Health

Free at-home chlamydia urine testing kits.

<https://www.qld.gov.au/health/staying-healthy/sexual-health/chlamydia-test>

Queensland Health

Clinical guidelines and frameworks for supporting adolescent sexual health, including Aboriginal and Torres Strait Islander sexual health and sexual health education animation series

<https://www.health.qld.gov.au/clinical-practice/guidelines-procedures/sex-health/guidelines>

Queensland Health

Implementing Enhanced Sexual Health Services for State-wide School Based Youth Health Nurses guideline 2019

<https://qheps.health.qld.gov.au/ccyfhs/html/resources>

Queensland Health

you tube channel – search sexual health

<https://www.youtube.com/user/HealthierQueensland/videos>

Prevalence

- Adolescence is an age when young people may begin to experiment with substances.
- Recent data (2017) surrounding the proportion of young people aged 12-17 years who have engaged in substance use in the year previous indicate³⁵⁵:
 - 46% had drunk alcohol
 - 1 in 20 are current smokers
 - 18% have tried inhalants
 - 15% have tried cannabis
 - 13% have used an e-cigarette
 - The use of other illicit drugs is low, ranging between 2% for cocaine and opiates, to 3% for ecstasy and performance enhancing drugs
- Substance use can have a variety of short and long term consequences³⁵⁶.
- 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 people³⁵⁶.
- 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 drinking ³³³.
- 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 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.
- Due to the strong influence of parental role modelling with statistics showing 43% young people access alcohol from their parents and 20% of regular cannabis users used at home ³⁵⁵, 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.



Queensland Health - Youth Resources

Information and **resources** on a wide range of topics aimed at supporting young people
<https://www.qld.gov.au/youth>

Dovetail - Alcohol and other drugs in schools

Best practice guide to assist school communities to better prevent and respond to alcohol and other drug use

<https://www.dovetail.org.au/resources/alcohol-and-other-drugs-in-schools>

QUIT

Fact sheets, curriculum resources and youth-focused activities to support smoking prevention.

www.oxygen.org.au/

Insight

Centre for alcohol and other drug training and workforce development

<https://insight.qld.edu.au/>

Cannabis Information and Support

Information and resources for health professionals, parents and young people

<https://cannabissupport.com.au/>

School Health and Alcohol Harm Reduction Project

An evidence-based classroom program supported by the National Drug Research Institute

<http://ndri.curtin.edu.au/>

Climate Schools Australia

Modules designed around alcohol and other drug education to reduce harm and improve student wellbeing

<https://www.climateschools.com.au/>

State of Victoria

Get Ready Drug Education Resource

<https://fuse.education.vic.gov.au/Secondary>

Prevalence

- Exposure to ultraviolet radiation (UVR) during outdoor activity and inadequate sun protection increases a young person's risk of developing skin cancer. Queensland's UVR levels can cause skin damage all year round.
- 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 2018, over 50% of young people aged 12 - 17 years in Queensland admitted to getting sunburnt in the previous 12 month period .
- Melanoma is the most dangerous type of skin cancer with a strong causative link to sunlight exposure. Australia and New Zealand have the highest melanoma incidence rates globally, and melanoma rates in Queensland are 3 times higher than the national average - the highest of all states and territories.
- Although the melanoma incidence rate for young people (15–29 years) declined by 23% over the past decade, it is still the most common cancer in this age group, comprising 25% of all cancer cases.
- 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.

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:
 - **Slip** on a shirt - Wear sun protective clothing that covers as much of their body as possible.
 - **Slop** on broad spectrum SPF 30 or higher sunscreen – Apply liberally to clean, dry skin, at least 20 minutes before being exposed to the sun, and reapply at least every two hours when outdoors. It is suggested to make this part of the morning routine to provide protection against the harmful effects of everyday sun exposure.
 - **Slap** on a broad-brimmed hat - One that shades their face, neck and ears.
 - **Seek** shade.
 - **Slide** on some sunglasses – Wear sunglasses that meet Australian standards and wrap around to protect the eyes as much as possible.
- 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.
 - **B** 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).

Cautions / things to avoid

- For maximum UVR protection, avoid using sunscreen 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 (e.g. 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.



Queensland Health Sun Safety in schools

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.

<https://www.health.qld.gov.au/public-health/schools/sun>

QUEST

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 must register to access these resources.

<https://cancerqld.org.au/cancer-prevention/programs-resources/>

Melanoma Institute Australia

Information to support education of young people about skin checks for melanoma.

<https://www.melanoma.org.au/preventing-melanoma/>



Freepik.com

Prevalence

- Asthma, a chronic inflammatory condition of the airways, is one of the most common long-term conditions affecting young Australians.
- 10.5% of young people aged 15-24 years reported asthma as a long-term condition in 2017–18.
- Asthma is the leading cause of total burden of disease among 5-14 year olds.
- The overall prevalence of self-reported asthma among young people was similar for males and females.
- 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 months³⁶⁰.

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.
- Chronic conditions should routinely be assessed for in conjunction with a HEEADSSS 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
 - 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.
- 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.

Cautions / things to avoid

- It is the role of Department of Education 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.



Asthma Australia- Kiss My Asthma App

Apps to assist people with asthma and their carers, including the Kiss My Asthma App – developed by young people for young people.

<https://asthma.org.au/what-we-do/how-we-can-help/apps/>

Asthma Australia

Guidelines, training and resources for primary and secondary schools

<https://asthma.org.au/about-asthma/asthma-in-schools/>

Prevalence

- Type 1 Diabetes is a common auto-immune disease that destroys the beta cells in the pancreas that produce the hormone insulin. Without insulin, the body cannot get glucose, which is the main energy source and essential for brain function. People living with type 1 diabetes need to inject insulin multiple times a day to ensure blood glucose doesn't build up in life-threatening amounts. People with Type 1 Diabetes are also susceptible to other auto-immune conditions.
- 60% of people diagnosed with Type 1 Diabetes were aged under 25, with the highest rate of diagnosis among those aged 10-14, that is 34 cases per 100,000. The incidence is higher in males than in females.
- Common symptoms of hyperglycaemia are weight loss, polydipsia, polyuria, lethargy, enuresis, constipation, dehydration or an unresolving common illness that is not responding to usual treatment. Symptoms of high blood glucose masquerade as other common childhood symptoms and children can appear well despite being symptomatic of hyperglycaemia. Health professionals need to be aware of the classic 4T symptoms (Tired, Thin, Thirst, Toilet), and urgently refer for a same day blood glucose fingerpick test to exclude hyperglycaemia and prevent Diabetic Ketoacidosis (DKA).
- Weight loss is easily attributed to a growth spurt or seen as a positive thing by older children concerned with body image, and parents can explain away other symptoms of hyperglycaemia attributing the behaviours to hot weather and challenging age related behaviours. These symptoms are subtle and easy to miss in Queensland's hot climate and preverbal infants wearing disposable nappies.
- There are about 11,000 school aged children living with type 1 diabetes. More than 1000 school aged children were diagnosed in 2019.
- If hyperglycaemia in children is not diagnosed and treated, delays lead to the metabolic emergency of DKA. DKA is life-threatening and is associated with longer-term morbidity from cerebral oedema and deep vein thrombosis, i.e. ongoing poor glycaemic control, subsequent recurrent episodes of DKA, long-term spatial memory performance, lower cognitive scores and altered brain growth.
- Queensland has unacceptable rates of paediatric DKA at diagnosis of type 1 diabetes, with a state average of 45% when less than 25% would be acceptable. Studies have shown the most common reason attributed for high rates of DKA at diagnosis of type 1 diabetes are parents and primary health care clinicians not being aware of the prodromal signs and symptoms to recognise and respond for a timely diagnosis. Children are seen two to three times by a primary care clinician before presenting to hospital in DKA.
- The risk group with the highest incidence of DKA is children under 2years and those with a lower BMI.
- Hormonal changes during the transition to adolescence in females and psychological conditions such as eating disorders can increase the risk of DKA in people with Type 1 diabetes. In Australia in 2015, the DKA rate among females peaked at age 15–19 years.
- The risk is also higher in children whose parents report an education level lower than 9 years, lower socio-economic situation; are culturally and linguistically diverse or aged between 4-5years.
- In 2020, the Diabetes in Schools program was launched nationally to provide free specific training for school staff to meet the needs of children with type 1 diabetes so that they can learn, develop and thrive.

- Living with Type 1 Diabetes is a 24/7, 365 day a year job. People living with type 1 diabetes receive diabetes education to self-manage insulin dosing and adjustment. Evolving technologies have reduced some of the burden of living with Type 1 Diabetes, for example many people receive funding for continuous glucose monitoring (CGM) devices and insulin pumps. These technologies require students have their smart device with them so that they can see their blood glucose trend.
- Students with Type 1 diabetes are eligible to apply for principal-reported Access Arrangements and Reasonable Adjustments (AARA) to the Queensland Curriculum and Assessment Authority. Possible adjustment to assessment and or conditions include bite-sized food, drink, blood-glucose monitoring equipment, rest breaks to eat, measure blood-glucose level or access toilet facilities, varied seating and rest time for the practical aspects of managing the conditions. Further information is available at: <https://www.qcaa.qld.edu.au/senior/certificates-and-qualifications/qce-qcia-handbook/6-aara/6.4-reporting-approving#3>

Recommendations

- The early identification of prodromal symptoms of hyperglycaemia in children can prevent DKA at diagnosis of type 1 diabetes. Youth health professionals need to be aware of the early signs of hyperglycaemia and refer the child/adolescent for an urgent (same day) finger prick blood glucose check. Be on alert for the classic 4T symptoms - Tired, Thin, Thirst, Toilet.
- Often school staff are the first to notice the symptoms of hyperglycaemia, prior to the diagnosis of type 1 diabetes. Any of the classic 4 symptoms of hyperglycaemia: polyuria, polydipsia, lethargy, weight loss should be investigated promptly with a same day finger prick blood glucose test to exclude type 1 diabetes and prevent DKA.
- Youth health professionals should work with the child/adolescent and their family, the DiabetesinSchools program and school principal to support students to manage their type 1 diabetes at school so they have the chance to learn and achieve, and be the best they can be.
- Type 1 diabetes that is in a steady state ought not preclude students from fully participating in all school activities.
- Each school principal is responsible for ensuring each student with type 1 diabetes has a diabetes care plan. The aim of the plan is to ensure the teachers and staff can provide support to enable the student to fully participate in all aspects of school. See the DiabetesinSchools website for details on accessing training. www.diabetesinschools.com.au

Cautions / things to avoid

- As children enter the teen years the usual developmental behaviours of freedom and independence need to be balanced with continual responsibilities of Type 1 diabetes self-management. Independence and safety need to match with the young person's developmental growth stage



DiabetesinSchools website

Information and accessing training.

www.diabetesinschools.com.au

Diabetes Australia

<https://www.diabetesaustralia.com.au/continuous-glucose-monitoring>



E-Learning - Diabetic Ketoacidosis

Primary prevention and early identification of hyperglycaemia in children and young people, to reduce the rate of DKA at diagnosis of Type 1 Diabetes

<https://ilearncatalogue.health.qld.gov.au/course/1581/preventing-dka-at-diagnosis-of-type-1-diabetes-mellitus-in-children-under-16>

Prevalence

- Dental caries (decay) is one of the most prevalent health issues in Australia across all age groups.
- In 2014 in Queensland, over 50% of 12-14 year olds had at least one decayed tooth and young people aged 15-34years, had on average 5 decayed, missing or filled teeth.
- Children and young people living in rural and remote areas, are socially disadvantaged or on low incomes, have specialised health care needs or identify as Aboriginal and Torres Strait Islander people have poorer oral health than the general population and also experience barriers to accessing oral health.
- 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, oral cancers and stroke.
- Dental caries is highly preventable and is related to both dietary issues and the build-up and retention of plaque through infrequent, substandard tooth cleaning. Only around 50% of teenagers brush their teeth twice a day³⁶³.
- Young people have increasing control over their diet and hygiene habits. Dietary choices are strongly influenced by peer pressure and media influences, and during growth spurts young people may also be frequently hungry between meals and snacking on high sugar foods that contribute to dental caries.

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 twice daily tooth brushing with fluoridated toothpastes should also be promoted.
- Young people should be encouraged to wear a mouthguard when training for or playing contact sports.
- Public oral health services are available to all children aged four years or older who have not yet completed year 10 at school or who are a dependent/holder of a Centrelink concession card. For further information, see below.
- 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 generations.
- SBYHNs should provide opportunistic health messages around oral health during the conduct of a HEEADSSS assessment with young people.
- Smoking, alcohol and drug misuse can also impact on oral health, as can bulimia and anorexia. Poor oral hygiene and dental care can also cause disease, for example endocarditis in people with rheumatic heart disease.
- SBYHNs should be mindful of promoting oral health where these issues are a concern.

Cautions / things to avoid

- Young people who live in areas where the water supply is fluoridated should be encouraged to drink this in preference to bottled water.
- Routine dental health checks to assess the health of teeth is still important even if the young person is receiving orthodontic care.
- 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 jewelry with plastic jewelry which causes less damage to teeth. They should also brush piercings with a soft toothbrush twice per day, and periodically remove and clean the jewelry, as well as remove jewelry during sleep and sporting activities.
- 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. 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 (e.g. avoiding embarrassment and teasing associated with missing teeth).



Queensland Health - Youth Resources

Information and resources on a wide range of topics aimed at supporting young people

<https://www.qld.gov.au/youth>

Child and Adolescent Oral Health Services (School Dental Service)

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

<https://www.health.qld.gov.au/oralhealth/services/school>

Child Dental Benefit Schedule

Young people may also qualify for subsidised basic dental care through private dentists.

For further information and eligibility criteria, see: www.humanservices.gov.au/customer/services/medicare/child-dental-benefits-schedule



Healthy Teeth for Life

Fact sheets available on QHEPS that may be used to support health promotion surrounding specific concerns with oral health (e.g. bad breath; oral piercing; gum disease etc). Many of the fact sheets are available in different languages.

https://www.health.qld.gov.au/oralhealth/healthy_teeth/fact_sheet

Building Strong Teeth

pictorial flipchart with information targeted at school aged Aboriginal and Torres Strait Islander children and their teachers

https://www.health.qld.gov.au/__data/assets/pdf_file/0036/154899/StrongTeeth_updated.pdf

Prevalence

- Transport accidents and assaults are two leading causes of injury in young people aged 15-24 years, 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.

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
- Multiple strategies and a whole-of-school approach are therefore needed to address injury prevention in young people. These may include³⁶⁶:
 - 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
 - modifications to the school environment to better support the physical safety and wellbeing of students

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 effect³⁶⁷.
- 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 practiced.
- 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.



Queensland Health - Youth Resources

Information and resources on a wide range of topics aimed at supporting young people
<https://www.qld.gov.au/youth>

Skills for Preventing Injury in Youth (SPIY)

Targeted at Year 9 students, 8-week, teacher delivered attitude and behaviour change curriculum with peer protection and first aid messages.

<https://acrs.org.au/trust-report/skills-for-preventing-injury-in-youth-spiy-program/>

RACQ – Educational Programs| Docudrama and other free programs aimed at secondary school students

<https://www.racq.com.au/cars-and-driving/safety-on-the-road/educational-programs/secondary-school-program>

Queensland Department of Transport and Main Roads

Information and resources on preventing transport accidents, including resources for education in schools.

<https://www.tmr.qld.gov.au/Safety/School-road-safety/Student-driver-education>

Road Safety Education Victoria

Range of curriculum resources and video clips surrounding driver and pedestrian safety.

<http://www.roadsafetyeducation.vic.gov.au/>

Party Safe

Queensland Police Service site providing information for parents and young people to promote a safe approach to partying; clarification of associated legal issues; and a portal to register upcoming parties

<https://www.police.qld.gov.au/initiatives/party-safe>

Red Frogs Australia

Offer education programs address a number of real-life issues students face to engage students' critical thinking skills and capabilities

<https://redfrogs.com.au/programs/education/information-for-teachers>

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.
- Despite this well-established SIP, completion of adolescent immunisation schedules in Australia is sub-optimal. The Queensland Health Immunisation Strategy 2017-2022 objective is for an 85% adolescent immunisation rate.
- In 2018 in Queensland: HPV course completion rate was 67%; dTpa uptake was 76.% and Meningococcal ACWY was 68%.

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.



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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.
- Be aware of negative messages propagated by anti-vaccine movements so you may answer questions accurately and counter concerns through your health promotion efforts.



School Immunisation Program

Resources including consent forms and fact sheets.

<https://www.health.qld.gov.au/clinical-practice/guidelines-procedures/diseases-infection/immunisation/schools>

School Immunisation Program

Resource kit for vaccine service providers implementing a SIP

www.health.qld.gov.au/publications/clinical-practice/guidelines-procedures/sbvp-vsp-resource-kit.pdf

Australian Government Department of Health

Comprehensive information about immunisation including strategies to address myths and misconceptions, and video clips for high school students on what to expect when receiving vaccinations at school.

<https://www.health.gov.au/health-topics/immunisation>

Translated Immunisation factsheets

<https://www.qld.gov.au/health/conditions/immunisation/translated-fact-sheets>

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.
 - › 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 Support 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, written 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 consider the context of the screening, their HHS and school policies regarding parental/caregiver consent for students' participation in screening activities and ensure appropriate consent processes are in place prior to screening students.

- SBYHNs may lend support for selective interventions for
 - › other identified high-risk groups within the school.
 - › 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. Department of Education 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 childcare.
 - 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 childcare.
 - 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.



Department of Education

Pregnant and parenting students

Information regarding ways to support pregnant and parent students, including links to other useful websites

<https://education.qld.gov.au/student/inclusive-education/Pages/pregnantAndParentingstudent.aspx>

LGBTIQ+ young people

- Australians identifying as LGBTIQ+ face health disparities in terms of their mental health, sexual health and rates of substance use⁷⁴.
- This population group has been identified as a priority in several key documents including the National Action Plan for the Health of Children and Young People: 2020-2030 and The Fifth National Mental Health and Suicide Prevention Plan
- LGBTIQ+ individuals often experience stigma, discrimination, social exclusion and isolation, which can lead to poorer mental health outcomes
 - LGBTIQ+ people have the highest rate of suicidality of any group in the country, with the average age of a first suicide attempt being 16 years⁷⁴.
 - 72% of young people in the National Survey of Secondary Students and Sexual Health in 2018, reported experiencing abuse because of their sexuality and / or gender identity³¹⁵.
- A previous negative experience may prevent individuals from accessing healthcare when required, or high levels of stress caused from marginalisation may lead to unhealthy coping behaviors. LGBTIQ+ people are more likely to use alcohol and other drugs, have higher rates of substance abuse and are more likely to continue heavy drinking into adulthood ³⁵⁴.
- LGBTIQ+ young people have specific health needs and health promotion and information should address sexual health needs, particularly prevention of infectious disease, contraception and healthy relationships³⁵⁴.
- Creating an affirming environment, communicating with knowledge and understanding, being proactively inclusive and reducing stigma and discrimination, are important in improving care and ultimately the health of this vulnerable population group³⁰⁴.
- Sensitive, respectful communication is required when interacting with this population group. For example³²⁹:
 - When addressing new clients, avoid pronouns or gender terms.
 - Politely and privately ask if you are unsure about their preferred name or pronouns.
 - Use the terms they use to describe themselves.
 - Only ask for information that is required.
 - Apologise with sincerity if you make a mistake.



National LGBT Health Education Center

Providing Inclusive Services and Care for LGBT People : A Guide for Health Care Staff

<https://www.lgbtqiahealtheducation.org/Providing-Inclusive-Services-and-Care-for-LGBT-People>

Queensland Sexual Health Strategy 2016-2021

https://www.health.qld.gov.au/__data/assets/pdf_file/0024/601935/qh-sexual-health-strategy.pdf

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 experiences³⁷².
- 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 wellbeing³⁷³.
- 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.
<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. <https://metrosouth.health.qld.gov.au/qtmhc>
- Further multicultural health resources are available from the **Queensland Health Multicultural Health website**, including practice guides, cultural information and community profiles.
<https://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 people¹³². 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 tailored to the specific needs of the community⁷.
- 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 community³⁷⁴.
- 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;
- investigate, support or implement programs such as Deadly Choices (tobacco cessation) and Foetal Alcohol Spectrum Disorder (FASD) 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);
- advocate and support culturally responsive care during sad news, sorry business;
- 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.



Aboriginal and Torres Strait Islander families

See page 262

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, require more intensive intervention and support to adequately meet their care needs³⁷⁵.
- 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 system³⁷⁵.
- 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 issues³⁷⁵.

- The Statement of Intent outlines Queensland Health's commitment to addressing the health needs of vulnerable children and young people including those who are²⁵⁷:
 - at risk of entering the child protection system (0 – 18 years of age);
 - currently in out of home care (OOHC) (0 – 18 years of age);
 - transitioning to independence following a care experience (15 – 21 years of age).

Queensland Health's commitment to these vulnerable children and young people is demonstrated by prioritising access to health services wherever possible.

- 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 **Queensland Government** has an information website for young people in care. It includes information on education support plans, expected standards of care and transitioning from out-of-home care. <https://www.qld.gov.au/youth/family-social-support/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 <https://create.org.au/>
 - **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 <https://education.qld.gov.au/students/student-health-safety-wellbeing/students-with-diverse-needs#outofhome>



Freepik.com

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 endeavours³⁷⁶.
- 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**²⁰ 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 (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: <https://www.familyrelationships.gov.au/>
- 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.
 - FPM 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.
 - It 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/ccyfh/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 / review meeting with medical and/or allied health staff to provide an inter-disciplinary perspective to support care management and referral pathways (such as staff from the local CYMHS).

- Timeframes for scheduling case reviews will be commensurate with the level of risk identified. This will also influence whether the case 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, 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 case review documentation (refer to [Appendix 14](#) for an example) or relevant notations in the client's progress notes.



Young Person Case Review
See Appendix 14

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 support ³⁷⁷.
- 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 for example,
 - loss and grief education programs to strengthen the social and emotional wellbeing of young people who are dealing with significant loss or change for example, the death of a loved one, parental divorce or separation, the experience and aftermath of natural disaster and moving house or school e.g. Seasons for Growth <https://www.goodgrief.org.au/seasons-for-growth>
 - support students at risk of disengagement from school e.g. Rock and Water <https://rockandwatertraining.com.au/>
- 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;
- 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^{80, 317}. 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^{378, 379}.
- 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 competency 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.
- The Fraser guidelines involves a determination that³⁸⁰:
 - 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;
 - the young person’s best interests require contraceptive advice, treatment or supplies to be given without parental consent.

- 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 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.
 - Accurate, non-judgmental 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-judgmental information regarding all 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.
- The SBYHN needs to consider relevant child safety legislation and mandatory reporting requirements and assess if the young person is³²⁷:
 - not capable of understanding the implications of the health care decision;
 - is at risk due to the nature of the sexual encounter:
 - › is non-consensual;
 - › occurs between family members;
 - › there is a significant age gap (five years or more) between the young person and alleged offender;
 - › suggests an inappropriate power differential;
 - › involves coercion to engage in any unlawful sexual activity, including prostitution; and/or
 - › exposes them to, or uses them in, pornographic performances or material.
- 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.
- The **Implementing Enhanced Sexual Health Services for State-wide School Based Youth Health Nurses guideline** has been developed to guide the establishment and clinical processes, and associated training for SBYHNs in the safe delivery of enhanced sexual health services.



Queensland Health

Implementing Enhanced Sexual Health Services for State-wide School Based Youth Health Nurses guideline 2019

<https://qheps.health.qld.gov.au/ccyfh/html/resources>



SBYH Professional Development Course

Role of the School Based Youth Health Nurse Learning modules available on iLearn for all SBYH nurses to complete.

Contact line manager or Nurse Manager Statewide SBYH, for enrollment details



Appendix & References

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 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

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 Children are born ready to learn	Be a good, healthy model for your child as they learn from you. Eat healthy meals together – lots of fruit and vegetables.
The best learning happens in nurturing relationships	Experiences shape how you child’s brain grows, learns and develops. Play games with your child and establish predictable routines.
The brain develops through use	Your child’s brain develops healthily through loving, caring, stable and supportive relationships. Hold, caress, cuddle and talk to your baby. 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.

 <p>Children's Health Queensland Hospital and Health Service Child & Youth Community Health Service</p>	(Affix patient identification label here)								
	URN: Family Name: Given Names: Address: Date of Birth: Sex: <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> I								
Family Health Assessment									
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 (specify): _____ <input type="checkbox"/> AIDET: Explanation of Child Health Service & roles, <i>Family Health Assessment</i> and working in partnership (refer to Section 1 of the guideline)									
Who participated in this interview? <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Grandparent <input type="checkbox"/> Other (specify): _____ <input type="checkbox"/> Interpreter present									
Family members and other's living in the household			<input type="checkbox"/> Genogram completed						
Surname	Given name/s	Date of birth	Relationship to child						
Other services supporting the family (state name): <table border="1" style="width: 100%;"> <tr> <td><input type="checkbox"/> General Practitioner:</td> <td><input type="checkbox"/> Paediatrician:</td> </tr> <tr> <td><input type="checkbox"/> Allied Health Professional:</td> <td><input type="checkbox"/> Mental Health Professional:</td> </tr> <tr> <td><input type="checkbox"/> Child Safety Service:</td> <td><input type="checkbox"/> Other:</td> </tr> </table>				<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:
<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: <input type="checkbox"/> Partner employed <input type="checkbox"/> Family support <input type="checkbox"/> Community support <input type="checkbox"/> Childcare arrangements <input type="checkbox"/> Able to access support <input type="checkbox"/> Other (specify): _____									
Does the parent identify any immediate concerns for their child/ren's health or wellbeing? If yes, describe: 									
Name:			Signature:						
Designation:	Date:	Time:							

DO NOT WRITE IN THIS BINDING MARGIN



APPENDIX 3 (2)

 <p>Queensland Government</p>	<p>Children's Health Queensland Hospital and Health Service Child & Youth Community Health Service</p>	<p>(Affix patient identification label here)</p> <p>URN:</p> <p>Family Name:</p> <p>Given Names:</p> <p>Address:</p> <p>Date of Birth: Sex: <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> I</p>
<h3>Family Health Assessment</h3>		
<p>Social Circumstances and Family Functioning (Discuss using suggested questions in Section 2 of the <i>Family Health Assessment Guideline</i>)</p>		
<p>What cultural / social issues are identified with the family that may impact on the child and/or parenting? (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 <input type="checkbox"/> Other <input type="checkbox"/> Financial stress <input type="checkbox"/> Housing stress <input type="checkbox"/> Lone parent <input type="checkbox"/> Mother aged <18 years <input type="checkbox"/> Transition times/critical events <input type="checkbox"/> >4 siblings </p>		
<p>Maternal</p>		
<p>Paternal</p>		
<p>Parental Physical and Mental Wellbeing (Discuss using suggested questions in Section 3 of the <i>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? (describe)</p> <p> <input type="checkbox"/> Nil <input type="checkbox"/> Medical illness <input type="checkbox"/> Physical disability <input type="checkbox"/> Intellectual disability <input type="checkbox"/> History of mental illness <input type="checkbox"/> Current mental health problem <input type="checkbox"/> Other </p>		
<p>Maternal</p>		
<p>Paternal</p>		
<p>Name:</p>		<p>Signature:</p>
<p>Designation: Date: Time:</p>		

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 <p>Children's Health Queensland Hospital and Health Service Child & Youth Community Health Service</p> <p>Family Health Assessment</p>	(Affix patient identification label here)	
	URN: Family Name: Given Names: Address: Date of Birth: Sex: <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> I	
Domestic and Family Violence (Discuss using suggested questions in Section 4 of the <i>Family Health Assessment Guideline</i>)		
What relationship issues are identified with the family that may impact on their child and/or parenting? (describe)		
<input type="checkbox"/> Nil <input type="checkbox"/> Past abuse - abuse as a child <input type="checkbox"/> Current environment abuse <input type="checkbox"/> Other		
Maternal		
Paternal		
Alcohol, Tobacco and Other Drug Use (Discuss using suggested questions in Section 5 of the <i>Family Health Assessment Guideline</i>)		
What substance use issues are identified with the family that may impact on their child and/or parenting? (describe)		
<input type="checkbox"/> Nil <input type="checkbox"/> Alcohol use <input type="checkbox"/> >2 standards drinks per day <input type="checkbox"/> >5 standard drinks on any one occasion <input type="checkbox"/> Tobacco use <input type="checkbox"/> Psychoactive drug use <input type="checkbox"/> Prescribed medications <input type="checkbox"/> Other		
Maternal		
Paternal		
Name:		Signature:
Designation:	Date: Time:	

APPENDIX 3 (4)

 <p>Children's Health Queensland Hospital and Health Service Child & Youth Community Health Service</p> <p>Family Health Assessment</p>	<p>(Affix patient identification label here)</p> <p>URN:</p> <p>Family Name:</p> <p>Given Names:</p> <p>Address:</p> <p>Date of Birth: Sex: <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> I</p>
<p>Pregnancy Outcomes (Discuss using suggested questions in Section 6 of the <i>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? (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 complications, birth trauma)</p>	
<p>Infant Health (Discuss using suggested questions in Section 6 of the <i>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 <i>Newborn Assessment</i> and describe)</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?</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><input type="checkbox"/> Peer/interdisciplinary review required <input type="checkbox"/> Care plan documented</p>	
<p>Thank the parent for their participation.</p>	
<p>Name:</p>	<p>Signature:</p>
<p>Designation:</p>	<p>Date: Time:</p>

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00007-800037

<div style="text-align: center;"> Children's Health Queensland Hospital and Health Service </div> <div style="text-align: center; margin-top: 20px;"> Domestic Violence Inventory </div>	<div style="text-align: center; margin-top: 20px;"> (Affix patient identification label here) </div>
Health professional to explain the following in own words <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. 	URN: _____ Family Name: _____ Given Names: _____ Address: _____ Date of Birth: _____ Sex: <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> I
Health worker to ask the following questions of ALL female patients on their own.	
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
If domestic violence has been identified in any of the above questions, continue to questions 5 & 6	
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
Doctor's name: _____ Address: _____ Ph: _____	Signature of client: _____ Date: _____
DV Risk Status Domestic violence not identified <input type="checkbox"/> Domestic violence identified, help refused <input type="checkbox"/> Domestic violence identified, help provided <input type="checkbox"/> Provided with: Contact phone numbers for DV <input type="checkbox"/> Written information for DV <input type="checkbox"/> Referral to hospital-based service <input type="checkbox"/> Referral to community DV service <input type="checkbox"/> Referral to GP <input type="checkbox"/> Other (state): _____	Screening not completed due to: Presence of partner <input type="checkbox"/> Presence of family members / friends <input type="checkbox"/> Absence of interpreter <input type="checkbox"/> Women refused to answer the questions <input type="checkbox"/> Additional comments: _____ _____ _____
Name: _____ Designation: _____	Signature: _____ Date: _____ Time: _____

 <p>Children's Health Queensland Hospital and Health Service</p> <p>Edinburgh Postnatal Depression Scale (EPDS)</p>	<p>(Affix patient identification label here)</p> <p>URN:</p> <p>Family Name:</p> <p>Given Names:</p> <p>Address:</p> <p>Date of Birth: Sex: <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> I</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>Yes, all the time</td> <td style="text-align: center;"><input type="radio"/></td> <td></td> </tr> <tr> <td>Yes, most of the time</td> <td style="text-align: center;"><input checked="" type="radio"/></td> <td>This would mean 'I have felt happy most of the time during the past week'.</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>Please complete the other questions in the same way.</td> </tr> </table>		Yes, all the time	<input type="radio"/>		Yes, most of the time	<input checked="" type="radio"/>	This would mean 'I have felt happy most of the time during the past week'.	No, not very often	<input type="radio"/>		No, not at all	<input type="radio"/>	Please complete the other questions in the same way.
Yes, all the time	<input type="radio"/>												
Yes, most of the time	<input checked="" type="radio"/>	This would mean 'I have felt happy most of the time during the past week'.											
No, not very often	<input type="radio"/>												
No, not at all	<input type="radio"/>	Please complete the other questions in the same way.											
In the past 7 days:													
<p>1. I have felt 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>2. I have looked forward with enjoyment to things:</p> <p>As much as I ever did <input type="radio"/></p> <p>Rather less than I used to <input type="radio"/></p> <p>Definitely not so much now <input type="radio"/></p> <p>Hardly 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>4. I have felt worried and anxious for no very 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>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 as much <input type="radio"/></p> <p>No, 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 <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>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>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>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>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>												
Administered / reviewed by:													
Name:	Date:												
Designation:	Time:												

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00007:256140

Name	DOB	UR No
<h2>Edinburgh Postnatal Depression Scale¹ (EPDS)</h2> <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 <i>Beyond Blue: The National Depression Initiative, 2007</i></p> <p>Information Line: 1300 22 4636 W: www.beyondblue.org.au</p>		
<h2>Scoring</h2> <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>		
<h2>Instructions for using the Edinburgh Postnatal Depression Scale</h2> <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>Sources</p> <ol style="list-style-type: none"> 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. K.L. Wisner, B.L. Parry, C.M. Piontek, Postpartum Depression <i>N Engl J Med</i> vol. 347, No3, July 18, 2002 194-199. 		

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APPENDIX 6 (1)

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00007:800025

 <p>Children's Health Queensland Hospital and Health Service Child & Youth Community Health Service</p> <p>Clinician Assessment of Breastfeeding & Lactation</p>		(Affix patient identification label here)		
Child's age:	Gestation:	URN: _____		
Birth weight:	Weight today:	Family Name: _____		
Reason for attending:		Given Names: _____		
		Address: _____		
		Date of Birth: _____ Sex: <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> I		
Maternal social support:				
Maternal confidence in breastfeeding:				
Previous advice or plan of care provided by others:				
Birth and Pregnancy History	Y	N	N/A	Comment
Assisted fertility / conception				
Vaginal				
Surgical birth				
Medication in labour: • Narcotic analgesia • Epidural • Spinal • Nitrous oxide				
Postnatal Experience				
Skin to skin contact following birth				
Separation from baby				
Supplementation				
Lactation aid: • Bottle • SNS Supplemental Nursing System • Nipple Shield • Other:				
Pacifier				

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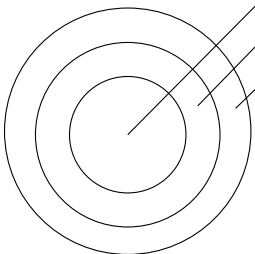
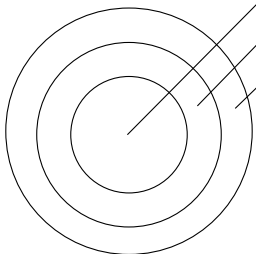
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Name		DOB			UR No
Child Assessment	Y	N	N/A	Comment	
Number of breastfeeds in past 24 hours:	Number and volume of formula or expressed breastmilk feeds in past 24 hours:				
<ul style="list-style-type: none"> • Normal general appearance • Facial symmetry • Palate intact • Tongue Tie • Other: 					
Elimination: Wet nappies – number and colour					
Stools – number and colour					
Parent recognises feeding cues?					
<ul style="list-style-type: none"> • Early • Mid • Late 					
Breast Appearance & Assessment					
Nipples: <ul style="list-style-type: none"> • Inverted • Flat • Nipple trauma • Intact 					
Breasts: <ul style="list-style-type: none"> • Soft • Full • Engorged • History of breast surgery 					
<div style="display: flex; justify-content: space-around;"> <div style="text-align: center;"> <p>Right breast</p>  </div> <div style="text-align: center;"> <p>Left breast</p>  </div> </div>					
Breastfeed Observation					
<ul style="list-style-type: none"> • Nutritive sucking • Non-nutritive sucking • Clicking • Swallowing: Audible Observed 					
Latch Dyad needing assistance Baby refuses Level of comfort as identified by mother: 1 No pain or discomfort 2 Slight tugging 3 Moderate pain 4 Severe pain 5 Extreme pain					
Plan					
Name:			Date:		Signature:
Designation:			Time:		

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APPENDIX 7 (2)

Name	DOB	UR No
Developmental Assessment		
Has the parent / carer any concerns with their child's development? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Posture and Large Movements	Y	N
✓ Supine: Mildly extensor, good limb movements, head to midline and side to side		
✓ Supine: Brings hands together into midline		
✓ Prone: Lifts head up and upper chest well with weight on forearms >15 secs; good head control		
✓ Attempts to roll from supine to side (bringing arm across body) or prone to side		
✓ Pulled to sit: Little or no head lag		
✓ Supported sitting: Head held steady, back nearly straight		
Vision and Fine Movements	Y	N
✓ Follows / turns head to suspended object at 30-45cm full range 180° (crossing midline)		
✓ Watches face and follows with eye movement		
✓ Hands unclenched – voluntary hand grasp if finger or rattle placed on palm		
Communication and Hearing	Y	N
✓ Turns head towards sound source		
✓ Vocalising (squeals, gurgles, laughs aloud, chuckles)		
Social Behaviour and Play	Y	N
✓ Smiles, plays with parent / carer, anticipates being picked up		
✓ Holds toy, plays with own fingers, attempts to reach for toy		
✓ Regards own hands		
✓ Aware of familiar situations / aware of new situations		
Guidelines for Developmental Assessment <ul style="list-style-type: none"> • ✓ indicates that this particular skill should have been acquired at appropriate age level • If in any one section (e.g. 'Posture and Large Movements', 'Communication and Hearing' etc) one ✓ is not achieved consult appropriately if required and/or implement a plan and then review. • If two or more skills with the ✓ 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>		
Assessment Outcome		
<input type="checkbox"/> Satisfactory / Pass <input type="checkbox"/> Review <input type="checkbox"/> Refer		
Anticipatory Guidance (tick if discussed)		
Items need only be ticked / used as required. They provide some guidance as to relevant issues for the age. Prioritise according to need.		
<input type="checkbox"/> Feeding / solids – signs of readiness <input type="checkbox"/> Immunisation <input type="checkbox"/> Oral health <input type="checkbox"/> Stimulating language <input type="checkbox"/> Play <input type="checkbox"/> Adjustment to parenting <input type="checkbox"/> Being a family <input type="checkbox"/> Never shake a baby	<input type="checkbox"/> Maternal / family mental health & wellbeing <input type="checkbox"/> Parent self-care <input type="checkbox"/> Parent supports / groups <input type="checkbox"/> Safe sleeping / SUDI <input type="checkbox"/> Safe medication admin & 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
Comments / plan:		
Name:		Signature:
Designation:	Date: Time:	

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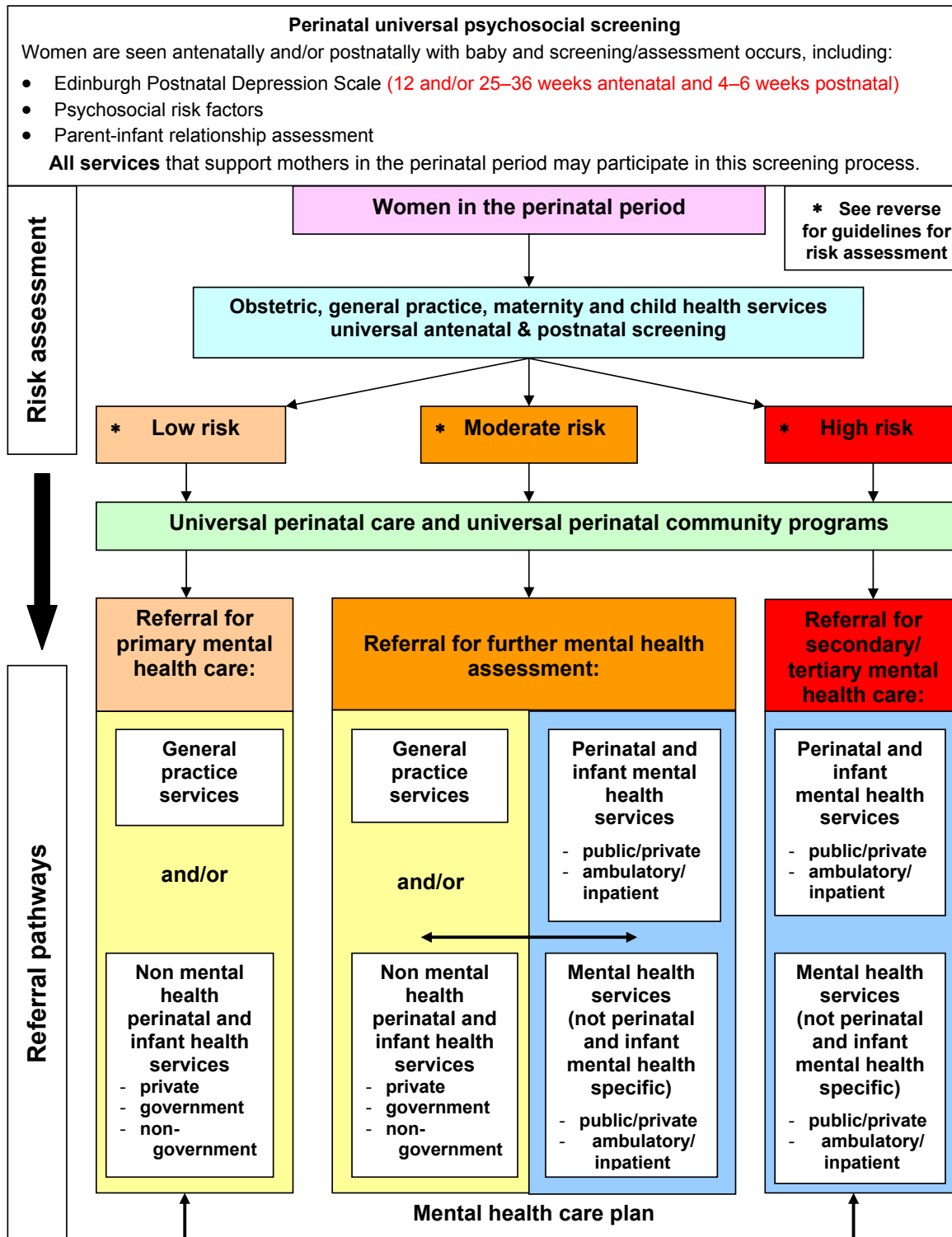
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Perinatal and infant mental health universal risk assessment and referral pathways



Business Plan

.....State Secondary School

School Based Youth Health Service

2020

The School Based Youth Health Service is centred on early intervention, harm minimisation and prevention.

The purpose of the School Based Youth Health Nurse Service is to:

- Promote positive health outcomes for young people through the delivery of accessible, acceptable, appropriate and culturally respectful Primary Health Care Services in the school setting;
- Provide the opportunity for young people, their parents/carers, and members of the school community to access a health professional in the school setting for matters relating to the health and well-being of young people;
- Support school communities to adopt a whole of 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. This is achieved through:
 - Curriculum, teaching and learning activities
 - Provision of health information and referral
 - Supporting the development of an environment and school culture that supports health and well-being.

The planning of health education and health promotion activities should occur in partnership with the school's leadership, health and well-being teams and consist of evidenced based resources and programs in response to health priority areas. This ensures the activities the School Based Youth health Nurse (SBYHN) provides relate to student/school, local, state and national health priorities.

Queensland Department of Health Strategic Plan 2016 – 2020 https://www.health.qld.gov.au/_data/assets/pdf_file/0026/662921/strategic-plan-16-20-v5.pdf

Queensland Sexual Health Strategy 2016 – 2021 https://www.health.qld.gov.au/_data/assets/pdf_file/0024/601935/qh-sexual-health-strategy.pdf

Queensland Mental Health, Drug and Alcohol *Strategic Plan 2014–2019* https://www.qmhc.qld.gov.au/wp-content/uploads/2014/10/QMHC-Mental-Health-Drug-and-Alcohol-Strategic-Plan-2014-2019_web.pdf

This Business Plan is not designed to articulate all the work undertaken by the SBYHN, but provides a strategic overview for addressing the agreed activities.

Agreement

We the undersigned, as representatives of the School Based Youth Health Nurse Service of Child and Youth Community Health Services, Children's Health Queensland Hospital and Health Service,
and State Secondary School, Education district, Department of Education and Training, hereby agree to work together to achieve the strategies outlined in the Business Plan by the end of the academic year at State Secondary School.

For the School Based Youth Health Nurse Service

Clinical Nurse Consultant: Signed _____ Date: _____
School Based Youth Health Nurse: Signed _____ Date: _____

For State Secondary School:

Principal [Insert name] Signed _____ Date: _____
OR delegate: Signed _____ Date: _____

Insert document title

Health Priority Area

Core Business	Strategic Direction	Action Steps	Persons Involved/ Responsible	Timeframe	Resources Required	Expected Outcomes
Whole of School Health Promotion	Focus area 1					
	Curriculum teaching and learning					
	School Organisation, ethos and environment					
	Partnerships and Services					
Core Business	Strategic Direction	Action Steps	Persons Involved/ Responsible	Timeframe	Resources Required	Expected Outcomes
Whole of School Health	Focus area 2					
	Curriculum teaching and learning					

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	School Organisation, ethos and environment					
	Partnerships and Services					

Repeat focuss areas as required

Core Business	Strategic Direction	Action Steps	Persons Involved/Responsible	Timeframe	Resources Required	Expected Outcomes
Provision of SBYHN enhanced services within the school	SBYHN Enhanced Services					
	Curriculum teaching and learning					
	School Organisation, ethos and environment					
	Partnerships and Services					

Children's Health Queensland Hospital and Health Service

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Enhanced Services needs separate signing as an additional service.

For the School Based Youth Health Nurse Service

For [Insert school name] State Secondary School:

Principal[Insert name] Signed_____ Date:

Agenda

Local Consultative Team Meeting

SBYHN Service, Children's Health QLD and Department of Education State Secondary School

Date: [Insert date]

Time: [Insert time]

Venue: [Insert venue]

Apologies: [Insert names]

No	Item	Attachments	Time	Resp. officer
1	Meeting opening			
1.1	Welcome and apologies			
1.2	Confirmation of the previous minutes			
1.3	Business arising from the previous minutes			
2	Report of Business Plan			
2.1	BP report discussed/ New BP tabled			
2.2	Health priority areas discussed/ identified			
3	SBYHN Health Consultations/Engagement			
3.1	Feedback on health consultations/ engagement (de identified)			
3.2	Appointment/ referral systems and processes			
3.3	Emerging issues			
4	School Community Participation/Engagement			
4.1	Feedback from meetings attended			
4.2	Opportunities for engagement with key stakeholders			
4.3	Upcoming curriculum planning days			
5	WH&S and Risk Management			
5.1	Feedback on room audits			
6	Professional and HHS Requirements			
6.1	Upcoming professional and organisational requirements			
7	Provision of Enhanced Services			
7.1	Feedback of note			
7.2	Emerging issues			
8	Acknowledgement of Feedback			



APPENDIX 10 (2)

Agenda				
8.1	Stakeholder Evaluation feedback			
9	Any Other Business			
9.1				
9.2				
10	Relevant Documents			
10.1	MOU & PMG			
11	Next LCT meeting date set:			

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Children's Health Queensland Hospital and Health Service

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Children's Health Queensland Hospital and Health Service		(Affix patient identification label here)	
Genogram		URN:	
		Family Name:	
		Given Names:	
		Address:	
		Date of Birth:	
Sex: <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> I			
Full name:		URN:	FIN:
		Date of birth:	
PLEASE ENSURE GENOGRAM IS COMPLETED			
Legend: <input type="checkbox"/> Male (placed left) <input type="checkbox"/> Trans Male <input type="checkbox"/> Intersex Male <input type="checkbox"/> Unknown <input type="checkbox"/> Female (placed right) <input type="checkbox"/> Trans Female <input type="checkbox"/> Intersex Female Offspring/s // Divorce / Separation ... Family Grouping <input checked="" type="checkbox"/> Death			
Name:		Signature:	
Designation:		Date:	

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GENOGRAM

APPENDIX 12 (1)

* HEEADSSS adapted from Goldenring and Cohen 1988



Children's Health Queensland
Hospital and Health Service
School Based Youth Health Nurse Service

Young Person Health Record HEEADSSS* Assessment

(Affix patient identification label here)

School:

URN:

Year level:

Family Name:

Psychosocial Assessment

Given Names:

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)?

Address:

Date of Birth: Sex: ☐ M ☐ F ☐ I

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?

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 e.g. do you walk to school, ride bike etc (nutrition, vegetarianism, eating patterns, weight gains/loss, fitness energy)?

Breakfast:

Lunch:

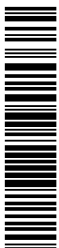
Dinner:

Snacks:

A – Activities, 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? How much sleep do you get? Consider hobbies, belonging to peer group, peer activities & venues, lifestyle factors.

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APPENDIX 12 (2)

 <p style="text-align: center;">Children's Health Queensland Hospital and Health Service</p> <p style="text-align: center;">School Based Youth Health Nurse Service</p> <p style="text-align: center; font-weight: bold; font-size: 1.2em;">Young Person Health Record HEEADSSS* Assessment</p>	<p style="text-align: center;">(Affix patient identification label here)</p>
<p>D – Drug Use / Cigarettes / Alcohol</p> <p>Many young people at your age starting experimenting with cigarettes / drugs / alcohol. Have you or 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> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/>	
<p>S – Sexual Activity & Sexuality</p> <p>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)?</p> <p>Older adolescent – do you identify yourself as being heterosexual or gay, lesbian, bisexual, transgender or questioning your sexuality. Consider sexual activity, puberty/menstruation, safe sex practices, same sex attraction, STI screening, pregnancy.</p> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/>	
<p>S – Suicide, Self Harm, Depression</p> <p>How have you been feeling lately – happy / sad / teary? Sometimes when people feel really down they feel like hurting themselves. Have you ever felt that way? If yes, explore self harm, recency, plans, lethality and protective factors. Develop <i>Safety Plan</i> if appropriate (consider normal vs clinical depression, anxiety, reactions to stress, sleep, mood, if appropriate, mental status exam, risk assessment, relapse plan).</p> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/>	
<p>How would you describe your happiness on a scale of 1 – 10?</p> <p>(Sad) 1 _____ 10 (Happy)</p>	
<p>S – Safety / Spirituality</p> <p>Some people have had some traumatic things happen in their life – has anything happened to you? Have you ever been seriously hurt? Is there a lot of violence at home/school/neighbourhood? Have you ever got into a physical fight? 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 e.g. helmet, mouth guards, sun screen? Do you belong to a faith group or church?</p> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/>	
<p>Staff name / designation:</p>	<p>Signature:</p> <hr/> <p>Date: / / Time:</p>

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 <p>Children's Health Queensland Hospital and Health Service School Based Youth Health Nurse Service</p> <p>Young Person Mental Health Assessment</p>				(Affix patient identification label here)			
School:				URN:			
Year level:				Family Name:			
SUICIDAL RISK ASSESSMENT				Given Names:			
RISK FACTOR	Yes	No	Not known	Address:			
Hopelessness / perceived lack of control over life				Date of Birth: _____ Sex: <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> I			
History of suicide of someone close				PROTECTIVE FACTOR	Yes	No	Not known
Previous suicide attempt/s				Strong perceived social supports			
Loss or death or separation of friend/ close family member including relationship break-up				Positive values and beliefs			
History of self-harm				Positive coping and problem-solving			
Stressors in last 6 months				Responsibility to society			
Lack of supportive relationships – family/ friends				Positive self-esteem			
Long-standing problems e.g. school, physical illness/pain				Ability to seek and access help			
Distress / anger				Family cohesion, connectedness			
Isolated and lonely				Identify emergency contacts			
				Current contact with Mental Health Services			
				Negotiate an agreed safety plan			
INTENT TO HARM SELF							
<input type="checkbox"/> None <input type="checkbox"/> Active <input type="checkbox"/> Plan <input type="checkbox"/> Intent <input type="checkbox"/> Means							
INTENT TO HARM OTHERS							
<input type="checkbox"/> None <input type="checkbox"/> Active <input type="checkbox"/> Plan <input type="checkbox"/> Intent <input type="checkbox"/> Means							
Clinical and Risk Assessment (considering Risk and Protective Factors)							
Overall Risk	Low	Med	High	Unknown	Comments		
Suicide							
Other self-harm							
Harm to others							
<div style="text-align: center;">  Medium / High Risk requires assessment from Emergency Dept / CYMHS </div>							
SBYH CNC contacted: <input type="checkbox"/> Yes <input type="checkbox"/> No				School / GP contacted: <input type="checkbox"/> Yes <input type="checkbox"/> No			
CYMHS contacted: <input type="checkbox"/> Yes <input type="checkbox"/> No				Care Review completed: <input type="checkbox"/> Yes <input type="checkbox"/> No			
Clinician name:						Clinician signature:	
Designation:						Date:	

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<p>Children's Health Queensland Hospital and Health Service</p> <p>School Based Youth Health Nurse Service</p>		<p>(Affix patient identification label here)</p>																																																	
Young Person Case Review																																																			
School:		URN: _____																																																	
Year level:		Family Name: _____																																																	
Identify	Review Type: <input type="checkbox"/> Clinical Nurse Consultant / Peer Review <input type="checkbox"/> Interdisciplinary Case Review: _____		Given Names: _____ Address: _____ Date of Birth: _____ Sex: <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> I																																																
	Clinician Details Name / designation: _____ Service: _____ Signature: _____ Date: / /																																																		
	Reason for presentation: _____																																																		
	HEEADSSS / Circumstances (critical events)																																																		
Situation	Home: _____ <input type="checkbox"/> Yes	Presenting Issues (tick appropriate box) <table border="1" style="width: 100%; border-collapse: collapse;"> <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"/></td><td style="text-align: center;"><input type="checkbox"/></td></tr> <tr><td>Mental health concern</td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td></tr> <tr><td>Drug usage</td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td></tr> <tr><td>Tobacco usage</td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td></tr> <tr><td>Alcohol usage</td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td></tr> <tr><td>Relationship – B/G</td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td></tr> <tr><td>Relationship – Family</td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td></tr> <tr><td>Relationship – Peer</td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td></tr> <tr><td>Abuse</td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td></tr> <tr><td>Bullying</td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td></tr> <tr><td>Loss</td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td></tr> <tr><td>Disability</td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td></tr> <tr><td>Stress</td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td></tr> <tr><td>Sexual Health</td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td></tr> <tr><td>Other: _____</td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td></tr> </tbody> </table>			Student	Parents	Medical illness	<input type="checkbox"/>	<input type="checkbox"/>	Mental health concern	<input type="checkbox"/>	<input type="checkbox"/>	Drug usage	<input type="checkbox"/>	<input type="checkbox"/>	Tobacco usage	<input type="checkbox"/>	<input type="checkbox"/>	Alcohol usage	<input type="checkbox"/>	<input type="checkbox"/>	Relationship – B/G	<input type="checkbox"/>	<input type="checkbox"/>	Relationship – Family	<input type="checkbox"/>	<input type="checkbox"/>	Relationship – Peer	<input type="checkbox"/>	<input type="checkbox"/>	Abuse	<input type="checkbox"/>	<input type="checkbox"/>	Bullying	<input type="checkbox"/>	<input type="checkbox"/>	Loss	<input type="checkbox"/>	<input type="checkbox"/>	Disability	<input type="checkbox"/>	<input type="checkbox"/>	Stress	<input type="checkbox"/>	<input type="checkbox"/>	Sexual Health	<input type="checkbox"/>	<input type="checkbox"/>	Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
				Student	Parents																																														
	Medical illness			<input type="checkbox"/>	<input type="checkbox"/>																																														
	Mental health concern			<input type="checkbox"/>	<input type="checkbox"/>																																														
	Drug usage			<input type="checkbox"/>	<input type="checkbox"/>																																														
	Tobacco usage			<input type="checkbox"/>	<input type="checkbox"/>																																														
	Alcohol usage			<input type="checkbox"/>	<input type="checkbox"/>																																														
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Relationship – Peer	<input type="checkbox"/>	<input type="checkbox"/>																																																	
Abuse	<input type="checkbox"/>	<input type="checkbox"/>																																																	
Bullying	<input type="checkbox"/>	<input type="checkbox"/>																																																	
Loss	<input type="checkbox"/>	<input type="checkbox"/>																																																	
Disability	<input type="checkbox"/>	<input type="checkbox"/>																																																	
Stress	<input type="checkbox"/>	<input type="checkbox"/>																																																	
Sexual Health	<input type="checkbox"/>	<input type="checkbox"/>																																																	
Other: _____	<input type="checkbox"/>	<input type="checkbox"/>																																																	
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																																																			
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: _____																																																			

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 <p>Children's Health Queensland Hospital and Health Service School Based Youth Health Nurse Service</p> <p>Young Person Potential Eating Disorder Assessment Tool</p>		(Affix patient identification label here)	
School:		URN:	
Year level:		Family Name:	
<p>Initially undertake HEEADSSS Assessment – explore '(E) Eating and Exercise' section</p>		Given Names:	
		Address:	
		Date of Birth: Sex: <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> I	
		Yes	No
Do other people express concern about your weight or eating?			
Do you worry you have lost control over how much you eat?			
Has your weight or body shape influenced how you judge yourself as a person?			
Are you worried/afraid of gaining weight or getting fat?			
Do you believe yourself to be fat when others say you are too thin?			
Do you try things to manage your weight?			
<input type="checkbox"/> Restricting food intake <input type="checkbox"/> Excessive intense exercise <input type="checkbox"/> Use of laxatives <input type="checkbox"/> Induce vomiting			
Have you recently lost more than 6kg in a three-month period?			
Do you make excuses to avoid family or social activities that involve food e.g. meal times?			
Do you regularly overeat (more food than most people would in a similar situation) quickly and feel a lack of control?			
Do you ever eat in secret?			
Do you feel ashamed at the amount of food you have eaten in one episode?			
If yes to any of the above questions plus weight loss consider 'PHYSICAL SIGNS' and refer as below			
PHYSICAL SIGNS			
Pulse rate – Lying: bpm Standing: bpm			
If <50 bpm or >120 bpm or postural increase in heart rate >20 ► SEND TO EMERGENCY			
If client complains of: <input type="checkbox"/> Chest pain <input type="checkbox"/> Shortness of breath			
<input type="checkbox"/> Palpitations <input type="checkbox"/> Fainting ► REFER TO EMERGENCY			
If client: <input type="checkbox"/> Appears very underweight			
<input type="checkbox"/> Periods have stopped			
<input type="checkbox"/> Fatigue/muscle weakness ► REFER TO GP OR CYMHS ASAP			
CNC consulted: <input type="checkbox"/> No <input type="checkbox"/> Yes ► date:			
NOTES:			
Name:		Signature:	
Designation:			
Date:			

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