Food allergy is estimated to occur in approximately 1 in 20 children. The majority of food allergies are not known to be associated with an increased risk of food allergy. However, the allergy that a child develops might not be the same as the parents’ allergies. Despite this, most children with food allergy do not have parents with food allergy (Australian Society of Clinical Immunology and Allergy [ASCIA], 2009).

PREVENTION OF FOOD ALLERGY – WHAT YOU CAN DO

The following advice (based on information from the Australian Society of Clinical Immunology and Allergy [ASCIA], 2009) may be offered if parents are concerned that their baby may be at risk. Alternatively, parents may be concerned by stories in the media about children who have had severe anaphylactic reactions to nuts. Often food allergy and food intolerance are discussed as interchangeable problems. However, there are important differences. Food allergy is defined as a reaction that is due to an immunological mechanism, usually immunoglobulin E (IgE), the reaction may be immediate or delayed, and mild or severe. A severe reaction may be an anaphylactic reaction. Food intolerance refers to reactions involving known or unknown non-immunological mechanisms (Wilson, 2008).

Food allergy may be a problem for their baby.

• Introduce solid foods from the age of 4-6 months** and when the baby is showing signs that he or she is ready. When introducing the baby to solid food, new foods can be introduced gradually. A discussion with a Paediatrician or Accredited Practising Dietitian may be helpful when considering hydrolysed foods.

**Please note: The National Health and Medical Research Council (NHMRC) currently recommends that babies are exclusively breastfed for the first six months of life. After six months, solids can be introduced in conjunction with breastfeeding.

DIAGNOSING FOOD ALLERGIES AND INTOLERANCES

Almost 95% of food allergies are caused by seven foods: cows’ milk, hen’s eggs, soybeans, tree nuts in a peel (Brazil, cashew), wheat, and fish and shellfish (ASCIA, 2009). The most common food intolerance is due to dairy products, food additives (including flavour enhancers such as monosodium glutamate (i.e. MSG), strawberry, citrus fruit, tomatoes, red wine and other foods containing histamines). Raising Children Network, 2009.

Children who are displaying the symptoms of food allergy or intolerance generally need to be reviewed by a doctor who may refer the child to an allergist for testing. Tests for sudden-onset allergies include:

Skin-prick test (SPT): a small amount of the suspected food (the subject that causes an allergy) is placed on the skin and then pricked with a sharp needle. If the wheal (swell) forms at the test site if the child is allergic to the suspected allergen.

Oral food challenge: the child will eat the food and the allergist will watch to see what happens. This test measures the risk of a child having an allergy and reaction and should be conducted by a specialist in a supervised setting.

Medical Research Council (NHMRC) currently recommends that babies are exclusively breastfed for the first six months of life. After six months, solids can be introduced in conjunction with breastfeeding.

There is some evidence that hydrolysed formulas may reduce the risk of allergy in high-risk infants – e.g. where there is a history of allergy in their parents or siblings. In Australia and New Zealand, only partially hydrolysed formulas (usually labelled ‘HA’ or ‘Hyposensitised’) are recommended for allergy prevention. These are different to extensively hydrolysed formula (EHF), which is only available on prescription for treatment of cows’ milk allergy. A discussion with a Paediatrician or Accredited Practising Dietitian may be helpful when considering hydrolysed foods.

Food allergies

• Blood tests: a blood test called the radio allergosorbent test (or RAST) can be used, along with the SPT.

Elimination diet: this can be useful to see if a cow’s milk RAST has detected an allergy to certain foods. The child will be asked to avoid eating certain foods. A discussion with a Paediatrician or Accredited Practising Dietitian may be helpful when considering nutrients.

• Introduction of solids before 12 months* and when the baby is showing signs that he or she is ready. When introducing the baby to solid food, new foods can be introduced gradually. A discussion with a Paediatrician or Accredited Practising Dietitian may be helpful when considering hydrolysed foods.

*Please note: The National Health and Medical Research Council (NHMRC) currently recommends that babies are exclusively breastfed for the first six months of life. After six months, solids can be introduced in conjunction with breastfeeding.

Food allergy is estimated to occur in approximately 1 in 20 children. The majority of food allergies are not associated with an increased risk of food allergy. However, the allergy that a child develops might not be the same as the parents’ allergies. Despite this, most children with food allergy do not have parents with food allergy (Australian Society of Clinical Immunology and Allergy [ASCIA], 2009). This paper seeks to describe the experiences of health professionals to support vulnerable families accessing their service to feel safe, respected and welcome.

COMMUNITY PAEDIATRIC REVIEW

ENSURING OUR SERVICES ARE INCLUSIVE

COMMUNITY INTERVENTION REVIEW

It is well established that the vulnerable groups in our society (those who need our services the most) access services the least. This is particularly true for Aboriginal and Torres Strait Islander families. While it is true that Aboriginal and Torres Strait Islander families commonly suffer the worst outcomes, we also need to look at ‘unusual outcomes as social injustices, rather than as products of disadvantage’ (Brackertz et al., 2008). There is a growing consensus that, rather than focusing on client numbers, we need to work to reduce barriers and to improve how we engage with our clients. The Federal Government has acknowledged the problems with accessing services among those who most need them and has included a priority (www.socialclusion.gov.au) with the establishment of the Australian Social Inclusion Board. They are funding initiatives to support both families and workers in our sector to get to and give the most out of available resources. In this way, the government is working with the sector to increase the likelihood of people finding services and retaining them to support their children.

Looking forward

Our own preconceptions and assumptions can play a role in the difficulties faced by some families in making contact with their local services. We need to work to understand our clients, improve our services, and work with others to ensure that our clients are treated with respect. We are trying to engage (Brackertz, 2007). The Federal Government has acknowledged the problems with accessing services among those who most need them and has included a priority (www.socialclusion.gov.au) with the establishment of the Australian Social Inclusion Board. They are funding initiatives to support both families and workers in our sector to get to and give the most out of available resources. In this way, the government is working with the sector to increase the likelihood of people finding services and retaining them to support their children.

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Formal services cannot and should not replace family or informal support, however there is potential for services to get alongside and build the capacity of these informal networks (Katz, 2004).

The highest level of social and economic resources in Australia, around 37% of parents regard themselves as not needing services to get alongside and build the capacity of these informal networks (Katz, 2007).

Housing. Housing has to offer (listening, taking part in interactive reading supporting materials etc).

Clearing each of these hurdles requires considerable effort and strategic planning on the part of service providers, yet it is clear that in fact, quite often much more effort and thought goes into designing the content of the intervention than in planning how to deal with implementation challenges.

**What are the barriers?**

Based on a review of the barriers to vulnerable families accessing mainstream services, Katz, LaFae and Hartung (2004) identify a number of strategies which can be used by family and parental support services to engage with parents. Some of the strategies which families especially found useful are: Targeted services could link more effectively with ‘first to know’ agencies such as Housing, Centremilk, child health services and general practitioners. Some services which are often the first to know what is happening to vulnerable parents are undervalued by more targeted, or secondary level, family support services. Leveraging the contact that ‘first to know’ agencies have with eligible families could particularly apply in the case of general practitioners, child health services, Centremilk and Housing.

Non-formal, non-stigmatising environments (schools, childcare) are well placed to assist parents who do not trust formal services. Parents indicate that schools and childcare are their most trusted source of support they also tend to be ambivalent and fragile.

Building the capacity of informal networks is a concern for emotional support if they are respectful, flexible and consistent. These informal networks (Katz, 2007) can help parents to understand and navigate the social and economic resources available to their children.

Informing and targeting. Consultation with service users and their involvement in planning services can be an effective means of reducing barriers to engagement and advancing social inclusion. Information and advice needs to be tailored not only in content but also in the mode of delivery, so that parents from different groups can have equal access.

Community development approaches. Parents can be included in services at a number of levels other than as service users, e.g. decision-making processes within service delivery, involvement in case planning, and involvement in service evaluation monitoring service planning, and strategic planning. Community development approaches have enormous potential for increasing the engagement of parents.

Children’s learning is compromised by a number of factors. Our dilemma is that many of the children who are missing out on the opportunities available for development in their early years come from families whose parents are likely to ask for help in the future. This makes it more likely that they will allow problems to escalate. This makes it more likely that they will become disillusioned with services and are less likely to ask for help in the future. This makes it more likely that they will become disillusioned with services and are less likely to ask for help in the future.

Questions the assumptions you have about the families particularly those without power. To reduce the power imbalance and to help parents to use services more accessible, consider:

**Being mindful of our symbols of power – our uniform, the stethoscope, the office structure (placement of chairs, etc)

**Sitting alongside, not opposite guests or clients (e.g. Aboriginal and Torres Strait Islander parents, young parents, refugee parents)

**Exploring the clients’ understanding of a particular subject before you ‘induct’ them

**Questioning the assumptions you have about the parents – are any of them naïve?

Finaly it does depend on whether you do many of them well, and have different values and beliefs, it is really important that we question our right to advise. This means that the children are not able to have their parents in the flats and also that they would not let their children invite friends friends or relatives to visit them in the flats and also that they would not let their children invite friends

**Community development approaches have enormous potential for increasing the engagement of parents.

**Any of these barriers being met?**

In an Australian study of strategies to promote more inclusive and universal early childhood services in Lefebvre, Fraser and Lambourne (2004) conclude that, despite the limited data, what was available suggested the majority of children and parents make good use of existing services. However, it was also clear that service use varied along a continuum from very high to very low, and that there was a small but significant minority of families that underused some of these services to get alongside and build the capacity of these informal networks.

**Acceptance of your advice.**

Parents whose request for help is turned down can be more likely to trust you, tell you their story and accept (comply) with your advice.

Being mindful of our symbols of power – our uniform, the stethoscope, the office structure (placement of chairs, etc)