



## Child and Adolescent Health Service (CAHS)

**Inquiry Submission:** The most effective ways for Western Australia to address food insecurity for children and young people affected by poverty

8 June 2022



Healthy kids, healthy communities

Compassion

Excellence

Collaboration

Accountability

Equity

Respect

Neonatology | Community Health | Mental Health | Perth Children's Hospital

The information in this submission has been provided by the CAHS Refugee Health Service (RHS) which comprises of Perth Children's Hospital Refugee Health Service (PCH-RHS) and Community Refugee Health Service (CRHS). The response has been purposely structured to address the seven terms of reference.

## **1. The impact of poor nutrition on children and young people and the extent of the problem in Western Australia.**

The RHS provides an integrated state-wide multidisciplinary service model of care to recently resettled children, adolescents and families from refugee-like backgrounds. The RHS has a tertiary hospital and community stream who work collaboratively to support families as they settle in our local Western Australian (WA) community and empowers transition over time into mainstream health services. RHS care is culturally-safe and trauma-informed, as well as nuanced for families with limited English proficiency, variable health literacy or broader socioeconomic disadvantage. From inception (2006) there has been an embedded RHS paediatric dietitian in recognition of the critical interplay of nutrition, poverty and social disadvantage and subsequent impact on growth, health and well-being outcomes. All RHS children/adolescents and parents have a history of malnutrition. For many poor nutrition and food insecurity continues post-resettlement. The services provided by RHS include home and school visiting, multidisciplinary outpatient clinics, inpatient consultation and urgent outpatient assessment for children arriving in WA with Federal health undertakings or complex care needs. The RHS is supported by professional interpreters; over 97% of refugee families are have limited English proficiency (LEP). The PCH-RHS team comprises of medical, nursing, dietetic, social work, clinical psychology and dental staff, assisted by a School of Special Educational Needs liaison teacher. The CRHS provides a comprehensive range of health promotion and early identification and intervention community-based services to newly arrived refugee children under 18 years and their primary carers with a focus on growth and development in the early years. The nursing team provide best practice health-care child-centred service delivery, clinical expertise, and specialist advanced complex client care within the community setting; collaborating and advocating with key community-based stakeholders and integrating their practice with the PCH-RHS staff. The CHRT actively support the families to access the health services in their local community and assist to find important community linkages.

RHS patients and families also have regular contact with mainstream services across CAHS through the breadth of Community Health, CAMHS, Neonates and other PCH subspecialties. RHS staff assist patients and families in navigating the complexities of our health system using a family-centred approach. Over 4500 newly arrived refugee children and adolescents have been assessed and managed through the RHS since 2006, which has been recognised as the benchmark national paediatric refugee health service.

The RHS have culturally and specialty-trained multidisciplinary staff with integrated dietitians with knowledge and experience of the relationship between trauma and food; interpreters readily available. No similar comprehensive health service directed at paediatric refugees and families is available anywhere else in WA. The majority of RHS patients have nutritional problems which require early intervention and appropriate interdisciplinary management as per community and national standards in the context of complex trauma and socioeconomic vulnerability.

### **Scale of malnutrition, poverty and food insecurity in the RHS cohort**

Malnutrition is complex to diagnose correctly as it requires extensive and specialised dietetic knowledge and clinical judgement. The causes are wide-ranging and require a true multidisciplinary approach to appropriately tackle complications and cultural risks. Refugee children experience multiple disruptions to food access and these will vary dependent on country of origin, country/countries of transit, experiences of direct war, infections or environmental hardship, family disruption, health access barriers, gender or disability considerations, detention exposures and post-resettlement challenges. Some refugee children have brief periods of acute malnutrition; in contrast many have subacute and/or chronic malnutrition with acute periods of exacerbation. This may impact on growth and health trajectories at formative periods of a child's life including early infancy and/or puberty and may result in neurocognitive impairment, disability, stunting, chronic health conditions and predispose to obesity and/or metabolic complications in adulthood. In a small percentage of children and adolescents, trauma may manifest in disordered eating and restrictive behaviours, which if not addressed in a comprehensive culturally sensitive team-based manner, may deteriorate to development of formal eating disorders requiring supplementation and/or inpatient management.

Due to the inherent vulnerabilities associated with being a newly arrived refugee or asylum seeker, as well as being culturally and ethnolinguistically diverse (ELD), these children and adolescents are more at risk of poorer health outcomes including poverty and food insecurity (Hirani et al 2018; Brophy-Williams et al 2021; Newman et al 2018, Sheikh 2009, Mutch 2012). Various demographic factors, trauma exposures and socioeconomic determinants of health relevant to this population group also need consideration which will impact on service delivery, health access, cultural appropriateness of health promotion and education programmes following resettlement. Nutritional and growth assessments are integral components of comprehensive resettlement screening and assessment as outlined in binational Australasian guidelines (Chaves et al 2016).

Children and adolescents from refugee-like backgrounds are heterogeneous and very different in transit experiences to voluntary migrants. Whilst there are some similarities to socioeconomic factors related to deprivation and disadvantage found in Aboriginal communities, the populations are different. As such models of health care for refugee and Aboriginal people need nuancing for respective cohorts reflecting differences in trauma exposure, intergenerational considerations, cultural stigma or beliefs, traditional healing practices, food preferences, language and literacy barriers, access to transportation, education and employment and broader social constructs. Use of multidisciplinary teams as well as “hub and spoke” holistic health approaches are beneficial and well received by families of refugee-like backgrounds who have competing resettlement priorities and often large family size compared to traditional Caucasian Australian families.

Diagnosing and implementing treatment requires access to longitudinal growth records (which refugees do not have), birthdates (many families do not know their child’s actual age or are randomly assigned by Immigration) and parental heights to calculate expected height potentials for the children (most of our patients’ parents have had extended transit times are likely stunted from their own long-term malnutrition). Examples include:

- Food insecurity experienced before arriving in Australia, requiring a sound understanding of overseas food availabilities (in multiple continents) to understand and request appropriate nutrition-related foods.
- Current food insecurity which is often experienced due to having large families and no access to income – this was highlighted by Newman et al (2018 JPCH).
- Understanding of the mother’s access to antenatal health care (or lack thereof) and the impacts on growth and nutrition in the infant.
- The impacts of breast milk production and composition, access to formula in various countries.
- if they’re not able to breastfeed and other breastfeeding complexities.
- Multi-system, complex and rare genetic conditions causing food refusal, growth retardation, incontinence, stomas etc. all impacting on patient’s ability and willingness to eat.
- Restrictive eating disorders likely intertwined with trauma and early childhood adversity experiences or signify impending cultural child protection risks including early child marriage.
- Lack of access to age-appropriate food and healthy choices (e.g. asylum-seekers in Held or Community detention).
- Trauma induced anxiety and depressive disorders causing food refusal and poor appetite.
- Poorly managed Autism Spectrum Disorder (ASD) related feeding practices, such as oral aversion (ASD has high prevalence rates in countries on the horn of Africa), from a lack of understanding of our health care system and how to manage this highly challenging condition.

- Impact of limited education and health illiteracy (parents and children) on knowledge and outcomes needs to be addressed sensitively and in a cultural context.
- Cultural shame and stigma related to children with disability.

### **Published WA paediatric refugee nutrition data (Newman et al)**

The RHS has undertaken a retrospective audit of over 1100 newly resettled WA refugee children and adolescents (Newman et al, 2018). This is the largest published international dataset assessing growth and nutritional needs of refugee children resettled in the developed world.

- The majority experienced socioeconomic disadvantage had limited parental education and required interpreters.
- Nutritional deficiencies were very common but varied across age and ethnicities: iron deficiency (ID) (12.3%), anaemia (7.3%) and inadequate dairy intake (41.0%).
- A third of children (32.6%) did not consume meat which was due to food insecurity rather than religious or dietary choice.
- Infant breastfeeding was sustained (77.8%) in infants <12 months. Prolonged breastfeeding (44.9% aged 12–24 months) was associated with an increased risk of ID (odds ratio 4.0, 95% confidence interval 1.4–11.6) and related to limited parental health education related to infant weaning, lack of cultural community dietetic support and parental health education.
- Of concern, the median body mass index increased significantly for those >24 months between referral and initial RHS assessment (median period 1.8 months).
- Overall, 27.1% required additional formal dietetic follow-up, with higher nutritional concerns in refugee children <24 months compared to older patients.
- Identification of frequent post-settlement nutritional concerns within the RHS cohort are captured through structured multidisciplinary paediatric health screening. Specific screening for socioeconomic influencing factors including education, language and literacy concerns, poverty and food insecurity during refugee clinical assessments is now standard practice within the multidisciplinary RHS assessments. However, this is not routinely undertaken in normal (mainstream) paediatric practice or primary care.

The CRHS continue to see high rates of iron deficiency requiring supplementation in Culturally and Linguistically Diverse (CaLD) children. There is often a correlation between this and developmental delays i.e. speech. There are also high rates of B12 deficiency. Often the poor nutrition can be contributed to food consumed i.e. high milk-based or grain based, along with appetite changes from infections such as *Helicobacter pylori* and intestinal parasites. Anaemia, iron deficiency, other blood conditions (refugeehealthguide.org.au) and tooth decay are also an impact we commonly see in CaLD children due to poor nutrition i.e. sugary foods and drinks.

## 2. Challenges for children and young people in accessing enough nutritious food

As outlined above, malnutrition and growth faltering can permanently impair children's development (Pernitez-Agan et al. 2019); while overweight and obesity is associated with increased risk of obesity in adulthood and therefore chronic disease such as diabetes and cardiovascular disease (Pernitez-Agan et al. 2019). Given the importance of nutrition and adequate growth in childhood/adolescents, ensuring newly arrived refugees have access to effective dietetic education that results in changes in eating habits is essential to ensure adequate nutrition, optimise early resettlement health preventative measures and provide culturally relevant education which is age and ethnolinguistically appropriate. Such measures will assist in addressing the health risks and negative sequelae of poverty and food insecurity, but also be cost and time efficient, maximising scarce health care resources and potential lessen complications of chronic disease which increase adult non-communicable care burdens.

Food insecurity is linked to increased levels of overweight and obesity and low intake of micronutrients, fibre, fruit and vegetables (Nolan 2006). Food insecurity was reported by 55.9% of resettled Western Australian (WA) migrants and refugees, with up to 75% reported in Burmese subgroups (Pallocios 2014). Other Australian studies reinforce this high prevalence of food insecurity in resettled refugees and asylum-seekers. (Gallegos 2008, McKay, Nolan 2006). Population linkage data have also demonstrated the impacts on maternal health, antenatal care, birth outcomes and early growth restriction in WA children of immigrant backgrounds (Abdullahi 2019) reflecting the need to have a whole of population approach to child and adolescent poverty and food insecurity concerns.

Our local WA data (Newman 2018) demonstrate the high percentage of refugees requiring nutritional follow-up, highlighting the importance of embedding dietetic personnel within holistic resettlement assessments. The RHS has now developed resources for a culturally and linguistically diverse population accommodating literacy requirements (pictorial base and translated) to facilitate care between specialist services, community child health and primary care (see section 6). Incorporating routine questions about food insecurity into refugee health assessments is beneficial, particularly considering meat restriction and socio-economic disadvantage. The American Academy of Paediatrics has endorsed a two-question screening tool (Hunger Vital Sign) to be used in routine clinical assessments which is now incorporated into routine RHS first visits and dietetic evaluations.

The families require a specialist RHS dietitian who is culturally competent, has an understanding of trauma and the relationship with food, the compassion to take the time, the ability to use interpreters and translated resources to ensure understanding, the

communication skills to pitch an education at such a basic level to people who are often illiterate, and yet has the advanced clinical knowledge to correctly assess and re-correct their malnutrition with such diverse causes.

Within WA, the majority of those from refugee-like backgrounds reside in areas of highest relative national socio-economic disadvantage. Over 75% of RHS families reside in the lowest ABS ISRD deciles following resettlement. This impacts on health accessibility, access to safe spaces for play and recreation, accessibility to fresh and affordable food options, disproportionate supply of fast-food franchises and reflects restrictions on housing affordability, employment and public education options. Housing itinerancy, temporary housing, detention exposure, limited garden spaces and experiences of family domestic violence and/or use of refuges also increase disadvantage, impoverishment and access to affordable food and nutrition for some families. Private rental agreements have seen housing costs increase sharply, leaving many families with limited disposable income for food (particularly meat and fresh produce), with families choosing to pay for utilities and compromise on nutritional quality and quantity. Access to play, whilst improved on arrival in WA, remains still limited (McMillian et al 2015) increasing risks for those who are overweight or obese but cannot afford structured group exercise or paid sporting activities (eg swimming lessons or club sport).

Food insecurity, poverty, socio-economic disadvantage and malnutrition (under and over nutrition) are also linked to wider negative health outcomes in refugee children and adolescents. Emergent overweight, obesity and dental caries burden is highly prevalent in this cohort. Between 60-80% of the RHS cohort had dental caries, which is multifactorial in nature and reflects post pre- and post-resettlement factors including poor nutrition, health literacy barriers and limited options for public dental especially in children <6 years of age. (Nicol et al 2015). Access to cheap sugary drinks, fast-food items, vitamin D insufficiency, overseas lack of dental hygiene and inability to manage early childhood caries (tooth decay) are interlinked factors within refugee and other marginalised or disadvantaged paediatric groups. Poorly managed dental caries results in pain, suboptimal diet (eg difficulties in consumption of hard fruits/vegetables), poor sleep and infection risk; all these factors further negatively influence growth and nutrition and long-term health outcomes. Misconceptions in resettled families that “juice” is nutritious, junk food advertising and/or accessibility to cheap fast food here in Australia is a sign of good fortune in some communities, also further increase risks of malnutrition and dental burdens. These are important considerations when healthy food options and preventive dental care (which requires private access < 6 years) is often unattainable for families on Centrelink and/or otherwise impoverished.

There are also invisible cohorts of children who have additional challenges. These include children in detention (Held or Community), those in women’s refuges, children and families



who are on temporary visas and those who are negatively determined who have lost all access to Centrelink, work rights and Medicare. The latter rely on predominantly non-Government organisations, Foodbank parcels (often only supplied weekly) and/or good will of community members for additional food, money and housing. These children and families are below the poverty line; many parents and children have significant mental health sequelae and ongoing food insecurity. The RHS have several families in this situation.

Aboriginal children and young people experience serious challenges with access to healthy food. CAHS is currently piloting the Deadly Koolinga Chef Program to address this.

Exercise or sporting programs for children from refugee-like backgrounds or other socially disadvantaged groups are often costly and/or inaccessible due to transportation or literacy barriers. The lack of community engagement opportunities thus further limit children from “expending energy” in a supportive peer environment, and thus further reduce opportunities to negate risks related to excess consumption of non-healthy foods/suboptimal nutrition choices.

### **3. The extent to which food relief is:**

- a) Currently accessed by children and young people, including at school and in early childhood education and care settings.**
- b) Effective.**

Food relief is provided to some families from refugee-like backgrounds. However, it is not uniformly accessible and relies on extreme impoverishment and/or demonstration of relative risk to children and/or family. The RHS work closely with organisations such as the Australian Red Cross and CARAD who have associations with FoodBank and will organise food relief where required. See further detail in sections above.

Certain schools also provide excellent support and linkage to food relief within educational environments (e.g. breakfast clubs). However, many schools have a higher focus on indigenous rather than refugee-like children/adolescents despite similar socioeconomic challenges and risks of food insecurity. Food relief programmes are not always culturally accessible, known to parents of refugee-like backgrounds nor always accessible due to language barriers, shame or stigma associated with poverty. Refugee families also are less prevalent within mainstream child care settings (due to costs associated with care) so are unlikely to be accessing food relief through this avenue. COVID-19 and related home schooling has also increased marginalisation and/or invisibility of some children and adolescents, who then may have been referred to food relief programmes if they were attending school.



The food is often provided by the parents who may have reduced income for nutritious food and reduced health literacy on the impact poor nutrition has on health. Language is a barrier to accessing nutrition information, reading labels and identifying food products at supermarkets. Often families only prepare foods known to them in the country of origin and are not familiar with using cooking techniques once settled in Australia.

There are a small number of families accessing food relief. Often shame will hinder access to these services, along with the difficult process to access services in a second language. The food is often not culturally appropriate ie. not Halal or unfamiliar. Lack of transport prevents access when they do want to engage with food relief services.

#### **4. The extent to which food literacy programs aimed at children and young people and/or their parents/carers are:**

- a) Currently accessed.**
- b) Effective.**

All evidence supports early intervention for best outcomes for underweight, overweight and obese children, as well as optimising early childhood growth, nutrition and health outcomes. Food literacy programmes are essential but mainstream WA programmes fail to target key groups, especially those with limited English proficiency, linguistic or ethnocultural diversity and/or cater for parents who may be illiterate or have limited formal education.

Within the RHS, a moderate number of patients demonstrate a steep increase in growth percentile lines within the first 6 months of arriving in Australia. This can be attributed to several factors including (i) health literacy (many families have no understanding of a nutritious diet according to Australian Standards), (ii) previous severe food insecurity and (iii) differing cultural view (eg in some ethnicities obesity is a sign of prosperity and not a health concern).

Many RHS patients who lost dedicated RHS Dietitian access (between 2016 to September 2018) are now being referred on to the PCH Healthy Weight Service (HWS). Previously these families would have been managed in a timely manner preventively by the RHS Dietitian from point of initial RHS assessment. In contrast, the HWS is aimed at children who are at risk of dying from respiratory complications or developing type 2 diabetes associated with their severe obesity. The HWS is primarily designed as a group-based program. RHS patients cannot participate in groups (language, transport barriers, trauma, cultural differences, health illiteracy) and are referrals are thus declined by HWS team, further exacerbating health inequity, reducing access to food literacy and health intervention and increasing long-term health complications and cost to the WA health system. Without adequate RHS Dietetic support and culturally appropriate food literacy and nutrition programmes, RHS

children/adolescents have no service equivalent to community standard for their health diagnosis compared to Australian-born English proficient counterparts. There is also a lack of publicly funded paediatric dietetic support in secondary hospitals, outreach capacity (not including specialist services such as Diabetes) or regional/rural areas. There is inadequate resourcing within the paediatric tertiary system with resources directed to 'complex' patients. This "triage" process overlooks and minimises the clear cost-efficiency and longer-term gains of providing health intervention and food literacy education earlier, especially to families from disadvantaged backgrounds who otherwise cannot access assistance or resources. Refugee families and/or those from socioeconomically disadvantaged families do not have the financial resources to access private dietetics; interpreters are also not provided in these contexts.

### **RHS targeted health/food literacy interventions**

The Newman data (2018 publication) highlights the risks and clinical need for this population. The RHS Dietitian is supported within the multidisciplinary team (specialist paediatric, nursing, social work, clinical psychologist, dental and education staff) with access to professional interpreters, transportation and family-focused assessments.

The RHS used the Newman data and identified gaps in care to successfully obtain 3 sequential PCH Foundation (PCHF) targeted seeding education and training grants. This was a staged process which incorporated (i) assessment of parental nutritional knowledge gaps (PCH internal audit data), (ii) identification of relevant socioeconomic determinants of health including food insecurity risks, cultural and ethnospecific nutritional needs and (iii) development of targeted cultural paediatric nutrition health education/food literacy modules and parental resources. Knowledge of healthy eating recommendations were based on the Australian Guide to Healthy Eating (AGHE) which is the basis of all evidenced based healthy eating advice in Australia (NHMRC 2019). Federal approval from the AGHE governance team was also provided to translate the AGHE pictorial resources into the key language groups for RHS patients. Targeted parental food literacy resources were developed in consultation with RHS consumers and now translated into the 10 most frequent RHS languages. These food literacy and nutrition resources are used within the RHS, so that knowledge can be reinforced within the home/community settings and increase effectiveness of messaging and accessibility.

Clinical improvements in food group consumption aligning with recommended AGHE framework especially fibre, protein and diet with corresponding reduction in "extra food" consumption was demonstrated in low complexity patient after one dietetic session. Given the importance of nutrition in childhood and adolescents for development and disease prevention, this service is effective in reducing health inequalities in this disadvantaged group. Given these

findings, CAHS are also able to use this as demonstrable evidence towards our commitment, as an organisation, to equity and to the WA Sustainable Health Review 2019 priorities 1.2 and 1.3 (Government of Western Australia 2019).

Both individual and language group education RHS sessions have been undertaken, with extremely positive feedback and engagement. Co-location of the food literacy/nutrition education group sessions with the Ishar (Multicultural Women's Association) has been very positive, providing mothers with a safe, culturally accessible venue supported by bilingual workers and interpreters.

CRHS has seen a good uptake for food literacy programmes that are culturally sensitive with specific cultural group workshops on nutrition, cooking and Foodbank.

## **5. Government funded school lunch programs**

Please see comments above (section 3). Limited options for government funded school lunch programmes and also not culturally targeted. There is a gap for adolescent patients, who have addition nutritional needs (puberty), but may be relatively invisible. Food insecurity, impoverishment and malnutrition impact on school attendance, concentration, academic outcomes, peer relationships, trauma, sleep quality and emotional regulation. There is also an interplay with risk of school disengagement and maladaptive health risk behaviours (e.g. drug or substance use and/or petty crime) with chronic food insecurity.

## **6. Any other existing of potential initiatives**

### **2022 CAHS RHS-Ishar Healthway grant “Healthy Food, Healthy Cultures”**

The RHS PCHF Education Grant projects (outlined in section 4) demonstrated that refugee families are able to not only take culturally nuanced and targeted dietary health information and translate that information into positive behaviour change.

Leading off this success, RHS has collaborated with Ishar (WA Multicultural Women's Association) and been awarded a 2022 Healthway grant (“Healthy Food, Healthy Cultures”). This innovative pilot 3-year nutrition education program will focus on families from multicultural backgrounds (refugees and migrants). The primary objective of the program is the provision of synergistic and culturally appropriate nutrition education that promotes healthy eating throughout the life course and prevents or delays the onset of chronic disease. The program will have two elements: (1) the development and delivery of nutrition education workshops and (2) service provider training.

The “Healthy Food, Healthy Cultures” program will provide holistic preventative health education and promotion from infancy through to adulthood. It will be flexible to meet the needs of different communities and adapted for community participants with limited prior education and/or health literacy. A key program strategy will be focusing on ethnic groups with the highest numbers of people with limited English proficiency (LEP) and humanitarian entrants resettled in Perth which are populations commonly overlooked in mainstream health promotion programs.

The Ishar-CAHS RHS collaboration has the relevant expertise, cultural knowledge and community engagement to deliver this program. Activities will include a range of nutrition workshops which can be delivered as individual sessions or as a series of workshops. Workshops will include cooking sessions and the opportunity for participants to sample easily affordable Australian foods and demonstrate healthy food choices which are culturally appropriate for the participants. Ishar will form an advisory group consisting of bicultural support workers from at least five ethnic groups to help with the development of materials and ensure they are culturally appropriate and relevant to their communities. Bicultural support workers will also be involved in the delivery of the workshops. Additionally, awareness of the wider barriers to access health programs, such as lack of transportation, social isolation, trauma and lack of extended family or community will be considered for new arrivals to Australia. This will ensure participants and family members don't miss out on vital preventative healthcare that can positively change their health trajectory and reduce their risk of developing lifestyle related chronic disease or early childhood malnutrition-related concerns.

### **RHS Dental “New Beginnings; healthy teeth, healthy lives”**

The collaborative and novel RHS Dental “New Beginnings; healthy teeth, healthy lives” refugee health dental program integrates dental, medical and dietetic health prevention and early intervention. The programme incorporates consumer feedback (Nicol et al 2015) as well as efficacy analyses of previous community pathways, which demonstrated high dental needs which could be served better through embedded point of care RHS dental programmes (Nicol et al 2014 Nicol et al 2015). Over 210 RHS patients have been successfully recruited into the RHS “Arresting Dental Caries” randomised controlled trial, overcoming research enrolment barriers in patients with limited English proficiency. The RHS has also collaborated with the “Clinics to Communities” Oral Health Promotion program. The program facilitates the provision of oral hygiene kits alongside tailored oral health education as part of a holistic prevention and health promotion strategy for all new PCH RHS families. Similarly, the targeted RHS dietary health education program allows culturally specific tailored health education to be provided to families at the same time. The importance of simultaneous dental, medical and dietetic intervention early in refugee's resettlement to change dietary patterns and therefore prevent/delay the onset of chronic disease and reduce the need for dental extractions from

severe dental caries. The CRHS team reinforce these messages and health education in the community and can use the translated resources to assist families during outreach visits and for early intervention for local-born children. Overall this integrated multidisciplinary RHS approach translates into cost effective healthcare which is likely to decrease health burden on these disadvantaged families, which therefore prevents the need for public healthcare in the future.

Wider PCH initiatives address gaps in nutritional, health literacy and food insecurity. Local PCH Diabetes education has been culturally adapted in recognition of poorer diabetic outcomes in families from culturally and ELD backgrounds and reinforced by local qualitative research findings (Binkowski et al; manuscript under review 2022).

The RHS also is active in health education (undergraduate and postgraduate) across disciplines. Education provided highlights the need for culturally relevant health education programmes and assessments that identify contributions to malnutrition including acknowledgement of socio-economic determinants of health, food insecurity, barriers to health access, cultural and ethnolinguistic considerations and synergistic benefits of integrated multidisciplinary health care approaches.

ISHAR (Woman's Multicultural health centre) are about to commence workshops on nutrition and also provide a GP care plan funded dietician service with access to interpreters.

## **7. Western Australia's obligations and responsibilities to monitor and address food insecurity as an aspect of child well-being**

WA does have obligations and responsibilities to monitor and address food insecurity as an aspect of infant, child and adolescent well-being. This responsibility should also extend to antenatal care and perinatal risks. It is a part of the RHS role to assess access to food and link with appropriate support.

The benefits of community education, heightened awareness of food insecurity and related risks of impoverishment and early intervention will be long lasting and cost-effective. This approach will also be aligned with substantive equity principles and the overarching rights of the child. Adequately resourcing health services and wider community organisations that already have in- reach to marginalised paediatric/adolescent populations (e.g Aboriginal health, refugee health, out of care home services, detention services) is also essential in this approach.

Under the UN Convention of the Rights of the Child, simply stated, "Children have the right to live a full life. Governments should ensure that children survive and develop healthily." (Article

6) AND “Children have the right to good quality health care, clean water, nutritious food and a clean environment so that they will stay healthy.” (Article 24)(1).

The following are recommendations for consideration by the Commissioner for Children and Young People, based on experiences within the service providing healthcare for babies, children, youth and their families, and of other jurisdictional activities.

There is no question that many families are living in poverty, with children experiencing food insecurity across WA – we see this on a daily basis within our service. As health professionals, it is imperative that we see change for the children and youth of today, to enhance child health and wellbeing outcomes for the healthy future of WA.

Adverse Childhood Experiences impact on child health and wellbeing outcomes, and it is imperative that external sources of stress (including poverty and food insecurity) are reduced to ensure healthy child development. (2)

### **Macro-level recommendations:**

#### **1) Map the scope of the problem of child poverty.**

More than one in five children under 5 in WA (20.7%) are living in families experiencing poverty. Over 94,000 children are affected, and this is increasing – WA now ranks third in the rate of poverty among children under 5 years in Australia. (3)

Tracking this progress over time should lie at a State Government level for WA and is critical in determining which actions may be having a positive impact.

#### **2) Accountability: Develop child poverty measures, targets and indicators to track progress over time.**

An example of this is the work of the New Zealand Government, with the Child Poverty Reduction Act, requiring the Government of the day to set long-term and intermediate targets on a defined set of child poverty measures and report annually on the set of child poverty measures.(4) The Community Affairs References Committee recommended the Australian Government set a national definition of poverty, and these State measures could align with this, if a definition is created nationally. Comments were also made on the importance of using poverty measures within the Committee’s recommendations. (5)

#### **3) Assist those in need by lifting children and their families out of poverty.**

The welfare system can work to reduce environmental stressors on children, such as insufficient food by meeting basic needs. (2) The Community Affairs References Committee recommended the Australian Government immediately undertake a review of the income

support system, to ensure that all eligible income support recipients do not live in poverty, as well as review the adequacy of the Commonwealth Rent Assistance program, to ensure it significantly improves rental affordability. (5)

#### **4) Address the food environment to ensure sustainable food sources.**

Malnutrition in its varied forms is the leading cause of poor health globally. (6) Food insecurity will become increasingly intertwined with obesity and climate change. This global syndemic, including obesity, undernutrition and climate change will have effects on health for humans globally. (6) State Government needs to acknowledge the importance of addressing climate change, and obesity alongside malnutrition, and take action in order to ensure sustainable food resources long term.

#### **Specific recommendations as they relate to food insecurity**

##### **1) Screen and offer immediate support for those that need it that is devoid of judgement – the situation of many families is due to system failings.**

Many families experience shame that they do not have enough food to feed their children. Professionals should be comfortable asking about food security. There are simple specific tools, such as the following questions which can be added to screening within such services as Universal Child Health program, both in early childhood and through school. Targeted health services are also a priority area for screening, and screening is already occurring within the RHS. Acknowledging that circumstances change for families, it would be helpful to explore with the education sector how screening for food insecurity could be incorporated when engaging with new families.

A 2-item screen to identify families at risk for food insecurity from the United States has been developed that provides a brief, sensitive, specific and valid food insecurity screen (the Hunger Vital Sign). (7) This has been adopted by international colleagues successfully in healthy lifestyle programs, and includes:

*Within the past 12 months we worried whether our food would run out before we got money to buy more.* (Often true, sometimes true, vs never true)

*Within the past 12 months the food we bought just didn't last and we didn't have money to get more.* (Often true, sometimes true, vs never true) (7)

This tool could be rolled out for use across WA.

Having the ability to act if there is an admission of food insecurity is critical. Therefore, having a clear stocktake of what services are available in the area is important before instigating this approach. The following can then be asked:



*Would you like me to give you information on services that provide free food in your area?*

## **2) Ensure supports are sustainable.**

Government support must be increased and ongoing for charitable organisations if they are to remain the main providers of food assistance. Lack of sustainability of funding for shelters and places providing food assistance increases stress on families seeking support and places the sustainability of these organisations into question.

### **References:**

Terms of Reference items 1-6

- Abdullahi I, Wong K, Glasson E, Mutch R, de Klerk N, Downs J, Cherian S and Leonard H. Are preterm births and intra-uterine growth restriction more common in Western Australian children of immigrant backgrounds? A population-based data linkage study. *BMC Preg and Childbirth* 2019 Aug 9;19(1):287. doi: 10.1186/s12884-019-2437.
- Binkowski S, Fried L, Roberts A, Nicholas J, Frearson K, Davis E, Cherian S, Abraham M. Perspective of culturally and linguistically diverse families in the management of a child with type 1 diabetes: A qualitative study. 2021 [manuscript under review]
- Brophy-Williams S, Boylen S, Gill F, Wilson S, Cherian S. Use of professional interpreters for children and families with limited English proficiency: the intersection with quality and safety. *J Paediatr Child Health* 2020 Apr 7. doi: 10.1111/jpc.14880. [Epub ahead of print]
- Chaves NJ, Paxton G, Biggs BA, Thambiran A, Smith M, Williams J, Gardiner J, Davis J on behalf of the Australasian Society of Infectious Diseases and Refugee Health Network of Australia Working Group. Recommendations for comprehensive post-arrival health assessment for people of refugee-like backgrounds. Second Edition. 2016. Australasian Society of Infectious Diseases, Sydney, Australia.
- Gallegos G, Ellies P, Wright J. Still there's no food! Food insecurity in a refugee population in Perth, Western Australia. *Nutr. Diet.* 2008; 65: 73–83.
- Government of Western Australia. Sustainable Health Review: Final report of the Government of Western Australia. Department of Health, Perth, Western Australia 2019.
- Hirani K, Payne DN, Mutch R, et al. Medical needs of adolescent refugees resettling in Western Australia. *Arch Dis Child* 2019; 104
- Lindsay K, Hanes G, McKinnon B, Mutch R, Cherian S. Comprehensive resettlement assessments of Syrian and Iraqi paediatric refugees. 2021 *Arch Dis Child*. 2021 Oct

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1. United Nations. A Simplified Version of the United Nations Convention on the Rights of the Child. UNICEF; 1996.

2. Center on the Developing Child. Applying the Science of Child Development in Child Welfare Systems: Harvard University; 2016.
3. Cassells R. DM, Duncan A., Kiely D., Kirkness, M., Nguyen T., Seymour, R., and Twomey C. The Early Years: Investing in Our Future, Focus on Western Australia Report Series. Bankwest Curtin Economics Centre, Curtin University; August, 2020.
4. Department of the Prime Minister and Cabinet. Child poverty reduction and wellbeing legislation Wellington: New Zealand Government; 2022 [Available from: <https://www.childyouthwellbeing.govt.nz/our-aspirations/context/child-poverty-reduction-and-wellbeing-legislation.>]
5. Senate Community Affairs References Committee. Adequacy of Newstart and related payments and alternative mechanisms to determine the level of income support payments in Australia. Canberra: Commonwealth of Australia; 2020.
6. Swinburn BA, Kraak VI, Allender S, Atkins VJ, Baker PI, Bogard JR, et al. The Global Syndemic of Obesity, Undernutrition, and Climate Change: The Lancet Commission report. *Lancet*. 2019;393(10173):791-846.
7. Hager ER, Quigg AM, Black MM, Coleman SM, Heeren T, Rose-Jacobs R, et al. Development and validity of a 2-item screen to identify families at risk for food insecurity. *Pediatrics*. 2010;126(1):e26-32.