



Government
of South Australia



Child and Family Health Service

Model of Care

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Acknowledgement of Country

The Child and Family Health Service acknowledge Aboriginal people as the traditional custodians of country throughout South Australia and respect their continuing connection to land, sea and community. We also pay our respects to the cultural authority of Aboriginal and Torres Strait Islander people from other areas of Australia who reside in South Australia.





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Director's Foreword

The Child and Family Health Service (CaFHS) is a critical part of South Australia's child development system with a mandate to improve health, development and wellbeing outcomes for young children.

CaFHS plays a pivotal role in a child's early years and is one of many organisations in an integrated early childhood system which comprises health, education, child protection, disability and social welfare services from both the government and non-government sectors.

To meet this mandate and to ensure services are contemporary, evidence-informed, child-centred, culturally responsive and effective, CaFHS embarked on a review of how it delivers services to families and respond to the 20,000 births each year which includes an estimated 900 births to Aboriginal families.

In undertaking the review, CaFHS has looked at the latest available data and other evidence about children in the early years, and has consulted with staff and other key partners about our approach to delivering services. This has resulted in the development of CaFHS' Model of Care which articulates a new way of working, including stronger relationships with our partners.

CaFHS will achieve this by:

- listening and responding to the cues and voices of children;
- working collaboratively with families and other agencies to improve children's outcomes;
- using a holistic life-course approach to intervene early in the lives of children; and
- using evidence to drive improved outcomes.

At the centre of the Model of Care is recognition of the fact that most parents and families seek to provide the best start possible for their children in the early years. At the same time however, the realities of life and living mean that the ability of some parents and families to provide for and support their children in the way they had hoped, can be impacted by a number of issues and challenges, including those which may have been unforeseen and unexpected.

While significant energy and effort has been invested to get us to this point, in many ways this marks just the beginning of CaFHS' journey moving forward. Next will be the important process of implementing the Model of Care in practice, and ensuring we embed robust processes to measure and monitor its effectiveness. Ongoing reflection and evaluation will help to ensure that we deliver the highest quality service, and remain connected to each other and to the children and families we support.

The Model of Care sets out CaFHS' position within the integrated early childhood system and will enable the service to work with its partners to ensure children and families achieve the best possible health, development and wellbeing outcomes.

In releasing the Model of Care, I would like to formally thank and acknowledge everyone who has contributed to this important process.

Mel Bradley

Director, Child and Family Health Service



A snapshot of the Model of Care

The key elements of the Model of Care include:

- The criticality of ensuring that the child remains at the centre of our approach. All infants and children have the right to a strong foundation for life. We must ensure we 'keep the child in mind' and that this notion underpins our decision-making and approaches to the provision of care and support to infants, children and families.
- The need for an ongoing commitment to embed at a systems level the provision of culturally safe and responsive support to Aboriginal infants, children and families. We must acknowledge the significant health challenges faced by many Aboriginal families, due to the impact that past policies and practices have had on health and wellbeing, and in addition, the source of strength that being connected to Aboriginal culture can bring.
- Support for a service model underpinned by the notion of progressive universalism which recognises that not all infants, children and families need or require the same level of service, and which caters for the fact that the circumstances of some children will mean that a more targeted and intensive service response will be required.
- That CaFHS as a state-wide service is faced with the challenge of being able to meet the needs of all infants, children and families in South Australia and in doing so must acknowledge the unique and varied needs of metropolitan, rural and remote areas. It must also recognise geographical regions and population cohorts who face additional challenges and service responses must be modified appropriately to address these.
- That any enhanced service delivery approach must be underpinned by a broader and more inclusive definition and application of 'parent' and 'family' - both traditional and non-traditional. CaFHS must be responsive to the individual and unique needs of the full range of family groups that it assists and supports. This extends to fathers, extended family members, Aboriginal Elders and community, carers other than mothers and fathers, and diverse family models.
- The importance of early intervention and including a focus on the provision of antenatal care and support that extends to working with antenatal providers to ensure families are aware of CaFHS' services, enabling CaFHS to actively engage with families where indicated.
- Ensuring that the needs of families from Culturally and Linguistically Diverse (CALD) backgrounds are taken into account and are able to be met.
- The significant value and richness that an inter-professional approach to service delivery can bring.



1 Introduction

CaFHS is committed to providing the best possible services to support infants, children and their families in the early years of their development, from birth to five years of age. In particular, CaFHS has as its focus the delivery of services that support building strong families and communities, and which help to secure a bright future for future generations.

CaFHS does this under the leadership and policy direction of the Department for Education and Child Development (DECD) whilst services continue to be delivered for families through the Women's and Children's Health Network (WCHN).

CaFHS also works collaboratively with other organisations across the health, education, social and family support sectors, in particular medical and paediatric services, allied health services (e.g. speech pathology), the Department for Child Protection (DCP), Child and Adolescent Mental Health Service (CAMHS) and Children's Centres. This supports infants, children and families to navigate the system, to access timely and coordinated care and to ensure continuity of care across transition times. CaFHS is committed to enabling clear pathways of care between CaFHS and specialist services to support timely and accessible services in response to identified needs such as child health and development.

Welcoming an infant/child into a family is a significant life event which can result in a number of major life changes. The rapid physical development of infants/children in their early years is obvious as they grow and change physically. What can be less obvious however are the physiological and emotional foundations that are also laid during these crucial early years and their tremendous significance. Brain growth serves as one key example. In the first three months of life, an infant will have developed 55% of their adult brain size¹.

It is now widely accepted that circumstances experienced by an infant/child in early life provide an important foundation for the health and development of that infant/child over their life course². However, what is also well understood is that stark differences in health and development outcomes exist for children at age five relative to their socioeconomic circumstances, ethnicity, and geographic location³. In turn, experiencing poor health and development at age five increases the likelihood of continuing poor academic trajectories throughout school⁴, with impacts upon the ability to achieve later educational and economic success^{5,6}.

¹Holland D, Chang L, Ernst TM, Curran M, Buchthal SD, Alicata D, Skranes J, Johansen H, Hernandez A, Yamakawa R, Kuperman JM & Dale AM. (2014). JAMA Neurology. 71(10): 1266-74.

²Sawyer, A., Gialamas, A., Pearce, A., Sawyer, M., & Lynch, J. (2014). *Five by Five: A Supporting Systems Framework for Child Health and Development*, [online]. Available at: <https://health.adelaide.edu.au/population-health/research/grants/five-by-five-final-140915.pdf>.

³Brinkman SA, Gialamas A, Rahman A, et al. (2012) Jurisdictional, socioeconomic and gender inequalities in child health and development: analysis of a national census of 5-year-olds in Australia. BMJ open. 2(5).

⁴Brinkman S, Gregory T, Harris J, Hart B, Blackmore S, Janus M. (2013) Associations Between the Early Development Instrument at Age 5, and Reading and Numeracy Skills at Ages 8, 10 and 12: a Prospective Linked Data Study. Child Indic Res.6(4):695-708.

⁵Houng B, Justman M. (2014) NAPLAN Scores as Predictors of Access to Higher Education in Victoria. October 2014 ed. Melbourne: Melbourne Institute of Applied Economic and Social Research, The University of Melbourne.

⁶Heckman JJ. (2008) Schools, skills, and synapses. Economic Inquiry. 46(3):289-324



With respect to the most vulnerable children, the Child Protection Systems Royal Commission recently identified the need to substantially grow preventative and early intervention services that help families safely care for children and remain out of the child protection system⁷.

Through the suite of services offered via a coordinated state-wide population approach, the aim of CaFHS is to ensure that every infant/child has the best opportunity to develop a strong foundation for ongoing health, development and wellbeing throughout their childhood and into adult life by supporting families to adjust to parenting through the provision of services according to need.

CaFHS has developed this Model of Care to ensure its approach to service delivery continues to best meet the needs of South Australian families. It has defined its ways of working with a particular focus on the most vulnerable and to assist and support all infants, children and families into the future.

The decision of CaFHS to embark upon this journey has been reinforced by a number of key factors, which include:

- ever expanding research on the importance of early life for continuing health and development;
- new, local evidence regarding those factors which contribute to vulnerability within families and how this increases challenges to supporting infant/child health, development and wellbeing;
- recent data which indicates that the proportion of infants/children experiencing increased levels of adversity, poor development and poor academic outcomes has remained stable over the past decade;
- the undeniable discrepancies in health outcomes between Aboriginal and non-Aboriginal people, and the crucial responsibility that the health sector has to address factors which contribute to health inequity;
- an understanding that innovative approaches are required to improve health and development outcomes for children, including the need to integrate early childhood services across health, education and social welfare; and
- the need to develop an integrated family support service approach with DECD Children's Centres and the emerging Child and Family Assessment and Referral Networks (CFARNs). (CFARNs aim to prevent re-notification and progression in the statutory child protection system of children who have come to the attention of the DCP - Child Safety Pathway. CFARNs will collaborate with other providers in local regions to deliver a cross-sector, coordinated and responsive approach with a strong focus on early intervention, linking families in need to new referral pathways and services, tailored to their individual needs. CFARNs will be integrated into DECD Early Childhood Services in Children's Centres.)

As a result of the review process undertaken, and cognisant of the rich and valuable feedback received during the consultation process, CaFHS has developed this Model of Care. The Model of Care is designed to be contemporary, evidence-informed, child-focused, culturally responsive and effective, with a view to supporting the provision of best health, development and wellbeing outcomes for children. The purpose of this document is to describe the Model of Care.

⁷ Government of South Australia, Child Protection Systems Royal Commission, (2016) *The life they deserve: Child Protection Systems Royal Commissioner Report*



1.1 Key references

In the Model of Care the terms 'Aboriginal', 'Caregiver', 'Carer' and 'Parent' are referenced regularly. The following provides important context for these references as part of CaFHS' new ways of working.

TERM	CONTEXT
ABORIGINAL	In this document, we use the term 'Aboriginal' to refer to people who identify as Aboriginal, Torres Strait Islander, or both Aboriginal and Torres Strait Islander. We do this because the people indigenous to South Australia are Aboriginal, and we respect that many Aboriginal people prefer the term 'Aboriginal'. We also acknowledge and respect that many Aboriginal South Australians prefer to be known by their specific language group/s.
CAREGIVER/CARER	A term used to refer to foster parents, kinship or relative carers, or persons employed to care for children either by Department for Child Protection or commercial agencies ⁸ . In some instances, members of a child's immediate family may be involved in providing care, and in these instances 'caregivers' also extends to include reference to immediate family members.
PARENT	In this document, 'parent' is used to describe a person performing the role of caregiver to a child. This parent may or may not be the biological parent; they may be a step-parent, foster parent, grandparent, or other carer.

⁸ Ibid



2 Background

2.1 Aligning support to need

In developing its Model of Care, CaFHS has taken into account the most current literature and data on the developmental journey for infants and children, what it reveals about the early childhood years and how best to support and nurture infants and children during this period.

A key document that has been particularly influential is a report published in 2014 by the BetterStart Child Health and Development Research Group (BetterStart), a collaboration between the University of Adelaide and the University College London, which focussed on seeking to better understand the steps required to lay a solid foundation for infants and children in the early years to inform their health and development over the life course.

The report, titled '*Five by Five: A Supporting Systems Framework for Child Health and Development*' (Five by Five), provides an overview of the main concepts behind early child health and development by synthesising the current evidence base. In particular, it summarises the goals of healthy development for infants and children through a concept called 'Five by Five'. Five by Five refers to five basic developmental domains (physical, language, attachment, social emotional and cognitive) which infants and children generally achieve in five stages from pregnancy until age five years. Each domain and each stage requires specific supports and parenting skills, and implies that different social supporting sectors will take the lead in service provision at different times.

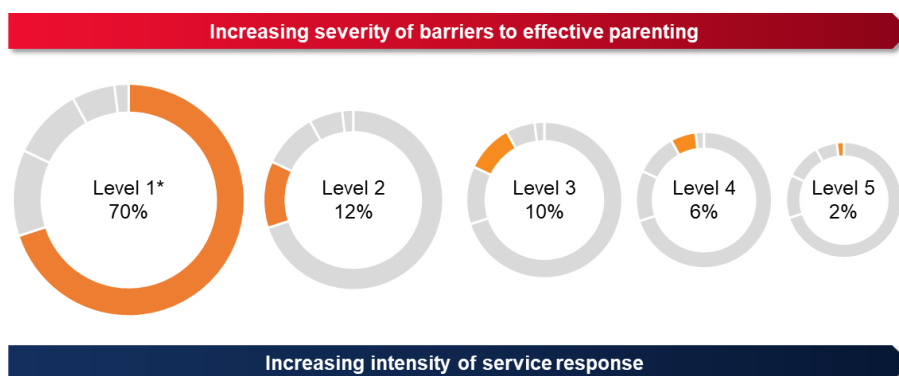
In identifying the goals of healthy development for infants and children from birth to age five and how best to support parents in achieving these, Five by Five discusses the fact that the support families will require will vary from family unit to family unit, and will depend on the barrier/s that a parent or parents may be facing. The broad notion is that the greater the number of barriers a parent or parents may face, the more support, and therefore, the more hands-on and assertive the services will be, that they are likely to need.

Figure A is adapted from Five by Five and provides an estimate of the proportion of the population in South Australia (as at the date of the Five by Five Report⁹), that the authors consider would be likely to experience a larger versus smaller number of barriers to their parenting. It suggests that about 70% of the South Australian population are largely self-managing and experience 'normal day-to-day parenting challenges' (Level 1), whilst 6% (Level 4) and 2% (Level 5) of the population respectively face significant parenting barriers which are likely to require more comprehensive service support.

⁹ Sawyer, A., Gialamas, A., Pearce, A., Sawyer, M., & Lynch, J. (2014). *Five by Five: A Supporting Systems Framework for Child Health and Development*, [online]. Available at: <https://health.adelaide.edu.au/population-health/research/grants/five-by-five-final-140915.pdf>.



Figure A: 'Five by Five' - Distribution of population according to increasing barriers to parenting¹⁰



*Decreasing size across the five levels refers in general terms to relative proportions of the population likely to require an associated service response, noting that proportions for Aboriginal children and families are likely to be inverse.

In developing its Model of Care, CaFHS has adapted the concept of various levels of effective parenting as articulated in Five by Five, as it provides an evidence-informed foundation upon which to align services and supports. In particular, it:

- provides a structured framework from which to discuss child development with providers who work in the early years, providing a common understanding and a common language
- challenges providers, including CaFHS, to review and ensure that the services provided are evidence-informed and designed to minimise the impact of any barriers to parenting identified
- recognises that there are many opportunities to 'provide more to those who need it most'.

2.2 Model of Care – the journey so far

The development of the CaFHS Model of Care commenced in mid-2015 and has included consultation with a wide range of stakeholders, the inclusion of feedback received and the support of CaFHS staff and partner agencies in developing the service detail. An overview of the development process is given as *Appendix B – Model of care journey* and an overview of the timeline and key phases associated with the Model of Care is provided in *Appendix C – Model of care timeline*.

¹⁰ Sawyer, A., Gialamas, A., Pearce, A., Sawyer, M., & Lynch, J. (2014) op. cit.



3 Context for the Model of Care

The purpose of this section is to provide an overview of the Model of Care. Additional information in relation to each of the key components of the Model of Care are set out in sections 4 to 7 subsequent.

3.1 Our principles

Noting the criticality of this phase in childhood development and its lifelong impact, the Model of Care will place a focus on the early years of life.

The Model of Care is underpinned by the following key principles:

PRINCIPLE	DESCRIPTION
CHILD-CENTRED	The needs of the infant and child are at the forefront of our approach to service delivery and decision making with families. We seek to support families to understand and respond to their infant/child's needs by being attuned and sensitive to the voice of the infant/child, including the non-verbal cues that infants and young children give. We recognise the importance of the relationship between the infant/child and parents and are informed by the knowledge that infants/children are best understood and that the most appropriate services are planned for, within the context of their primary relationships. Through this process, the voices and cues of infants and children inform and influence the supports and services we provide to families.
EVIDENCE-INFORMED	Our approach to service delivery is informed by the latest research and data in relation to early childhood development, as well as established and recognised theories and approaches. These include Attachment Theory; Brain Development; Life Course Development; Social Learning Theory and Trauma Informed Care.
EQUITY OF SERVICE PROVISION	The development of a truly equitable state-wide service model must recognise both the geographical regions and population cohorts who face additional challenges. Service responses must be modified appropriately to address these to ensure children and families get the same access to reduce health status inequity. Examples include those who live in regional and remote areas, Aboriginal children and families, and children and families from Culturally and Linguistically Diverse backgrounds.
PROGRESSIVE UNIVERSALISM	Our Model of Care is structured to ensure a clinically informed understanding of child and family needs across the whole population. We deliver proportionate universal services by offering services and supports to all children and families, with a view to increasing the intensity of these services and supports for those identified as having greater need through provision of a Targeted and Sustained Service response.
FLEXIBLE AND ADAPTIVE	We acknowledge that life circumstances change over time and that the needs of infants, children and families likewise change. Our services are flexible and adaptive enough to ensure that children and families receive the support and services they need when they need them and at the intensity they need, to assist them in managing and addressing life challenges and risk factors.
EARLY INTERVENTION AND PREVENTION AS KEY	Our goal is to engage and work with infants, children and families as early as possible, noting that the global benefits of prevention and early intervention in supporting positive outcomes for children are well documented. This results in us reaching out to, and engaging with, families before children are born.



PRINCIPLE	DESCRIPTION
RESPECT FOR DIVERSITY	<p>We recognise and value the diverse nature of families in Australia and that these include both traditional and non-traditional units that can involve relatives, foster carers and others in the role of caregivers.</p> <p>We specifically acknowledge and respect family and kinship structures within Aboriginal communities, understanding that Aboriginal communities have their own distinct histories, politics, cultures and linguistic experiences. Our ultimate goal is to provide services to children in all family and kinship structures that are culturally responsive, supportive and kind.</p> <p>We acknowledge the range of challenges facing families from new and establishing communities which can potentially impact on parenting and infant/child outcomes as well as limit access to health and support services. We aim to offer culturally safe and responsive services in meeting the needs of these communities.</p> <p>We recognise experiences of racism and discrimination present barriers to access and participation, and acknowledge this directly impacts on the health, development and wellbeing outcomes of people experiencing this.</p>
COMMUNICATION AND ENGAGEMENT	<p>The services and supports we provide are rendered all the more powerful and sustainable through our commitment to actively communicating and engaging with consumers and other agencies (both government and non-government) in the work that we do. We are focussed on ensuring we meet the needs of those children and families who could benefit from our services and in this way ensure we treat our consumers with dignity and respect. We communicate information clearly and openly, actively involve consumers in decision-making and are positive and kind in our interactions with all consumers.</p>
BROADER VIEW OF 'PARENTS' AND 'FAMILIES'	<p>We will adopt a broader and more inclusive definition and application of 'parent' and 'family' and be responsive to the individual and unique needs of the full range of family groups that we assist and support. This includes consideration of fathers, extended family members, Aboriginal Elders and community, or caregivers other than mothers, as well as diverse family models such as single parent, same sex, adoptive and foster families.</p>



3.2 Our core service domains

There are three core service domains that will underpin the Model of Care. These service domains articulate the scope of services and supports that CaFHS will provide to all infants, children and families. They describe the ‘what’ of CaFHS’ services and can be summarised as follows:

- Child health, development and emotional wellbeing
- Caregiver wellbeing and parenting
- Relationships.

Fundamental to CaFHS’ approach to supporting children and families is the recognition that a comprehensive and meaningful service response places the infant or child at the centre of all services and takes into account all aspects of their surrounding environment. This includes socioeconomic circumstances, availability of family support, culture and the wider community and environment. All of these factors impact and influence an infant or child’s experience of the world, and more broadly, their growth and development. In order to achieve lasting improvements it is essential for CaFHS to increase its knowledge and understanding of the ways people experience racism and discrimination and the barriers this presents to access and participation. In order to address health, development and wellbeing outcomes it is critical to have an environment where there is zero tolerance of racism, to ensure a genuine availability of culturally safe and culturally responsive services for all families.

Figure B: CaFHS’ Core Service Domains

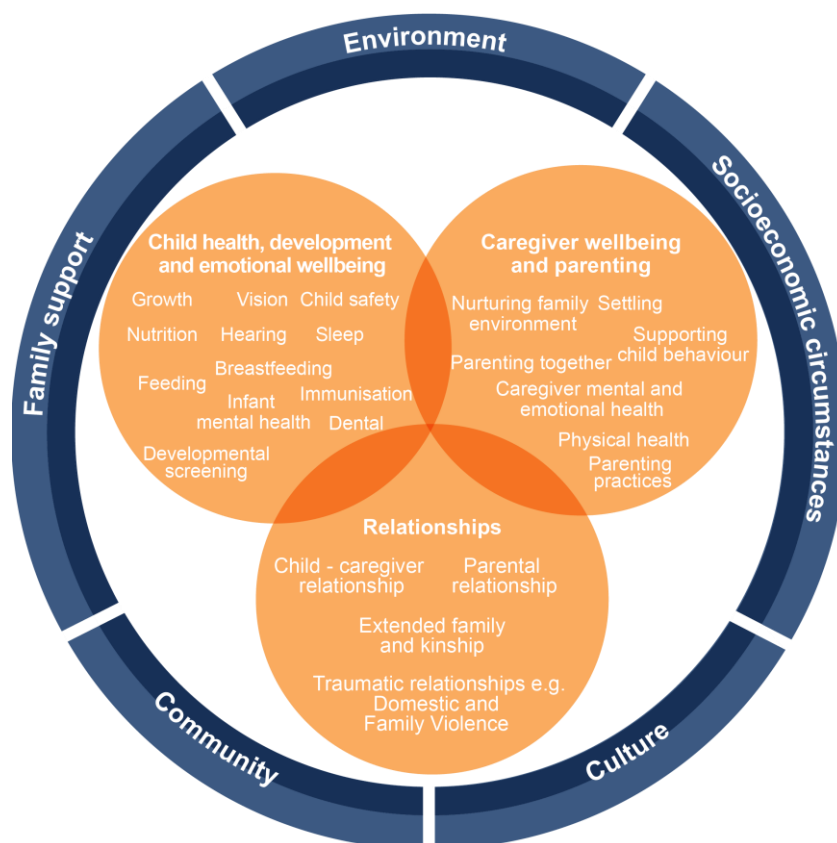


Figure B provides an overview of CaFHS’ core service domains and their interrelationship in the context of the broader environment in which each infant and child lives.



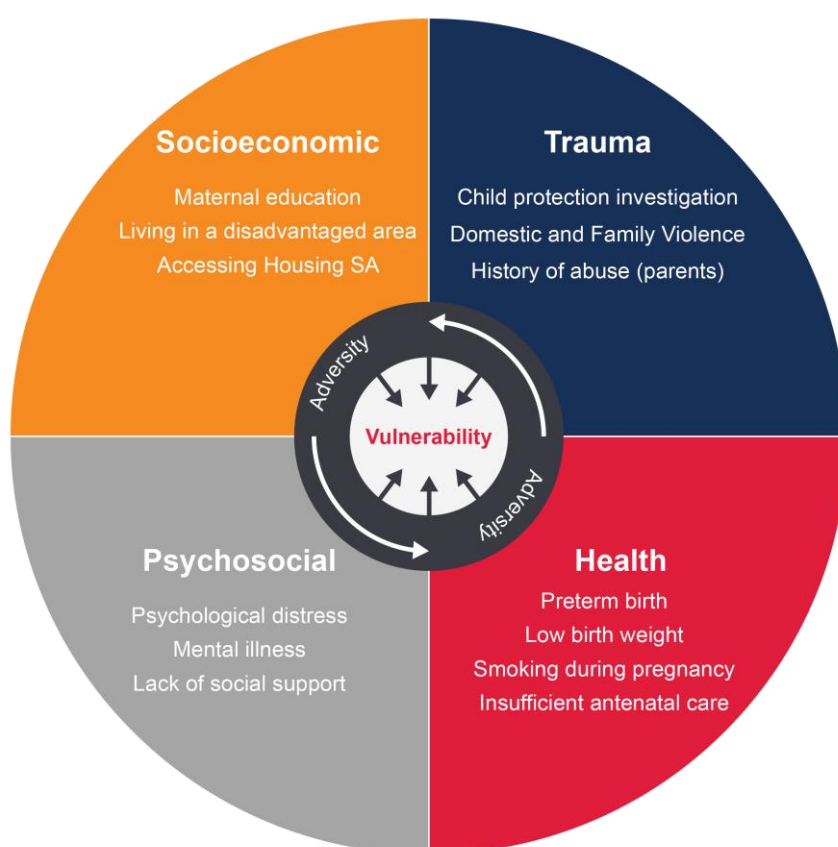
3.3 Characterising vulnerability for South Australian children

The development of the Model of Care has required a comprehensive understanding of the concept of 'vulnerability' and the nature and extent of vulnerability as experienced by infants and children across South Australia. As articulated in section 3.1 - *Our principles*, a key focus in designing the Model of Care has been to ensure that it supports the provision of services to all infants, children and families, whilst having the flexibility to enable a more intensive and sustained service response to be provided to those children and families identified as most in need.

There is no standard definition of what adverse conditions and events make an infant or child 'vulnerable' to experiencing poorer health, development and wellbeing outcomes. Designating a child as 'vulnerable' depends on how that classification is made. As a consequence of experiencing various forms of adversity that may be caused by specific events, or general social, economic or environmental conditions, a child's capacity to develop and participate in the community to their full potential may be compromised. It is this experience that is typically referred to in the context of 'vulnerability'¹¹.

The adjacent diagram provides an overview of the different risk factors that may lead to an infant or child experiencing adversity and vulnerability. The list is limited by the data included in the South Australian Early Childhood Data Project, which is being undertaken by the BetterStart Child Health and Development Research Group¹². There are obviously other risk factors, such as caregiver use of alcohol and other drugs, and clearly these other factors impact on the infant or child's experience of adversity. Unfortunately, reliable sources of such data at the population level are unavailable at this time and have not been included in this model. However, such risk factors are considered in the normal clinical practice of CaFHS including as part of the assessment process in determining the extent of vulnerability experienced by the infant, child and family. Developing reliable population level data sources on factors such as alcohol and drug use is a priority for the SA Early Childhood Data Project. Different risk factors will often be interrelated or interdependent such that

Figure C: Risk factors measured in the SA Early Childhood Data Project that may lead to adversity and increased vulnerability



¹¹ Pilkington R, & Lynch J. (2017) *Vulnerability in early life in South Australia. A research brief for the SA Child and Family Health Service.*

¹² The *BetterStart* Child Health and Development Research Group within the University of Adelaide comprises inter-disciplinary researchers from epidemiology, public health, nutrition, paediatrics, biostatistics, and psychology who are trying to better understand how to ensure infants and children have the best start in life that will enhance their health, development and human capability formation over the life course.

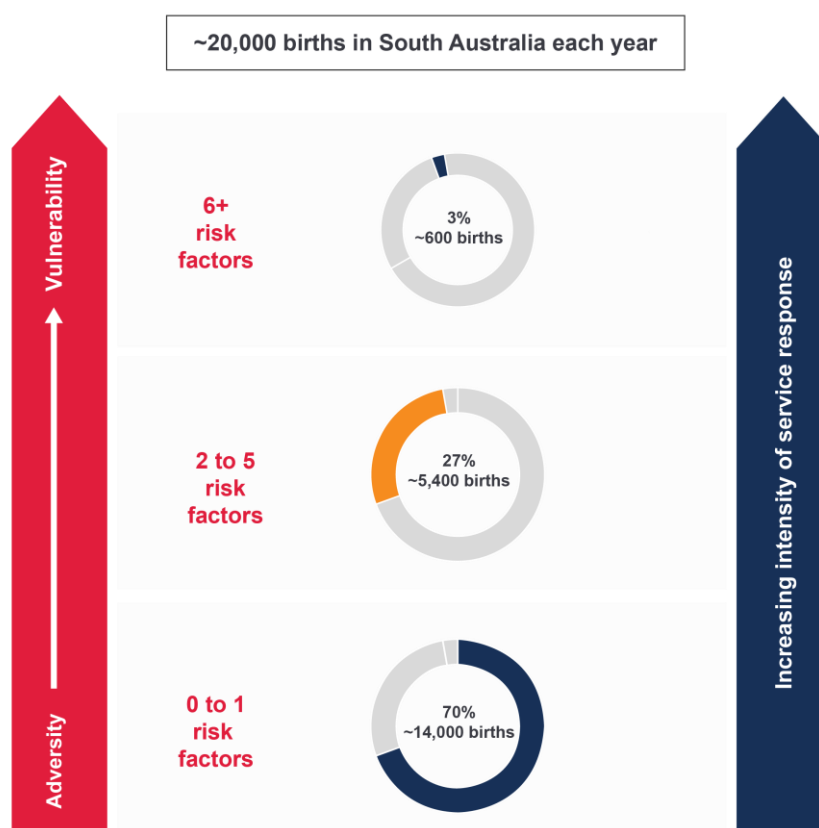


experiencing one risk factor may increase the propensity of other associated risks also being experienced. Some children may only experience one type of risk whilst others may experience several risks simultaneously.

One method that can be used to understand the nature and complexity of adversity experienced by a child is to understand the number of risk factors that are experienced by different segments of the population, with a greater number of risk factors pointing to increased adversity and vulnerability, which in turn results in an increased risk of poorer child development outcomes.

Data recently collected by the SA Early Childhood Data Project has enabled CaFHS to gain a valuable insight into the estimated proportion of those children born in South Australia each year (an estimated total of 20,000 births per annum¹³) who experience one or less risk factors, versus those children who experience two or more risk factors. Figure D below shows the distribution of risk factors in the whole South Australian population.

Figure D: The distribution of risk factors in the whole population with an estimate of the average number of births per year experiencing different levels of vulnerability.¹⁴



What the data shows is that whilst 70% of infants and children across South Australia experience one or less risk factors and are therefore considered 'low risk', 30% of infants and children are experiencing higher levels of adversity and vulnerability.¹⁵

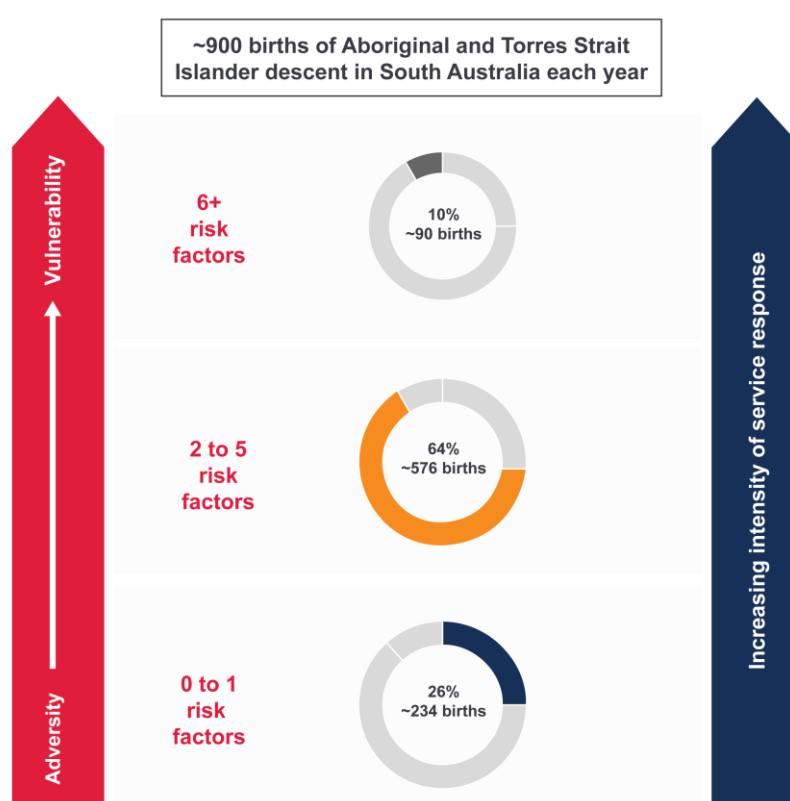
¹³ Pilkington R, & Lynch J. (2017) *Vulnerability in early life in South Australia. A research brief for the SA Child and Family Health Service*

¹⁴ Nuske T, Pilkington R, Gialamas A, Chittleborough C, Smithers L, Lynch J., Adelaide: School of Public Health, The University of Adelaide (2016) *The Early Childhood Data Project. Research Series 2016.*, 2016. p 3.



Whilst the total estimated number of births each year includes Aboriginal and Torres Strait Islander children (about 900 births per year), we also know that, on average, Aboriginal and Torres Strait Islander infants and children experience more adversity and vulnerability than the general population. This was made very clear in feedback on the original *Five by Five* report. With this in mind, the BetterStart Research Group undertook further data analysis to better understand the picture of adversity for Aboriginal and Torres Strait Islander children born in South Australia, related to the socioeconomic, health, trauma and psychosocial risk factors. Figure E below shows the distribution of risk factors in the South Australian Aboriginal and Torres Strait Islander population.

Figure E: The distribution of risk factors in the Aboriginal and Torres Strait Islander population with an estimate of the average number of births per year experiencing different levels of vulnerability.¹⁶



What this data shows is that of the ~900 Aboriginal and Torres Strait Islander children born each year, 26% can be considered 'low risk' in terms of adversity and vulnerability, whilst more than 70% of infants and children experience higher levels of adversity and associated increased risk of poor health and development outcomes.¹⁷ *Appendix D – Vulnerability in early life in South Australia* provides a description of the data used by the BetterStart Child Health and Development Research Group to estimate adversity and vulnerability.

¹⁵ Ibid p4

¹⁶ Nuske T, Pilkington R, Gialamas A, Chittleborough C, Smithers L, Lynch J. op. cit., p 4.

¹⁷ Ibid



4 Model of Care

4.1 Current context for the Model of Care

CaFHS' Model of Care is based upon a differentiated service model. This approach has been informed through:

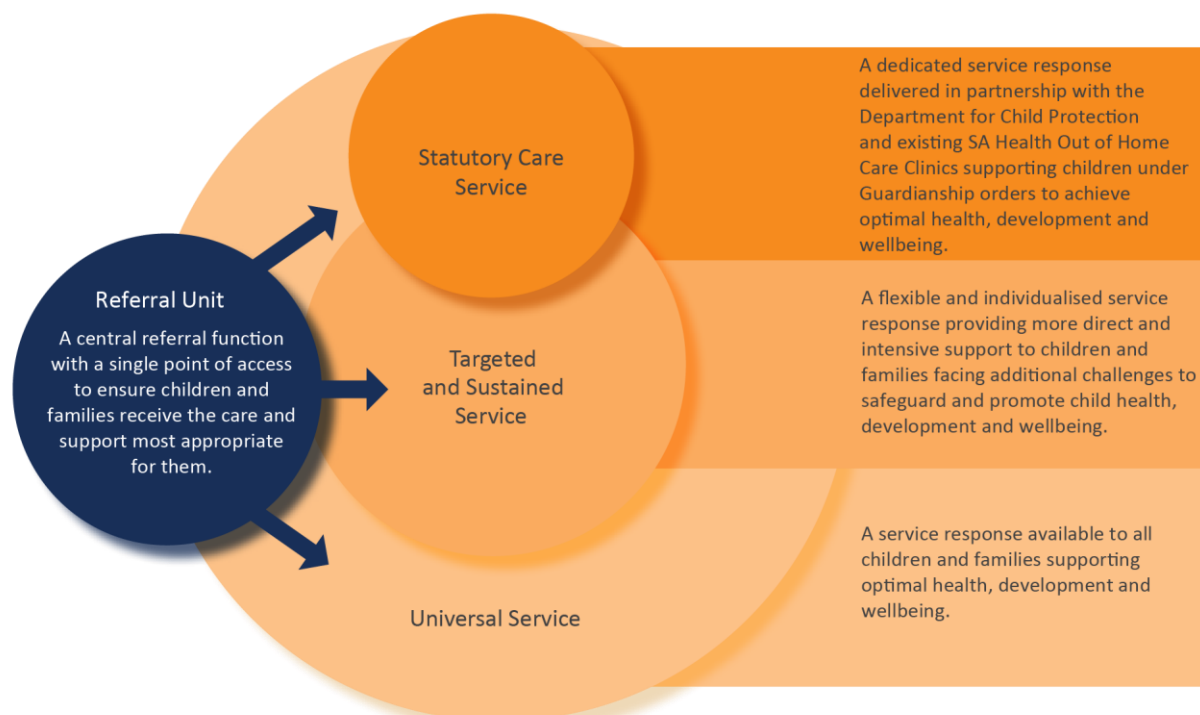
- an increased understanding of adversity and vulnerability currently experienced across the South Australian community based upon the work undertaken through the SA Early Childhood Data Project
- the need to design an evidence-informed service response which reflects and seeks to address the latest available data on early childhood vulnerability in South Australia, considering:
 - approximately 70% of infants and children experience one or less risk factors and therefore are likely to require less intensive support and as such are able to self-determine and make decisions based around the best interests of their child and family
 - approximately 30% of infants and children experience two or more risk factors, and in order to minimise the impact on health and development outcomes, require access to more intensive support
- more than 70% of Aboriginal and Torres Strait Islander infants and children experience higher levels of adversity, necessitating access to more intensive services and support in seeking to address, and where possible minimise, negative impacts on health, development and wellbeing outcomes
- the need to establish ways of working which enable more intensive, yet flexible and practical, services to be delivered to those infants, children and families identified at most risk/need but which is not excessively prescriptive
- acknowledgement of the fact that experiences of adversity and vulnerability are not linear and vary from one infant/child and family to another
- recognition that the circumstances of infants, children and families can change over time (i.e. improve or worsen) with impacts on any associated adversity and vulnerability. This in turn is likely to impact the intensity and longevity of any service response.
- feedback from staff and key stakeholders as a result of consultations undertaken by CaFHS in 2016 and 2017 about CaFHS' proposal to reform its service approach moving forward.

Figure F provides an overview of the Model of Care



4.2 Key components of the Model of Care

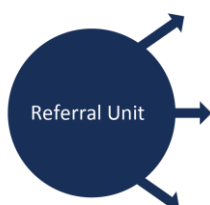
Figure F: CaFHS' Model of Care – Overview



The Model of Care comprises a central referral mechanism (**‘CaFHS Referral Unit’**) and three service streams (**Universal Service, Targeted and Sustained Service** and **Statutory Care Service**). Each of the components are described in more detail in the subsequent sections, however the following provides an overview of the key elements of the central referral mechanism and three service streams.

MODEL OF CARE COMPONENT

DESCRIPTION OF KEY ELEMENTS




- a central referral hub for the assessment and triage of all referrals and other information received by CaFHS about infants, children and families to support access and flow into CaFHS
- a single point of entry into CaFHS
- assessment and triage of referrals and other information received by CaFHS about infants, children and families undertaken by an experienced inter-professional team comprising appropriate clinical and non-clinical staff, and Aboriginal workers
- systems and processes to ensure all infants, children and families receive the services and supports that are most appropriate to their individual circumstances.





Universal Service

- a service response available to all infants, children and families from birth to five years, with a core focus on the early years, which facilitates access to professional support and advice to optimise health, growth and development of children, and promotes parent and caregiver health and developmental literacy
- the opportunity for families to receive home visits from experienced clinicians and staff to provide assistance and support in the early weeks following the birth of an infant
- access to periodic clinic visits for infants, children and families including at six to nine months, and eighteen months to two years of age, to provide advice, information and support at key developmental junctures/or critical periods of development
- access to additional follow up and points of contact in cases where it is identified that the circumstances of a child and/or family potentially would benefit from further support to manage increased risk of poor health, development and wellbeing. This is a shorter-term outcome oriented intervention.



Targeted and Sustained Service

- a dynamic and flexible service response which provides more direct and intensive support to infants, children and families who may benefit from additional help in safeguarding and promoting health, development and wellbeing
- a service response which is available in the antenatal period and during the early years
- a specific focus on early intervention to ensure, as far as possible, that infants, children and families identified as requiring additional assistance and support receive a service response promptly, and ideally before the child reaches three years of age
- access to services and supports that are tailored to the specific circumstances of each infant, child and family, which may exist for weeks, months or years in duration, up until the child reaches eligibility for preschool
- services delivered by an inter-professional team with an identified lead professional who is chosen based upon the specific needs of each infant, child and family.



Statutory Care Service

- a dedicated and flexible service response which is also nurturing and compassionate, and is delivered in partnership with the Department for Child Protection and existing SA Health Out of Home Care Clinics to support infants and children who are under Guardianship orders and, where relevant, their carers
- provision of key services and supports including: regular health and development checks, provision of direct care such as immunisations where indicated
- holistic wellbeing assessments that are inclusive of cultural considerations
- development of referrals for support and assistance to other appropriate agencies
- development of individualised Care Plans based on the needs of each infant and child, as well as parenting/carer support requirements



4.3 Service delivery approach

Promotion of the Model of Care will occur in the antenatal period to ensure all families are aware of how to access CaFHS' services once their infant is born.

The service delivery approach impacts on a family's willingness and ability to engage with, and benefit from, services. Modalities used by CaFHS need to be contemporary, efficient, effective, and support accessibility. With this in mind, services will be delivered:

- from a range of geographic locations
- from a variety of location types (CaFHS' sites, homes, DECD Children's Centres, community venues) i.e. in homes to enable skill building with consumers in their own environment
- in a way that supports families to develop their ability to self-determine and self-manage their own family's care, i.e. encouraging community service access where appropriate
- in partnership with a range of providers to best meet need and avoid service duplication
- though group delivery rather than by individual approach where appropriate
- to assist consumers in identifying good quality sources of information, such as websites and mobile phone applications (apps), to support them in their ongoing role as caregivers
- to assist consumer to navigate health and other systems to access support.

4.3.1 Workforce

The Model of Care will have a focus on common outcomes for infants and children which leverage the strengths of the various professional disciplines within and across CaFHS in all areas (i.e. knowledge, skills and attributes).

Evidence from practice suggests that the identification of a lead professional role is a key element of effective service delivery and creates a better experience for infants, children and their families. Given this, CaFHS will utilise an inter-professional team model to inform its service delivery approach across the three key service streams. In practical terms, this will see an appropriate professional taking a lead role for each child and family who engages with CaFHS. The decision in each case will be made taking into account the service outcomes to be attained and the availability of the workforce across South Australia.

Inter-professional teams allocated to work with specific infants, children and families will include:

- Aboriginal workforce
- Administration
- Allied Health
- Nursing

The role of a professional nominated as the lead for a particular infant, child and family will include the following:

- serve as the main point of contact for the family - an individual the family can trust and who can engage the family in making choices and effecting change



- coordinate the delivery of any actions agreed by workers involved with an infant, child and family to ensure that families receive an effective service which is regularly reviewed and is based on a thorough assessment process
- reduce overlap and inconsistency in any services received, whether these are CaFHS services or services delivered by an external provider
- support inter-agency collaboration.

Where any risk to an infant or child is identified, clinical discussion with the CaFHS inter-professional team will form part of the decision-making process and where it is deemed that a statutory response is required a notification to the Department for Child Protection will be made. Where possible, a respectful and transparent discussion with the parent or caregiver regarding any concerns about risk to the infant or child will occur.

4.3.2 Engagement

Establishing positive and effective working relationships with infants, children and families will form a key foundation of the Model of Care and will support the achievement of more effective and sustainable outcomes, ensuring that the best interests of the child remain paramount. The focus of initial engagement with infants, children and families will be to:

- provide a responsive environment in which the needs of the infant, child and family are recognised and supported
- develop a Care Plan in partnership with the family.

When it comes to effective communication and engagement there is no 'one size fits all'. Instead appropriate strategies and approaches must be adopted taking into account the specific nature of each family unit and taking time to understand how that family and any children prefer to engage. The family are considered integral in the process in recognition of their expertise regarding their infant/child and their broader family circumstances and environments. In addition, it is important to emphasise that engagement with all caregivers is considered of vital importance. This extends to fathers, partners, other caregivers and community.

Some of the engagement strategies that will be adopted by CaFHS in delivering services as part of the Model of Care include the following:

- culturally appropriate engagement, sensitive to the needs of infants, children and families led by the Aboriginal workforce
- staff utilising enhanced communication underpinned by a strength-based approach
- involvement of parents and caregivers as central in decision-making and care-planning
- offering infants, children and families access to services at flexible times.

The following active strategies will be used to support engagement where the initial assessment indicates concerns for infant/child health, development or wellbeing:

- lead professional identified to actively engage with the infant, child and family
- coordinate a team around the family where appropriate to support improved outcomes
- Aboriginal cultural leadership to guide practice deliverables where appropriate



- recall process and booking appointments in advance at key points of contact
- provision of immunisation as a service enabler.

Service design will incorporate consideration of families who are unable to be contacted; are unable to be engaged; or who decline the opportunity to receive a service. Families maintain the right to self-determine and exercise choice in regard to accepting/receiving services and this is respected and acknowledged while also giving consideration to any imminent risk of harm to an infant/child.

In cases where a family has declined to engage with CaFHS, and in the presence of health, development and wellbeing concerns, a review will be undertaken internally in an effort to identify and consider any possible reasons for their lack of engagement with the service. Discussion with families about unsuccessful engagement will occur whenever possible in order to understand associated reasoning and, where possible, to discuss alternatives such as other service providers in the community.

4.3.3 Assessment

Assessment of infants, children and families who engage with CaFHS will provide an important component of all service delivery, and will help to ensure each infant, child and family is linked with the service or services most appropriate to their needs.

The tools utilised across the three service streams will include the following and, wherever possible and practicable, will include culturally safe tools:

- Ages and Stages Questionnaire
- Ages and Stages Questionnaire: Social-Emotional
- Breastfeeding Assessment and Care Plan
- Child and Family Assessment
- Domestic and Family Violence Screening
- Edinburgh Postnatal Depression Scale
- Parenting Confidence
- Sleeping Baby Safely.

A short description of each tool appears as *Appendix E – Tools and guidelines*.

4.3.4 Governance and Accountability

CaFHS' governance structure will focus on corporate systems, clinical practice, safety and quality and performance to provide the scaffold from which to operationalise the Model of Care.

A Consumer Committee and Aboriginal Health Sub-Committee will add further rigour and authenticity to the approach to supporting infants, children and families in South Australia. There is acknowledgment that the governance structure must take into account existing state-wide governance mechanisms – building and sharing evidence to lead and support cross organisational working.



5 Referral Unit

5.1 Overview

The mechanism to support the Model of Care will be characterised by a single, centralised point of entry by way of a central referral hub. The hub, to be known as the Referral Unit, will be geographically located in the Adelaide central business district but with virtual access by all CaFHS' sites via electronic means (email, facsimile). The Referral Unit will be staffed by experienced administrative and clinical staff together with Aboriginal workers who will work inter-professionally to review and undertake an assessment of all referrals and other information received by CaFHS about infants, children and families seeking to access CaFHS' services. The purpose of the assessment of referrals and information by the Referral Unit is to identify and recommend a care pathway based on information received and additional information gathered to support access and flow into CaFHS. This assessment does not include face-to-face contact with the consumer. In each case it will be ensured that the infant/child and their family are referred to the most appropriate CaFHS' care pathway.

5.2 Objective

The primary objective of the Referral Unit will be to maximise the efficiency and effectiveness with which all cases referred to CaFHS are managed, and to ensure a consistent approach to support access and flow into CaFHS. This new approach will replace existing practices which have seen infants, children and families assessed via a decentralised model with risks of associated delays and inconsistencies of approach to assessment and entry into the service. It will also provide a single point of contact for all referrals and other information received by CaFHS' services.

Having an experienced, inter-professional team which is focussed exclusively on facilitating timely assessment and triage of infants, children and their families to one of CaFHS' three service streams, relative to their identified needs and circumstances, will support infants, children and families to be connected with the most appropriate service response first time, every time. In circumstances where an infant, child and family have previously accessed CaFHS' services, a centralised model will minimise the need for consumers to repeat their story multiple times and enable relevant historical information to be accessed and taken into account as part of each assessment process. This ensures any service referral is made on a fully informed basis.

5.3 Key elements

The following provides an overview of the key elements of the Referral Unit.

TOPIC	SUMMARY
FOCUS POPULATION	All infants, children and families referred and/or re-referred to CaFHS, including to its residential service (Torrens House).
REFERRAL SOURCES	Referral sources are inclusive of but not limited to: birthing hospitals; Government and Non-Government Organisations (i.e. Department for Child Protection, Department for Education and Child Development, Playgroup SA, Aboriginal Health Services); Parent Helpline; general practitioners.

TOPIC	SUMMARY
REFERRAL SOURCES (continued)	<p>Liaison roles operating as part of the Referral Unit will have a presence at and promote CaFHS as a service at South Australian metropolitan and country birthing hospitals</p> <p>Self-referral by consumers may be received directly through the Referral Unit or through direct presentation at local CaFHS sites where a care pathway may be recommended.</p>
SERVICE ENTRY POINT(S)	<p>Antenatal</p> <p>Postnatal up to age five years, with a focus on the early years.</p>
STAFFING PROFILE	<p>Inter-professional team working in a collaborative model. Team members will include: Aboriginal workforce; Administration; Allied Health; Nursing and Liaison roles</p> <p>Where referral or information is received about an Aboriginal infant, child or family the assessment and triage process will be led by the Aboriginal workforce.</p>
TRIAGE AND ASSESSMENT	<p>All referrals received will be triaged and assessed using standardised tools</p> <p>Triage and assessment undertaken by an inter-professional team</p> <p>Assessment to incorporate the three CaFHS' service domains (Child health, development and emotional wellbeing; Caregiver wellbeing and parenting; Relationships)</p> <p>Assessment will enable identification and recommendation of a care pathway based on information gathered from the referral</p> <p>Additional information may be sourced to support decision-making such as from electronic Client Health Information Management System (eCHIMS) and Open Architecture Clinical Information System (OACIS)</p> <p>Face-to-face contact with the family will not be required as part of the assessment process however phone contact may be used to clarify any aspects of the referral</p> <p>Staff from the Referral Unit may liaise with regional CaFHS staff to incorporate knowledge about local services to inform recommendation of a care pathway as required.</p>
RECOMMENDATION OF CARE PATHWAY	<p>A Recommended Care Pathway Plan created for each referral indicating the CaFHS' service stream considered to be most appropriate.</p>
TRANSFER OF CARE	<p>Receipt of referral/information confirmed promptly to referrer</p> <p>Planning for transfer of care to relevant CaFHS' service stream commences at assessment, via a documented set of criteria clearly identifying the recommended care pathway</p> <p>Formalised clinical handover provided to the nominated CaFHS' service stream at a geographical location best aligned with infant/child and family needs and circumstances</p> <p>Particular CaFHS' staff member allocated to a specific infant, child and family to be determined taking into account location of child and family, the recommended care pathway and the local skills, competencies and capacity for this service identified.</p>
ESCALATION OF CARE	<p>In circumstances where an appropriate care pathway is unable to be recommended by the inter-professional team and/or an infant, child and family have been identified at significant risk and require immediate intervention, formal mechanisms will support prompt escalation to appropriate clinical lead/s for timely action. Where collaboration with other services is required information sharing principles will be applied as defined in the Information Sharing Guidelines (refer to <i>Appendix E – Tools and guidelines</i>)</p>

A process flow diagram which summarises the intended operation of the Referral Unit in practice appears at *Appendix F – Clinical pathway | Referral Unit*.

5.4 Benefits

The establishment of the Referral Unit will deliver a number of benefits not only to infants, children and families seeking to access CaFHS' services but for CaFHS' staff and referrers alike.

	BENEFIT	INFANTS, CHILDREN AND FAMILIES	CaFHS STAFF	REFERRERS
ACCESS	<ul style="list-style-type: none"> Single point-of-entry for all referrals/re-referrals to CaFHS' services 	✓	✓	✓
	<ul style="list-style-type: none"> Seamless and timely entry to the most appropriate care pathway 	✓		✓
	<ul style="list-style-type: none"> Establishment of procedures in line with policy frameworks to support enhanced access and equity through a consistent approach 	✓	✓	
REFERRAL MANAGEMENT	<ul style="list-style-type: none"> Well defined and documented referral/re-referral processes which are transparent and support continuity of care in the interests of achieving optimal child health, development and wellbeing outcomes 	✓	✓	✓
	<ul style="list-style-type: none"> Single point-of-referral and single point-of-contact to maximise timely access to key information by referrers both at the time of referral and otherwise 	✓		✓
	<ul style="list-style-type: none"> Consistent and standardised approach to referral management to support daily service capacity and monitoring of outcome measures 	✓	✓	✓
	<ul style="list-style-type: none"> Single referral form with defined Minimum Data Set to ensure referrals include all necessary information to facilitate timely assessment and triage 	✓	✓	✓
ASSESSMENT AND TRIAGE	<ul style="list-style-type: none"> Standardised, evidence-informed assessment and triage tools to support a consistent approach 	✓	✓	
	<ul style="list-style-type: none"> Highly-skilled and trained inter-professional assessment team to triage and recommend initial care pathway 	✓	✓	
	<ul style="list-style-type: none"> Aboriginal workers embedded as part of core inter-professional team to ensure culturally appropriate and responsive care pathways are recommended from the outset and that all cultural considerations and sensitivities are considered as part of the assessment process 	✓	✓	✓
	<ul style="list-style-type: none"> Well defined and documented referral criteria and parameters for each CaFHS service stream to support effective and efficient triage and transfer of care 	✓	✓	✓
GOVERNANCE	<ul style="list-style-type: none"> Strong governance structure including robust clinical governance and associated clinical risk management and quality management processes 	✓	✓	✓
	<ul style="list-style-type: none"> Regular monitoring and measurement of performance against agreed and documented metrics to ensure the highest quality outcomes. 	✓	✓	

6 Universal Service

6.1 Overview

CaFHS' Universal Service is an evidence-informed service response available to all infants, children and families from birth to five years of age. The service facilitates access to professional support and advice to optimise growth and development of infants and children in their early years.

As set out in section 3.3, approximately 70% of infants and children are considered to be 'low risk' from a child health, development and wellbeing perspective, in so far as they and their families, on average, experience one or less risk factors known to be associated with adversity and vulnerability. While these infants, children and families may not have the need for a targeted and sustained service response, it is nonetheless critical that they have access to services that are available to them at key milestones and junctures in the early years and when otherwise needed. This recognition is supported by the *National Framework for Universal Child and Family Health Services*¹⁸, which provides that the availability of universal services for all infants, children and their families, including at key transitions, are important for ensuring all children have an equal opportunity for optimal growth and development in the early years. In addition, the Universal Service is also underpinned by a number of well-established frameworks and approaches including: population health; primary health care; and strength-based perspective. A list of relevant frameworks, approaches and theories that have underpinned the development of the Model of Care appear in *Appendix G – Theoretical frameworks and approaches*.

As identified in the *National Framework for Universal Child and Family Health Services*, CaFHS Universal Service works in partnership with families and collaborates with other health service providers to deliver health promotion activities including primary prevention strategies (e.g. immunisation), health education (e.g. safe sleep), anticipatory guidance (e.g. infant's tired signs), parenting skill development (e.g. toddler behaviour) and provides support for parents (e.g. reassurance, normalisation of child behaviour). As part of these activities the Universal Service will respond to identified needs by providing short-term, outcome orientated interventions and timely referral to other services as required.

6.2 Objective

The objective of the Universal Service response is to provide support to parents and caregivers both at key transition points, and at other times of need as they nurture their children through the first five years of life.

Ensuring that families and caregivers are supported during the early stages and phases of a child's life is critical. It is well documented that the first five years of life have a profound impact on the life of that child into adolescence, and subsequently adulthood. Each developmental stage builds on the successful attainment of the previous stage, in this way laying a critical foundation for life. If one development stage is not successfully attained, it can make it more difficult to attain

¹⁸ Australian Health Ministers' Advisory Council (AHMAC). (2011). *National Framework for Universal Child and Family Health Services*, [online]. Available at: [http://www.health.gov.au/internet/main/publishing.nsf/content/AFF3C1C460BA5300CA257BF0001A8D86/\\$File/NFUCFHS.PDF](http://www.health.gov.au/internet/main/publishing.nsf/content/AFF3C1C460BA5300CA257BF0001A8D86/$File/NFUCFHS.PDF)



subsequent stages¹⁹. The Universal Service will support parents in seeking to meet the health, development and wellbeing needs of their infants/children; understand and manage their expectations of parenthood; make the necessary adjustment to their lifestyle and relationships that parenting requires; and encourage wellbeing strategies.

6.3 Eligibility

The Universal Service will be available to all families with children from birth, with a focus on the early years, and will provide the foundation for all other CaFHS services.

Many parents and caregivers who access this service will feel able to manage day-to-day parenting challenges and keep the best interests of their child in mind. To this end, the Universal Service will provide a welcoming point of support and contact for families and caregivers to assist them generally in caring for and nurturing their infants/children.

In the context of the Universal Service, there may be some instances where infants, children and families are identified as experiencing some additional challenges that may increase the risk of poor child health, developmental or wellbeing outcomes but are not such that they require a targeted and sustained service. In these cases, infants, children and families will be actively engaged for follow up and offered additional points of contact. If, over time, the circumstances for a child or family unit change such that more assertive or intensive services are required, established processes and procedures will facilitate the child and family being connected with the most appropriate additional CaFHS service/s (for example CaFHS' Targeted and Sustained Service) and to ensure maximum flexibility in the transition between services.

The tables below provide an overview of some of the circumstances which may be experienced by an infant, child and family who is accessing or who has accessed the Universal Service, and which may indicate the need for additional points of contact and/or access to additional active engagement strategies.

PARENT/CAREGIVER	
Social isolation	Parental disability
Single parent	Birth trauma
Transience	Parental mental health concerns
Family out of work	New arrival to Australia
Difficulties in initial adjustment to parenting	Disconnection from culture
Low income	Prior recipient of CaFHS Targeted and Sustained Service for a previous child

¹⁹ Sawyer, A., Gialamas, A., Pearce, A., Sawyer, M., & Lynch, J. op. cit.



INFANT/CHILD	
Preterm birth	Health issues including congenital abnormality
Low birth weight	Birth complications
Child development concern	Multiple birth
Feeding issues	Settling Issues

Review processes will be embedded within the Universal Service to ensure that the service is meeting the needs of infants, children and families. Review will occur where there is a change in circumstances for the family, wherever appropriate, and may include input from the inter-professional team as required.

6.4 Referral and triage

Referral into the Universal Service will occur via CaFHS' Referral Unit. It is anticipated that most referrals will be triggered in one of the following circumstances:

- following the birth of an infant
- when families have moved from interstate or arrived from overseas
- as part of discharge planning when a handover process occurs from an Aboriginal Worker, for example an Aboriginal Maternal and Infant Care (AMIC) worker to a CaFHS' Aboriginal worker.

A decision to triage an infant or child and family to the Universal Service will be taken based upon all relevant key information including:

- available clinical information regarding the infant/child such as gestation, birth details and maternal history
- age of infant
- geographical location and associated information
- cultural context (where necessary an interpreter may be engaged to assist).

6.5 Service elements

The Universal Service includes the following key elements:

- initial contact visits
- periodic infant and child health assessments and checks
- health promotion activities
- additional parenting and child development services and supports.

Each of these elements are described in more detail below.



6.5.1 Initial contact visits

This element of the Universal Service involves initial contact with an infant/child and family undertaken by way of two visits within an eight-week period following the birth of an infant. This may extend to a third visit in response to identified need. Visits may either be undertaken in the home of the family or in a CaFHS clinic.

Initial contact visits support continuity of care for parents between the birthing hospital and community care, and can provide important and much needed assistance and reassurance to parents in the early days immediately following the birth of an infant.

These visits are an opportunity to support parents, from the earliest weeks in the infant's life, to begin to be invited into the world of the infant. It is a vital opportunity to begin to support the family to see and understand each other so that each member of the family can begin to develop a healthy relationship. It is the support of this relationship that has the potential to influence the trajectory of the infant's development and encourage positive family wellbeing.

While Universal Contact Visits have formed a fundamental component of the services offered by CaFHS for a number of years, traditionally each family received one visit as part of the standard service delivery approach. Feedback from staff over time, and in addition feedback received during consultation undertaken regarding CaFHS Model of Care, has highlighted, in practice, families will either need or benefit from more than one visit. Reasons for this include the following:

- it can be overwhelming for a family with a new infant, where sleep deprivation is likely also to be a factor, to cope with a long visit and detailed assessment process
- there are benefits for a visiting clinician taking time to get to know the family at the first visit and providing gentle support and assistance as required. Through discussion with the family being able to identify the level of support that they require, and to continue this at a follow up visit
- challenges faced by families with an infant do not always emerge immediately and may arise after some days or weeks, at which point, parents are then in need of support and assistance in areas that may not even have occurred to them earlier
- the ability to support families over more than one visit can enable CaFHS' staff to see more families in any given day, thereby increasing CaFHS' reach to new families.

It is hoped that expanding the flexibility of the initial contact visits to support each family receiving two visits as a matter of course, and potentially three visits where indicated by professional or parent concern, will enrich and strengthen the nature and extent of the support that CaFHS is able to meaningfully provide to families. It is also hoped to increase the opportunity for CaFHS to identify and assist any families who are experiencing numerous challenges simultaneously and who may benefit from being connected with the Targeted and Sustained Service.

The following provides a summary of the focus of the initial contact visits and key activities associated with each:



CONTACT	FOCUS	KEY ACTIVITIES
First Contact	<ul style="list-style-type: none"> Physical wellbeing and health of the newborn infant including sleep environment Undertake Child Health Assessment Parental concerns Parental education and health promotion Consideration and response to referral information and specific indicators such as Domestic and Family Violence 	<ul style="list-style-type: none"> Introduction to service Respond to parental concerns Discuss parental wellbeing and initial adjustment to parenting Safety and health care of infant Assess health, growth and wellbeing of infant (building on any existing antenatal and postnatal assessments to minimise need for family to repeat information to CaFHS' workers) Promote developmental monitoring/surveillance and promote opportunities for developmental screening Support for establishment of breastfeeding and commence the Breastfeeding Assessment and Care Plan where indicated Observe sleep environment and discuss safe sleep Complete 1 – 4 week health assessment of infant Facilitate review with general practitioner at six weeks Provide health education and anticipatory guidance Promote access of other health service providers e.g. general practitioner Develop Care Plan in partnership with parents Provide overview of content of 'My Health and Development Record' (Blue Book) and highlight specific resources.
Second Contact	<ul style="list-style-type: none"> Assess maternal wellbeing Undertake Domestic and Family Violence screening Review child health Parental education and health promotion 	<ul style="list-style-type: none"> Build on previous contact to respond to needs of parents and infants Completion of Edinburgh Postnatal Depression Scale (EPDS) Review infant health, development and wellbeing and discuss with parents Support adjustment to parenting Focus on parental wellbeing using validated and consistent screening tools Undertake Domestic and Family Violence screening Promote or provide immunisation Identify Children's Centres and other services Link with community supports including groups Promote developmental screening activities Discuss child and home safety Develop Care Plan in partnership with parents.
Potential Third Contact	<ul style="list-style-type: none"> To follow up any unresolved actions from Care Plan 	<p>Examples include:</p> <ul style="list-style-type: none"> Feeding or settling issues Ongoing support for breastfeeding establishment and management of challenges Prematurity of infant Multiple birth Elevated EPDS that does not meet threshold for referral to Targeted and Sustained Service Continue adjustment to parenting focus.

Clear guidelines and governance structures will exist to support decision-making in relation to the need for an additional one or more visits over and above the two visits that will be routinely offered as a standard to all infants and families.

A Care Plan will be developed as part of all initial contact visits with the intent to clearly document any agreed next steps for a family and to ensure the family knows how, where and when to access any services they may require moving forward - whether a CaFHS' service or otherwise. For

example, a Care Plan may include reference to future periodic assessments for an infant or child, when these need to occur and how to arrange an appointment, and may include a recommended periodic follow up with a family's general practitioner.

Each Care Plan developed will:

- be developed with parents to support them in being able to identify the services that could be of assistance
- respond to the individual needs of an infant, child and family, based on the assessment undertaken and the goals that the family has identified
- support families to identify their strengths, and available resources and the knowledge they have in relation to child health, development and safety. These strengths and resources will be documented as part of the Care Plan
- be responsive to any cultural needs a family may have. In the case of Aboriginal families, the care planning process is likely to include consultancy from an Aboriginal worker within CaFHS
- identify referral pathways as appropriate, both internal and external to CaFHS.

A copy of the Care Plan developed with and for a family will be provided to that family for reference.

6.5.2 Periodic infant and child health assessments and checks

This element of the Universal Service supports periodic assessments and checks of infants and children at specific intervals to ensure the attainment of key developmental milestones and, where indicated, to assist a family in seeking additional investigation and assessment.

Health assessments and checks are generally indicated and undertaken at: six to nine months and eighteen months to two years. In response to identified need based on parental or professional concern, additional contacts may be arranged at twelve months and at between two to five years as part of a more targeted service response.

The table below provides an overview of the key, standard milestone assessments and checks and what these entail.

TIMING BY AGE OF INFANT/CHILD	KEY ASSESSMENT ACTIVITIES
0 → 8 weeks	(over the course of 2-3 visits) <ul style="list-style-type: none"> • 1-4 week Child Health Assessment • Sleeping Baby Safely • Parental education and health promotion – safety/signs of infant health and wellbeing • Child and family assessment (tool to be developed) • Breastfeeding Assessment and Care Plan (in response to identified need) • Edinburgh Postnatal Depression Scale • Promote general practitioner medical review at 6 weeks • Domestic and Family Violence Screening • Promote and/or administer immunisation

TIMING BY AGE OF INFANT/CHILD	KEY ASSESSMENT ACTIVITIES
6 → 9 months	<ul style="list-style-type: none"> • Ages and Stages Questionnaire • Child Health Assessment • Review of infant growth • Parental education and health promotion – nutrition and growth, sleep and settling • Promote and/or administer immunisation
12 months	(in response to identified need) <ul style="list-style-type: none"> • Ages and Stages Questionnaire • Child Health Assessment • Review of child growth • Promote and/or administer immunisation • Parental education and health promotion – behaviour, growth and development
18 months → 2 years	<ul style="list-style-type: none"> • Ages and Stages Questionnaire • Child Health Assessment • Parental education and health promotion – behaviour, growth and development • Promote and/or administer immunisation
2 → 5 years	(in response to identified need) <ul style="list-style-type: none"> • Child development screening i.e. Ages and Stages Questionnaire • Child Health Assessment • Promotion of preschool and playgroup • Parental education and health promotion

6.5.3 Additional parenting and child development services and supports

The third key element of the Universal Service involves various additional initiatives, programs, activities and targeted services which operate to complement the universal visits and health assessments and checks. Examples include the following:

TOPIC	OVERVIEW
Breastfeeding	<ul style="list-style-type: none"> • Protection and promotion of breastfeeding through the provision of education and support, including contemporary, practical problem-solving in the early post-natal period • A focus on the education of fathers, and other caregivers, in influencing breastfeeding initiation, duration and weaning • Parents respected for their choices with individual education and support provided in relation to safe preparation and use of infant formula.
Immunisation	<ul style="list-style-type: none"> • Promotion of immunisation to parents as per the <i>National Immunisation Program Schedule</i> • Advice on where immunisation can be accessed locally (i.e. general practitioners, local Council services) • Provide immunisation in cases where local services are not available or limited.

TOPIC	OVERVIEW
Parenting Groups	<ul style="list-style-type: none"> Assisting parents to increase their confidence, skills and knowledge and to strengthen infant/child-parent interaction and foster the development of informal support networks through parenting groups Regular 'Welcome to CaFHS' sessions held at key CaFHS' sites to provide orientation of services, and information regarding the broader services within CaFHS and across the early childhood system An opportunity for families to connect and be informed by peer parents who have accessed CaFHS' services themselves, with the intention that sessions will be led by peer parents 'Early Parenting Groups' for first time parents to provide education sessions on topics such as; adjustment to parenting, sleep and settling, play and development, and nutrition A range of one-off sessions, covering topics such as; introduction to solid foods, understanding toddler behaviour, and sleep Culturally safe and responsive groups to enable Aboriginal infants, children and families to access culturally relevant information Culturally safe and responsive groups for culturally and linguistically diverse communities Groups primarily facilitated by nurses but may be co-facilitated with Aboriginal workers or Allied Health staff in an open or closed format.
Online Resources	<ul style="list-style-type: none"> Support parents with the responsible and safe use of information technology, and facilitate access to reliable sources of information.
Residential Service (Torrens House)	<ul style="list-style-type: none"> Provide intensive short-term intervention to support adjustment to parenting, with the focus on intervening early in response to unresolved feeding and settling issues.
Parent Helpline	<ul style="list-style-type: none"> Helpline available 24 hours a day, 7 days a week though collaboration with HealthDirect Australia, staffed by a professional clinical team Provides support, education and phone advice to parents Self-initiated option for parents.
Parental Education	<ul style="list-style-type: none"> Child safety Immunisation Nutrition Promoting an enriching environment for child health, development and wellbeing Child growth, development and emotional wellbeing.

A process flow diagram which summarises the clinical pathway for Universal Service, appears at *Appendix H – Clinical pathway | Universal Service*.

6.6 Health literacy

Encouraging and supporting the improved health and developmental literacy of parents and caregivers will underpin each of the key Universal Service components. This will be achieved through mechanisms including the following:

- undertaking child health and development screening with health assessments and the Ages and Stages Questionnaire (ASQ) at scheduled times, to support parents to improve health literacy
- continuing commitment to maintaining Baby Friendly Health Initiative (BFHI) accreditation by protecting, promoting and supporting breastfeeding. Where mothers are not breastfeeding they will be provided with individual education and support about the safe preparation and giving of infant formula

- delivering the 'Lift the Lip' dental program used to identify signs of early tooth decay and educating parents about how to do this with their children
- encouraging the use of the 'My Health and Development Record' (Blue Book)
- informing families about outreach services at playgroups, Children's Centres and preschools where parents can seek guidance with a nurse about their child's wellbeing and safety
- promoting the use of self-weigh facilities through CaFHS or other service providers to monitor an infant/child's growth
- establishing an enriching environment for supporting development
- providing parents with practical information about 'what to expect' in relation to the infant/child's behaviour, growth and development in the immediate and longer term through anticipatory guidance
- providing an introduction to the concept of infant/child attachment
- developing parental health education strategies in key topic areas including the following:
 - child development fundamentals, for example the domains of development and key developmental milestones
 - responsive sleep and settling
 - immunisation, nutrition and safety
 - infant/child social and emotional health
 - indicators of adequate growth including through the use of percentile charts and when to seek clarification and support
 - signs of wellness and deterioration in the condition of infants and children including services which provide first aid courses to new parents
 - reliable sources of child health and development information
 - parental emotional wellbeing
 - contraception and sexual health.
- providing parents and caregivers with awareness about available resources and services through which health information and associated support can be accessed. Examples include:
 - phone support including via the Parent Helpline and the Pregnancy, Birth and Baby Helpline - part of HealthDirect Australia
 - websites such as the Raising Children Network and SA Health Child and Youth Health website (www.cyh.com)
 - perinatal mental health resources, for example beyondblue.org.au and www.panda.org.au
 - consumer-friendly resources, including *Parenting SA Parent Easy Guides*
 - culturally appropriate resources such as *Parenting SA Aboriginal Parent Easy Guides*.

6.7 Transfer of care

A child and family who is accessing or has accessed CaFHS' Universal Service may be re-referred to another CaFHS' service and/or to external services if it is assessed that this is required by the

circumstances of the infant, child and family. Where the need for referral is identified, collaboration with service partners will occur, applying information sharing principles as defined in the Information Sharing Guidelines (refer to *Appendix E – Tools and guidelines*), to determine the most suitable pathway.

Instances in which a transfer of care may occur include the following:

- when through assessment it is identified that the family requires a Targeted and Sustained Service
- where the Department for Child Protection place an infant or child under a Guardianship order and their care is transferred to CaFHS' Statutory Care Service
- when the needs of the infant or child require a specialised response such as children who receive disability services
- successful transition to General Practice.

Completion of an episode of care will occur when:

- a family decides that they prefer to access another service provider
- the family declines or chooses to withdraw from the Universal Service and no risk of harm has been identified for the infant or child.

A file closure will occur when:

- a child reaches eligibility for preschool.



7 Targeted and Sustained Service

7.1 Overview

CaFHS' Targeted and Sustained Service is a flexible and dynamic service response which provides more direct and intensive support to infants, children and families who may benefit from additional help in safeguarding and promoting health, wellbeing and development. The service is offered during pregnancy and following birth according to need, and is focussed on the provision of a sustained service that continues over time to support the achievement of improved outcomes for infants, children and families that cannot be achieved successfully through single or individual episodes of care. Further integration with the emerging CFARNs and the Strong Start Program²⁰ will be critical to the Targeted and Sustained Service.

As set out in section 3.3, approximately 30% of infants born in South Australia each year (about 6,000 births) experience increased levels of adversity, thereby placing them at much higher risk in terms of health, development and wellbeing outcomes. Considering what is well known about the vital importance of the first five years of life, it is imperative that CaFHS' Model of Care incorporates a service response that ensures these infants, children and families have access to appropriate intensive support. The core intention is to assist and address and/or manage circumstances, with a view to help improve developmental, health and wellbeing outcomes both in the immediate and longer term. Ultimately, the intention of the service response is to assist in building strong and resilient families and to safeguard and promote the voice and needs of the infant/child.

The Targeted and Sustained Service is underpinned by a number of well-established frameworks and approaches including: the 'Two-Generation' approach; attachment theory; sensitive development periods; ecological model; trauma informed care and reflective capacity. A list of relevant frameworks, approaches and theories that have underpinned the development of the Model of Care appear in *Appendix G – Theoretical frameworks and approaches*.

A process flow diagram which summarises the clinical pathway for Targeted and Sustained Service response appears at *Appendix I – Clinical pathway | Targeted and Sustained Service*.

7.2 Objective

The Targeted and Sustained Service builds on the foundations laid by the Universal Service response to provide longer term and more specialist support to families experiencing more significant challenges. The service is designed to enable the nature and degree of support offered by CaFHS to be tailored to the particular needs of each family relative to the challenges being faced. To this end, the intention is for services to be delivered whilst there is an identified need, and at the frequency that will have the most benefit to the infant/child and family. Regular review

²⁰ Strong Start is a DECD program that commences antenatally and aims to support first time mothers who are experiencing complex challenges.

points will inform duration of episode, and any change to risk profile and challenges being experienced.

The aim of the service is to ensure a strong focus on early intervention to ensure as much as possible that infants, children and families who are identified as requiring additional assistance and support, receive a service response quickly, and ideally before the child reaches three years of age.

This service is strongly linked to the emerging CFARNs as this is the key service delivery area that will act as a backbone.

7.3 Eligibility

The Targeted and Sustained Service will be offered to families and infants/children that are assessed by the Referral Unit, or the Universal Service, as requiring more intensive support. Assessment and service delivery may commence any time from the antenatal period or following the birth of a child up to age three with CaFHS remaining involved with some children up to school age. The early intervention focus will see services offered to infants and children before they reach the age of three years in recognition of the importance of the early years and in particular the period of infancy. The integrated family support service approach will occur in partnership with DECD including Children's Centres and the emerging CFARNs.

The service aims to be inclusive of infants, children and families experiencing vulnerability and additional challenges wherever possible. Exclusion is therefore limited to:

- infants, children and families who can be adequately supported by CaFHS' Universal Service
- infants and children who are under a Guardianship order as CaFHS' Statutory Care Service response is more appropriate
- infants, children and their families, where a more appropriate support option, external to CaFHS has been identified.

Infants and children who have Department for Child Protection involvement but are not under Guardianship orders will be supported through the Targeted and Sustained Service.

There are a range of adverse conditions and events that may lead to infants and children being 'vulnerable' and which may compromise their capacity to develop to their full potential. Adversity can take many forms and may be caused by difficult relationships, specific events, or general social, economic, or environmental conditions.²¹ It is the multiplicity of these adverse conditions and events that may make parenting more challenging and place infants and children at increased risk of poorer health, development and wellbeing outcomes including poor emotional and mental health. Summarised in Figure G are a range of factors that may impact on parenting and outcomes for infants/children.

²¹ Pilkington R & Lynch J. op. cit. p 15.

Figure G: Potential factors impacting on parenting and health, development and wellbeing outcomes for infants and children



Source: Infant/Child resilience²²

²² Center on the Developing Child (2015). *The Science of Resilience* (InBrief). Available at: www.developingchild.harvard.edu

7.4 Referral and triage

Referral into the Targeted and Sustained Service will occur primarily through CaFHS' Referral Unit. The majority of referrals will be received from birthing hospitals on identification of vulnerability during the antenatal period, while others will be identified following the birth of an infant. There will also be potential to receive referrals through other community and partner organisations, as well as via CaFHS' Universal Service and self-referral.

It is anticipated that most referrals will be triggered in one of the following circumstances:

- during pregnancy
- following the birth of an infant
- when families have moved from interstate or arrived from overseas
- as part of discharge planning when a handover process from an Aboriginal Worker, for example an Aboriginal Maternal and Infant Care (AMIC) worker, to a CaFHS' Aboriginal worker occurs
- when the circumstances of the family unit change and their needs are no longer able to be met by the Universal Service.

A decision to triage an infant, child and family to the Targeted and Sustained Service will be taken based upon all relevant key information including:

- available clinical information regarding the infant such as gestation, birth details and maternal history
- age of infant
- the needs of the infant, child and family and the available mechanism/s to provide the appropriate level of support
- the outcome of any consultation with the family and their individual preference
- geographical location of the infant/child and family
- cultural context (where necessary an interpreter may be engaged to assist)
- the need for inter-agency collaboration in circumstances where other agencies or providers are working with the family.

7.5 Initial engagement

Effective early engagement with infants, children and families triaged to the Targeted and Sustained Service will be critical and is not only likely to heavily influence the extent to which the family chooses to continue working with CaFHS but will set the tone for the partnership between the family and CaFHS moving forward. First contact is an opportunity to commence building trust

with each family. To this end, initial contact with families will be underpinned by the following key elements:

- respect and kindness
- a non-judgemental approach that is empathic to the circumstances of the family
- recognition of the importance of establishing a connection with all family members present at the initial and any later visits, including infants and children
- the need to prioritise any immediate concerns or needs of the family
- flexible service provision, for example in a range of locations that best support the engagement of the family, including the family home, clinics or other community settings

Where a child and/or family identify as Aboriginal, the initial contact will be made by an Aboriginal member of the CaFHS' team to ensure a culturally-safe service response and to assist in supporting strong, effective engagement.

7.6 Service approach

The Targeted and Sustained Service response is underpinned by a theory of change in which child health, development and wellbeing outcomes can be improved by strengthening child-parent interactions and relationships; increasing the knowledge, skills and capacity of parents; increasing the capacity of parents to be reflective about their parenting as well as their own experiences of being parented; and increasing the capacity and skills of parents to regulate emotions for themselves and their infants/children. This will in turn improve parental wellbeing, family functioning and health and developmental literacy of parents and optimum health, development and emotional wellbeing for infants and children. In doing this, parents may be better equipped to protect their children and provide safe, stable and nurturing relationships that foster the development of resilience in children. The values of staff are an imperative part of the response in being able to hold in mind the possibilities they can see for individual infants, children and families that they work with. Early interventions that are implemented in partnership with families will work towards the goal of self-management and assist parents to understand the importance of their child's health, development and emotional needs; to make informed decisions; problem-solve; take appropriate actions and build their own resilience.

In the case of Aboriginal infants, children and families, all interventions will be underpinned by an understanding and recognition of the importance of Aboriginal culture, practices and beliefs which are in turn reflected in the support provided to children and families.

In some instances, situations may be identified where infants, children and families require an intensive short-term intervention to support adjustment to parenting. In these cases, an admission to CaFHS' residential service, Torrens House, may be identified as being beneficial. This will provide the opportunity to understand challenges the family may be experiencing in a more intense manner. The inter-professional team will contribute to the development of Torrens House referrals as well as the care planning process through admission and discharge. Continuity and support from the service will be maintained throughout the Torrens House response.

7.7 Service elements

The Targeted and Sustained Service will be stratified to deliver services that ensure sufficient intensity and frequency dependant on the level of need identified within the family structure. The key elements of the service will include:

- Initial child and parent health assessment utilising a formalised, agreed assessment tool
- Development of a comprehensive Care Plan in collaboration with parents, family and other identified service providers
- Provision of sustained, intensive support to both infants/children and their parents/caregivers
- Provision of a range of therapeutic approaches
- Collaboration and active communication with other service providers to support the infant, child and family
- Ongoing infant, child and caregiver assessments.

Each of these elements are described in more detail below.

7.7.1 Initial infant, child and parent health assessment

As an infant, child and family's needs increase, a more specialised assessment is required to inform and guide individually tailored and coordinated intervention and support that most closely meets the needs of the family. For this reason, comprehensive infant, child and parent assessments will comprise an important initial component of the Targeted and Sustained Service.

An adapted common assessment tool which builds upon and incorporates information from any other assessments previously undertaken for the infant, child and/or family will be utilised, to the extent that CaFHS is provided with a copy of or otherwise made aware of any prior assessments. This will serve as a critical step, not only because access to historical assessments will help to ensure all relevant information is taken into account as part of any assessment undertaken by CaFHS, but will also minimise the need for families to retell their stories.

Evidence-informed screening and assessment tools used as part of the assessment process will include, but not be limited to, those administered as part of the CaFHS' Universal Service. Examples include the Ages and Stages Questionnaire (ASQ), Ages and Stages Questionnaire: Social-Emotional (ASQ:SE), Edinburgh Postnatal Depression Scale (EPDS), the Depression, Anxiety and Stress Scale (DASS), Standardised Assessment of Personality Abbreviated Scale (SAPAS), and the Home Observation for Measurement of the Environment (HOME) Inventory. When assessing the needs of Aboriginal infants, children and families, CaFHS will identify and utilise culturally appropriate tools where possible. All screening tools used will help inform the assessment, Care Plan, and outcomes. Refer *Appendix E – Tools and guidelines*.

The initial assessment process undertaken within the context of the Targeted and Sustained Service will be focussed on enabling CaFHS to gain an insight into the infant/child and family and the way in which their circumstances, relationships and lifestyle factors are shaping and influencing developmental progress and outcomes. The assessment will include information from the following

domains which will be considered within the context of the family's interaction with the social and community environment.

ASSESSMENT DOMAIN	DESCRIPTION
Child health, development and emotional wellbeing	Child development and ongoing developmental needs from pregnancy through to present time, inclusive of physical, social-emotional, cognitive, language and behaviour and the impact of any trauma experienced by the infant/child.
Caregiver wellbeing and parenting	Caregiver health and wellbeing inclusive of physical and mental health, alcohol and other drug use, self-harm and risk taking behaviour, and experiences of trauma Cultural and spiritual considerations Observation of parenting including: preparation for birth, antenatal care, basic care and routines, safety, emotional warmth, stimulation, guidance and boundaries, stability.
Relationships	Observations of interactions between infant, child and parent as well as the ability of the parents to keep the infant/child in mind Issues arising from family of origin, trauma, child protection history within the family, relationship with partner and wider family and community relationships.

Effective assessment of these domains will provide key information to support both the family and the inter-professional team developing a clear and shared insight into the following:

- the reason for the referral from the perspective of both the family and referrer
- the current circumstances of the infant/child and parent
- the historical circumstances of the parent and the relationship between this and the present challenges/reasons for referral
- clarity around what needs to look different from the perspectives of the infant, child, parent and CaFHS' inter-professional team
- those indicators that will demonstrate to the parent and CaFHS' team that strategies and supports implemented are making a difference
- difficulties or obstacles that may impact the working relationship between the family and CaFHS and the capacity of the parent to respond to support offered.

The lead professional is responsible for coordinating the assessment and acquiring a shared understanding that is developed in partnership with the family which will support the care planning process.

In undertaking each assessment, the importance of each of the following will also be taken into account, and embedded as a fundamental consideration in the process overall:

- obtaining the parent's interpretation and understanding of both their circumstances as an individual and the needs of their infant/child within the broader context of their cultural background

- being mindful of Aboriginal and other cultural child-rearing practices, values and beliefs and understanding cultural identity and affiliation, including a broader focus on family and community
- actively engaging the parent and the infant/child in the process to ensure all relevant input, information and perspectives are incorporated. Verbal engagement with the child will necessarily be limited given many children will have limited language and expression skills, however physical presentation, reactions to and interactions with their parents and health and developmental status will provide critical insight into the child's overall wellbeing and will represent the infant/child's voice
- ensuring the inter-professional team works as a collective to leverage the knowledge and experience base of individual team members and their specific interactions with the infant/child and family. The inter-professional team will also have common clear expectations of roles and will take into account the specific needs of the family
- ensuring that the inter-professional team works collaboratively with other identified service providers.

7.7.2 Development of a comprehensive Care Plan

Based upon the information gathered as part of the detailed assessment process, a comprehensive Care Plan will be developed for the infant/child and family in partnership with the parent/s. This will involve:

- developing an explicit partnership agreement between the family and CaFHS
- ensuring that the voice of the infant or child is represented
- recognising the significance of cultural beliefs and practices and understanding the diversity of Aboriginal cultures and ensuring these are reflected in the Care Plan for Aboriginal infants, children and families
- recognising and understanding the significance of cultural beliefs and practices and ensuring these are reflected in the Care Plan for children and families from culturally and linguistically diverse backgrounds
- identifying the specific challenges and issues facing the infant/child and family and which are impacting, or are at risk of impacting, the wellbeing and development of the infant/child
- exploring strategies to assist the family in addressing or managing the identified issues and challenges which make best use of family strengths, knowledge and expertise
- identifying potential obstacles to implementing goals and clearly discussing and planning to address these obstacles
- encouraging the family to generate options for achieving goals and evaluating these in partnership with the family
- assisting the family to develop skills, expertise, resources and confidence to enable them to carry out the agreed and documented Care Plan.

7.7.3 Provision of sustained, intensive support to parents

The provision of sustained, intensive support to parents will be a key aspect of the Targeted and Sustained Service approach. This will require strong partnership with the CFARNs who will be working in a case coordination role from early in the antenatal period. Ensuring that parents have the knowledge, insight, skills and support to safeguard and foster the health, wellbeing and development of infants and children lies at the heart of CaFHS' focus.

In each case the supports that are offered to parents will be tailored to meet the identified and specific needs of each family however the suite of supports available will extend to and include the following:

- antenatal support and guidance in areas including:
 - preparation for parenting
 - establishing a direct line of contact between parents and the nominated CaFHS lead professional
 - collaboration with birthing hospitals
 - addressing psychosocial barriers to preparation for the arrival of the infant
 - strengthening support networks
 - supporting the development of the identity of the unborn infant as a responsive being
 - encouraging the development of a healthy relationship between caregivers and the unborn infant
 - engaging fathers and other caregivers throughout this process.
- modelling and fostering a range of parenting knowledge and skills incorporating health and developmental literacy
- protecting, promoting and supporting breastfeeding
- supporting the development of parent's capacity to reflect on themselves and their parenting
- recognising depression, anxiety and other forms of psychological distress and providing linkages to appropriate support
- recognising risk factors impacting on parenting capacity, for example substance abuse, domestic and family violence, and disability, and referral for support
- identifying and challenging behaviours that may have a negative impact on the infant, child or family and supporting changes to improve these behaviours
- providing advice to assist families to discover personal strengths and abilities
- providing specific services to fathers and recognising their key role within many families
- providing support regarding options for contraception and sexual health services
- promoting the benefits of immunisation
- increasing the capacity of parents to identify and navigate other support systems
- providing practical support related to the role of being a parent
- connecting parents with existing community-based networks and groups.

7.7.4 Provision of a range of therapeutic approaches

Therapeutic approaches are another important component of the Targeted and Sustained Service and will be adopted by the inter-professional team in consultation with the family based upon identified need and the approach or approaches that are considered to be of most potential benefit in supporting the family. CaFHS recognises the significance of the quality of the infant/child and caregiver relationship in the life trajectory of the child and in buffering children from the effects of adversity. Lasting change comes from caregivers developing specific relationship capacities rather than learning techniques alone²³. As a result, parental state of mind, reflective functioning, emotion regulation and the development of empathy within the caregiver will be targets of therapeutic support. Therapeutic support will also be available through the antenatal period where there is an emotional disconnection from the imagined infant or unresolved trauma that is emerging as the result of pregnancy/impending birth. Examples of therapeutic approaches include: infant/child-parent therapy, and therapeutic groups focused on the caregiver and infant/child together.

7.7.5 Collaboration with other service providers to support the child and family

In the context of the Targeted and Sustained Service, the nature and circumstances of challenges and issues faced by infants, children and families are often likely to be such that the most comprehensive and effective response is likely to extend beyond those services able to be provided by CaFHS alone. In many instances a multi-faceted, collaborative response involving multiple agencies and services with CaFHS amongst them, will deliver sustainable outcomes for infants, children and families. An example will include the capacity for CaFHS to work as part of the inter-agency service system response for children identified as vulnerable and needing additional support.

With this in mind, the Targeted and Sustained Service will place a strong emphasis on the establishment of collaborative partnerships and working relationships with other providers to support parents in key areas including:

- engagement with antenatal care and health education
- preparation for the adjustment to parenting
- infant and child health and developmental literacy.

In the case of those families who CaFHS may engage with during the antenatal period, CaFHS' staff will be required to engage in the existing inter-agency forums that will be auspiced by the CFARNs to discuss and agree strategies related to an infant that has been identified as being at potentially high risk.

²³ Cooper, G., Hoffman, K., Powell, B., and Marvin, R. (2005). The Circle of Security Intervention: Differential Diagnosis and Differential Treatment. In: Berlin, L.J., Ziv, Y., Amaya-Jackson, L., and Greenberg, M.T., (eds). *Enhancing Early Attachments: Theory, research, Intervention and Policy*. New York: The Guilford Press, pp 127-151.

7.7.6 Ongoing infant, child and caregiver assessments

Once the initial assessment and Care Plan has been developed for a family as part of the Targeted and Sustained Service, ongoing follow up assessments will be undertaken periodically for both the infant, child and parent/s. At a minimum these will be at similar intervals as for the Universal Service (i.e. at six to nine months; eighteen months to two years) and for children over the age of two years will continue on at least a bi-annual basis.

The frequency of any ongoing health checks and assessments undertaken will be determined for each individual infant, child and family based upon identified need and may change over time (either decrease or increase in frequency) as the circumstances of the family change. For example, a short-term intensive service response up to six months, or a longer-term moderate to high service level response with review points at 3, 6, 12 and 18 months up to three years of age.

A review process will be built into the service schedule for each child and family who work with CaFHS as part of the Targeted and Sustained Service. The purpose of the review process will be to reflect upon the journey of the child and family within the context of the CaFHS service response; to acknowledge and celebrate achievements; revisit the Care Plan and make adjustments to this in considering and planning next steps. In particular, the review process will be a catalyst for shared decision-making and will include the inter-professional team and enable families to participate jointly to discuss options, benefits and harm as well as consider individual values, preferences and circumstances. The number and nature of reviews undertaken will vary between families subject to the nature of the engagement with those families, any preferences expressed by a family and the context in which the service delivery is occurring.

In addition, it will be important to gain an understanding of each family's strengths and their knowledge relating to child health, development and wellbeing, and to ensure there is clarity provided in terms of safe parenting practices.

7.8 Transfer of care

A child and family who are accessing or who have accessed CaFHS' Targeted and Sustained Service may be re-referred to another CaFHS' service and/or external services if it is assessed that this is supported by the circumstances of the child and family. Where the need for referral is identified, collaboration with service partners will occur, applying information sharing principles as defined in the Information Sharing Guidelines (refer to *Appendix E*), to determine the most suitable pathway. A transfer of care will involve shared decision-making with the family and will include consideration of CaFHS' three service domains (refer section 3.2) and whether these have been met or how they ought to be met. The following will also be taken into account in the context of any contemplated transfer of care:

- sustained improvement in the issues with which a family initially presented
- the infant/child's health, development and wellbeing needs
- a positive emerging relationship with the infant/child
- parent/caregiver child health and developmental literacy
- the ability of parents/caregivers to keep the infant/child in mind.

Instances in which a transfer of care may occur include the following:

- when it is identified that the family and infant/child would benefit from an alternative or more specialised service response
- transfer to a DECD Children's Centre as a component of the integrated family support service pathway, or
- when an infant/child who is being supported through the Targeted and Sustained Service becomes the subject of a Guardianship order and therefore should more appropriately be referred to CaFHS' Statutory Care Service.

Completion of an episode of care will occur when:

- contact is lost with a family despite repeated attempts to engage;
- the family decides that they prefer to access another service provider; and/or
- a family declines or chooses to withdraw from the service

In these situations a review of any potential risks of harm for the infant/child will occur in determining any actions required prior to the completion of an episode of care.

CaFHS will close its file for an infant/child and family when:

- a child who is approaching preschool age has been successfully transitioned to other supports or services agreed as being appropriate, such as DECD Children's Centres.

8 Statutory Care Service

8.1 Overview

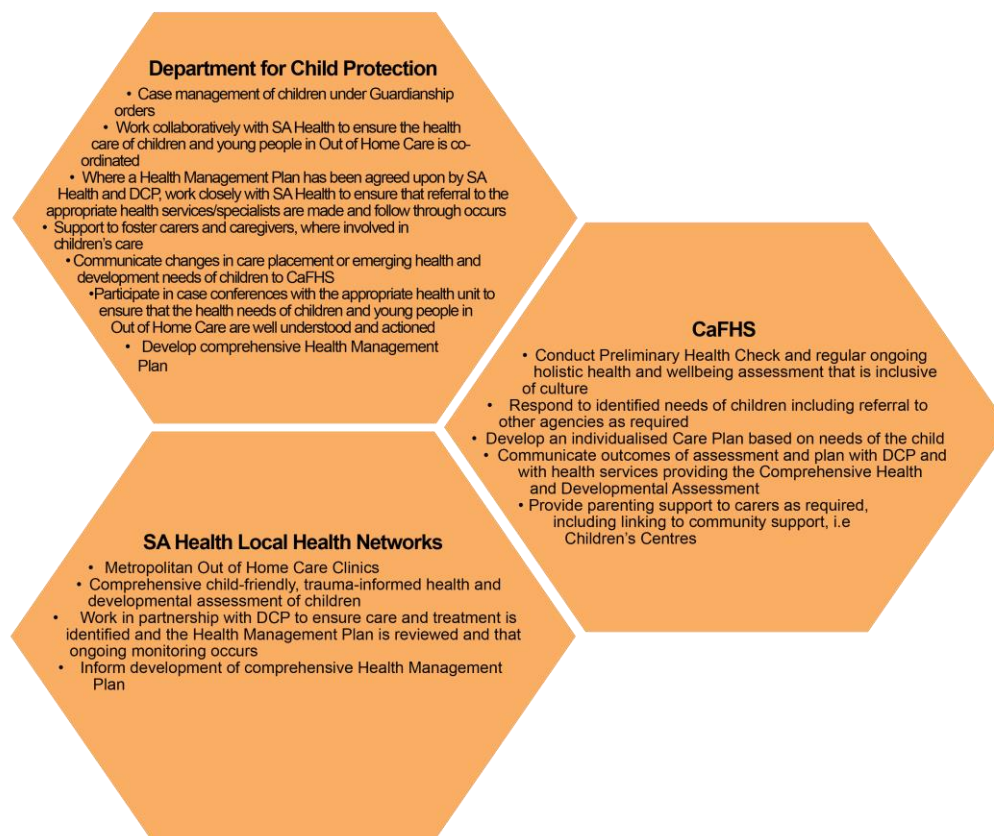
CaFHS' Statutory Care Service is a dedicated and flexible service response, centred on sensitivity and compassion, and holding the voice of the infant/child as central to the process. The service is delivered in partnership with the Department for Child Protection to support infants and children who are under Guardianship orders and, where relevant, their carers. In the context of the Statutory Care Service and this section of the document, the term 'carer/s' is used to refer to foster parents, kinship or relative carers or persons employed to care for children under Guardianship orders. It is acknowledged that in some instances, members of an infant/child's immediate family may be involved in providing care, and in these instances 'caregivers' also extends to include reference to immediate family members.

Statutory Care Service provides timely support to infants, children and carers from the point at which a child is placed into care, and may be offered to infants, children and carers at any time from birth to school age. This Service recognises that there are many different circumstances which may lead to a child being placed into care, and for this reason is tailored to the particular identified needs of each individual infant or child. The service response is focussed on positively engaging with, and providing continuity of care to, infants/children who have experienced abuse, neglect and/or trauma, to provide them with trusting and safe relationship/s; and promoting and fostering safe and nurturing family environments that are free from harm. A critical element will be to ensure the service delivery focus is on the health and development needs of the infant/child.

In South Australia at any one time around 700 infants and children aged under five years are in the care of the State under Guardianship orders. Children raised in these circumstances have a right to high quality of care, including priority access to health and educational services, and a high level of attention to, and investment in, helping them to recover from the experiences that initially brought them into care.

The State assumes responsibility to provide for the physical, emotional, psychological and developmental safety of infants and children placed under a Guardianship order. A range of other agencies, including CaFHS, have a role in responding to the specific needs of children under Guardianship. The following figure illustrates the respective roles of SA Health (through the Local Health Networks and CaFHS), and the Department for Child Protection, in providing support and care to children under Guardianship orders.

Figure H: Alignment of CaFHS response with Department for Child Protection and SA Health



CaFHS' service response for infants and children in statutory care is underpinned by a set of overarching theoretical frameworks, with recognition of the special needs and experiences of children under Guardianship orders. These include: the effect of trauma in critical and sensitive development periods; trauma informed care; impacts of neglect; and impacts of child abuse. A list of relevant frameworks, approaches and theories that have underpinned the development of the Model of Care appear in *Appendix G – Theoretical frameworks and approaches*.

Further, CaFHS' Statutory Care Service response has been developed with consideration of the *National Standards for Out-of-Home Care*²⁴, which seeks to drive improvements in the quality of care such that children and young people in out of home care have the same opportunities as other children and young people to reach their potential in life. The standards require that each child and young person has:

²⁴ Department of Social Services (2011), An outline of National Standards for out-of-home care [online]. Available at: <https://www.dss.gov.au/our-responsibilities/families-and-children/publications-articles/an-outline-of-national-standards-for-out-of-home-care-2011>

- an individualised plan detailing their health, education and other needs
- their physical, developmental, psychosocial and mental health needs assessed and attended to in a timely way
- access to and participates in education and early childhood services to maximise educational outcomes.

A process flow diagram which summarises the clinical pathway for Statutory Care Service response appears at *Appendix J – Clinical pathway | Statutory Care Service*.

8.2 Objective

Children in out of home care are a highly vulnerable group as a result of their experiences prior to and entering care. The trauma, abuse, and lack of protection as well as safe and predictable caregiving, leads to higher levels of need and difficulties in multiple spheres of their lives. Physical, mental and social health and consequently development can all be impaired and can culminate in unmet health needs. Children who experience child abuse and neglect are more likely to develop a disorganised attachment which results in an incoherent internalised model of self and others and an inability to clearly signal distress²⁵.

The objective of the Statutory Care Service response is to support children who are under Guardianship orders to achieve optimal health, growth, development and wellbeing. Children with disorganised attachment can be helped to develop more organised and predictable internal working models through exposure to safe, reliable and responsive caregiving as early as possible²⁶. The Statutory Care Service will recognise the experience of the child and the significant impact of trauma on their health and wellbeing and deliver a nurturing and compassionate service response. This service response will be centred on providing consistent, safe, responsive and predictable care in a nurturing environment to the State's most vulnerable infants and children.

8.3 Eligibility

The Statutory Care Service response will be available for children, aged under five, on Guardianship orders under the terms of the *Children's Protection Act 1993*, namely one of the following:

- 12 month Guardianship orders
- Guardianship until 18 years of age
- Other eligible children²⁷

²⁵ McLean, S. (2016). Children's attachment needs in the context of out-of-home care. *CFCA Practice Resource – November 2016*. Australian Institute of Family Studies, [online]. Available at: <https://aifs.gov.au/cfca/publications/childrens-attachment-needs-context-out-home-care>.

²⁶ *ibid*

²⁷ 12 month custody orders, granted under section 38(1)(b); Unaccompanied humanitarian refugee minors, for whom guardianship has been delegated to the Department for Child Protection by the Minister of Immigration; Family Care Meeting Agreements and Other Person Guardianship arrangements.

Children who have Department for Child Protection involvement without a Guardianship order, for example under section 16, interim orders, investigation and assessment orders, will be supported elsewhere across CaFHS' service spectrum, including via the Universal Service and the Targeted and Sustained Service.

8.4 Referral and triage

Referral to Statutory Care Service will occur through the CaFHS Referral Unit. It is anticipated that the Department for Child Protection will serve as the primary source of referrals to the service.

Other sources of referral may include:

- Self-referral from carers
- DECD Children's Centres
- CFARNs
- SA Health Out of Home Care Clinics.

8.5 Initial engagement

Once CaFHS is informed of an infant or child being placed under a Guardianship order, an arrangement for completion of a Preliminary Health Check will be made, in negotiation with a worker from the Department for Child Protection and the carer. CaFHS will be guided by staff from the Department for Child Protection, who have overall responsibility for coordination of care, about the most appropriate way to engage with the carer and infant/child. In instances where the child is Aboriginal, the allocated CaFHS Aboriginal worker will lead the engagement and support the establishment of the relationship, with a focus on advocating for the cultural needs of the infant/child.

A key focus of initial engagement will be to establish robust relationships with relevant staff from the Department for Child Protection, the carers and the infant/child. The building and maintenance of a strong relationship with the Department for Child Protection worker involved, as the primary point of contact for the child, is crucial as they may be the only consistent person for the child. Beyond this, relationships with the Department for Child Protection will be underpinned by more formal inter-agency agreements, to support the transfer of information to inform care planning. In addition, CaFHS will have direct working relationships with Out of Home Care Clinics to ensure the timely sharing of information (applying information sharing principles as defined in the Information Sharing Guidelines - refer to *Appendix E – Tools and guidelines*) about the health, development and emotional wellbeing needs of the infant/child. These will be identified through contact with CaFHS and can inform the Comprehensive Health and Developmental Assessment (CHDA) to support infants and children receiving a more timely response.

As part of the initial engagement with an infant/child and carer CaFHS will:

- focus on the voice and cues of the infant/child; keeping their voice as central to the process will ensure consideration is given to their individual circumstances and needs
- build a solid relationship with the carers of an infant/child under a Guardianship order in recognition of the knowledge they have about the infant/child and to ensure CaFHS are responsive to any concerns that carers may have about them

- build a nurturing relationship with the infant/child through a trauma informed lens and offer a flexible service response based on the care arrangements and presentation of the infant/child
- provide services at various locations, with flexible timing and lengths of appointments; be paced accordingly in response to engagement and disengagement cues of the infant/child; and prioritise the key areas of service focus.

Regular contact with the Department for Child Protection worker will be maintained to ensure that infants/children engage with CaFHS at key points, as per the needs of each individual infant/child.

8.6 Service approach

It is of the utmost importance that at the centre of CaFHS' Statutory Care Service response approach is a focus on responding to and supporting the needs of infants and children who have experienced trauma, neglect and abuse. The pillars of the service approach, to maintain this focus, are as follows:

- early intervention
- alignment of staff to infants and children based on experiences and individual needs of the child
- consideration of the complex circumstances
- working in partnership with other service providers
- cultural appropriateness.

8.6.1 Early intervention

There are already many considerations relating to trauma, neglect and abuse in place for infants/children under Guardianship orders, and the extreme difficulty in alleviating the impact of these, often long standing factors, is recognised. Notwithstanding, CaFHS' Statutory Care Service response is intended to identify and respond to health, development and wellbeing needs of infants/children through early intervention at key times whilst they are under the care of the State. It is this anticipatory approach to providing support and care that is most likely to result in positive outcomes where harm is minimised.

8.6.2 Alignment of staff to children based on experiences and individual needs of the child

All Statutory Care Service staff will possess the skills and experience to respond to and support the needs of infants and children who have experienced trauma, neglect and abuse. Responding to neglect and abuse will also require an acute awareness of the importance and significance of culture; particularly in respect of Aboriginal infants, children and families, and those of other cultures. In addition to this, consideration will be made of individual staff experiences and competencies when assigning them to an infant/child placed in care under a Guardianship order. This will provide the best opportunity for enhancing the relationship between the CaFHS worker and the infant/child.

8.6.3 Consideration of complex circumstances

All services provided by CaFHS to children under Guardianship orders will be delivered in a child-friendly manner using a trauma informed approach that supports the infant/child to feel safe during the assessment and service provision process. To support the infant/child to feel safe, service delivery will need to be flexible and provided in a calm and welcoming environment, given the severe complexity of the circumstances faced by children in State care.

Children's experiences of trauma and disrupted attachment relationships also have implications for the way in which CaFHS' staff interact and support carers. The complexities of caring for infants/children who have experienced trauma will be acknowledged, and used to inform how care and support is delivered to carers.

Another added complexity for infants/children under Guardianship orders is the variation in State care environments, including: rotational care, commercial care or foster care. CaFHS workers will have an awareness of an infant/child's current care arrangement and be mindful of the demands on carers given their past/recent experiences and needs.

8.6.4 Working in partnership with other service providers

The CaFHS' service response for children under Guardianship orders requires collaboration with the Department for Child Protection, Out of Home Care Clinics and other relevant service providers, to ensure that care and support is provided in a consistent and coordinated manner, and aligned to achieve the best possible outcome for the infant/child. For this to occur, it is imperative that the lines of communication between services remain open and transparent, and flow of information occurs in a timely manner. A partnership approach to care provision will help to ensure continuity of care for each infant/child and carer, the development of a comprehensive and complete service response and will support the development of a robust and advantageous relationship with infants, children and carers.

CaFHS' workers providing services to infants, children and carers as part of the Statutory Care Service will be cognisant of the signs to look for when an infant/child may benefit from or require a therapeutic response or specialist service. In such case, the CaFHS worker will engage with the relevant Department for Child Protection worker to ensure that an appropriate service provider can be engaged via referral.

8.6.5 Culturally appropriate

CaFHS will provide care to Aboriginal infants and children that is trauma informed, culturally safe, sensitive and responsive to their cultural needs. Culturally safe practices have an integral role in supporting the development of the relationship with Aboriginal families and the CaFHS' staff providing services. The significant impact of the experiences of intergenerational and direct trauma for Aboriginal infants, children, families and communities, within the context of their own cultural and spiritual beliefs, will be essential in developing clinical Care Plans and services to address the needs of the infant/child. CaFHS places high value in recognising the importance of addressing cultural concerns as an opportunity to effectively address clinical risk.

The attachment needs of Aboriginal infants/children will be considered beyond the dyadic model recognising the importance of multiple attachment relationships which reflect Aboriginal child care practices, where child rearing is a shared responsibility of the extended family and community.

8.7 Service elements

The Statutory Care Service includes the following four key elements:

- infant and child health assessments and checks
- development of individualised Care Plans
- provision of support to carers in partnership with the Department for Child Protection as lead
- periodic reviews.

8.7.1 Infant and child health assessments and checks

The infant and child health assessments and checks for children under Guardianship orders consist of two components:

- the Preliminary Health Check for infants and children aged under five
- the Comprehensive Health and Developmental Assessment.

The domains for health assessment and checks of infants/children under Guardianship orders are informed by the *National Clinical Assessment Framework for Children in Out of Home Care* and in addition the *SA Health Out of Home Care Clinics Model of Care* that is under development as at the date of this document. CaFHS' involvement in checks and assessments of infants/children under Guardianship orders will be complementary to these processes and will not duplicate other assessments completed.

The Preliminary Health Check will be undertaken within 30 days of an infant/child being placed in the care of the State under a Guardianship order. The check provides a setting for carers to raise any concerns, or bring forward any questions they may have with regards to the infant/child, and to provide carers with age-appropriate health and development information as well as anticipatory guidance about what to expect in the infant/child's behaviour, growth and development in the immediate and longer term. This initial health check is also intended to build on what is currently known of the infant/child under Guardianship order, through any previous engagement in health services. In undertaking the Preliminary Health Check, CaFHS' staff will ensure that the approach adopted minimises the need to ask many, if any, duplicative questions and likewise minimises the need for any infant/child to take part in unnecessary processes. Prior to any assessments and checks being undertaken, CaFHS' staff will consider whether the infant/child has had any prior service involvement with CaFHS, and if so, whether any existing or historical information can be accessed to minimise the need for information to be repeated.

Either CaFHS, a general practitioner or other nominated primary health care worker will complete the Preliminary Health Check for infants and children under Guardianship orders. A decision regarding who is best placed to complete the check in each circumstance is made by the Department for Child Protection based on consideration of a number of factors including: the needs of the infant/child; continuity of care; and cognisance of services that have had previous contact with the infant/child.

The components of the Preliminary Health Check include:

- health history

- physical examination including growth assessment, dental assessment through 'Lift the Lip', and vision and hearing assessment as required
- immunisation status
- diet and nutrition
- sleep
- developmental review using the Ages and Stages Questionnaire and the Ages and Stages Questionnaire: Social-Emotional
- identification of any emotional and behavioural concerns
- clinical observation of the infant or child with a focus on age-appropriate engagement and consideration of any indicators of the impact of trauma.

On the completion of the Preliminary Health Check by CaFHS, in response to any identified concerns any immediate physical health, developmental, psychosocial and mental health needs will be addressed and a CaFHS plan for follow up arranged. Feedback will be provided to the Department for Child Protection and referral for the Comprehensive Health and Developmental Assessment (CHDA) through the Out of Home Care Clinic or specialist Paediatrician.

The CHDA will be undertaken by staff at an Out of Home Care Clinic or specialist Paediatrician within three months of an infant or child being placed under a Care and Protection order by the Youth Court. Comprehensive Health and Developmental Assessments include the following domains:

DOMAIN	COMPONENTS
Physical Health	<ul style="list-style-type: none"> • Physical health history • Physical examination and assessment • Oral health assessment • Health literacy
Developmental Health	<ul style="list-style-type: none"> • Developmental history • Speech, language and communication • Motor development • Cognitive development • Sensory
Psychosocial and Mental Health	<ul style="list-style-type: none"> • History • Mental health • Behavioural • Emotional development – ASQ:SE • Social competence – ASQ:SE • Development of identity (including cultural and spiritual identity, particularly for Aboriginal children)

Following the assessment, a Health Management Plan is developed for the child by the Department for Child Protection who will continue to liaise and work in partnership with CaFHS.

8.7.2 Development of individualised CaFHS Care Plan

Care planning provides a framework for shared decision-making to achieve identified outcomes for the infant/child. It is a critical activity based on an assessment of the infant/child's needs and determines the tasks and activities of all parties involved in their care.

As part of the Statutory Care Service, a child-centred Care Plan will be developed by CaFHS in response to any areas of concern identified through the Preliminary Health Check.

The CaFHS Care Plan will be informed by any previous assessment that may have been undertaken in relation to the infant/child and will be developed in response to the individual needs of the infant/child and in partnership with their carer. A copy of the CaFHS Care Plan will be shared with the allocated worker from the Department for Child Protection, and where required, input from the worker may be sought to support the development of the CaFHS Care Plan to ensure a coordinated response for the infant/child is established.

In developing the CaFHS Care Plan, extensive consideration will be given to the context of development for each individual infant/child, which will include their personal experience(s) of trauma, abuse and disrupted attachment relationships, and how this may be evidenced in the way they present. This may include making recommendations about referral to relevant health service or specialist support, and having a plan to evaluate effectiveness. For Aboriginal infants and children, cultural context and input will be included in any CaFHS Care Plan developed.

At regular points of contact with the Department for Child Protection, SA Health, or any other partnered service provider, CaFHS will take responsibility to update the CaFHS Care Plan for an infant/child as indicated, taking into consideration any change in circumstances for them.

8.7.3 Provision of support to carers

The provision of sustained, intensive support to carers will be a key aspect of the Statutory Care Service. Ensuring that carers have the knowledge, insight, skills and support to safeguard and foster the health, development and wellbeing of infants/children in their care lies at the heart of the CaFHS' focus.

In each case the supports that are offered to carers will be tailored to meet the identified and specific needs of each infant/child; however the supports available will extend to and include the following:

- support carers in understanding that infants and children are ready to learn from birth
- reinforce to carers that they can enable infants and children in their care to learn by including them in the activities of everyday life
- ensure carers have access to adequate knowledge and skills in parenting to support the unique needs of the infant/child in their care
- support the health and developmental literacy of carers
- support the development of healthy infant/child-carer relationships that recognise the impact of the infant/child's past experiences and disrupted caregiver relationships to provide an opportunity for them to thrive and develop new attachment relationships
- encourage carers to work in partnership with CaFHS and infants/children in their care.

8.7.4 Periodic review

Once initial infant and child assessments and checks are undertaken, as set out in section 8.7.1, it is critical that ongoing review of the health and development needs of infants and children under Guardianship orders is undertaken to support identification and early intervention of escalating factors that could result in increased harm to their development.

CaFHS will review the health and development of infants and children under Guardianship orders at least:

- every two months for infants aged under six months
- six-monthly for infants and children aged six months to two years
- annually for children aged three to five
- where there is a change in care placement.

These reviews will include a physical assessment and review of development using the Ages and Stages Questionnaire and the Ages and Stages Questionnaire: Social-Emotional. After each assessment, a summary of the assessment and an updated copy of the CaFHS Care Plan will be communicated to the relevant worker from the Department for Child Protection and the relevant Out of Home Care Clinic.

8.8 Transfer of care

An infant/child and carer who are accessing or have accessed CaFHS' Statutory Care Service may be re-referred to another CaFHS service and/or to external services if it is assessed that this is supported by the circumstances of the infant/child and carer. Where the need for referral is identified, collaboration with service partners will occur, applying information sharing principles as defined in the Information Sharing Guidelines (refer to *Appendix E - Tools and guidelines*), to determine the most suitable pathway. Instances in which a transfer of care may occur include the following:

- when the carer, through negotiation with the Department for Child Protection, decides that they prefer to access another service provider
- when the needs of the infant/child require a specialised response such as those who receive disability services
- where the infant/child's Guardianship order ends, a review of their situation will occur to determine the most suitable CaFHS' service response moving forward. This could include a transfer of care to the Targeted and Sustained Service in situations where reunification has occurred between an infant/child and family.

A file closure will occur when:

- A child reaches the age of five or attends school and support options are available within the broader early childhood service system, for example through general practitioners or DECD.

9 Sustainability and continuous improvement

CaFHS' Model of Care will assist in the delivery of a comprehensive service response that embodies a culture of sustainability, evaluation and continuous improvement; and can be modified when practice and evaluation evidence indicates positive outcomes are not being achieved for consumers. As part of this shift, an evaluation framework is being developed with plans to use qualitative and quantitative data to measure, monitor, appraise and report on the processes and performance of the Referral Unit and three streams of service response that sit within the Model of Care. The evaluation framework is likely to include:

- performance, monitoring, and reporting component
- clinical practice audit program
- service model outcome evaluation.

9.1 Outcomes

The broader intended outcomes of the Model of Care include the following:

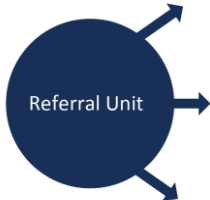

TOPIC	DESCRIPTION OF KEY OUTCOMES
CaFHS as an organisation	<ul style="list-style-type: none"> • Increased capacity of CaFHS to improve the lives of infants, children and families through flexible, integrated service delivery • CaFHS is positioned as a leader of health and early childhood services.
Children and families	<ul style="list-style-type: none"> • More intensive services are delivered to those with greater need and with flexibility to account for changing life circumstances • Improved ability of CaFHS to respond to the immediate needs of the infant/child and family.
Early childhood development system	<ul style="list-style-type: none"> • Integrated service delivery becomes a reality as formal partnerships with health and education are established.

In addition to these broader whole of CaFHS' outcomes, the Referral Unit and each of the three service streams will likewise deliver upon a number of additional outcomes. These are summarised in Table I.



The outcomes will be refined and expanded over time as the Model of Care is implemented and transitions into business as usual. An associated performance framework will also be developed to provide measurable indicators to monitor achievement of agreed outcomes across all service areas and streams.



Table I: Process and Health Outcomes for the Model of Care, Unit and Service Streams

Service Response	Process Outcomes	Health Outcomes
 <p>Referral Unit</p>	<ul style="list-style-type: none"> Enhanced, timely and culturally responsive clinical assessment that meets the individual needs of families. Equitable access to CaFHS' services by consumers. Enhanced triage and flow functions, resulting in improved access to CaFHS' services. Quality of referrals from external referrers optimised. Referrers are provided with greater clarity on CaFHS' processes, and are consulted as appropriate. All information required to form an initial assessment for triage is received from antenatal service. A single point of contact is established for all CaFHS' services. 	<ul style="list-style-type: none"> Early intervention enabled by improved access to CaFHS' services minimises exposure to harm for at risk infants and children.
 <p>Universal Service</p>	<ul style="list-style-type: none"> Families are actively engaged with Universal Service workers after the birth of an infant. Aboriginal infants, children and families are provided access to a culturally responsive service. Support for infants, children and families is provided in accordance with a Care Plan, developed specifically for them. Infants and children identified as at risk of experiencing health, development and wellbeing concerns are engaged for assessment in a timely manner. CaFHS' services are promoted to families during the antenatal period, and relevant service providers are made aware of the range of services offered by CaFHS. Parents are satisfied with the support provided, and feel their needs are being met through the service. 	<ul style="list-style-type: none"> Breastfeeding rates for South Australian families are in line with national averages. Health, development and wellbeing needs of infants and children are identified at key ages, and referrals are made for assessment and support. Parents experience an increased level of confidence following support provided through the Universal Service response. Parents experience an increased level of knowledge and developmental literacy following support provided through the Universal Service response. Parents assessed with mild to moderate postnatal depression are provided with additional support in a timely manner.



Service Response	Process Outcomes	Health Outcomes
 <p>Targeted and Sustained Service</p>	<ul style="list-style-type: none"> Care Plans for infants and children are developed in partnership with parents. ASQs are undertaken for infants and children within clinically appropriate time frames. Families engaged antenatally are more likely to engage postnatally. 	<ul style="list-style-type: none"> Parents display increased levels of parental sensitivity. Immunisation is actively promoted, and infants and children are immunised by CaFHS where the service is made available. Increased rates of immunisation schedule completion. Increased number of infants and children presenting to community and primary health services (such as general practitioners). Increased rates of child health checks undertaken. Reduced hospital admissions for accidents, injuries or poison ingestion. Children have increased exposure to early childhood education, school dental services and community resources. Reduction in the rate of removal of infants and children into the statutory system. Developmental concerns in infants and children are identified early, and referral for necessary intervention is undertaken in a timely manner. Improved age appropriate growth and nutritional status for infants and children. Breastfeeding rate for children at six months in line with current national averages. Health, development and wellbeing needs of infants and children are met and assessed at key times.
 <p>Statutory Care Service</p>	<ul style="list-style-type: none"> CaFHS are informed of all infants and children under Guardianship orders in a timely manner. Health, development and wellbeing needs of infants and children are identified at key ages, and referred for assessment and support in a timely manner, as part of a coordinated approach to care planning, involving Department for Child Protection, SA Health and other service providers. Preliminary Health Checks are completed for infants and children in a timely manner. Increased levels of continuity of care for infants and children under Guardianship orders. 	<ul style="list-style-type: none"> Health and development of infants and children are assessed at regular intervals. Immunisation provided to all children under Guardianship orders by either CaFHS or other service provider. Developmental concerns in infants and children are identified early, and referral for necessary intervention is undertaken in a timely manner. Carers display increased levels of parental sensitivity.



Appendix A – Acronyms

AEDC	Australian Early Development Census
AMIC	Aboriginal Maternal and Infant Care
ASQ	Ages and Stages Questionnaire
ASQ:SE	Ages and Stages Questionnaire: Social-Emotional
BFHI	Baby Friendly Health Initiative
CaFHS	Child and Family Health Service
CALD	Culturally and Linguistically Diverse
CFARNS	Child and Family Assessment and Referral Networks
CHDA	Comprehensive Health and Developmental Assessment
DASS	Depression, Anxiety and Stress Scale
DCP	Department for Child Protection
DECD	Department for Education and Child Development
eCHIMS	electronic Client Health Information Management System
EPDS	Edinburgh Postnatal Depression Scale
eSDF	Enhanced Service Delivery Framework
HOME	Home Observation for Measurement of the Environment
ISG	Information Sharing Guidelines
KPI	Key Performance Indicator
OACIS	Open Architecture Clinical Information System
OOHC	Out of Home Care
SAPAS	Standardised Assessment of Personality Abbreviated Scale
SEIFA	Socio-Economic Indexes for Areas
WCHN	Women's and Children's Health Network



Appendix B – Model of Care Journey

The journey to develop the CaFHS' Model of Care began in mid-2015. We knew that if we were to develop an enhanced approach to delivering our services, it would need to be grounded solidly in the latest available evidence and data about the early years. We also knew that it would need to incorporate a comprehensive consultation process, and enable us to continue to grow and develop the elements of our current service delivery approach which are working well, while providing an opportunity for us to improve and strengthen other aspects of our services which could be delivered more effectively.



In early 2016 CaFHS developed two discussion papers to outline current and emerging research in relation to the early years and to seek feedback on the proposed enhanced Framework for service delivery. The discussion papers (*The Case for Change: Proposing an Enhanced Service Delivery Framework for the Child and Family Health Service* and *Recognising the Strength of Culture: Aboriginal Cultural Response for the Child and Family Health Service*) were released for consultation in April 2016.




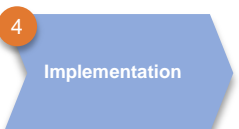

To enable CaFHS to synthesise the feedback received in 224 submissions and to reassure staff and other key stakeholders that their feedback had been heard and taken into account, a comprehensive consultation summary report was developed and released to staff and other stakeholders in December 2016. The *CaFHS Proposed Enhanced Service Delivery Framework Consultation Summary Report* provided an overview of key themes and other pertinent points to have emerged from the feedback and provided a set of overarching observations arising both from the consultation process itself and the feedback received.

The outcomes of the consultation process on the discussion papers released in 2016 were instrumental in shaping the proposed Model of Care. Following the circulation of the Consultation Summary Report, work commenced developing the proposed services. Work was undertaken via a series of interagency, interprofessional working groups led by senior CaFHS clinicians. In line with feedback received, the original five-tiered proposed Service Delivery Framework was simplified into a proposed Model of Care comprising an Access and Flow Unit and three services.



Appendix C – Model of Care Timeline



PHASE	ACTIVITIES
 <p>1 Planning</p>	<ul style="list-style-type: none"> Gather and review the most up-to-date evidence and associated data about the development of children in the early years to understand the key messages from a service delivery perspective Consider and reflect on our existing service delivery model – what is working well and what could be improved Develop discussion papers for consultation.
 <p>2 Consultation</p>	<ul style="list-style-type: none"> Consultation with CaFHS' staff and other key stakeholders on two discussion papers Synthesise and analyse feedback to distil key messages and themes to inform development of a proposed Enhanced Service Delivery Framework Develop CaFHS' Enhanced Service Delivery Framework Consultation Summary Report.
 <p>3 Design and Development</p>	<ul style="list-style-type: none"> Design and develop CaFHS' proposed Model of Care taking into account: recent evidence and data; feedback from consultation process; lessons and opportunities from existing service model as otherwise identified Final consultation on the proposed Model of Care.
 <p>4 Implementation</p>	<ul style="list-style-type: none"> Develop Implementation Plan for roll out of proposed Model of Care Implement Model of Care across all CaFHS' sites and services.
 <p>5 Roadmap for Sustainability and Continuous Improvement</p>	<ul style="list-style-type: none"> Embed robust evaluation systems and processes to ensure we track our progress as the Model of Care is rolled out and becomes embedded as business as usual Deliver on our commitment to continuous improvement and celebrate our successes.



Appendix D – Vulnerability in early life in South Australia

In April 2017, the BetterStart Child Health and Development Research Group released a paper²⁸ to; describe how different dimensions of ‘adversity’ can be used to inform service delivery priorities to population groups with greater levels of vulnerability; and provide an estimate of the proportion of different populations that experience different levels of adversity and consequent vulnerability, to inform service provision to the South Australian child population by CaFHS.

The BetterStart Child Health and Development Research Group comprises inter-disciplinary researchers from epidemiology, public health, nutrition, paediatrics, biostatistics, and psychology who are trying to better understand how to ensure infants and children have the best start in life that will enhance their health, development and human capability formation over the life course.

Figure C, section 3.3, depicts a conceptualisation of different risk factors that may lead to experiencing adversity and vulnerability. Table L below demonstrates the source of each risk factor used to estimate the level of adversity and vulnerability experienced by children in South Australia.

The material presented here may not necessarily reflect the views of our government partners.

Table L: A description of the data used to estimate adversity and vulnerability.

RISK FACTOR	DETAIL	DATA SOURCE
SOCIOECONOMIC		
Maternal education	Self-report by caregiver.	CaFHS – Pathways to Parenting data
Living in a disadvantaged area	This is categorised according to the Australian Bureau of Statistics Socio-economic Indexes for Areas (SEIFA) using suburb of residence at birth. SEIFA is an area based measure that ranks areas in Australia according to relative socioeconomic advantage and disadvantage. The indicator utilized for this report indicates children lived in an area ranked in most disadvantaged quintile of the Index for Relative Socioeconomic Advantage and Disadvantage.	Births registrations and Perinatal Statistics
Accessing Housing SA	Self-report by caregiver.	CaFHS – Pathways to Parenting data
TRAUMA		
Child protection investigation	The child has been subject to at least one child protection investigation up to age 9.	Department for Child Protection data
Domestic violence	Self-report by caregiver – experiencing any form of abuse from a partner in last 12 months.	CaFHS – Pathways to Parenting data
History of abuse (parents)	Self-report by caregiver and partner if present – harmed, abused or neglected as a child in any way.	CaFHS – Pathways to Parenting data

²⁸ Pilkington R & Lynch J. op. cit. p 15.



RISK FACTOR	DETAIL	DATA SOURCE
HEALTH		
Preterm birth	Classified as birth prior to 37 weeks' gestation. Recorded on the Supplementary Birth Record form at the birthing hospital by a midwife or nurse.	Perinatal Statistics
Low birth weight	Classified as birth at a weight of less than 2500 grams. Recorded on the Supplementary Birth Record form at the birthing hospital by a midwife or nurse.	Perinatal Statistics
Smoking in pregnancy	Self-report by the mother. Recorded on the Supplementary Birth Record form at the birthing hospital by a midwife or nurse.	Perinatal Statistics
Insufficient antenatal care	Classified as less than 7 antenatal visits, this is considered insufficient antenatal care for a normal pregnancy according to SA Perinatal Practice guidelines.	Perinatal Statistics
PSYCHOSOCIAL		
Psychological distress	Self-report – troubled by 2+ negative feelings for at least two weeks in the past 12 months (anxious, sad, angry, depressed, the blues, other).	CaFHS – Pathways to Parenting data
Mental illness	Self-report “Have you been told by a doctor or health professional...” you have anxiety, depression, a stress related or any other mental health problem.	CaFHS – Pathways to Parenting data
Lack of social support	Self-report by caregiver – does not have friends, family or partner they can rely on for support.	CaFHS – Pathways to Parenting data



Appendix E – Tools and guidelines

Ages and Stages Questionnaire (ASQ): There is a wide range of what is considered within the normal range for child development as children progress through the same stages of development at different rates.

The ASQ is a highly valid and reliable screening tool to assess children's development in the five domains of: communication, gross motor, fine motor, problem solving and personal social. Within CaFHS the ASQ-3 questionnaire is used as a developmental screening tool at six to nine months and at eighteen months to two years. The questionnaire can also be used opportunistically from one month up to sixty months of age. The use of ASQ-TRAK is currently being trialled for use with Aboriginal children and will be included in the Universal Service once endorsed.

Ages and Stages Questionnaire: Social-Emotional (ASQ:SE): The ASQ:SE is a highly reliable tool which enables the identification of young children who are at risk of social or emotional difficulties. The tool screens children in the following areas: self-regulation, compliance, communication, adaptive behaviours, autonomy, affect and interaction with people and can be used with children from one to seventy-two months.

Breastfeeding Assessment and Care Plan: Early assessment and response to any breastfeeding challenges supports early initiation and duration of breastfeeding. The National Health and Medical Research Council recommend exclusive breastfeeding until around 6 months and continued breastfeeding thereafter for improved child and maternal health outcomes²⁹. The Breastfeeding Assessment and Care Plan supports nurses in completing a comprehensive assessment and development of a response to any identified breastfeeding concerns.

Child and Family Assessment (Common Assessment Tool under development in partnership with DECD): Discussion with caregivers regarding their family circumstances including consideration of their strengths, availability of support networks and protective factors, provides families with an understanding of the resources they can draw on to support them in their parenting role.

Depression Anxiety and Stress Scale (DASS): DASS is made up of three self-report scales (containing 42 items) designed to measure the negative emotional states of depression, anxiety and tension/stress. Each scale identifies the severity/frequency of the experienced state over the past week. Results may indicate the need for further support and assessment.

Domestic and Family Violence Screening: The World Health Organization (WHO) has identified domestic and family violence as a global public preventable health problem with significant morbidity and mortality.³⁰ Domestic and family violence can be defined as violent, threatening and intimidating behaviour that is used as an ongoing tactic to exercise power and control over a

²⁹ National Health and Medical Research Council. (2015). Eat for Health: Infant Feeding Guidelines. Information for health workers. Canberra: NHMRC. Available at: https://www.nhmrc.gov.au/files_nhmrc/file/publications/170131_n56_infant_feeding_guidelines.pdf

³⁰ Krug, E.G., Dahlberg, L.L., Mercy, J.A., Zwi A.B., & Lozano, R (Eds). (2002). *World report on violence and health*. World Health Organization. Available at: http://www.who.int/violence_injury_prevention/violence/world_report/en/



current or former partner. It is a pattern of abusive behaviour that can escalate over time.³¹
Domestic and family violence can include:

- Physical abuse
- Sexual abuse
- Emotional abuse
- Verbal abuse
- Social and geographical isolation
- Financial abuse
- Spiritual abuse.

There can also be other behaviours that instil fear and intimidation such as property damage, cruelty to pets, and threats and abuse via technology.³²

While men may be victims of domestic and family violence, women are subjected to domestic and family violence at disproportionately higher levels, and it is predominantly perpetrated by men.³³

Edinburgh Postnatal Depression Scale: The Edinburgh Postnatal Depression Scale (EPDS) is a ten item self-report questionnaire recommended for use as a screening tool that aims to identify women with symptoms of depression who may benefit from follow-up care, such as mental health assessment. The EPDS has been validated across several cultures and countries for detection of perinatal depression and has been translated into a range of languages. It has also been shown to be a valid and reliable screening tool for fathers.

Home Observation for Measurement of the Environment (HOME) Inventory: HOME contains 45 items and is a measure of the quality and extent of stimulation available to a child in the home environment. Both interactional and physical environment are assessed by the professional in the home through observation and exploration with the caregiver.

Information Sharing Guidelines (ISG): The ISG³⁴ provide guidance about when and how it is appropriate to share consumer information with and without consent and provide a consistent approach for information sharing when it is believed a person is at risk of harm (from others or as a result of their own actions) and adverse outcomes can be expected unless appropriate services are provided.

³¹ Australian Medical Association, (2015). *Supporting Patients Experiencing Family Violence, A resource for medical practitioners*. Available at: https://ama.com.au/sites/default/files/documents/AMA%20Supporting%20Patients%20Experiencing%20Family%20Violence%20Resource%20_0.pdf

³² Ibid

³³ Council of Australian Governments (2010). *The National Plan to Reduce Violence against Women and their Children 2010-2022*. Australian Government. Available at: <https://www.dss.gov.au/women/programs-services/reducing-violence/the-national-plan-to-reduce-violence-against-women-and-their-children-2010-2022>

³⁴ Ombudsman SA. (2013). *Information Sharing Guidelines for promoting safety and wellbeing*. Available at <http://www.ombudsman.sa.gov.au/wp-content/uploads/ISG-Guidelines1.pdf>



Parenting Confidence: The assessment of parental confidence in caring for an infant or child assists in the identification of potential barriers to competent parenting and the capacity to create nurturing environments. High parenting confidence has been shown to act as a buffer against factors such as parental depression, stress and relationship difficulties and is associated with parenting competence and positive child outcomes and therefore the identification of difficulties allows for supportive interventions that improve parental confidence³⁵. There are a number of tools available to assess parenting confidence and the specific tool that CaFHS will adopt for use is still to be determined.

Sleeping Baby Safely: Discussion with caregivers regarding how they can sleep their baby safely will occur at the first point of contact within two weeks of an infant's birth. Further information is contained within the Infant Sleep Environment Assessment and Observation (CaFHS) procedure.

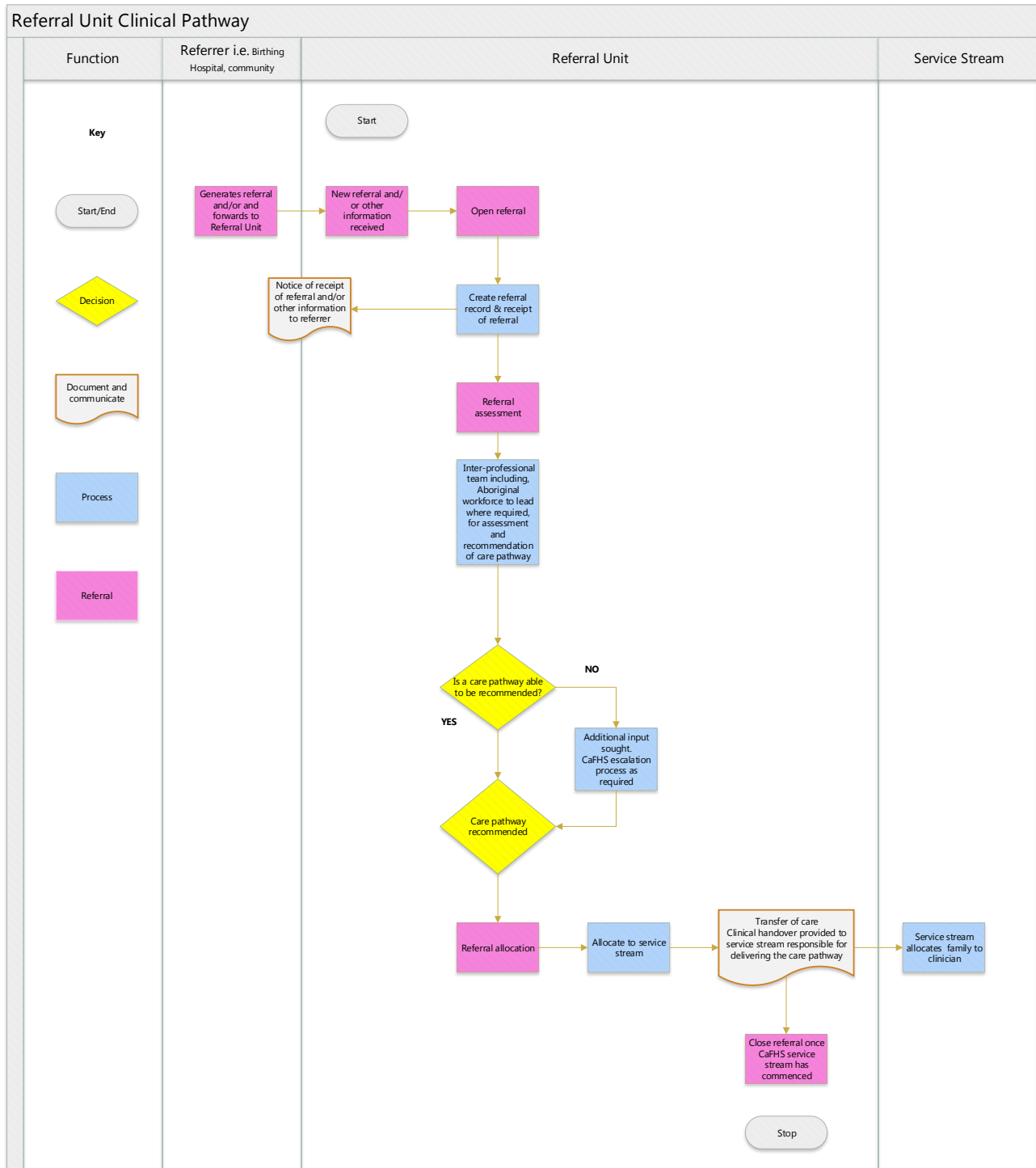
Standardised Assessment of Personality Abbreviated Scale (SAPAS): SAPAS is a brief screen for personality disorder involving eight clinician lead items seeking a yes/no response from consumers. Results may indicate the presence of personality disorder requiring further assessment.

³⁵ Crncec, R., Barnett, B., & Matthey, S. (2010) Review of Scales of Parenting Confidence. Journal of Nursing Measurement, 18(3), 210-40.



Appendix F – Clinical pathway | Referral Unit

The following diagram presents the clinical pathway for the Referral Unit.



Appendix G – Theoretical frameworks and approaches

FRAMEWORK/ APPROACH	DESCRIPTION
Social Determinants of Health	The Social Determinants of Health are the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life. These forces and systems include economic policies and systems, development agendas, social norms, social policies and political systems.
Population Health	Population health is focused on understanding health and disease in the community, and on improving health and well-being through priority health approaches addressing the disparities in health status between social groups. The overall goal is to maintain and improve the health of the entire population and to reduce the inequalities in health between population groups ³⁶ .
Primary Health Care ³⁷	Primary health care is socially appropriate, universally accessible, scientifically sound first level care provided by health services and systems with a suitably trained workforce comprised of inter-professional teams supported by integrated referral systems in a way that: gives priority to those most in need and addresses health inequalities; maximises community and individual self-reliance, participation and control; and involves collaboration and partnership with other sectors to promote public health. Comprehensive primary health care includes health promotion, illness prevention, treatment and care of the sick, community development, and advocacy and rehabilitation.
Attachment Theory	Attachment is one specific aspect of the relationship between a child and a caregiver with its purpose being to make a child safe, secure and protected. Attachment is distinguished from other aspects of parenting, such as disciplining, entertaining and teaching. ³⁸
Developmental and Health Literacy	<p>Health Literacy represents the cognitive and social skills which determine the motivation and ability of individuals to gain access to understand and use information in ways which promote and maintain good health. Health Literacy means more than being able to read pamphlets and successfully make appointments. By improving people's access to health information and their capacity to use it effectively, health literacy is critical to empowerment.³⁹</p> <p>Developmental Literacy is the knowledge and beliefs about child health and development that can aid in early recognition and support of children with developmental disorders and health concerns.⁴⁰</p>

³⁶ Australian Institute of Health and Welfare. (2017). *Population Health*, [online]. Available at: www.aihw.gov.au/population-health/.

³⁷ Australian Primary Health Care Institute (APHCRI) (2009) *Primary Health Care Reform in Australia: Report to Support Australia's First National Primary Health Care Strategy*.

³⁸ Benoit, D. (2004). Infant-parent attachment: Definition, types, antecedents, measurement and outcome. *Journal of Paediatrics and Child Health*. Oct; 9(8), pp. 541–545.

³⁹ Nutbeam, D. (1998). Health Promotion Glossary. *Health Promotion International*, Oxford University Press, 13. pp 349-364. [online]. Available at: https://www.researchgate.net/profile/Don_Nutbeam/publication/12979284_The_WHO_health_promotion_glossary/links/542022590cf203f155c2aa6e.pdf.

⁴⁰ Jeyaseelan, D., & Sawyer, M. (2017). Developmental and health literacy. *Journal of Paediatrics and Child Health*, [online]. Accessed from: <http://www.onlinelibrary.wiley.com/doi/10.1111/jpc.13456/abstract>



FRAMEWORK/ APPROACH	DESCRIPTION
Brain Development	Early experiences affect the development of brain architecture, which provides the foundation for all future learning, behaviour, and health. Just as a weak foundation compromises the quality and strength of a house, adverse experiences early in life can impair brain architecture, with negative effects lasting into adulthood. ⁴¹
Strength-based Approach	A strength-based approach recognises the strengths and resilience that families can draw on to overcome challenges and support their children. This is dependent on positive attitudes about peoples' dignity, capacity, rights, uniqueness, culture and commonalities, and helps people to mobilise their strengths and resources rather than compensating for their perceived deficits. ⁴² Through working with caregivers the unique strengths and skills of each family, including the ability to access and use health and development information, will be fostered. The strength and resilience that many Aboriginal families experience through their culture will also be acknowledged and incorporated into practice to support good health and development outcomes. The inherent strengths of culture for families has been identified as a protective factor for Aboriginal children. ⁴³
Ecological Model	Developed initially by Bronfenbrenner (1977) ⁴⁴ , this model describes the interrelatedness of different spheres of social life and the interactions between individuals and their environments. Ecological conceptualisations of health or social problems aim to change behaviour by targeting the environmental factors that are most likely to influence people's decisions and actions. ⁴⁵
Life Course Development	Life course approach considers how health later in life is shaped by earlier experiences. A life course approach examines the physical and social hazards during gestation, childhood, adolescence, young adulthood and midlife that affects chronic disease risk and health outcomes in later life. It aims to identify the underlying biological, behavioural and psychosocial processes that operate across the lifespan ⁴⁶ .
Social Learning Theory	People learning from one another, via observation, imitation and modelling.

⁴¹ Harvard University, Center on the Developing Child (2017), Brain Architecture, [online]. Available at: <http://developingchild.harvard.edu/science/key-concepts/brain-architecture/>

⁴² McCashen, W., St Lukes Anglicare, Bendigo. (2005) *The Strengths Approach: A strengths based resource for sharing power and creating change*, [online]. Available at: <https://innovativeresources.org/resources/books/strengths-approach/>.

⁴³ Lohoar, S., Butera, N., & Kennedy, E. (2014). Strengths of Australian Aboriginal cultural practices in family life and child rearing (pp.1–20). Child Family Community Australia paper No. 24. Melbourne.

⁴⁴ Di Clemente, R., Salazar, L., & Crosby, R. (2011). *Health Behavior Theory For Public Health. Principles, Foundations and Applications*. USA: Medicine & Health Science Books @ Amazon.com.

⁴⁵ *ibid*

⁴⁶ World Health Organization. (2013). *Promoting health through the life-course*, [online]. Available at: www.who.int/entity/maternal_child_adolescent/documents/investing_e.cd/en/.



FRAMEWORK/ APPROACH	DESCRIPTION
Trauma Informed Care	Trauma Informed Care and Practice is a strength-based framework grounded in an understanding of and responsiveness to the impact of trauma, that emphasises physical, psychological, and emotional safety for both providers and survivors, and that creates opportunities for survivors to rebuild a sense of control and empowerment. ⁴⁷
Two-Generation Approach	Two-generation approaches provide opportunities to meet the needs of children and their parents together. They build education, economic assets, social capital, and health and wellbeing to create a legacy of economic security that passes from one generation to the next. ⁴⁸
Reflective Capacity	Our capacity to understand that our own and another's behaviours are linked in meaningful, predictable ways to underlying mental states, to feelings, wishes, thoughts, and desires. In the context of child-parent relationships this can refer to a parent's capacity to hold in their own mind the notion of their child as having feelings, desires, and intentions allowing the child to discover their own internal experience via their parents' experience of them. ⁴⁹

⁴⁷ Kezelman, C., & Stavropoulos, P. (2012). *Practice Guidelines for Treatment of Complex Trauma and Trauma Informed Care and Service Delivery*. Blue Knot Foundation, [online]. Available at: <http://www.blueknot.org.au/Workers-Practitioners/For-Health-Professionals/Resources-for-Health-Professionals/Trauma-Informed-Care>.

⁴⁸ Pilyoung, K., & Watamura, S.E. (2015). *Two Open Windows: Infant and Parent Neurobiological Change*. University of Denver - Stress, Early Experiences and Development Research Center. Ascend, The Aspen Institute, [online]. Available at: <http://ascend.aspeninstitute.org/pages/two-open-windows-infant-and-parent-neurobiologic-change>.

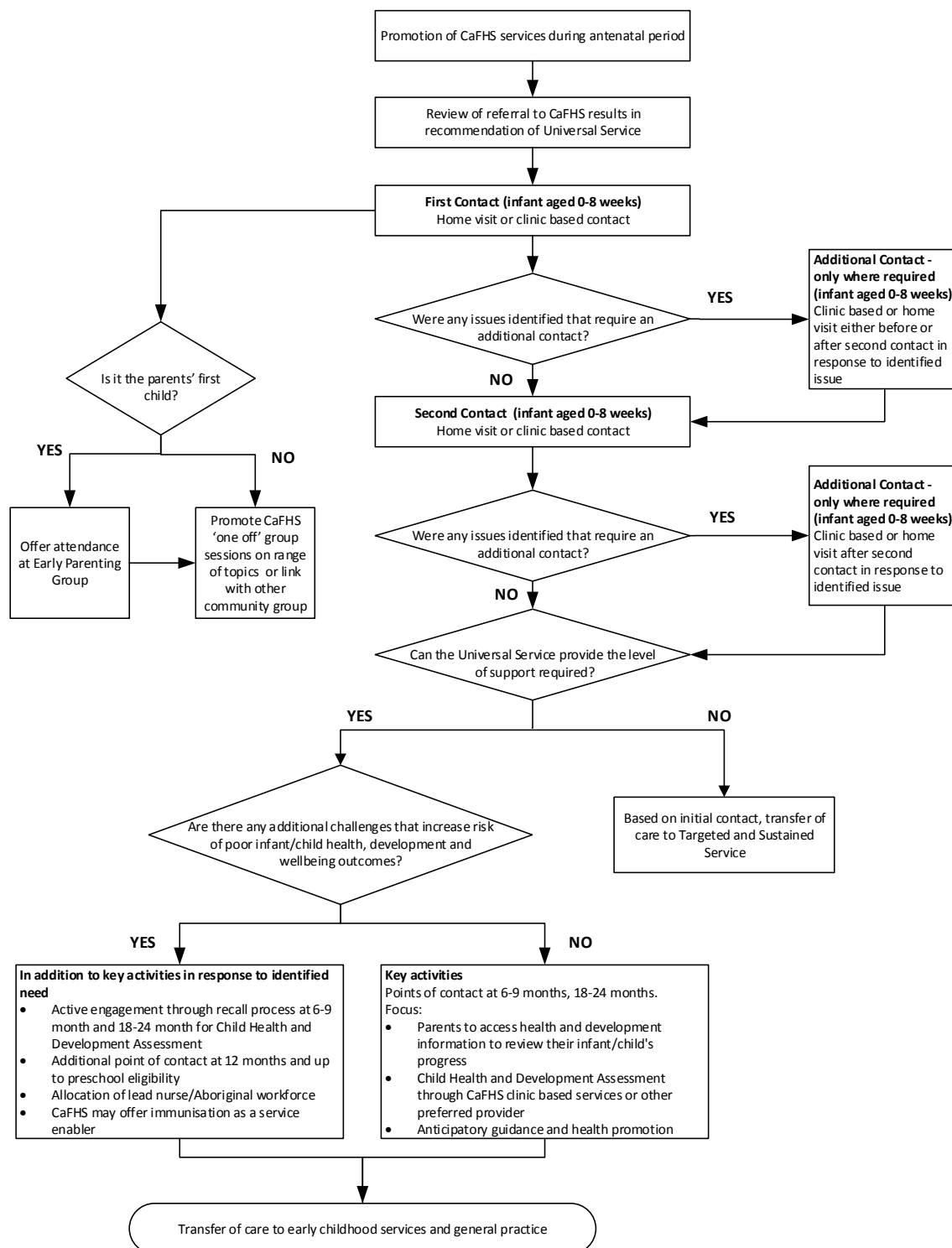
⁴⁹ Slade, A. (2002). Keeping the Baby in Mind: A Critical Factor in Perinatal Mental Health. *Zero to Three, June/July 2002*, [online]. Available at: <https://www.zerotothree.org/resources/114-the-fundamentals-of-infant-early-childhood-mental-health>.



Appendix H – Clinical pathway | Universal Service

The following diagram presents the clinical pathway for Universal Service.

Universal Service Clinical Pathway

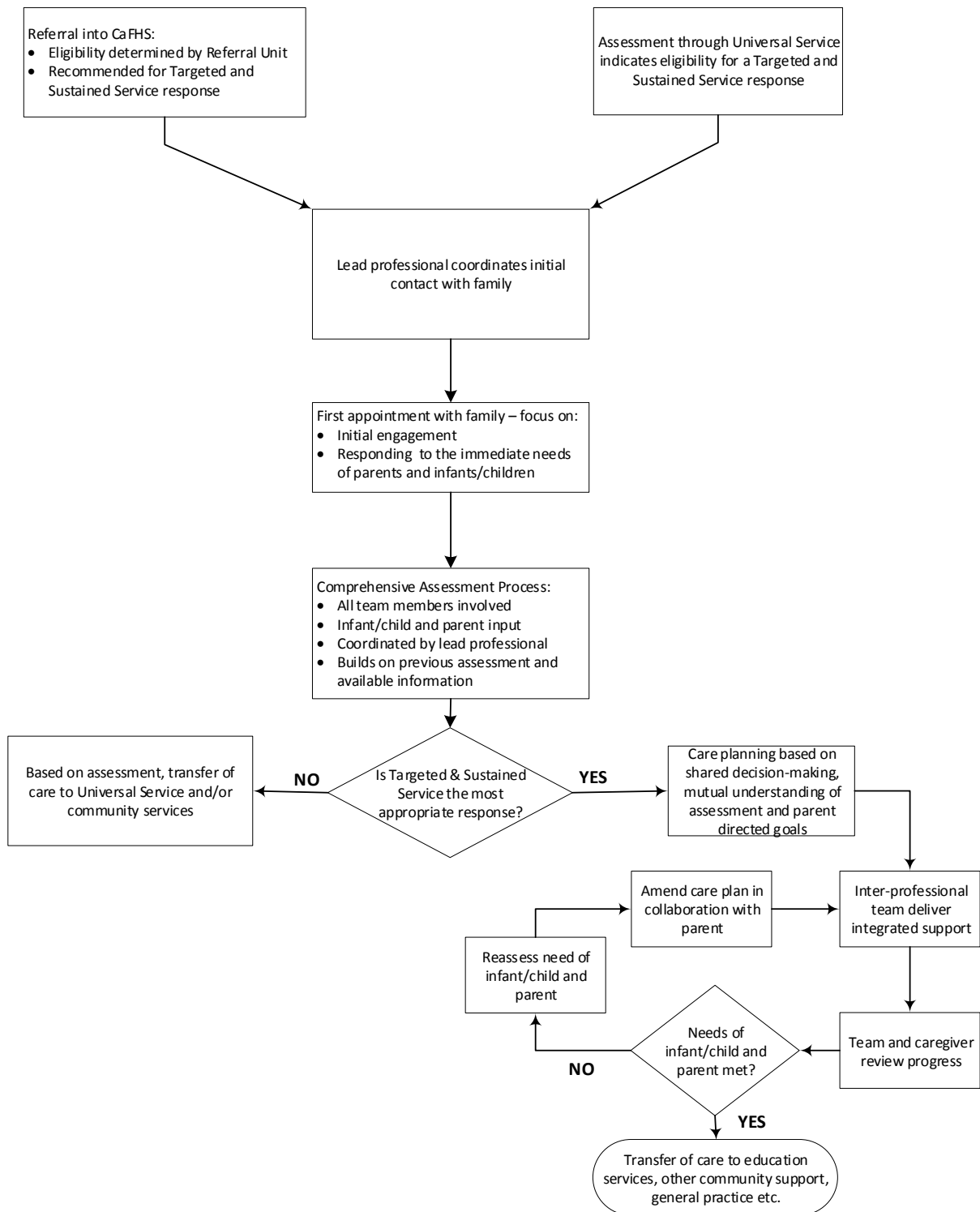


**** NB** where any health issues are identified at any point that require additional service contacts these will be care planned and evaluated accordingly

Appendix I – Clinical pathway | Targeted and Sustained Service

The following diagram presents the overall clinical pathway for Targeted and Sustained Service.

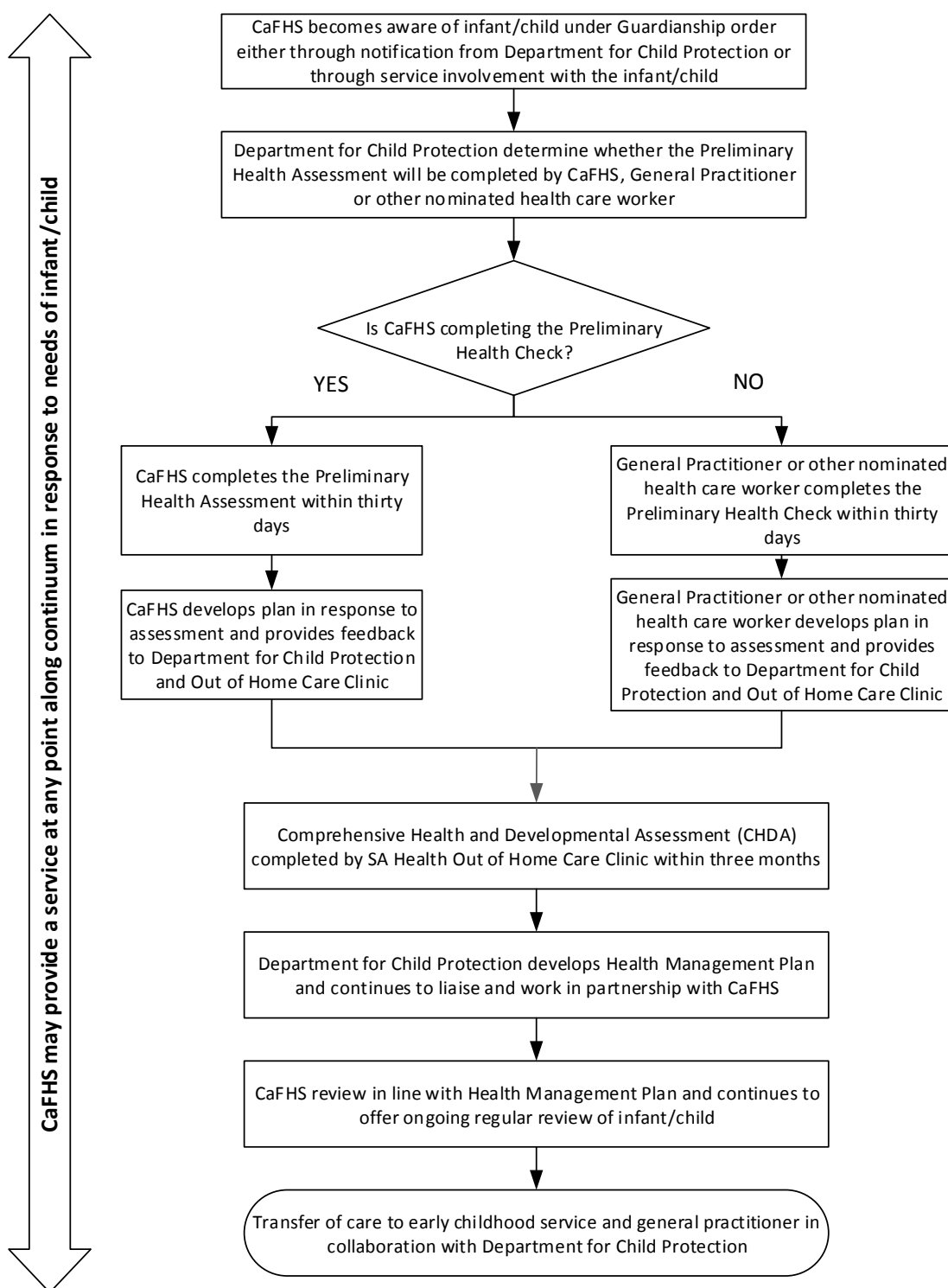
Targeted and Sustained Service Clinical Pathway



Appendix J – Clinical pathway | Statutory Care Service

The following diagram presents the clinical pathway for Statutory Care Service and how assessments undertaken by CaFHS will inform, or be informed, by assessments undertaken by other agencies.

Statutory Care Service Clinical Pathway



Appendix K – References

The following lists the documents, articles and data that are referenced in this document and/or which have otherwise been used by CaFHS in the development of its Model of Care.

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