ENHANCED MATERNAL AND CHILD HEALTH PROGRAM GUIDELINES

ABOUT THIS DOCUMENT 2

1 / BACKGROUND 4

2 / ROLES AND RESPONSIBILITIES 7

3 / PROGRAM OBJECTIVES AND MODEL 8

4 / DETAILS OF MODEL OF CARE (MOC) AND PROGRAM DELIVERY 12

5 / OPERATIONAL REQUIREMENTS AND FUNDING 20

REFERENCES 25

APPENDIX 1 / EMCH REFERRAL FORM 27

APPENDIX 2 / EMCH PROGRAM LOGIC 33

APPENDIX 3 / OVERVIEW OF ADDITIONAL ASSESSMENT TOOLS 34

APPENDIX 4 / CHILD AND FAMILY ACTION PLAN TEMPLATE 36

APPENDIX 5 / CHILD AND FAMILY OUTCOMES 39

APPENDIX 6 / EMCH PROGRAM ON A PAGE 40

APPENDIX 7 / CASE SCENARIOS - PATHWAYS THROUGH THE EMCH PROGRAM 41

Melbourne Jul-18 © State of Victoria (Department of Education and Training) 2018

The copyright in this document is owned by the State of Victoria (Department of Education and Training), or in the case of some materials, by third parties (third party materials). No part may be reproduced by any process except in accordance with the provisions of the Copyright Act 1968, the National Education Access Licence for Schools (NEALS) (see below) or with permission.

An educational institution situated in Australia which is not conducted for profit, or a body responsible for administering such an institution may copy and communicate the materials, other than third party materials, for the educational purposes of the institution.

Authorised by the Department of Education and Training, 2 Treasury Place, East Melbourne, Victoria, 3002

# ABOUT THIS DOCUMENT

**The Enhanced Maternal Child Health (EMCH) program is part of Victoria’s Maternal and Child Health (MCH) Service and is offered to selected families as an extension of the Universal Maternal and Child Health (UMCH) program. The EMCH program offers flexible actions and interventions to families who would benefit from targeted support.**

From July 2018, the EMCH program is being expanded to support children up to their third birthday with a stronger focus on: infant mental health and wellbeing; identification of, and support for, families affected by family violence; and a clearer role for the EMCH program in the context of facilitating system-wide supports and engagement for families from pregnancy and throughout the early years of life.

This document sets out the guidelines for the expanded EMCH program. It aims to equip the EMCH workforce with the information and resources to maximise support for families who need it most. This document is structured around five key areas:

Section 1: *Background on the EMCH program*

Section 2: *Local and state government roles and responsibilities for delivery of the program*

Section 3: *Program objectives and Model of Care (MoC)*

Section 4: *Program delivery (covering entry, management and transfer of care)*

Section 5: *Key requirements related to funding, staffing, data collection and continuous quality improvement.*

These guidelines have been developed to provide clear, standardised guidance to local government, EMCH nurses and other clinicians involved in the program. The guidelines establish a common basis for program delivery across the state, which is supported by the Department of Education and Training (DET) and the Municipal Association of Victoria (MAV). Development of the guidelines has been informed in consultation with representatives of the MCH workforce across Victoria.

Successful implementation of the guidelines will assist with:

* establishing a consistent and contemporary MoC to support inclusive practice and meet the needs of a diverse population
* providing clear planning pathways for families and staff
* strengthening partnerships with complementary services to provide integrated care for families.

Following statewide implementation and evaluation of the MoC, a process of continuous improvement will be used to maintain its currency. Iterative adjustments will be made to the guidelines to best meet the needs of the infants, children and families who are engaged in the EMCH program.

## List of abbreviations

|  |  |
| --- | --- |
| Acronym | Meaning |
| ARIA | Accessibility Remoteness Index of Australia |
| APHRA | Australian Health Practitioner Regulation Agency |
| CALD | Culturally and Linguistically Diverse |
| CDIS | Child Development Information System |
| CFAP | Child and Family Action Plan |
| CRAF | Family Violence Common Risk Assessment |
| CRC | Convention on the Rights of the Child |
| CYFA | The Children, Youth and Families Act 2005 |
| DET | Department of Education and Training |
| DHHS | Department of Health and Human Services |
| EMCH | Enhanced Maternal and Child Health |
| EPDS | Edinburgh Postnatal Depression Scale |
| FTE | Full Time Equivalent |
| IRIS | Integrated Reports and Information System |
| KAS | Key Ages and Stages |
| LGA | Local Government Area |
| MaCHS | Maternal and Child Health System |
| MAV | Municipal Association of Victoria |
| MCH | Maternal and Child Health |
| MoC | Model of Care |
| OoHC | Out-of-Home Care |
| PEDS | Parents’ Evaluation of Developmental Status |
| SIP | Service Improvement Plan |
| UMCH | Universal Maternal and Child Health |
| VEYLDF | Victorian Early Years Learning and Development Framework |

## Key Terminology

In this document, the term ‘**Aboriginal**’ is used to refer to Australian Aboriginal people and Torres Strait Islander people.

**Clinical supervision** is a formal process for reflection on practice with the aim of improved outcomes for the clients as well as support and professional development for the maternal and child health nurse (Child and Family Health Nurses Association (NSW), 2003; Department of Education and Training, 2018).

The term ‘**family**’, as used in these guidelines, is inclusive of carers as well as parents.

‘**Family violence**’ refers to any act or behaviour towards a family member that is: physically, sexually, emotionally, psychologically or economically abusive; threatening or coercive; controls or dominates; causes fear for the safety or well-being of themselves or another person. It also refers to behaviour that causes a child to hear, witness, or otherwise be exposed to the effects of any behaviour referred to above.

The term ‘**father**’ is used to refer to a male caregiver who provides parenting to a child. The definition includes biological and social fathers (such as step- fathers, foster carers, male partners) and father figures such as uncles and grandfathers.

The terms ‘**infant**’ and ‘**child**’ are used to refer to the child or infant who is the focus of the services that are being provided by the EMCH program.

A **MCH Nurse** in Victoria refers to nurses who hold current registration with the Australian Health Practitioner Regulation Authority Agency (APHRA) as a Division 1 Registered Nurse and Registered Midwife and in addition hold an accredited post graduate qualification in Maternal and Child Health nursing (Maternal and Child Health Service Program Standards 2009, p. 35 and Maternal and Child Health Service Guidelines 2011, p. 21).

‘**MCH Service**’ is used to refer to the overarching, statewide Maternal and Health Service. ‘**MCH service(s)**’ refers to individual services located within local government.

The term ‘**mother**’ is used to refer to a female caregiver who provides parenting to a child. The definition includes biological as well as social mothers (such as step-mothers, foster carers, female partners) and mother figures such as aunts and grandmothers. It is understood that the care of the biological mother includes both antenatal and postnatal assessment, advice and referral.

The EMCH program is led and delivered primarily by MCH nurses. In this guideline, the term ‘**nurse**’ is used to refer to the MCH nurses delivering the EMCH program.

For the purposes of these guidelines, the terms ‘**parent**’ and ‘**carer**’ are used to describe the person or people who have substantial responsibility for ongoing care and support of the child or infant for whom the EMCH program is being provided. This parent may or may not be the biological parent; they may be a step-parent, foster parent, grandparent, or other carer.

**Progressive universalism** is an approach based upon a strong universal service base that adds levels of support progressively for those with additional needs and is a service-based response to address inequities (Boivin, 2012); (Human Early Learning Partnership, 2011); (The Marmot Review, 2010).

# 1 / BACKGROUND

**The early years of childhood are a time of significant brain growth and change across all domains of development. Research has demonstrated that both risk and protective factors experienced by a child during this period can have enduring consequences for learning, behaviour, and health. The environment in which a child spends these early years strongly shapes and lays the foundation for their future health, wellbeing, learning and development.**

There is growing evidence about the significant impact of prenatal and early childhood experiences on health, wellbeing, learning and development in later childhood and over the life course, which demonstrates the importance of the early years (Shonkoff, 2012). Children’s health, wellbeing, learning and development can be compromised by a number of direct adverse experiences during the prenatal and postnatal periods (Hertzman, 2017). Adverse experiences shown to be associated with later negative outcomes include: sustained poverty; neglect or recurrent physical, emotional or sexual abuse; parental substance use or mental illness; and family violence. Intervening earlier in life to support families and children can impact positively on the life trajectory of the child and family.

Optimising nutrition, growth and development, parent-child relationships and home learning environments is essential for improving the health and wellbeing of the whole population. Positive maternal health and wellbeing is a significant enabler to optimal child and infant health, wellbeing, learning and development. For good outcomes, infants and children need:

* responsive caregiving
* opportunities to interact, explore and participate in a range of social and physical environments
* adequate and appropriate nutrition and care
* protection from physical and psychosocial harms.

Victoria’s MCH Service has been delivering MCH nurse-led services in the home environment since 1917. The EMCH home visiting program has been offered to eligible Victorian families since 1999-2000.

During the last decade, services delivered in homes by nurses around the world have increasingly been used to enhance parent/child relationships and the quality of children’s home environments (Azzi- Lessing, 2011) (Chaffin & Friedrich, 2004). There is also evidence that nurse-led programs in Australia have beneficial outcomes for families experiencing a period of vulnerability (Kemp, et al., 2011), and that families benefit from interventions in a home-visiting environment (Axford, et al., 2015).

## The Maternal and Child Health Service

Victoria’s MCH Service is a highly regarded and long-established free universal platform delivering health, wellbeing, safety, learning and development support to every Victorian infant and child during the early years. The MCH Service, including the EMCH program, works in partnership with health, education, welfare and disability sectors to provide coordinated, multidisciplinary care and integrated service delivery.

The MCH Service offers support to all Victorian children and families, but recognises that more support is required by those with greater needs.

**The MCH Service comprises three core components:**

* the **Universal MCH (UMCH) program** – available to all families in Victoria. This is a service that includes ten Key Ages and Stages (KAS) consultations and a flexible service capacity. Families can discuss their concerns, talk about parenting experiences and explore ways to improve their child’s health, growth, learning and development. The flexible component includes additional consultations to the KAS visits, the facilitation of group sessions, community strengthening activities and telephone consultations. The service supports families and their children with an emphasis on:
  + appropriate nutrition
  + parenting
  + prevention and health promotion
  + developmental assessment
  + early detection, intervention and referral
  + social supports
  + transitioning children and families to the next universal platform in care and education.
* the **Enhanced (EMCH) program** – responds assertively to the needs of children, mothers and families at risk of poor outcomes. It provides a more intensive level of support to those with additional needs, in the form of targeted actions and interventions. Families can access up to 20 hours of support for children up to three years of age with provisions made for rural and remote areas to receive an additional 2.67 hours. This is in addition to the hours children receive in the UMCH program.
* the **MCH Line** – a 24/7 telephone service where MCH nurses provide information, advice, support and referrals to Victorian families with children from birth to school age. The MCH Line is integral in linking families to the UMCH service and to other community, health and support services (Ph.: 13 22 29).

## The Enhanced Maternal and Child Health Program

The EMCH program was established in 1999-2000 in recognition of the importance of neurobiological, behavioural and environmental influences that affect the development of the infant and young child. In addition, research has identified the importance of providing support for parents to promote physical, intellectual, emotional, cultural growth and development of children, this is most important for children from vulnerable backgrounds.

The EMCH program provides an outreach service, led and primarily delivered by MCH nurses. It is focused on achieving improved outcomes for infants, children, mothers and their families who are experiencing a period of increased need, and who could benefit from targeted actions and interventions.

The EMCH program may also work alongside existing maternity services to commence care planning for mothers during the antenatal period. It is part of a continuum of service of the UMCH program (progressive universalism). The EMCH program is offered to vulnerable families in addition to the core set of services provided to all families by the UMCH program. The program is statewide and is delivered in all 79 Local Government Areas (LGAs) in Victoria. Families may exit and re-enter the EMCH program multiple times as they move into and out of periods of vulnerability.

The establishment of the EMCH program in Victoria has allowed the MCH Service to respond to families who require additional support. Since this time, there has been growing recognition of the positive role that the MCH service plays in intervening early and addressing developmental or family issues before they escalate.

## Guiding Principles

The EMCH program is underpinned by the following guiding principles which align with the *Maternal and Child Health Service Program Standards* 2009, *Competency Standards for the Maternal and Child Health Nurse in Victoria* 2010, *Maternal and Child Health Service Guidelines* 2011, *Documentation Standards for Maternal and Child Health Nurses*

*in Victoria* 2016, and the Practice Principles in the *Victorian Early Years Learning and Development Framework* (VEYLDF) 2016.

#### Child-centred, maternal and family-focused

* child-centred, maternal and family-focused practice is designed to respond to the needs of the family where they are currently trying to manage difficult circumstances

#### Connection with parents as partners

* follows a parent-led, strength-based approach, with families involved in decision making at all times
* responds to families in a respectful, strengths- based manner, and maintains each child and family’s privacy in line with relevant legislation

#### Health promoting, early intervention and preventative health activities

* focuses on the importance of keeping the child in mind and child/infant mental health
* supports self-determination for children, young people and families
* follows the principles of health promotion, prevention and early intervention

#### Equitable and inclusive service provision

* provides outreach support in a variety of settings, including the family’s home, the local MCH centre or another location within the community
* follows a place-based approach, and whilst care is consistent across the state, service delivery will vary between LGAs in response to factors such as differences in population, community needs, and rurality and remoteness
* supports Aboriginal families by working with Aboriginal staff and/or service providers, wherever possible
* responds assertively to the needs of infants, children and families who are susceptible to poorer outcomes, in particular where there are multiple complexities, by providing a more intensive level of support in addition to the suite of services offered by the UMCH program

#### Coordination, collaboration and partnership with local services and professionals

* involves collaboration and partnerships with other services such as: General Practitioners (GPs); paediatric services; maternity services; Support and Safety Hubs (now referred to as ‘The Orange Door’); Child FIRST; family services; housing and homelessness services; Child Protection; specialist family violence services; Supported Playgroups, parenting and early intervention services and early education and care services
* enables the MCH Service to intervene early to identify and proactively support families to engage with appropriate services
* provides supportive care coordination where necessary, and actively collaborates with other involved services
* utilises clinical supervision, reflective practice and continuous improvement to support the provision of high quality, safe care for families and the workforce.

# 2 / ROLES AND RESPONSIBILITIES

**In 2017, the Department of Education and Training (DET), Department of Health and Human Services (DHHS) and the Municipal Association of Victoria (MAV) jointly signed the** *Supporting Children and Families in the Early Years Compact***, which presents a shared vision for collaboration between state and local government to improve and sustain outcomes for Victorian children and families. Revision of the EMCH Guidelines is one of the initial priority areas identified in the Compact.**

DET, MAV and DHHS work together to guide the overall direction of the EMCH program in the context of the Compact, MCH Service and broader primary health care and family services systems.

## Local Government and MCH Services

Local government and MCH services are responsible for providing the EMCH program in accordance with these program guidelines, ensuring a high- quality service that responds to families’ needs and is delivered through establishing collaborative partnerships to support delivery of integrated care.

Local governments also manage recruitment for the EMCH workforce and clinical supervision for EMCH nurses (see Section 5 on operational requirements and funding for more information).

#### The role of local government and MCH services includes the following responsibilities:

* ensuring families receive a service response that supports improved family outcomes and parenting capability
* regularly assessing current capabilities, opportunities and barriers in relation to the EMCH program’s ability to meet the needs of local families, including the risk to and capability of staff to deliver targeted actions and interventions
* taking into account the diverse nature of families through inclusive practice
* maintaining continuity of care and care planning for families
* developing local networks for the EMCH program as relevant
* seeking opportunities to engage in service relationships with GPs, maternity services, community health, Support and Safety Hubs (now referred to as ‘The Orange Door’), specialist family violence services, Child FIRST, integrated family services, Child Protection, family support services, Supported Playgroups, kindergarten and early childhood education and care services where appropriate
* establishing links within, and engaging with, the wider community
* ensuring the EMCH workforce receives regular professional development
* ensuring EMCH nurses receive clinical supervision in accordance with the *Clinical Supervision Guidelines – Enhanced Maternal and Child Health Program* 2018
* creating and maintaining a safe working environment for the workforce including risk assessment processes prior to and during each home visit, Occupational Health and Safety and psychosocial support.

## Department of Education and Training

DET is responsible for funding, statewide leadership and guidance to support program delivery, including facilitating statewide partnerships and collaborative opportunities.

#### DET’s role includes the following responsibilities:

* leadership at the state level to facilitate the governance, direction and monitoring of the EMCH program
* developing and disseminating statewide policy and standards
* setting clear program guidelines for local governments to deliver the EMCH program
* managing service agreements that support the MCH service to implement the MoC (refer to Pages 12 and 13 for more information on the MoC)
* assisting with the establishment of operational processes that facilitate implementation and evaluation of Service Improvement Plans (SIPs)
* developing consistent data collection guidelines
* aligning funding to ensure the EMCH program operates effectively
* facilitating area level partnerships and monitoring EMCH program delivery through regional offices
* developing statewide relationships with clinical stakeholders involved with the provision of the program, such as GPs, maternity services, community health, Child FIRST, Child Protection, family support services and intensive parenting supports
* providing LGAs with funding to support the delivery of clinical supervision, and developing data collection guidelines to support acquittal of this funding

# 3 / PROGRAM OBJECTIVES AND MODEL

**The EMCH program aims to improve the health, wellbeing, safety, learning and developmental outcomes of young children and their families. To achieve this goal, the EMCH program utilises the expertise of the EMCH workforce and links with multi disciplinary supports to address specific areas of need and concern for the infant, child and family.**

The program also supports parent-child interactions by providing more focused and intensive MCH support when parents are experiencing significant early parenting difficulties. The program may also work to address parent or family risk factors that affect child development or the capacity of the family, such as parent emotional wellbeing and family violence.

The EMCH program is a child and family centred program that understands and prioritises the infant and child’s experience of the world and the factors impacting on this.

#### The objectives of the EMCH program are to:

* assess infant/child, maternal, parent, home and environmental risk factors, and family capacity to address identified concerns
* assist parents to manage risk factors, and build on strengths and protective factors[[1]](#footnote-1), to increase capacity, responsiveness and ability to keep the child in mind at all times
* provide targeted actions, and interventions or supports, to improve child health, wellbeing, safety, learning and developmental outcomes where concerns are present
* facilitate and strengthen the parent/carer’s ability to engage in their community as a key protective factor
* provide assertive and integrated services for higher-risk families, including care coordination when needed
* ensure appropriate and timely referral of infants, children and families to a range of services
* use a place-based approach to contribute to the development of the local system of care for families to promote health, wellbeing, safety, learning and developmental outcomes. In providing the EMCH program, it is recognised that changing the experience and life trajectory of children and families with additional needs or concerns is a shared responsibility across community, government, service providers and individuals.

## Scope of Program

All Victorian families with children from birth to school age are offered maternal and child health support via the UMCH program. The EMCH program is funded to provide targeted interventions for infants, children, mothers and families with additional needs, who are currently experiencing vulnerability with two or more risk factors identified (see Page 11).

Families engaged with the EMCH program are provided with the suite of services offered by the UMCH program as well as their targeted interventions available through EMCH. It is for each individual MCH service within a municipality to decide how the UMCH and EMCH programs are integrated at an operational level. Children, mothers and families may also receive support from other intensive support services outside of the MCH Service. The scope of the UMCH and EMCH programs are outlined in Table 1 below.

|  |
| --- |
| **UMCH program** |
| * Available to all families in Victoria with children from birth to school age. * Includes 10 KAS consultations at prescribed intervals from birth to 3.5 years. * Includes the facilitation of groups for families, including first-time parent groups and community strengthening activities. * Provides core advisory services or interventions for all families and offers additional, flexible services where required. |
| **EMCH program** |
| * Available to families with children up to their third birthday, who present with additional needs that cannot be met by the UMCH program due to time constraints and complexity of families. * Enables targeted, strength-based interventions. * Facilitates care-coordination[[2]](#footnote-2) for families with additional needs to maintain participation in the UMCH program and/ or engage with more intensive parenting supports and other agencies. * Offers up to 20 hours of support per child/ family, with families in rural or remote areas eligible to receive an additional 2.67 hours. |

###### TABLE 1. SCOPE OF MCH PROGRAMS (UMCH & EMCH)

## Program Eligibility

Families must meet three key requirements to be considered for entry into the EMCH program:

1. **Child’s age** – the child who is receiving service is under three years of age. While priority for services is given to vulnerable families with a child under three years of age, the aim of the EMCH is to provide additional support for vulnerable families presenting with multiple risk factors and may include (at an LGA’s discretion) families with children over three years of age, particularly as a strategy to link children and families with other primary or secondary services for longer term intervention and support (for example, link to Access to Early Learning and/or Early Start Kindergarten).
2. **Appropriate level of need** – families with two or more risk factors, as identified below, are eligible for the EMCH Program. Families are considered high risk, if they have insufficient protective factors - (refer to the table at the end of the referral form in Appendix 1)
3. **EMCH can respond effectively** – there is a clear role for the EMCH program (rather than the UMCH program with the addition of other external services) to provide intervention(s) and support to meet the child and family’s needs, and the EMCH program has capability and capacity to provide the necessary support to the family.

Each of these elements is considered and recorded through the EMCH Referral Form (Appendix 1) or through the MCH service’s client management system. Eligibility based on the above criteria does not guarantee entry into the program, this is determined following an assessment of: the family’s level of need and risk; most appropriate care pathway; and the program’s capability and capacity to support the family. This process is further explained under priority of access.

## Priority of Access

If a family meets the three key requirements of program eligibility they can be considered for entry to the EMCH program.

The process for determining program entry will vary between LGAs and also depends on whether the referral is coming from the UMCH program within the same LGA, elsewhere within the MCH Service, or from an external party.

If the family is not currently known to the MCH service, the MCH nurse will meet with the family to determine the family’s level of risk and need, prior to determining the most appropriate care pathway.

#### The primary focus for the EMCH program is families experiencing a period of vulnerability due to two or more of the following factors:

* mother/parent is less than 20 years of age
* infant/child is identified as being of Aboriginal or Torres Strait Islander descent and is not actively attending the UMCH program
* family is socially isolated (housing, cultural group, transport, unemployment)
* parent expresses and/or demonstrates poor attachment towards their infant/child
* mental health issue currently impacting parenting capacity
* substance abuse related issues currently impacting parenting capacity
* family violence currently impacting safety, parenting and infant/child development
* current intervention from Child Protection
* infant/child born with congenital abnormalities
* infant/child with complex growth, health and developmental issues
* concern on the part of the assessing nurse, or
* families who are not currently engaged with the UMCH program.

The list of factors assists the nurse to determine the family’s ‘appropriate level of need’ and prioritise referral. Consideration is given to the presence of family protective factors (refer **Appendix 1**) that may offset some of the impact of the challenges faced, enabling families to maintain positive outcomes for the child without requiring support from the EMCH program.

It is also recognised that not all families experiencing adversity will require additional support and that the challenges experienced by families may be transient or stable, and capable of being monitored through the UMCH program.

Families who have two or more risk factors and an absence of protective factors (refer to the table at the end of the referral form in **Appendix 1**) are considered high risk, and a referral into the EMCH program is recommended in consultation with the UMCH program and other agencies involved with the family.

Consultation with the UMCH program regarding program capability and capacity will help to determine the appropriate care pathway for the family.

The MCH nurse conducting the initial prioritisation of the family can draw on further information (verbal or written) from a number of sources, including: the birth notice and discharge summary; consultations with other agencies involved with the family; EMCH Referral Form; assessments from UMCH program consultations; domiciliary service discharge summary; or information gathered during the antenatal period to build a more complete picture of level of need.

Need/risk and protective factors from the EMCH Referral Form, the prioritisation process and consultations with the family are recorded in the EMCH program’s client management system, and form part of the health record for the child (refer to Section 5. Data Collection for more information). The MCH nurse will review these factors and edit the EMCH program’s client management system as necessary.

## Model of Care

The EMCH Model of Care (MoC) is shown in Figure 1 (next page). The MoC outlines the way a child and their family progresses through the EMCH program as a continuum of the UMCH service, from program entry to clinical management and the transfer of care. In practice, the MoC is delivered flexibly to respond to families’ needs, and will vary to reflect the diversity of service delivery across metropolitan, regional and rural areas in Victoria.

Families receiving support from the EMCH program will also be provided with the UMCH program and access to the MCH Line. They may also be receiving support from other external intensive support services during their engagement with the EMCH program. The inputs, outputs and outcomes from the MoC are shown in a program logic diagram in **Appendix 2**.

#### In the MoC, children and their families engage with the EMCH program through a range of activities, including:

* initial and ongoing assessment and screening
* development of Child and Family Action Plans (CFAP) and connected work to support families in meeting identified goals
* delivery of evidence-informed interventions to meet specific family needs
* building trust and relationships with families who are not currently engaged with the MCH Service to facilitate the family’s engagement and connection with the UMCH and/or EMCH program
* care coordination for families with higher levels of risk to support their engagement with other support services
* collaboration and engagement with, and referral to, other services.

The MoC recognises that the EMCH program is a tier of support offered to families whose needs cannot be adequately accommodated by the UMCH program.

## Continuity of Care

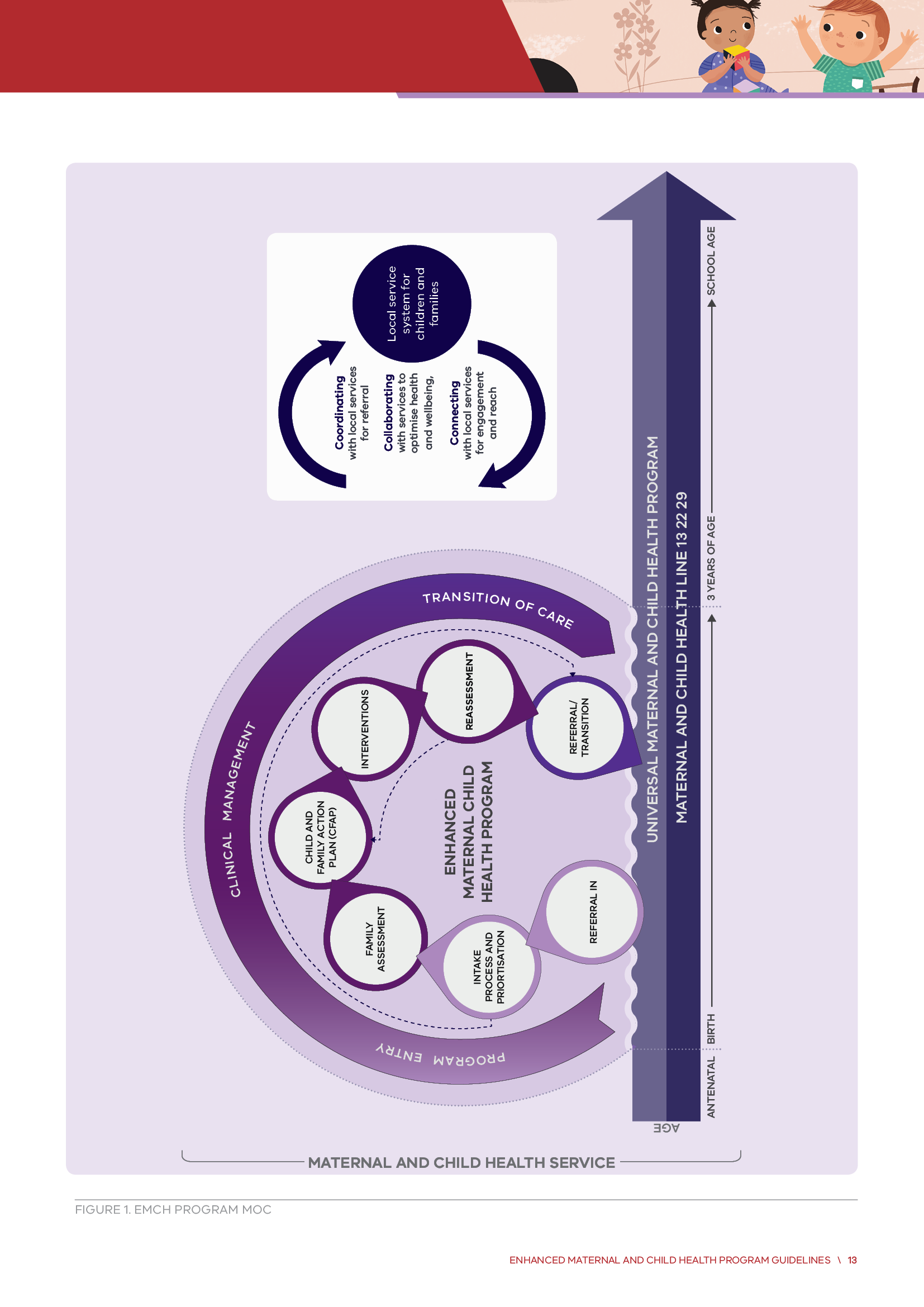
Continuity of care is critical when families are moving between the EMCH program and the UMCH program and/or other service providers. As EMCH is a continuum of the UMCH program, families will transition back to UMCH if they no longer require the additional support provided by the EMCH program.

Depending on individual MCH services in a municipality, families may receive the ten KAS visits from the UMCH program and rely on the EMCH program for support in other areas, or the UMCH and EMCH programs are delivered simultaneously as a combined program. Families may also be involved with other services in the broader service system.

The MCH Service works in partnership with health, education, welfare and disability sectors to provide coordinated, collaborative and connected multidisciplinary integrated service delivery.

MCH nurses are responsible for working collaboratively with others involved in the current or future care of the family, communicating effectively and sharing relevant information to support effective transfer between services and improved outcomes for children and their families. Information sharing should be reciprocated by other services so that there is a two-way flow of information between MCH and other services.

This is discussed in *Section 5 Operational requirements and funding*. Inclusive practice can also be supported by new initiatives such as Child Link.



# 4 / DETAILS OF MODEL OF CARE (MOC) AND PROGRAM DELIVERY

**The MoC (Figure 1 on Page 13) outlines three broad stages for the delivery of the EMCH program.**

#### EMCH program criteria and practices are discussed within each of the stages, as outlined below:

Stage 1 / Program entry

Program eligibility, referral pathways, transfer of client records, and intake process and prioritisation

Stage 2 / Clinical management

Family assessment, child and family action planning, interventions, and reassessment

Stage 3 / Transition of care

Transition, referral out, and outcomes monitoring.

## STAGE 1 / Program Entry

### REFERRAL PATHWAYS AND TRANSFER OF CLIENT RECORDS

##### Internal referrals from within the MCH Service (transfers)

Children may be transferred into the EMCH program when a family requires intensive support that cannot be provided by the UMCH program and/or when a family moves from another LGA where they had been involved in the EMCH program. The EMCH Referral Form may be used for transfers into the EMCH program, but referrals are more commonly initiated verbally via a phone call and then enacted electronically using the service’s client management system. In cases where a referral is coming from an MCH service in another LGA, the referrer seeks confirmation that the referral has been accepted.

The receiving service provides the referrer with confirmation of acceptance (or otherwise) of the referral within a maximum of five working days. Referrals from the MCH Line are initiated through contacting the appropriate MCH contact in an LGA. The EMCH referral form can be utilised for details of the referral and/or through the client management system.

##### External referrals into EMCH

External referrals into the EMCH program may come from a variety of sources such as Child Protection, social workers, hospitals, GPs, family services, and maternity services. Referrals may be made using the EMCH Referral Form (**Appendix 1**) or verbally. The EMCH Referral form can be used to assist referring practitioners to identify specific area/s of need and can be used by the service when making an initial assessment of the family’s eligibility for the program.

All referrals come to a central MCH point nominated by the local council for initial prioritisation, where they are then assessed by an MCH coordinator or nurse. During intake, the child/family’s level of need and risk, mitigating protective factors, and program capability will be examined to determine the most appropriate program or pathway (i.e. UMCH or EMCH +/- another specialist service external to the MCH Service). The intake nurse will also consult with the UMCH program within their service when determining a family’s eligibility and the ability for UMCH to respond to the family’s needs

For pregnant mothers who would benefit from receiving support from the EMCH program, the referring service (e.g. Domiciliary Midwifery, Early Parenting Centres, Koori Maternity Service or GPs) is responsible for ensuring that the MCH service is made aware of the family’s needs and is provided with an opportunity to work jointly on early care planning during the antenatal period wherever possible.

##### Transfer of client records

The timely and effective transfer of client records enables continuity of care and minimises the burden on families of undergoing repeated reassessments, while adhering to confidentiality requirements. Further information about privacy legislation is provided in *Section 5 Operational requirements and funding*.

For transfers between municipalities within the Victorian MCH Service, the transferring LGA is responsible for proactively initiating the information sharing process. Wherever possible, the transferring LGA will make contact with the central MCH intake point at the family’s new location to advise that the family is moving address. If the transferring LGA is unaware that a family has moved, it is the responsibility of the MCH service in the new LGA to make contact with the previous MCH service and initiate the information sharing process, as soon as they are aware the family is in their LGA.

The transferring LGA should follow up their referral to ensure priority of access to EMCH. Transfers must be conducted and confirmed within five working days.

Client records are transferred electronically, where possible, via a client management system.

### INTAKE PROCESS AND PRIORITISATION

During the intake process, an MCH coordinator or nurse establishes the family’s level of need, including an assessment of the risk and protective factors present, and determines the appropriate service response.

Where the intake nurse determines that the EMCH program is the most suitable support pathway, the family is enrolled in the EMCH program. Enrolment and informed consent is established in line with the MCH service’s processes, recognising that the program is part of the broader MCH Service.

#### The intake nurse may determine that the EMCH program is not suitable for the family if:

* children are over three years of age
* the family’s needs can be met by the UMCH program without progressive support from the EMCH program
* the family is already receiving active case management via another service or program (such as family support services or child and family services), and the family is receiving concurrent support from UMCH program
* the family requires more intensive support services (such as a tertiary parenting service), in which case they would be referred on as appropriate
* the family does not consent to receive services for the program
* acceptance of the family into the program would pose an unacceptable risk to nurses’ safety
* the EMCH program does not have capacity or capability to provide the family with the required support.

If the family requires support that the EMCH program is unable to provide, contingency planning takes place to assist the family to receive the necessary MCH universal service and additional support in an appropriate environment.

The intake nurse should consult with the UMCH program and/or other referrers if the EMCH program is assessed as unsuitable for the family.

If the referral was made using the referral form, the final section of the form is completed (see **Appendix 1** ‘Review by intake service’), and the form is signed electronically by the intake nurse. Details are recorded in the client management information system under the child and family’s records.

## STAGE 2 / Clinical Management

### FAMILY ASSESSMENT

Family assessment is the first step in the clinical management stage of the EMCH MoC. It is a required component of the EMCH program and is used to inform the development of the Child and Family Action Plan (CFAP), including determining the appropriate intervention(s) and expected outcomes for the family.

The choice of a specific assessment should be purposeful and be undertaken in a timely way. The MCH nurse should complete and upload assessment tools into the client record to ensure detailed records are kept for each child and family.

#### The assessment/s assist the MCH nurse to:

* understand the child’s changing needs and assess whether those needs are being met by the family and/or any services already provided
* analyse the nature and level of any risks of harm facing the child or parent as well as identifying protective factors
* recognise anomalies in development requiring further intervention and/or referral
* make decisions in the best interests of the child, build on strengths as well as identifying difficulties for the family
* focus on building on protective factors that promote the safety, stability and development of children
* plan and provide suitable interventions to address short term and medium-term goals
* coordinate, or deliver, and monitor a suite of flexible services
* respect diverse family structures, culture, religion, self-determination and ethnic origin
* record goals, objectives and the tasks required to achieve these
* monitor and review family progress against agreed objectives and goals outlined in the CFAP
* inform continuous improvement processes and build an evidence-informed knowledge base.

A range of assessment tools may be used. Table 2 below shows some of the tools commonly used by MCH services. Other tools and techniques (e.g. ecomaps, genograms) are often used in building a visual picture of the environment in which children are growing up. Further detail on these tools is provided in **Appendix 3**.

###### TABLE 2. OVERVIEW OF ASSESSMENTS AND TOOLS

|  |  |
| --- | --- |
| Domain | Commonly used by MCH services |
| Child health, wellbeing, safety learning and development | Parents’ Evaluation of Development Status (PEDS)  Brigance Early Childhood Screen tools  Key Ages and Stages assessments  Family Violence Common Risk Assessment Framework (CRAF[[3]](#footnote-3)) |
| Parenting capacity | Clinical observation/ Parenting Tool |
| Parent/family health, wellbeing and safety | Edinburgh Postnatal Depression Scale (EPDS)  Family Violence Common Risk Assessment Framework (CRAF3) |
| Environmental factors | Home Safety Visit Assessment |

##### Child and Family Action Plans

The next step in the clinical management process is development of a CFAP. Actively involving the family in the development of their CFAP enhances the MCH service’s relationship with the family and supports the principle of family-centred practice, engaging and empowering parents/carers as partners in the program.

#### A tailored CFAP is developed for each family involved in the EMCH program and contains the following elements:

* objectives and goals to help guide EMCH staff and family members in developing appropriate strategies and interventions for the child and family. Assessment and goals are discussed and agreed with the family and other services that may be involved
* appropriate learning goals for the child/ren (if appropriate). These may incorporate the Play, Learn and Grow resources. Goals and objectives should be flexible; new goals may be added to a CFAP at any stage and goals that are no longer relevant for the family may be removed
* the interventions to be undertaken, and the roles and responsibilities of family members and EMCH program staff in implementing these
* a transition plan for the family’s involvement in the program, which is used for EMCH closure or to identify the need for further assessment or service provision to support the child and family.

#### The CFAP should:

* seek to build on family strengths and include clear outcomes, short- and medium-term goals, and tasks designed to facilitate positive changes for the child and family
* demonstrate the intended outcomes for each child in the family and the roles and responsibilities of each person involved: the children themselves (if appropriate); parents and other family members; MCH staff; and other involved agencies
* contain timelines for the length of intervention and for monitoring and review.

A family’s progress against the agreed goals and outcomes in their CFAP is reassessed at each consultation. Goals and objectives are created and amended with flexibility in mind; new goals may be added to a CFAP at any stage and goals that are no longer relevant for the family may be removed. The frequency of review may increase as the duty of care and family circumstances change. A CFAP template is provided at **Appendix 4**.

The outcomes in the CFAP should link to the changes in behaviours or conditions that are required to improve the child’s health, wellbeing, safety, learning and/or development. Outcomes should address issues related to four areas:

* infant/child health, wellbeing, safety, learning and development
* parenting capacity
* parent/family health, wellbeing and safety
* environmental factors.

These are discussed in the ‘Outcome monitoring’ section in Stage 3.

The CFAP also includes a discharge plan for the family’s involvement in the program and is used for EMCH closure or to identify the need for further assessment or service provision to support the child and family.

At transition back to the UMCH program, the CFAP closure is signed by an EMCH nurse.

##### Actions and interventions

Once an assessment of the family has been completed and a CFAP has been developed, specific strategies, nurse-led actions and interventions and referrals to specialist supports are provided in response to identified needs and to meet the goals agreed in the CFAP.

#### Interventions should:

* build on strengths and protective factors identified in the child and family assessment
* increase parental knowledge and capacity to address a specific need as identified in the CFAP
* improve parenting confidence; and create long- lasting, sustainable change.

Table 3 shows some of the interventions and strategies commonly used within the program. The case scenarios in **Appendix 7** provide examples of interventions that may be used within the EMCH program.

###### TABLE 3. EXAMPLES OF INTERVENTIONS

|  |  |
| --- | --- |
| Domain | Commonly used by MCH services |
| Child health, wellbeing, safety learning and development | * Monitoring of child development and KAS checks * Assisting child to learn and communicate from birth (child literacy, language, nonverbal cognitive ability and home literacy environment) * Breastfeeding assistance * Sleep and settling support, sleep management plans * Referral to Supported Playgroups * Referral to Early Start Kindergarten * Opportunistic immunisation or linkage with immunisation services * Referral to Child FIRST |
| Parenting capacity | * New parent and other supportive group sessions * Referral to Supported Playgroups * Building parenting capacity to keep the child in mind at all times * Provision of a space for both the parent and child to feel safe, contained and heard * Infant mental health and attachment education * Assistance with building self-management * Play and art therapy * Motivational interviewing and support * Referral to Regional Parenting Services * Provision of advice and support to assist the parent to provide appropriate nutrition for the child |
| Parent/family health, wellbeing and safety | * Maternal antenatal and postnatal assessment and support * Parent health assessment and support * Parent mental health assessment and support * Referral to specific groups e.g. transition to parenthood and sleep and settling * Family violence risk assessment and risk management, including safety planning[[4]](#footnote-4) * Referral to Child FIRST * Assistance to improve social connectedness * Infant mental health and attachment education * Building links with other services or the UMCH program to enable continuity of care * Health promotion activities |
| Environmental factors | * Creating and maintaining a safe home environment * Creating and maintaining a safe sleeping environment * Creating and maintaining a home learning environment that supports the child’s growth and development |

Referral to another service provider does not necessarily represent transfer of care from the EMCH program; families may be referred to a complementary service while receiving support from the EMCH program.

The length and intensity of contact with a particular family is a matter for professional judgement based on the assessments undertaken and the complexity of the child and family’s needs. Careful planning and assessment of immediate need is recommended to enable appropriate additional support.

From 2017, all MCH nurses and services will have the option to provide an additional visit to families if they have concerns that the parent or child is at risk of, or experiencing, family violence. This additional consultation is recorded as a family consultation in the MCH client management system.

Flexible modes of delivery are used in the EMCH program based on the identified needs of families.

### MODES OF DELIVERY

Interventions in the EMCH program are delivered flexibly according to the individual child and family’s needs. Modes of delivery include:

* home-based services for families requiring intensive service provision
* parenting programs, including parenting education, parent training, parenting support and family skills training. Parenting programs can be delivered in a number of formats (individual, groups and self-directed) and in a range of settings, with varying intensity and duration. Parenting programs are usually based on:
  + relationships – linking attachment theory and psycho-dynamic approaches (example program: Circle of Security)
  + behavioural approaches – cognitive behaviour or social learning theories – effective across universal and targeted populations (example programs and practices may come from Triple P, Incredible Years, Parent Child Interaction, What Were We Thinking, Team Around the Child, Supported Playgroups).
* group activities for specific communities such as adolescent parents, Aboriginal families and culturally and linguistically diverse families (e.g. Supported Playgroups)
* referral pathways to link infants/children and families with other primary or secondary services for longer term intervention, support and safety
* referral and facilitation of enrolment in Supported Playgroups and Early Start Kindergarten for eligible children
* integrated service provision at various levels, with:
  + maternity services for high risk mothers including perinatal service provision
  + the UMCH program
  + local service providers including drug and alcohol, family violence, mental health, preventing homelessness, family support, early intervention, Supported Playgroups, kindergarten and Child Protection services
* liaison with acute service providers such as the Royal Children’s Hospital, Monash Children’s Hospital, GPs, paediatricians and primary health care.

During the intervention stage, regular appointments are made with the family to check progress against goals and revise the CFAP if needed.

### REASSESSMENT

The final step in the clinical management stage of the MoC is reassessment. Reassessment of the family’s goals and objectives, and progress towards these occurs continually throughout a family’s engagement with the EMCH program and is responsive to changing priorities.

Reassessment results in one of three outcomes.

#### The family may:

1. Continue to receive support from the EMCH program. External service providers may or may not also be providing the family with complementary support. Reassessment may result in changes to the family’s goals and objectives in their CFAP, or they may continue to work towards their original goals
2. Be referred to an external service if they require more intensive or specialist support (such as a tertiary parenting service). Families will continue to be engaged with the MCH service either through the UMCH and/or EMCH to receive core MCH services. The family’s need would be reassessed on completion of the more intensive support service
3. Be transitioned from the EMCH program to the UMCH program if they no longer require additional support and their needs can be met through the UMCH program alone.

Refer to case scenarios in **Appendix 7** for examples of how a family may move through the MoC.

## STAGE 3 / Transition of Care

### TRANSITION OF CARE

Transition of care from the program is a crucial point and continuity of care should be maintained to prevent adverse outcomes. Transitions are undertaken at the transfer of care stage in the MoC. Families who have been transitioned may return to the EMCH program if additional needs/risks are later identified.

##### Transition practices

Each service should have clearly documented transition practices. This involves ensuring that:

* service completion/ transition planning is identified in the development of the CFAP, and the CFAP is completed and signed off electronically by the MCH nurse
* family violence risk assessment and risk management, including safety plans are completed if family violence has been disclosed
* families are included at all times in decision making, wherever possible
* consultation with the family, and other professionals as appropriate, has been undertaken prior to transition and at key points
* necessary referrals have been provided and acknowledgement of the referral has been received
* the transition has been formalised in writing, with completion and signing of the CFAP, and follow up actions clearly indicated to other providers or professionals as appropriate
* the family has been facilitated to engage with the UMCH and provided with the MCH Line number, MCH App and emergency contact numbers. Families are also advised that they can access the EMCH program in the future if needed.

Transition occurs after the family has been successfully linked to the UMCH program and acknowledgement of this has been received by the EMCH program. If the family fails to continue to engage with the UMCH (and other support services as required) the family will be re-opened with the EMCH program to ensure the family continues to receive support.

##### Referral outside MCH services

Referrals out are a way of linking families to more intensive support services if the EMCH program is no longer suitable for their needs. Nurses should seek consent from the family to release appropriate information to alternative service providers wherever possible. EMCH nurses confirm that referrals have been successful within five working days of initiating the referral. Refer to the Information Sharing and Privacy section on Page 25 in this document for more information about legislative requirements.

During activity with more intensive services, families will continue to be engaged with the MCH service either through the UMCH and/or EMCH to receive core MCH services. The family’s need would be reassessed on completion of the more intensive support service to ascertain future appropriate MCH service provision.

##### Re-entry to the EMCH program

Nurses may consider that families would benefit from further interventions through the EMCH program. When this is the case, the process recommences at the family assessment stage of the MoC, with new interventions administered based on the family’s needs as identified in the CFAP assessment.

Other services may also refer children and families back to the EMCH program. This is attended with a new referral, using the same processes detailed in the Program Entry stage.

##### Outcome monitoring

As a tier of support that complements the UMCH program, the primary focus of the EMCH program’s efforts relate to achieving improved outcomes for children and families in the following areas: child development, parent-child interaction, and parent/ carer/family and environmental factors. Indicative outcomes are provided in Table 4 on page 21.

Outcomes are monitored through the family’s CFAP, and recorded against the client record in the EMCH program’s client management system. Sign-off on the CFAP at point of transition involves confirming whether the outcomes have been achieved. This data is also recorded in the program’s client management system.

###### TABLE 4. INDICATIVE OUTCOMES FOR THE EMCH PROGRAM

|  |  |
| --- | --- |
| Domain | Outcomes |
| Child health, wellbeing, safety learning and development | * Earlier detection of health, wellbeing, learning and developmental issues * Improved physical and mental health * Improved social, emotional, language and cognitive development * Better access to early childhood services |
| Parenting capacity | * Improved relationship between parent/carer and child * Improved parental knowledge, skills and confidence * Improved parental capacity to provide a positive home environment |
| Parent/family health, wellbeing and safety | * Reduction in social isolation and stronger linkages to community * Parent able to keep the child in mind * Improved parental health and wellbeing * Family environment free from conflict or violence * Better access to adult services and supports |
| Environmental factors | * Improved home safety environment * Improved home sleeping environment * Improved home learning environment |

# 5 / OPERATIONAL REQUIREMENTS AND FUNDING

## Staffing

#### The EMCH program is led and delivered primarily by MCH nurses who hold current registration with APHRA as:

* a Registered Nurse (Division 1)
* a Registered Midwife
* and hold an accredited post-graduate degree/ diploma (or equivalent) in maternal and child health nursing.

The EMCH program may also include a mix of other practitioners and allied health professionals including mental health practitioners, drug and alcohol workers, early years educators, cultural workers, family support officers, Aboriginal health workers, psychologists and social workers, whose involvement complements the work conducted by MCH nurses.

Other practitioners employed to support and complement the skills of maternal and child health nurses are to have relevant qualifications and or experience to meet the objectives of the MCH service, and where relevant, have professional registration and maintain the requirements of professional registration.

(*Maternal and Child Health Service Program Standards* 2009, p.35 and *Maternal and Child Health Service Guidelines* 2011, p. 21).

#### In addition to the items listed on Page 8, LGAs have a responsibility to:

* recruit suitably qualified staff as outlined above
* ensure staff are familiar with the aims and values of the MCH Service, including compliance with relevant guidelines, standards and legislation
* provide staff with an orientation to the service organisation
* offer clinical supervision in accordance with the *Clinical Supervision Guidelines – Enhanced Maternal and Child Health Program* 2018
* provide critical incident debriefing when necessary
* ensure clear policy and practice guidelines are in place including occupational health and safety standards, Child Protection protocols, risk assessment and workforce safety (particularly when working with families where violence may be present), and incident reporting
* encourage and support staff to engage with professional development opportunities including clinical supervision.

## Clinical Supervision

Clinical supervision provides an opportunity for EMCH nurses to discuss a broad range of issues related to client care in a supportive environment. It seeks to improve health and wellbeing for nurses and assists in the development of more informed case solutions for both nurses and families. As detailed in the *Clinical Supervision Guidelines – Enhanced Maternal and Child Health Program* 2018, clinical supervision is distinctly different from operational supervision and has a particular focus on reflective practice. It may be offered individually or in a facilitated group to meet the needs of the workforce.

Clinical supervision is coordinated by the MCH coordinator, and is delivered in a way that is tailored to the local needs of EMCH nurses on a monthly basis or accumulated on a pro-rata basis. Supervisory agreements formalise the supervisory relationship, agreed goals and purposes and acknowledge the implicit confidentiality that underpins the supervisory relationship.

Clinical supervision funding is based on the number of EMCH nurses at the MCH service as detailed in the annual Workforce Report. Clinical supervision outcomes are measured via an EMCH nurse survey and captured in the annual Workforce Report.

## Program Funding

Funding for EMCH is allocated to local governments based on a statewide funding formula, incorporating the agreed hourly rate of service delivery for the MCH service. Funding for the EMCH program is based on an average of 20 hours of service delivery per child/ family (20 hours of service delivery in metropolitan areas or 22.67 hours of service delivery per child in rural areas) in addition to the suite of services offered through the UMCH program. Funding is allocated according to socioeconomic disadvantage, calculated on the number of Family Tax Benefit recipients in an LGA and rurality using the Accessibility Remoteness Index of Australia (ARIA).

## Program Monitoring

Service providers that receive funding from the Department to deliver the Enhanced Maternal and Child Health (EMCH) program are required to:

* deliver the EMCH program in accordance with the service specifications in these guidelines
* meet the performance targets specified in these guidelines
* report to the Department information on the outcome measures of the program

Monitoring of the EMCH program takes place at two levels: contractual accountability between local government and DET, and outcomes for monitoring of service improvement.

Key performance measures and targets are included in the Service Plan that is part of the Service Agreement between local governments and DET.

These measures are:

* **Key Performance Measure 1** – Number of clients: this performance measure monitors the number of families receiving support from the EMCH program in each LGA.
* **Key Performance Measure 2** – Number of hours of service: this performance measure monitors the hours of service provided to each family. LGAs will need to measure the hours of direct / indirect service delivery with families. A direct service activity is an interaction, usually face-to face, with the family to deliver the program. An indirect activity comprises those activities and processes that occur separately from the face-to-face interaction with the family and that are necessary to achieve the case goals and effective outcomes for the family.

In addition, each LGA is also required to collect data via its client management system to support service performance monitoring and reporting back to the Department. Service performance monitoring will be managed through DET regional offices. Service requirements will be monitored through the collation of key performance measures and supported by an analysis of issues impacting on the performance achieved.

Outcomes for children and families are measured in four key areas: child health, wellbeing, safety, learning and development; parenting capacity; parent/family health, wellbeing and safety; and environmental factors. Specific outcomes are identified in Section 4 and in **Appendix 5**.

Each LGA is also required to collect data on the number of nurses who have been offered clinical supervision, and the number of nurses actually undertaking clinical supervision. The total number of hours of clinical supervision administered is required to support acquittal of clinical supervision funding.

The following performance targets apply to funding through the EMCH program.

## Performance Measures

|  |  |  |  |
| --- | --- | --- | --- |
|  | Performance Indicator | Target | Source of information |
| 1 | Number of families receiving support from the EMCH program | 100% as indicated in the service agreement | Client management system and funding agency data |
| 2 | Number of hours of service provided to each family receiving support from the EMCH program | An average of 20 hours per referral or reassessment in metropolitan areas / an average of 22.67 hours per referral in rural Victoria | Client management system |
| 3 | Child and Family Action Plan completed | 100% of all children/families enrolled in EMCH at completion of cycle/transfer of care | Client management system |
| 4 | Percentage of EMCH nurses engaged in clinical supervision as per attendance log | 100% | Annual workforce data |
| 5 | Percentage of EMCH nurses with an active clinical supervision agreement in place | 100% | Annual workforce data |

###### TABLE 5. PERFORMANCE MEASURES

## Outcome Measures

|  |  |  |  |
| --- | --- | --- | --- |
| Area | Measure | Target | Source of information |
| Child health, wellbeing, safety learning and development | KAS and immunisation up to date for age | 100% of all children enrolled in EMCH at completion of cycle/transfer of care | Client management system |
| Referral and facilitation into Supported Playgroups | Percentage of children eligible for Supported Playgroups who have been referred and attending | Client management system |
| Referral and facilitation into Early Start Kindergarten | Percentage of children eligible for Early Start Kindergarten who have been referred and attending | Client management system |
| Appropriate and timely referrals | Percentage of children referred to universal, secondary and tertiary services that have been attended | Client management system |
| Parenting capacity | Increase in parental and carer capacity | 85% of identified families with children enrolled in EMCH at completion of cycle/transfer of care have increased parental/carer capacity | Client management system |
| Parent/family health, wellbeing and safety | Percentage of identified families exposed to family violence with a completed family violence risk assessment and safety plan | 100% of identified families with children enrolled in EMCH exposed to family violence have a safety plan attended at completion of cycle/ transfer of care | Client management system |
| Percentage of families with increased social connectedness | 85% of families with children enrolled in EMCH at completion of cycle/transfer of care have increased social connectedness | Client management system |
| Appropriate and timely referrals | Percentage of families referred to universal, secondary and tertiary services that have been attended | Client management system |
| Environmental factors | Family home environment improved for sleeping, safety and home learning | 100% of families have improved family home environment for sleeping, safety and home learning | Client management system |

###### TABLE 6. OUTCOME MEASURES

## Data Collection

Information systems are used by MCH services for client records and to collect information about service provision. Currently these systems include IRIS and an additional MCH client information system such as MaCHS, CDIS or Xpedite. Future information systems will be refined to one system of entry for the EMCH program.

Data includes tracking key relationships, referrals and service duration and intensity over time. Effective documentation and data collection is essential as MCH records are a health record for the child and provide important information on the care that is provided to children and their families. These records can also be transferred between LGAs when children and families relocate.

The *Documentation Standards for Maternal and Child Health Nurses in Victoria* (2016) support MCH nurses to complete and maintain accurate records of the assessments, interventions and evaluations undertaken and are a useful tool in promoting effective communication and continuity of care between MCH nurses and other health professionals.

Data collection is also used to drive improved service quality and stronger outcomes for children and their families. Data can be used to demonstrate the achievements of and gaps in MCH service delivery, and progress towards achieving agreed outcomes. Additionally, local governments provide data to DET to demonstrate service provision and achievement against outcomes outlined in the service agreements.

## Information Sharing and Privacy

MCH services are required to comply with local and state policies and legislation. The legislative framework for the overall MCH Service, including the EMCH program, is outlined in the MCH Service Guidelines.

##### DET Privacy policy

As part of this, MCH services (through local government) comply with DET’s privacy policy. This policy meets the Privacy and *Data Protection Act 2014* (Vic) and the *Health Records Act 2001* (Vic), meaning that any personal and health information about clients of staff is collected, stored, transmitted, shared, used or disclosed in compliance with these Acts.

##### Child safety

MCH nurses may at times consider they should report or refer a concern to either Child Protection or Child FIRST where they are concerned about a child’s safety.

* A referral to Child FIRST should be considered if, after examining the available information, a nurse believes the concerns currently have a low to moderate impact on the child, where the immediate safety of the child is not compromised. Referrals to Child FIRST can be made by calling 1300 721 383. For more information, visit *Making a referral to Child FIRST*.
* MCH nurses are required by law to make a report to Child Protection whenever they form the belief on reasonable grounds that a child is in need of protection from abuse. When this occurs Children, Youth and Families Act 2005 supersedes all other legislation and giving of information to a protective intervener does not constitute unprofessional conduct or breach of professional ethics, or make that person subject to any liability. For more information, visit *Child Protection – reporting obligations*.

##### Information sharing

The Royal Commission into Family Violence acknowledged that organisations that work with victim survivors and perpetrators of family violence collect a wide variety of information in order to keep victims safe and hold perpetrators to account. The Royal Commission also identified barriers that prevent information from being shared as effectively as it could be, and found that the failure to share crucial information with frontline workers can have catastrophic consequences.

From September 2018, two new legislative schemes will apply to MCH services. They will enable nurses to share information to:

* assess and manage family violence risk (under the Family Violence Protection Amendment Act 2017)
* promote the wellbeing and safety of children (under the Children Legislation Amendment (Information Sharing) Act 2018).

These reforms will amend privacy laws to enable, and sometimes require, prescribed organisations to share information proactively and take a more collaborative approach to facilitating early intervention and promoting the safety and wellbeing of families and children.

Both regimes will enable information sharing without consent where a child is involved. The child’s right to safety and wellbeing is paramount – the regimes give precedence to the child’s right to safety and wellbeing over any individual’s right to privacy.

Further information and training will be available from September 2018.

##### Mandatory reporting

As mandatory reporters, MCH nurses are required by law to make a report to Child Protection whenever they form the belief on reasonable grounds that a child is in need of protection from abuse for any of the following reasons:

* the child has suffered or is likely to suffer significant harm as a result of:
  + physical injury and their parents are unable or unwilling to protect the child
  + sexual abuse and their parents are unable or unwilling to protect the child
  + emotional or psychological harm and their parents are unable or unwilling to protect the child.
* the child has been abandoned and there is no other suitable person who is willing and able to care for the child
* the child’s parents are dead or incapacitated and there is no other suitable person who is willing and able to care for the child
* the child’s physical development or health has been, or is likely to be significantly harmed and the parents are unable or unwilling to provide basic care, or effective medical or other remedial care.

Further information about possible indicators of abuse and the process for reporting suspected abuse or neglect is provided in the *Maternal and Child Health Service Guidelines* 2011.

##### Informed consent

Nurses are required to obtain informed consent from families receiving support from the MCH Service, and inform them that their client information cannot be shared with anyone unless the client agrees, or otherwise only in accordance with legislation. Informed consent may be written or verbal, and should be recorded in the LGA’s client management system.

MAV has supported the development of a privacy fact sheet and consent form that may be adopted by LGAs. These are available on the MAV website. LGAs are responsible for ensuring that families receiving support via the MCH Service understand that their information will remain confidential unless the parent consents to the release of information, or if required by law (such as in a medical emergency, if it is subpoenaed, or as a mandated professional).

## Guidelines Review

Following statewide implementation and evaluation of the MoC, a process of continuous improvement will be conducted to maintain the currency of this document. Iterative adjustments will be made to the guidelines to best meet the needs of the children and families who are engaged in the EMCH program in consultation with the MCH workforce and stakeholders.

# REFERENCES

American Academy of Pediatrics, 2005. Care coordination in the medical home: integrating health and related systems of care for children with special health care needs. *Pediatrics*, 116(5), pp. 1238-44.

Australian Health Ministers’ Advisory Council, 2011. *National Framework for Universal Child and Family Health Services,* Canberra: Australian Health Ministers’ Advisory Council.

Axford, N. et al., 2015. *Rapid Review to Update Evidence for the Healthy Child Programme 0–5*, London: Public Health England.

Azzi-Lessing, L., 2011. Home visitation programs: Critical Issues and Future Directions.. Early Childhood Research Quarterly, 26(4), p. 387–398.

Boivin, M. and Hertzman, C. (Eds.) and the Royal Society of Canada – Canadian Academy of Health Sciences Expert Panel (with Barr, R.G., Boyce, W.T., Fleming, A., MacMillan, H., Odgers, C., Sokolowski, M.B. and Trocmé, N.), 2012. *Early Childhood Development: Adverse experiences and developmental health*. [Online] Available at: http://www.newcahswebsite. com/wp-content/uploads/2012/11/ECD-Report- nov-15-2012.pdf

Boivin, M. a. H. C. (., 2012. *Early Childhood Development: Adverse experiences and developmental health*, Ottowa: Canadian Academy of Health Sciences and the Royal Society of Canada.

Case Management Society of America, 2014. *What is a Case Manager?*. [Online] Available at: http:// www.cmsa.org/Home/CMSA/WhatisaCaseManager/ tabid/224/Default.aspx [Accessed 11 August 2017].

Chaffin, M. & Friedrich, B., 2004. Evidence-based treatments in child abuse and neglect. *Children and Youth Services Review*, 26(11), pp. 1097 - 1113.

Child and Family Health Nurses Association (NSW), 2003. *Guidelines for clinical supervision for child and family health nurses : as child and family health nurses nurture families in parenting, nurses also need to be nurtured*. North Ryde: Child and Family Health Nurses Association (NSW) Inc.

Cross, T., Bazron, B., Dennis, K. & Issacs, M., 1989.

*Towards a culturally competent system of care Volume 1*, Washington: Georgetown University Child Development Centre, CASSP Technical Assistance Center.

Department of Education and Training, 2018. *Clinical Supervision Guidelines - Enhanced Maternal and Child Health Program*, Melbourne: Department of Education and Training.

Department of Education and Early Childhood Development, 2009. *Maternal and Child Health Program Standards*, Melbourne: Department of Education and Early Childhood Development.

Department of Education and Early Childhood Development, 2011. *Maternal and Childhealth Service Guidelines*, Melbourne: Department of Education and Early Childhood Development.

Department of Education and Training, 2016.

*Victorian Early Years Learning and Development Framework*, Melbourne: Department of Education and Training.

Hertzman, C., 2017. *Framework for the social determinants of early child development*. [Online] Available at: http://www.child-encyclopedia.com/ sites/default/files/textes-experts/en/669/framework- for-the-social-determinants-of-early-child- development.pdf

Human Early Learning Partnership, 2011. *Proportionate Universality. HELP Policy Brief*, Vancouver: Human Early Learning Partnership, University of British Columbia.

Kemp, L. et al., 2011. Child and family outcomes of a long-term nurse home visitation programme: a randomised controlled trial. *Archives of Disease in Childhood*, 96(6), pp. 533 - 540.

Kiplinger, V. L. & Harper Browne, C., 2014. *Parents’ Assessment of Protective Factors: User’s guide and technical report*, Washington: Center for the Study of Social Policy.

Sawyer, A. et al., 2014. *Five by Five: A Supporting Systems Framework for Child Health and Development*, Adelaide: Better Start Child Health and Development Research Group, School of Population Health, University of Adelaide.

Shonkoff, J. P., 2012. Leveraging the biology of adversity to address the roots of disparities in health and development.. *Proceedings of the National Academy of Sciences USA*, 109(Suppl. 2), pp. 17302-7.

The Marmot Review, 2010. *Fair Society, Healthy Lives: Strategic review of health inequalities in England post-2010*, London: Global Health Equity Group, Department of Epidemiology and Public Health, University College London.

The Victorian Equal Opportunity and Human Rights Commission, 2006. *The Victorian Charter of Human Rights and Responsibilities Act*, Melbourne: State of Victoria.

Victorian Association of Maternal and Child Health Nurses ANF (Vic Branch), 2010. *Competency Standards for the Maternal and Child Helath Nurse in Victoria*, Melbourne: Victorian Association of Maternal and Child Health Nurses ANF (Vic Branch).

Victorian Association of Maternal and Child Health Nurses, ANMF (Vic Branch), 2016. *Documentation Standards for Maternal and Child Health Nurses in Victoria*, Melbourne: Victorian Association of Maternal and Child Health Nurses, ANMF (Vic Branch).

World Health Organisation, 2008. *Integrated Health Services - What and Why?* Technical Brief No. 1, 2008, s.l.: WHO.

APPENDICES

# APPENDIX 1 / EMCH REFERRAL FORM

|  |
| --- |
| *Reference number e.g. CDIS etc.* |
|  |

*Office use only*

## EMCH referral form

Referral date: .......................................................................................................................................................

Referred by (MCH service or Agency): ..............................................................................................................

Referred by (Name, Position, contact number): ..................................................................................................

..............................................................................................................................................................................

**Urgent referral: Yes / No (please circle)**

#### Child and family details

|  |  |  |  |
| --- | --- | --- | --- |
| Details of child / children | | | |
| Name |  | **Name** |  |
| DOB |  | **DOB** |  |
| Age |  | **Age** |  |
| Last KAS |  | **Last KAS** |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Details of child / children | | | |
| Name |  | **Name** |  |
| DOB |  | **DOB** |  |
| Age |  | **Age** |  |
| Last KAS |  | **Last KAS** |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Family details | | | |
| Primary care giver | | **Secondary care giver** | |
| Name |  | **Name** |  |
| Date of Birth |  | **Date of Birth** |  |
| Address |  | **Address** |  |
| Phone number |  | **Phone number** |  |
| Cultural background |  | **Cultural background** |  |
| Aboriginal or Torres Strait Islander Australian | Yes / No | **Aboriginal or Torres Strait Islander Australian** | Yes / No |
| Language |  | **Language** |  |
| Interpreter required (specify) | Yes / No | **Interpreter required (specify)** | Yes / No |
| Employment |  | **Employment** |  |
| Relationship to child |  | **Relationship to child** |  |
| Family GP details |  | | |
| Relationship of caregivers |  | | |

#### Custody / Court Orders

|  |  |
| --- | --- |
| Are there any court orders / custody arrangements for the child? If yes, please attach a copy. | Yes / No |

#### Home safety visit assessment

|  |  |
| --- | --- |
| A Home Safety Visit Assessment has been completed? If yes, please attach a copy. | Yes / Not completed |
| Are there any alerts? | Yes / No / Not completed |

#### Protective and need/ risk factors

|  |  |
| --- | --- |
| **Protective factors present**  Enablers that assist the infant/child to be safe and healthy and have their wellbeing, learning and development needs met (see Appendix on final page of this form) | **Need/risk factors present**  Disablers that impact the infant/child’s safety, health, wellbeing, learning and development and/ or stop their needs from being met (see Appendix on final page of this form) |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |

#### Expectation of EMCH program support

The EMCH program works with children and families to address an increased need due to factors currently impacting on child development, parenting capacity, or family wellbeing. Please provide a short summary or dot points detailing the expectation of support from the EMCH program.

|  |
| --- |
|  |

#### What is parent/carer’s understanding of need for extra support?

|  |
| --- |
| Family has consented to be referred to EMCH: Yes / No |

#### Other relevant information. Include details of the supports that are currently in place.

|  |
| --- |
|  |

#### Other agencies involved

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Agency | Family member referred | Date referred | Date | Contact details (contact person, phone, email) |
| **Child Protection** |  |  |  |  |
| Child FIRST |  |  |  |  |
| Child Protection |  |  |  |  |
| DHHS |  |  |  |  |
| PASDS |  |  |  |  |
| **Family Violence** |  |  |  |  |
| Support and Safety hub |  |  |  |  |
| Family Violence Service  **Health** |  |  |  |  |
| GP or Paediatrician |  |  |  |  |
| Psych Service (CAT) |  |  |  |  |
| Mental Health Service |  |  |  |  |
| Disability Services |  |  |  |  |
| **Housing Support** |  |  |  |  |
| Housing Services |  |  |  |  |
| **Cultural** |  |  |  |  |
| Koori Maternity Service |  |  |  |  |
| VACCA |  |  |  |  |
| CALD Service |  |  |  |  |
| **Drug and Alcohol** |  |  |  |  |
| Drug and Alcohol Services |  |  |  |  |
| **Other** |  |  |  |  |

*Office use only – Intake nurse to complete*

#### Review by intake service

|  |  |
| --- | --- |
| Reviewed by: | |
| Name: |  |
| Position: |  |

|  |  |
| --- | --- |
| Review outcomes: | |
| Decision made: | Eligible for EMCH program / Not eligible for EMCH program |
| Reason/s for decision: |  |

Review date: ........................................................................................................................................................

Signature: ............................................................................................................................................................

## Appendix to referral form: Common protective and need/ risk factors

|  |  |
| --- | --- |
| Protective factors | Need/ Risk factors |
| Parenting capacity strong attachment to child  knowledge of parenting and child development  parenting self-efficacy  parenting capacity  parental resilience  strong reflective functioning Parent/family health and wellbeing parental self-esteem  family cohesion  family functioning  connection to culture  two-parent household  high level of education  employment Environmental factors positive social connection and support  access to health and social services  neighbourhood social capital  adequate housing  socio-economically advantaged neighbourhood | Child health, wellbeing, safety, learning and development premature infants and failure to thrive  complex feeding or sleep issues  children with poor social or emotional wellbeing (e.g. withdrawal, anxiety, behavioural issues, delayed communication)  children with a developmental delay or disability  children with chronic health conditions (often with multi-medical co-morbidities)  children with serious injury due to falls, accidents, assault, accidental poisoning and intentional self-harm  children affected by family violence  children expressing symptoms of trauma  child in Out of Home Care Parenting capacity parent is not able to keep the child in mind most of the time  multiple births  significant parent-child bonding issues  significant parent-child attachment issues  inadequate parenting skills (e.g. warmth/ nurturing, ability to provide home structure, communication)  lack of engagement with UMCH program Parent/family health, wellbeing and safety parent mental health issue (e.g. anxiety and/or depression)  parent with an intellectual or physical disability  parent with a chronic illness/unexpected illness  parent with drug, substance or alcohol issues  history of trauma having a current family impact  financial distress, low income or partner unemployed  parent affected by family violence  families currently known to Child Protection or currently have a child in kinship or out of home care (OoHC)  recent relationship breakdown/separation  contested custody/access to infant/child Environmental factors social or geographical isolation  housing issues or homelessness  Aboriginal families who are not linked into, and/or require additional support to the Universal MCH program |

# APPENDIX 2 / EMCH PROGRAM LOGIC

A close up of a piece of paper

Description generated with high confidence

# APPENDIX 3 / OVERVIEW OF ADDITIONAL ASSESSMENT TOOLS

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Assessment tool | Purpose | Focus | Description | Further information |
| Parents’ Evaluation of Development Status (PEDS) | Detection of developmental and behavioural problems | Child health, wellbeing, learning and development | Parents’ Evaluation of Developmental Status (PEDS) is an evidence-based method for detecting and addressing developmental and behavioural problems in children aged from birth to seven years and 11 months. PEDS is a simple, 10-item questionnaire that is completed by the parent. | https://www.rch.org. au/ccch/resources\_ and\_publications/ Monitoring\_Child\_ Development/ |
| Key Ages and Stages | Population health screening, early identification of health, wellbeing, learning and developmental issues | Child health, wellbeing, learning and development | The ten Key Ages and Stages consultations take place at prescribed intervals from birth to 3.5 years of age. At each of these consultations parents can discuss concerns, talk about their parenting experiences and any ways to improve their child's health, growth and development. | http://www.education. vic.gov.au/childhood/ professionals/health/ Pages/mchpolicy. aspx |
| Family Violence Common Risk Assessment Framework (CRAF) | To inform family violence risk assessment and assist with safety planning | Family violence | The Family Violence Risk Assessment and Risk Management Framework (also known as the Common Risk Assessment Framework or CRAF5) is a key aspect of integrated family violence reforms. CRAF is a tool designed to help professionals and practitioners working in a range of fields to identify risk factors associated with family violence and respond appropriately to victims affected by family violence. | https://providers. dhhs.vic.gov.au/ family-violence-risk- assessment-and- risk-management- framework |
| Edinburgh Postnatal Depression Scale (EPDS) | To screen for maternal anxiety and/or depression | Maternal mental health | The Edinburgh Postnatal Depression Scale (EPDS) is a set of 10 screening questions that can indicate whether a parent has symptoms that are common in women with depression and anxiety during pregnancy and in the year following the birth of a child. This is not intended to provide a diagnosis – only trained health professionals should do this. | http://www. education.vic.gov. au/Documents/ childhood/ professionals/ profdev/ |
| Parenting capacity clinical observation | To assess parenting capacity | Parent-child interactions | Global observation of the parent/child dyad. Involves:   * close review of referrer’s observations * direct observation of parent/child interactions including visual engagement between parent and child * parental tone of voice when speaking to child(ren) * interest exhibited by parent when nurse is speaking about development of child and the milestones the child will progress through * parental questions asked regarding child * negative comments indicating inability to keep child in mind |  |
| Brigance Screen | To screen children’s developmental progress | Child development | The Brigance screen is used as a secondary screen for developmental surveillance. | http://www.hbe.com. au/series-brigance/ early-childhood/ screens.html |
| Brigance: Self- Help and Social- Emotional Scales | To measure children’s self- help and social- emotional skills | Child wellbeing / development | The Brigance: Self-Help and Social-Emotional Scales are used to measure self-help skills (e.g. eating, toileting and dressing) and social-emotional skills (e.g. playing with others) for children aged 2 years to 5 years 11 months.  Information is collected from the parent with the clinician scoring the report. Standardised scores, percentiles and age equivalent can be determined for the child. | http://www.hbe.com. au/brigance-self- help-and-social- emotional-scales- 2-years-5-years-11- months.html |
| Brigance Parent- Child Interaction Scale (BPCIS) | To identify strengths and weaknesses in parent-child interaction | Parent-child | The Brigance Parent-Child Interaction Scale (BPCIS) explores parent-child interaction, identifying positive and negative indications of interaction. | http://www. pedstest.com/ Portals/0/TheBook/ BPCISinEnglish.pdf  www.pedstest.com/ Portals/0/TheBook/ BPCISscoring.doc |
| Outcomes Star: | To support and measure change | Progress towards agreed outcomes | The Outcomes Star is an evidence-based holistic tool that supports and measures change when working with families and children. The tool is designed to support effective parenting.  The Star covers areas of parenting essential to enabling children to thrive: physical health, parental wellbeing, meeting emotional needs, keeping your children safe, social networks, education and learning, boundaries and behaviour, family routine, home and money, and progress to work. | http://www. outcomesstar.org.uk/ using-the-star/find- your-star/families- and-children/ |

# APPENDIX 4 / CHILD AND FAMILY ACTION PLAN TEMPLATE

“Parent/carer name” and “Child name”

## Child and Family Action Plan

This Child and Family Action Plan includes sections for: **A) Goal identification; B) Goal review; and C) Transition of care**. Information appearing in grey text is to assist in creating a Child and Family Action Plan. This text helps you to determine what you should include in each section.

### A) Goal identification

Parents/carers and families work with MCH staff to set a small number of changes/goals for the program in one or more of the following areas: child development, parent-child interaction, parent/carer/family and environmental factors. These goal areas are aligned to the EMCH Program Outcomes and Protective and Need/ Risk factors.

The table below shows the specific change to be made and role of MCH staff (column 2) and Family role (column 3) in working towards these goals. Families and MCH staff work together to determine when the EMCH program will be complete, according to each goal (column 4).

|  |  |  |  |
| --- | --- | --- | --- |
| 1. Goal area | 2. What do you want to change and how can the Maternal and Child Health service help? | 3. What does “insert parent/carer name” need to do? | 4. The role of the EMCH program will be complete when... |
| Child health, wellbeing, safety, learning and development | What are the short and medium term changes to be made?  What does the MCH nurse need to do? | What does the family agree to do?  To talk about....  To participate in....  To practise.... |  |
| What are the short and medium term changes to be made?  What does the MCH nurse need to do? | What does the family agree to do?  To talk about....  To participate in....  To practise .... |  |
| Parenting capacity | What are the short and medium term changes to be made?  What does the MCH nurse need to do? | What does the family agree to do?  To talk about....  To participate in....  To practise .... |  |
| What are the short and medium term changes to be made?  What does the MCH nurse need to do? | What does the family agree to do?  To talk about....  To participate in....  To practise .... |  |
| Parent/family health, wellbeing and safety | What are the short and medium term changes to be made?  What does the MCH nurse need to do? | What does the family agree to do?  To talk about....  To participate in....  To practise .... |  |
| What are the short and medium term changes to be made?  What does the MCH nurse need to do? | What does the family agree to do?  To talk about....  To participate in....  To practise .... |  |
| Environmental factors | What are the short and medium term changes to be made?  What does the MCH nurse need to do? | What does the family agree to do?  To talk about....  To participate in....  To practise .... |  |
| What are the short and medium term changes to be made?  What does the MCH nurse need to do? | What does the family need to do?  To talk about....  To participate in....  To practise .... |  |

### B) Goal review

At EMCH appointments, families and staff check in to see progress against the goals. This is tracked in the table below.

|  |  |  |  |
| --- | --- | --- | --- |
| Goals | Goal review date 1 | Goal review date 2 | Final visit |
| “Add goal/s”  Add or delete rows as necessary | Date: Staff comment:  List whether goals have been: not met, partially met or fully met  Family comment: | Date: Staff comment:  Family comment: | Date: Staff comment:  Family comment: |
| “Add goal/s”  Add or delete rows as necessary | Date: Staff comment:  Family comment: | Date: Staff comment:  Family comment: | Date: Staff comment:  Family comment: |
| “Add goal/s”  Add or delete rows as necessary | Date: Staff comment:  Family comment: | Date: Staff comment:  Family comment: | Date: Staff comment:  Family comment: |

### C) Transition of care

In Section A (Goal identification), families and staff agreed when the program would be completed (according to each of the identified changes) –.

At this stage, please mark which of the following has been completed:

consultation with the family, and other professionals as appropriate, has been undertaken prior to transfer and at key transition points

necessary referrals have been undertaken and acknowledgement of the referral has been received

the family has been facilitated to access the UMCH program in the future, and has been provided with details of the MCH Line and MCH App and emergency contact numbers

the transition has been formalised in writing with completion of the CFAP and follow up actions clearly indicated to other providers or professionals as appropriate, and the CFAP is completed and signed off by the MCH nurse

goals and outcomes have been achieved. If not, please briefly describe reason: ........................................

..............................................................................................................................................................................

**Discharge review by service**

**Office use only**

|  |  |
| --- | --- |
| Review date: |  |
| Transition reviewed by: | |
| Name: |  |
| Position: |  |

# APPENDIX 5 / CHILD AND FAMILY OUTCOMES

The table below shows different areas of need that families may be experiencing (see Section 4 of this guideline) and the corresponding outcomes.

|  |  |  |
| --- | --- | --- |
|  | Need/ risk factors | EMCH intervention outcomes |
| Child heath, wellbeing, safety, learning and development | * Premature infants and failure to thrive * Complex feeding or sleep issues * Children with poor social or emotional wellbeing (e.g. withdrawal, anxiety, behavioural issues, delayed communication, symptoms of trauma) * Children with a developmental delay or disability * Children with chronic health conditions (often with multi-medical co-morbidities) * Children with serious injury due to falls, accidents, assault, accidental poisoning and intentional self-harm | * Earlier detection of health, wellbeing, learning and developmental issues * Improved physical health * Improved social, emotional, language and cognitive development * Better access to early childhood services |
| Parenting capacity | * Significant parent-child bonding issues * Inadequate parenting skills (e.g. warmth/ nurturing, ability to provide home structure, communication) | * Improved relationship between parent/ carer and child * Improved parental knowledge, skills and confidence * Improved home environment (and improved parental capacity to provide a positive home environment) |
| Parent/ family health, wellbeing and safety | * Parent is not able to keep the child in mind most of the time * Parent mental health issue (e.g. mild anxiety and/or depression) * Parent with an intellectual or physical disability * Parent with a chronic illness/ unexpected illness * Parent with mild drug, substance or alcohol issues * Financial distress, low income or partner unemployed * History of trauma having a current family impact * Parent affected by family violence * Families currently known to Child Protection or currently have a child in kinship or Out-of-Home care * Recent relationship breakdown/ separation * Contested custody/access to infant/ child * Social or geographical isolation * Housing issues or homelessness | * Parent able to keep the child in mind * Improved parental health and wellbeing * Family environment free from conflict or violence * Better access to adult services and supports * Reduction in social isolation and stronger linkages to community |
| Environmental factors | Unsafe sleep and home environment Lack of home learning environment | Assessment and interventions to improve sleep, home and learning environments. |

# APPENDIX 6 / EMCH PROGRAM ON A PAGE

|  |  |
| --- | --- |
| Feature | Description |
| Home visiting | The Enhanced Maternal and Child Health (EMCH) program offers a free, nursing-led, child- focused service to families who are experiencing a period of increased need from pregnancy to the child’s third birthday. Appointments may take place in-home, within an MCH setting or in another location in the community |
| Tiered service model | The program is a continuum of the Universal MCH (UMCH) program, and progressively offers additional support and short term actions/interventions to respond to vulnerable families’ needs, where those needs cannot be met by the UMCH program alone. The EMCH program is offered to selected families in addition to the core set of services provided to all families by the UMCH Service  Families may be transferred back to the UMCH program if they no longer are experiencing a period of increased need |
| Entry criteria | Child aged between birth and 3 years of age  Prioritisation assessment by the responsible LGA must identify two or more need / risk factors, particularly in the absence of protective factors  There must be a clear role for the EMCH program to provide actions and/or interventions to meet the child’s needs |
| Exclusion criteria | Children over three years of age  Children whose families are receiving actions/interventions from another intensive support program and/or the UMCH program who do not require extra support from the EMCH program |
| Program capacity | 15% of Victorian population aged 0-3 years |
| Program entry | Pathways in: referral by Universal MCH Nurses, the MCH Line, EMCH programs in other LGAs, General Practitioners, maternity services and other allied services  Pathways out: transition back to UMCH program, EMCH programs in other LGAs, re-referral to EMCH, referral to more intensive parenting support programs with MCH program support |
| Program dose | Program dose is dependent on child/family’s level of need and risk and program capability.  Children and families can access up to 20 hours of support per referral (additional to the UMCH program), with provisions made to allow children and families in rural and remote areas to receive an additional 2.67 hours |
| Types of support families can access | A wide variety of actions/interventions to improve child and infant health, wellbeing, learning and development. Actions/Interventions are strength-based and seek to build parenting capacity |
| Culturally responsive and inclusive practice | The EMCH program works in partnership with a wide range of families and seeks to provide culturally-sensitive and responsive care. The important role of fathers and male caregivers is acknowledged by the program. The program recognises the diversity that exists within contemporary families and aims to provide a respectful environment to support everyone who may be caring for children in Victoria |

# APPENDIX 7 / CASE SCENARIOS - PATHWAYS THROUGH THE EMCH PROGRAM

|  |  |
| --- | --- |
| Short-term, intensive 5 hour EMCH program case scenario | |
| Need/risk factors identified at intake | 22 year old mother with 6 month old child born with a congenital abnormality returning home from long term hospitalisation |
| Intervention | EMCH to build links with other services and transition to UMCH program to enable continuity of care  Assistance to improve social connectedness |
| Referral | Community Allied Health Services, National Disability Insurance Scheme (NDIS), Community Based Transport, Supported Playgroup, EMCH Family Support Program and UMCH |
| Reassessment | Observe parental engagement with services; assess maternal confidence when engaging with early childhood services. |
| Outcomes | Better access to early childhood services  Reduction in social isolation and stronger linkages to community  Transition to UMCH. |

|  |  |
| --- | --- |
| Longer-term, 20 hour EMCH program case scenario | |
| Need/risk factors identified at intake | 20 year old Aboriginal mother with a 2 year and 11 month old child. Father is no longer in the home and location is unknown. Father non-Aboriginal. Current involvement with Child Protection due to family violence incident impacting on safety, parenting and child development |
| Referral | Family violence service or Support and Safety Hub, counselling services for mother, Headspace for children, Housing Support Service, EMCH Family Support Program, Early Start Kindergarten, Special Child Care Benefit |
| Intervention | EMCH home visits to provide family violence risk assessment and risk management, including safety planning  Provision of a space for both the parent and child to feel safe, contained and heard Assistance with building self-management  Monitoring of child development and KAS checks  EMCH Family Support Program visits to build parenting capacity to keep the child in mind at all times |
| Reassessment | Reassess using CRAF, Brigance; BPCIS, safety plan, global observation of the parent/ child dyad and Outcomes Star tool |
| Outcomes | Family environment free from conflict or violence  Parent able to keep the child in mind  Improved parental health and wellbeing, Improved parental knowledge, skills and confidence  Improved parental capacity to provide a positive and safe home environment  Referred to UMCH |
| Need/risk factors identified at intake | 30 year old first time mother with poor family support and history of depression. She has a four month old baby with breastfeeding, sleep and settling issues. Mother EPNDS = 24 with thoughts of self-harm (Q10). Baby is continuously feeding and mother is exhausted but unable to sleep. Mother has a poor understanding of infant behaviour and displays decreased attachment to her infant. Mother states she has relationship and financial problems. Partner is not able to understand and feels overwhelmingly alone. |
| Referral | General Practitioner, Mother and Baby Unit, Psychologist and Psychiatrist, Circle of Security, First Time Parents Group, Music Group and Supported Playgroup. |
| Intervention | EMCH home visits to provide support re breastfeeding, sleep and settling of a four month old infant. Full assessment attended and management plan instigated. Support and guidance to partner to understand events and plan.  Home visits until mother is admitted to Mother and Baby Unit (3 week admission). Monitoring of infant feeding, sleep, growth and development.  Reengagement with EMCH on discharge from Mother and Baby Unit to provide ongoing support and referrals to community groups and financial advice. |
| Reassessment | Reassessment of mother’s wellbeing. Global observation of the parent/child dyad. Engagement with referral services and community supports. |
| Outcomes | Mother demonstrates low EPDS, increased confidence and ability to cope and demonstrates improved attachment to her infant. Relationship with partner improved. Maintaining connections with psychologist and psychiatrist. Feeding and sleep issues resolving. Improved parental knowledge, skills and confidence Referred back to UMCH. |

|  |  |
| --- | --- |
| Longer-term EMCH program case scenario with ongoing needs beyond 20 hours of support | |
| Need/risk factors identified at intake | 24 year old mother with 10 month old child. Child Protection involvement, 10 month old suffered non accidental serious injury. Mother has history of substance abuse (cannabis). Mother has limited parenting knowledge, skills and confidence. Mother and child must live with family supervision. |
| Intervention | EMCH home visits for personal and parenting support and monitoring of health and development of 10 month old child. Close liaison with paediatrician and tertiary hospital paediatric services.  PEDS and Brigance at commencement of service for child. Outcome Star tool.  Family violence risk assessment and risk management, including safety planning.  Team around the Child (TAC) meetings with Child Protection on a monthly basis. |
| Referral | Referral to community based allied health services, NDIS, Drug and Alcohol Service, Mental Health Service, Family Violence Service, Supported Playgroup, Intensive support services e.g. Parenting Residential Program, Cradle to Kinder. |
| Reassessment | Family have reached EMCH program limit of 20 hours (metro) or 22.67 hours (rural).  Re-assesses parenting knowledge, skills, and confidence: Outcomes Star tool; Brigance; Brigance Parent-Child Interaction Scale (BPCIS).  Family violence: family violence risk assessment tool. Child’s health and development: PEDS and Brigance. |
| Outcomes | Still ongoing need/risk factors despite additional intensive support services. Re-referral to EMCH |

With thanks to Dr. Jane Caldwell, Enhanced MCH Nurse, Wodonga City Council and Ms. Bernice Boland, Enhanced MCH Nurse, Yarra Ranges and Chair, Victorian Association of Maternal and Child Health Nurses for providing the case scenarios.

1. Protective factors are the “conditions or attributes of individuals, families, communities, or the larger society that both mitigate need/ risk factors and actively enhance wellbeing” (Kiplinger & Harper Browne, 2014). [↑](#footnote-ref-1)
2. Care coordination is a process that facilitates the linkage of children and their families with appropriate services and resources in a coordinated effort to achieve good health (American Academy of Pediatrics, 2005). [↑](#footnote-ref-2)
3. The CRAF is being redeveloped in response to findings from the Royal Commission into family Violence. A revised Framework including practice guidance will be available from September 2018. For more information on the CRAF, see: http://www.thelookout.org.au/training-events/craf [↑](#footnote-ref-3)
4. The CRAF provides guidance on risk assessment and risk management, including safety planning. See: http://www.thelookout.org.au/training-events/craf [↑](#footnote-ref-4)