NSW HEALTH

FAMILIES NSW SUPPORTING FAMILIES EARLY PACKAGE

Maternal and Child Health Primary Health Care Policy

families NSW
supporting families to raise children

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NSW Health / *Families NSW* Supporting Families Early package

The *NSW Health / Families NSW Supporting Families Early package* brings together initiatives from NSW Health's Primary Health and Community Partnerships Branch and Mental Health and Drug & Alcohol Office. It promotes an integrated approach to the care of women, their infants and families in the perinatal period. Three companion documents form the *Families NSW Supporting Families Early* package.

Supporting families early maternal and child health primary health care policy

The first part of the package is the *Supporting Families Early Maternal and Child Health Primary Health Care Policy.* It identifies a model for the provision of universal assessment, coordinated care, and home visiting, by NSW Health's maternity and community health services, for all parents expecting or caring for a new baby. This model is described within the context of current maternity and child and family health service systems.

SAFE START strategic policy

The second part of the package, the *SAFE START Strategic Policy*, provides direction for the provision of coordinated and planned mental health responses to primary health workers involved in the identification of families at risk of developing, or with, mental health problems, during the critical perinatal period. It outlines the core structure and components required by NSW mental health services to develop and implement the SAFE START model.

SAFE START guidelines: improving mental health outcomes for parents and infants

The third part of the package, the *SAFE START Guidelines: Improving Mental Health Outcomes for Parents and Infants*, outlines the rationale for psychosocial assessment, risk prevention and early intervention. It proposes a spectrum of coordinated clinical responses to the various configurations of risk factors and mental health issues identified through psychosocial assessment and depression screening in the perinatal period. It also outlines the importance of the broader specialist role of mental health services in addressing the needs of parents at risk of developing, or with, mental health problems.

Message from the Director-General

Pregnancy and becoming a parent is usually an exciting time, full of anticipation, joy and hope. It can also be a time of uncertainty or anxiety for parents and families. To support families fully during what can be a stressful period, it is important to address the range of physical, psychological and social issues affecting the infant and family. This range of issues and parents' understanding of the tasks and roles of parenthood are recognised as significant influences on the capacity of parents to provide a positive environment that encourages optimum development of the infant.

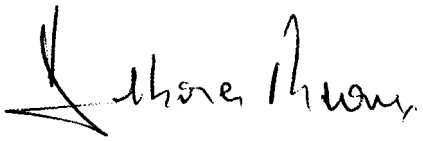
Providing support for infants, children and parents, beginning in pregnancy, including their physical and mental health, is a key priority of the NSW Government. This is clearly articulated in the NSW Action Plan for Early Childhood and Child Care which is part of the Council of Australian Government's National Reform Agenda, the NSW State Plan, and the NSW State Health Plan.

The NSW whole-of-government *Families NSW* initiative is an overarching strategy to enhance the health and wellbeing of children up to 8 years and their families. One way it does this is by improving the way agencies work together, so that parents get the services, support and information they need.

NSW Health is a key partner with other human service agencies in developing prevention and early intervention services that assist parents and communities to sustain children's health and wellbeing in the long term. Health services are the universal point of contact for these families entering the *Families NSW* service system.

NSW Health's vision is for a comprehensive and integrated health response for families. This response will encompass all stages of pregnancy and early childhood development and link hospital, community and specialist health services. The aim is to assist families in the transition to parenthood, build on their strengths, and ameliorate any identified risks that can contribute to the development of problems in infants and later on in life.

The *NSW Health / Families NSW Supporting Families Early* package integrates three NSW Health initiatives that are underpinned by a common understanding of the challenges that parenthood can involve, the importance of the early years of a child's development, and the benefits of appropriate early intervention programs. The initiatives contained within *Supporting Families Early* are an important contribution to the provision of services that enhance the health of parents and their infants, help to protect against child abuse and neglect, and enhance the wellbeing of the whole community.



Professor Debora Picone AM
Director-General
NSW Health

Acknowledgements

The *NSW Health / Families NSW Supporting Families Early, Maternal and Child Health Primary Health Care Policy* is the culmination of many people's work over many years. Area Health Services (AHSs) have developed over time a range of local programs, both universal and targeted, to support families with young children, beginning in pregnancy. The development of this Policy has drawn on the expertise of maternity and child and family health services across NSW and the experience of AHSs that are implementing health home visiting as part of the *Families NSW* strategy.

The staff of the Mental Health and Drug and Alcohol Office, NSW Health, and the Centre for Health Equity, Training, Research and Evaluation (CHETRE), collaborated in the development of this policy.

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SECTION 1

Introduction

All families need support to raise their children and some families need additional support for their particular needs. Providing this support effectively and promptly can help prevent problems developing and becoming entrenched.

The *NSW Health / Families NSW Supporting Families Early* package integrates three NSW Health initiatives that are underpinned by a common understanding of the challenges that parenthood can involve, the importance of the early years of a child's development and the benefits of appropriate early intervention programs. The three initiatives are:

1. *Supporting Families Early Maternal and Child Health Primary Health Care Policy*
2. *SAFE START Strategic Policy*
3. *SAFE START Guidelines: Improving Mental Health Outcomes for Parents and Infants*

The initiatives are an important contribution to the provision of services that enhance the health of parents and their infants, help to protect against child abuse and neglect, and enhance the wellbeing of the whole community.

The Primary Health and Community Partnerships Branch has developed the *Supporting Families Early Maternal and Child Health Primary Health Care Policy*. The Mental Health and Drug and Alcohol Office has developed the *SAFE START Strategic Policy* and the *SAFE START Guidelines: Improving Mental Health Outcomes for Parents and Infants*.

The *Supporting Families Early Maternal and Child Health Primary Health Care Policy* includes mandatory as well as recommended practices.

Section 2. Policy statement

The Policy Statement, clarifies what is expected both from the NSW Department of Health and Area Health Services (AHSs).

The policy is underpinned by a national and state commitment to early intervention and prevention. In particular the policy addresses targets in the following:

- Council of Australian Governments National Reform Agenda, NSW Action Plan for Early Childhood and Child Care.
- State plan priorities:
  - F4 embedding prevention and early intervention into government service delivery
  - F6 increased proportion of children with skills for life and learning at school entry
  - F7 reduced rates of child abuse and neglect.
- State Health Plan Strategic Direction 1: Make prevention everybody's business
- State Health Plan Strategic Direction 3: Strengthen primary health and continuing care in the community.

The Policy is underpinned by the *Families NSW* strategy, particularly the equity and clinical practice principles that include working in partnership with the family and facilitating the development of the parent-infant relationship.

Section 3. The primary health care model of perinatal and infant care

This section details the primary health care model of perinatal and infant care and outlines the pathways for primary health staff to determine vulnerability and the level of service delivery/care required to provide for ongoing coordinated care.

Section 4. Health home visiting

The requirement of health home visiting, which includes Universal Health Home Visiting (UHHV) and Sustained Health Home Visiting (SHHV), is explained in this section.

Section 5. Implementation requirements

The final section provides information on what is required to implement the Policy. This section includes information on a number of implementation issues such as planning, staffing, training, clinical supervision, confidentiality and evaluation.

SECTION 2

Policy statement

As NSW Health provides universal services to families who are expecting or caring for a baby, it is well placed to be the entry point for families into the broader *Families NSW* service network. The purpose of the *NSW Health / Families NSW Supporting Families Early Maternal and Child Health Primary Health Care Policy* is to ensure that NSW Health implements a consistent statewide approach to the provision of primary health care and health home visiting to parents expecting or caring for a new baby. NSW Health's maternity and community health services are the primary providers of these services, although the policy applies more broadly.

The policy is applicable to:

- Maternity services
- Child and family health services
- Early childhood health services
- Paediatric allied health services
- Paediatric inpatient services
- Emergency departments
- Family care centres
- Residential family care centres
- Child protection services
- Aboriginal health services
- Multicultural health services
- Mental health services
- Drug & alcohol services
- Youth health services
- Women's health services.

Primary health care pathways for integrated perinatal and infant care

The primary health model of care in the perinatal period consists of the following elements:

1. comprehensive primary health care assessment
2. determination of vulnerabilities and strengths
3. team management approach to case management and care planning
4. determination of level of care required
5. review and coordinated follow-on care.

This is supported by, and delivered in partnership with, other health staff that provide care to infants and their families through a team approach. The integrated approach to perinatal and infant care aims to achieve the following key results:

1. improved child health and wellbeing
2. enhanced family and social functioning
3. provision of services that meet the needs of children and families
4. improved continuity of care.

Health home visiting

Health home visiting is not delivered in isolation but forms part of the continuum of care and network of services for families with young children, beginning in pregnancy. Comprehensive assessment and coordinated care provide the platform for health home visiting. There are a number of models of health home visiting. It is mandatory for AHSs to provide Universal Health Home Visiting (UHHV). This is the offer and the provision of a home visit by a child and family health nurse to families with a new baby within two weeks of the birth of the baby.

NSW Health provides some isolated targeted home visiting programs to support women who are pregnant or caring for a new baby. Various staff, including midwives, nurses and social workers currently offer targeted home visiting programs. As part of a comprehensive approach to service delivery, families that require additional support may be offered Sustained Health Home Visiting (SHHV). SHHV is a structured program of health home visiting over a sustained period of time, beginning in pregnancy and continuing until the infant is two years old. If implemented in the AHS, SHHV is to follow the model that is described in section 4.4 of the Policy.

The NSW Department of Health and AHSs have responsibility to ensure that primary health care and health home visiting is effectively implemented in the community.

Areas of responsibility

Following are the areas of responsibility for the NSW Department of Health and AHSs under this Policy.

Table 1. Areas of responsibility

NSW Department of Health	Area Health Service
Organisational support for implementation	
■ Oversee the statewide implementation of the policy ■ Review the impact of the policy and respond to any recommendations that arise.	■ Oversee policy implementation and provision of Area Health Service leadership and direction in the provision of primary health care and health home visiting to parents expecting or caring for a new baby by maternity and community health services (refer to Mandatory Requirements). ■ Nominate a Senior Executive Sponsor with responsibility for *Families NSW* and policy implementation of Supporting Families Early.
Funding, and data collection	
■ Support, manage and monitor: – *Families NSW* funding to Area Health Services – Area Health Service data collection for *Families NSW*. ■ Ensure *Families NSW* data requirements are considered in the design and implementation of centrally developed data collection systems.	■ Refer to mandatory requirements (see over). ■ Ensure that data collection systems have the capacity to collect and analyse *Families NSW* data so that staff can collect data easily and on time. ■ Ensure that the *Families NSW* data collected is in accordance with Departmental requirements.
Workforce development and support	
■ Support, manage and monitor statewide *Families NSW* projects auspiced by NSW Health to support the implementation of *Families NSW*. ■ Support continued research into best-practice models for maternity and child and family health services. ■ Monitor Area Health Service plans to enhance and support the maternity and child and family health workforce and improve continuity. ■ Collaborate with training organisations to ensure that training programs are available statewide. ■ Support Area Health Service *Families NSW* coordinators through the *Families NSW* Network. The Network provides: – an effective two way communication link between the Department and Area Health Services – advice on policy development and review – education on current issues relating to *Families NSW* programs.	■ Refer to mandatory requirements (see over).
Intersectoral collaboration with organisations outside the NSW Health system	
■ Participate in intergovernmental forums established to promote the effective implementation of the *Families NSW* strategy, for example, the *Families NSW* Senior Officers Group.	■ Ensure participation in regional forums/networks established to promote effective governance of the *Families NSW* initiative.
Monitoring and reporting of policy implementation	
■ Prepare statewide annual *Families NSW* reports for the NSW Department of Community Services.	■ Ensure compliance with the practices and procedures outlined in this policy and evaluate on a regular basis that this is occurring. ■ Prepare an annual report for submission to the NSW Department of Health.

Mandatory requirements

Following are the mandatory requirements of the Policy.

The primary health care model of perinatal and infant care

- Ensure there is a comprehensive assessment process in place, which is consistent with the SAFE START (*formerly the Integrated Perinatal and infant Care – IPC*) model, in both maternity services and early childhood health services.
- Determine risk factors and vulnerability using a team-management approach to case discussion and care planning.
- Ensure that the continuity-of-care model is implemented in accordance with the Policy and that effective communication systems from maternity services to early childhood health services are established.

Reference: Policy Section 3

Health home visiting

- Implement UHHV. Ensure every family in NSW is offered a home visit by a child and family health nurse within two weeks of birth.
- Implementation of SHHV, when provided in AHSs, is to comply with the Policy. Note SHHV is not mandatory.

Reference: Policy Section 4

Implementation

Planning

Planning and coordinating health services that work with children, parents and families is the first step in effective implementation of primary health and home visiting services for families expecting a new baby or caring for young children. Families and communities are to be involved in these planning processes.

Staffing

Each AHS is to ensure that there are sufficient staffing levels to provide UHHV for the Area's population and characteristics.

Training

It is the responsibility of each AHS to ensure that staff who deliver child and family health services have appropriate qualifications, skills and training, including Family Partnership Training and SAFE START psychosocial assessment training.

Clinical supervision

Each AHS is to ensure that staff receive clinical supervision on a regular basis.

Service systems to support clinical practice

Universal child and family health services are to be underpinned by support from a Tier 2 multidisciplinary team that has four functions:

- participation in multidisciplinary case discussion to determine level of care
- consultation, support and education for Tier 1 primary workers
- direct service provision to families as required in collaboration with Tier 1 staff
- facilitation of referral to Tier 3 and Tier 4 services when required.

[Tier 2 includes a combination of direct service provision and consultation, support and training to Tier 1, delivered by staff with more specialised skills. Definitions of Tiers 1–4 can be found at Policy Section 5.5].

Service networks

Each AHS is to develop a directory of services and referral protocols both within NSW Health and with other service network partners, to facilitate optimal transition of care between services for families.

Occupational health and safety

Each AHS is to establish protocols and procedures that address the occupational health and safety considerations discussed in this policy, when implementing health home visiting.

Confidentiality

The sharing and transfer of information is to be conducted with regard to Information Privacy provisions. Refer to the NSW Health Policy Directive PD2005_593.

Resource requirements

The implementation of a home visiting service requires staff to be mobile and therefore they are to have access to the following equipment:

- motor vehicle
- mobile phone
- lockable briefcase
- clinical equipment.

Access to computers for data collection and to assist in clinical practice is required.

Funding

Each AHS is to ensure that adequate funding is provided for implementation of primary health care and health home visiting services for families expecting a baby or caring for young children.

Evaluation

- Each AHS is required to contribute to statewide and NSW Health evaluations of the *Families NSW* strategy.
- Compliance with the practices and procedures outlined in this policy is to be evaluated by each AHS on a regular basis.

Reporting

- Each AHS is to provide an annual report to the NSW Department of Health.
- Each AHS is to provide data on UHHV performance as requested by NSW Department of Health.

Reference: Policy Section 5.

SECTION 3

The primary health care model of perinatal and infant care

Within the *NSW Health / Families NSW Supporting Families Early* strategy, the importance of psychosocial assessment and integrated care in order to improve outcomes for women, their infants and families, is clearly defined. This section outlines the model for providing primary health care for families expecting or caring for a baby. It is consistent with the Mental Health and Drug and Alcohol Office's SAFE START model.

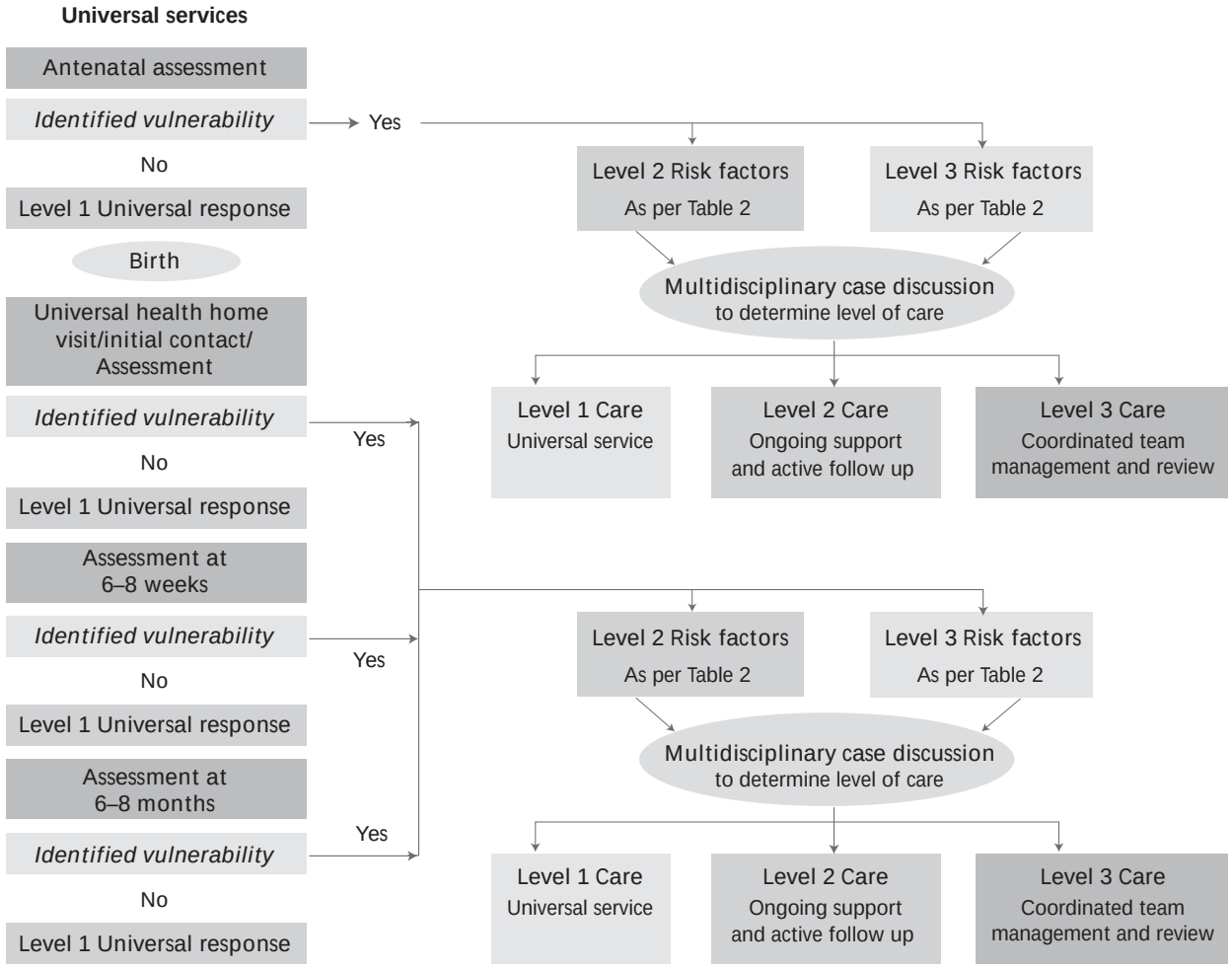
Primary health care pathways for SAFE START

The primary health model of care in the perinatal period consists of the following elements:

1. comprehensive primary health care assessments
2. determination of vulnerability and strengths
3. team management approach to case management and care planning
4. determination of the level of care required
5. review and coordinated follow-on care.

Figure 1 outlines this model and the pathways for primary health staff to determine vulnerability, the level of service delivery/care required, and to provide for ongoing coordinated care. This is supported by, and delivered in partnership with, other health staff who provide care to infants and their families within a team approach.

Figure 1. Primary care pathways for SAFE START



3.1 Comprehensive primary health care assessment

The aim of assessing all women/families during the antenatal and postnatal periods is to identify and provide care to those parents and their infants who are most at risk for adverse physical, social and mental health outcomes.

The assessment process should take into consideration that:

- the person experiencing the issue has the right to define the issue and identify his or her own needs
- all people have strengths and are generally capable of determining their own needs, finding their own answers and solving their own problems
- every person is shaped by his or her unique history and the context in which he or she lives
- families should be involved actively in the process and in decisions about their care.

Refer to Appendix 2 for principles underlying the policy.

3.1.1 The timing of assessments

A comprehensive primary health care assessment is to be conducted at the following times during pregnancy and the first 12 months postpartum:

1. Antenatally – at the first point of contact with NSW Health during pregnancy. This will occur at the first presentation for antenatal care or as early as possible in the antenatal period before 20 weeks of pregnancy. This will include the administration of an Edinburgh Depression Scale.
2. Postnatally – at the first health home visit services. The antenatal comprehensive primary care assessment will be reviewed, or where none has been previously attended, a comprehensive primary health care assessment will be conducted.
3. Six to eight week check – conducted by the child and family health service. The previous assessments will be reviewed and any new or emerging issues identified. If no previous assessment has been undertaken, a comprehensive primary health care assessment will be conducted. The Edinburgh Postnatal Depression Scale is to be administered at this visit or earlier in the postnatal care where there are clinical indications or concern that the family may not re-present at the six to eight week check.
4. It is recommended that a further assessment be conducted at six to eight months postnatally as part of the schedule of visits to the early childhood health service when the child health assessments recommended in the child Personal Health Record (blue book) are completed.

3.1.2 Process

The assessment is to be conducted in a non-intrusive manner to encourage the family to engage with the midwife/nurse and the health service. The woman and her partner (if present) are to be given information about:

- the assessment that will be conducted – a comprehensive assessment of physical, emotional, psychological and social factors
- the purpose of the assessment – to identify the individual care needs for each family
- confidentiality issues – the limits of confidentiality and advice as to who in the health service will have access to the information from the assessment (for information privacy issues – Refer to Section 5.8).

Rapport should be established so as to engage the mother prior to asking sensitive questions. The interview is to only be conducted when privacy can be assured. Questions that are sensitive for the mother, such as those asked about domestic violence and questions about past pregnancies/ terminations, must be asked with the mother alone. In circumstances where a child is present, the questions should be asked only if the child is aged under three years. It is recommended that sensitive questions be asked at the beginning of the interview and then the family can be invited into the interview with the nurse and mother. It is suggested that the requirement to see the mother alone initially be included in the letter confirming the antenatal booking, to provide an expectation that this will happen. Interviews need to be conducted in a manner that facilitates the parents identifying issues and concerns, and participating in making choices about the type and level of care and support they require.

If the parent does not speak or understand English, the use of an interpreter will be necessary. Services are to ensure that they have the capacity to identify those parents who speak little or no English and provide appropriate access to interpreters.

3.1.3 Scope of the assessment

The assessment process detailed in this Policy is compatible and consistent with the SAFE START model and adopts the SAFE START variables for assessment of psychosocial risk. AHSs are to ensure that there is a comprehensive assessment process in place in both maternity services and early childhood health services.

Comprehensive primary health care assessment

should assess all aspects of health and should include systematic exploration of the following domains:

- physical health
- medical history
- psychosocial issues (see below)
- family structure
- relationships
- support networks
- employment
- income/finances
- accommodation
- recent major stressors
- family strengths
- current or history of mental illness, substance use, child protection issues, domestic violence, physical, sexual or emotional abuse.

All available information regarding parents, baby and family is sought in order to inform the comprehensive primary health care assessment.

Psychosocial issues

Assessment of psychosocial issues is to be incorporated into the comprehensive primary health care assessment to ensure that psychological and social aspects of health, as well as physical health, are addressed. Incorporating psychosocial issues as part of a comprehensive assessment has implications for the skills and knowledge required by midwives/nurses, the setting in which the assessment takes place and the availability of, and access to, a network of appropriate referral services. Additional information about the psychosocial assessment can be found in the SAFE START documents, which are part of the *Supporting Families Early* package.

Questions to assess psychosocial health may be administered either as part of an interview conducted by the clinician or in a questionnaire format completed by the woman, generally during the appointment. There are advantages and disadvantages to each approach. Administering psychosocial questions as part of the interview may enhance the engagement between the clinician, the woman and her family and enable immediate discussion of issues in order to seek clarity. Conversely, administering the questions in the questionnaire format can ensure privacy for the respondent, particularly when other family members are present and can take less time and be easier for staff new to the process of psychosocial assessment. Where there are literacy problems, or there is a lack of familiarity with the English language, written questionnaires are not recommended.

The decision about which mode of administration to implement will depend on several factors, as described above however, the domestic violence questions should always be asked as required by the NSW Policy Directive *PD2006_084 Domestic Violence – Identifying and Responding*.

The SAFE START model recommends that the following minimum core set of psychosocial variables be assessed antenatally and postnatally (refer to Appendix 3):

- lack of social or emotional support – availability of practical and emotional support
- recent major stressors – recent (in the last 12 months) changes or losses, eg financial problems, migration issues, someone close dying
- low self-esteem – including self-confidence, high anxiety and perfectionistic traits
- history of anxiety, depression or other mental health problems, substance
- couple's relationship problems or dysfunction (if applicable)
- adverse childhood experiences
- domestic violence.

Use of the Edinburgh Postnatal Depression Scale

The Edinburgh Postnatal Depression Scale (EPDS) is a simple and reliable self-report questionnaire that is easy to administer and score. It is a useful tool to help professionals identify and assist women who are experiencing current distress or depression during the perinatal period, and are therefore potentially at risk of developing more complex health problems. Using the EPDS usually encourages women to start to talk about their feelings.

When used to screen for depression in the antenatal period and beyond, beyond the immediate postnatal period, the scale is referred to as the Edinburgh Depression Scale (EDS) as a generic term for depression screening during the perinatal period (Cox, Chapman, Murray and Jones, 1996; Murray, Cox, Chapman and Jones, 1995; Murray and Cox,

1990). When administered during the antenatal period the antenatal version of the EDS is recommended as this has an appropriate preamble acknowledging 'as you are about to have a baby' (Appendix 5).

Where there are any clinical concerns or if the clinician suspects that the family may not accept further contact after the UHHV, the EPDS should be administered at the initial universal postnatal contact, either at home or in the clinic.

Information on perinatal depression, anxiety, the EPDS and the importance of screening will be provided to the woman and her family at the initial home visit. Women will be encouraged to make an appointment for the six to eight week check, when the EPDS will also be administered. Early identification of vulnerable women will allow early intervention and support to be arranged.

Refer to Appendix 4 for a copy of the EDS/EPDS and scoring scale. For English speaking women:

- the antenatal score for probable major depression is 15 or more
- at least probable minor depression is 13 or more
- the postnatal score for probable major depression 13 or more
- for at least probable minor depression is 10 or more (Matthey, et al. 2006 p.313).

The EDS/EPDS has been translated into a number of languages which are available on the NSW Health website www.mhcs.health.nsw.gov.au/mhcs/index.html. Matthey et al. also recommends that for women from culturally and linguistically diverse backgrounds, reference should be made to studies using the EDS/EPDS from the particular culture/ethnic background for a cut off score.

Research (Cox & Holden, 2003 p.61) has indicated that for many women immediate intervention may be unnecessary for women scoring 15 and above antenatally and 13 and above postnatally with the absolute exception being any woman who scores above 0 (zero) on question 10 of the EDS/EDPS.

It is therefore recommended for these women (ie those scoring 15 and above antenatally and 13 and above postnatally, and 0 (zero) on question 10) that a second EDS/EPDS be administered two weeks after the initial screen before any intervention is planned or agreed. However, immediate intervention should occur where clinical judgement identifies the need.

For any score above 0 (zero) on question 10 it is imperative that the clinician undertakes further sensitive questioning. The safety of the mother, infant and family is a priority. Prior to any midwife or child and family health nurse undertaking administration of an EDS/EDPS it is important that she/he receive training in administration and scoring of the EDS/EDPS and is familiar with AHS policy for assessment and response to consumers with possible suicidal behaviour (based on NSW Health's PD2005_121).

Midwives and child and family health nurses must have appropriate training in preliminary suicide risk assessment and management and understand the requirements of the Framework for Suicide Risk Assessment and Management protocols for General Community Health Services (2004). Assessment of people at risk of suicide is complex and demanding. Wherever possible, all assessments of suicide should be discussed with a colleague or senior clinician at some stage of the assessment process. Support from the Area Mental Health Service may also be sought by the clinician and local protocols followed as per NSW Health's PD2005_121. Consideration should also be given to making a report to the Department of Community Services (DoCs) where the clinician suspects risk of harm to the infant.

AHSs will ensure that protocols are in place to support women in the postnatal/antenatal period who may be experiencing mental health issues including perinatal depression and/or anxiety. Pathways to care should be developed that assist clinicians to determine appropriate intervention for the mother, infant and family.

NSW Health has issued guidelines on the use of the EDS/EPDS, The Edinburgh Postnatal Depression Scale Guidelines for Use in Primary Health Care (NSW Health 1994). In addition, the SAFE START On-line Assessment and Training (2009) contains guidelines for the administration, scoring of the EDS/EPDS. The NSW Health Postnatal Depression Education Package (NSW Health 2001) – a train-the-trainer package – also contains information on the use of the EDS/EPDS.

Antenatal assessment

A comprehensive assessment incorporating psychosocial issues is to be conducted with all women as early as possible in the antenatal period. This will occur at booking-in or first visit to the maternity service. The timing of psychosocial assessment for individual women will vary, depending on their first contact with the maternity service, the preferred time is within the first 10 to 14 weeks of pregnancy.

The antenatal psychosocial assessment is in addition to the physical assessment of the mother's wellbeing and the progress of the pregnancy that is conducted by the midwife or doctor as part of an antenatal visit.

The antenatal psychosocial assessment is to include the:

- core psychosocial risk questions either as questions asked during the interview process or as a self-report questionnaire (note that domestic violence questions should be asked, not self-administered)
- Edinburgh Depression Scale (EDS) (see Appendix 4).

A care plan for pregnancy and birth that is informed by all of the above assessments and consultation with the client will then be developed. Where the family is identified as requiring additional support the care plan should include postnatal care and be developed in conjunction with the child and family health service. The UHHV will be included as part of the care plan.

Postnatal assessment

Maternity staff are to identify any emerging psychosocial issues and ensure that planning for a smooth transition from one service to another incorporates the management of pre-existing and emerging issues.

Initial assessment

It is important that child and family health clinicians be introduced early in the postnatal period to maximise engagement with the service and continue to optimise support. This is particularly important for families with identified vulnerabilities.

The antenatal care plan is to be reviewed and a care plan for the postnatal period developed that is informed by the above assessments and in consultation with the client and family.

It should be noted that maternity and child and family health staff may be providing care during the same period, each with their own unique focus.

Assessment between 6 and 8 weeks

If a comprehensive health assessment including psychosocial assessment has not occurred previously then this should be undertaken at this time.

In addition to the assessment of the baby that is conducted by the child and family health service as part of the 6 to 8 week schedule of visits in the Personal Health Record, it is also recommended that the following be included:

- review the core psychosocial risk questions to determine whether there have been any changes that have occurred in the family circumstances that may result in a change to the level of care for the family (refer section 3.4 Determination of level of care)
- administer the EPDS.

Assessment between 6 and 8 months

The third assessment should occur when the baby is between 6 and 8 months, either at the 6 month child health check or whenever the family presents to the early childhood health service during this period.

Issues for consideration at all postnatal assessments

In addition, the following issues should be considered at the above assessments:

- the birth experience
- psychological and social adjustment to parenthood, such as:
  - expectations of parenthood
  - mood
  - feelings about, and responsiveness to, the baby
  - ability to cope with the practical and emotional demands of caring for a new infant/s
  - ability to cope with the practical and emotional demands of caring for a family
  - self-care
  - relationship with partner
  - resuming social activities
  - child safety, including history of, or current, child protection concerns
- maternal physical adjustment, such as:
  - level of fatigue
  - energy levels
  - physical health including breastfeeding
- family adjustments to the new baby, such as:
  - parental concerns about child's development, temperament and progress
  - parental concerns about the care of the baby,

eg physical health, feeding and settling
  - siblings' acceptance of the new baby
- family environment
  - housing
  - unemployment current financial stress
  - isolation
- level of social support, including:
  - adequacy of available support
  - feelings of isolation
  - relationships with others, eg mother.

The care plan is to be reviewed and updated at each assessment/review based on the above assessments and consultation with the client/family.

Outcome of the assessment

Psychosocial risk factors impact significantly on a family's ability to parent, and subsequently the baby's development. The assessment process is designed to:

- indicate whether risk is present or potential
- identify the strengths and resources of the family.

Therefore, the purpose of the comprehensive primary health care assessment is to identify the broad range of issues that can affect parenting and the healthy development of the baby that may require further assessment or case discussion with the broader multidisciplinary team and linking to relevant resources.

At the completion of the assessment process, vulnerabilities and strengths need to be considered.

3.2 Determination of vulnerabilities and strengths

Vulnerability and resilience are dynamic and changing phenomena. Families are neither strong nor vulnerable by default, but go through stages of strength and instability. The relationship between vulnerability and resilience, risk and protective factors is complex. Risk factors for adverse outcomes often co-occur and may have cumulative effects over time. Risk and protective factors may change over time, and the salience of risk and protective factors will vary with individual and family characteristics and the sociocultural context in which the family lives. In general, families will be more vulnerable if exposed to more risk factors and less protective factors – and resilient when more protective factors are able to be put in place, reducing exposure to risk factors. A professional assessment of a family's needs include consideration of risk and resilience factors.

Risk factors are considered across several domains: the child, parent–infant relationship, maternal, partner, family, environment and life events and are categorised in the following way:

- Level 1 – no specific vulnerabilities detected
- Level 2 – factors that may impact on ability to parent that usually require a level 2 service response including; *unsupported parent, infant care concerns, multiple birth, housing, depression and anxiety* (see Table 2, Level 2)
- Level 3 – complex risk factors that usually require a level 3 service response including; *mental illness, drug and alcohol misuse, domestic violence, current/history of child protection issues* (see Table 2, Level 3).

The level of care required by a family must be ascertained in the context of a holistic professional assessment (refer to section 3.4 for information on the determination of the level of care).

It should be noted that as the number of risk factors increases so does the potential impact and effect of the risks. There can also be considerable variation between individuals in vulnerability and resilience to these risk factors. Consequently, a family with Level 2 risk factors present may actually require a service response similar to that of Level 3. Therefore, it is recommended that any client with Level 3 or multiple Level 2 vulnerabilities be discussed utilising a team-management-case-discussion approach, in order to consider the most appropriate level of care–service response required. It is recommended that where families are identified as multiple Level 2 and level 3, universal maternity/child and family health services should be provided however case management and care should be transferred to a more appropriate service, such as Brighter Futures, mental health and drug & alcohol services and relevant non-government organisations.

Child protection

Assessments may also identify child protection concerns for either the baby or other children. The *NSW Health Frontline Procedures for the Protection of Children and Young People* (NSW Health 2000) directs health workers to conduct comprehensive antenatal assessment and care planning for women, including a thorough psychosocial assessment. A thorough assessment of a woman's family, risk factors and strengths both during pregnancy and the postnatal period will help identify the need for any supports. If child protection issues are identified then the relevant procedures as outlined in the

NSW Health PD2005_299 and NSW Health PD2006_104 must be followed.

Maternity staff should be aware that domestic violence often begins or escalates during pregnancy. When responding to women where domestic violence is suspected or occurring, the NSW Health PD2006_084 should be consulted.

Section 25 of the *Children and Young Persons (Care and Protection) Act 1998* allows prenatal reports to be made to DoCS if there may be a risk of harm to the child after birth. Prenatal reporting may be particularly helpful for pregnant women in domestic violence situations, or with mental health or substance misuse in pregnancy issues, as it may be a catalyst for assistance. Prenatal reporting is not intended as a punitive measure, and should only be used where there are reasonable grounds to suspect that an infant or other children may be at risk of harm.

If a prenatal report has been made, any continuing or escalating risk of harm must be assessed following the child's birth.

Information regarding a child who is the subject of a prenatal report or their family may be exchanged with DoCS where the information relates to the safety, welfare and wellbeing of the child. For more information refer to NSW Health PD2007_023. These provisions aim to ensure that appropriate support and interventions are provided where there is a risk of harm to a child, including an unborn child.

3.3 Multi-disciplinary case discussion and team management approach

In situations where a woman or family has been identified through the assessment process as vulnerable to risk and in need of additional support, the AHS is to develop a process to support and assist the midwife or nurse to determine the best management strategy and to assist in linking the family to the most appropriate services. This is to be through the establishment of a multi-discilpinary approach to care planning and determination of the level of care–service response required.

The multidisciplinary team should include, when appropriate, clinicians from the following health services:

- Maternity
- Early childhood health
- Mental health/psychiatry
- Drug and alcohol
- Social work
- Psychology
- Child protection.

Case management meetings provide all team members with the opportunity to discuss complex families, seek support and advice and develop coordinated care plans. This approach may be instituted through the use of existing intake or case consultation meetings or the establishment of new meetings.

The team are to determine a care plan that addresses the presenting issues and areas of risk, and builds on the strengths of the parents and family. The care plan is to be developed in consultation with the family and is to address the priority issues identified with the family.

The care plan may include:

- specialist assessment and intervention
- ongoing support
- nurse health home visiting
- referral to appropriate services
- referral for sustained health home visiting where a funded service is available.

As part of the care planning process, the following are to be established:

- determination of level of care–service delivery required for each client
- clarification of the roles and responsibilities of team members
- identification of a key worker to coordinate care
- a process for team review of progress.

A team-management approach to care planning is particularly important in complex cases where the woman or family presents with multiple issues and areas of risk. A team-management approach is essential where Level 3 risk factors are present such as moderate to severe (or 'significant') drug and alcohol, mental health and/or child protection issues. A team-management approach to care planning should also be considered when there is identified social disadvantage and/or multiple Level 2 risk factors are present.

The establishment of a team-management approach to care planning as part of both antenatal and postnatal services is critical to providing comprehensive care to women or families identified as vulnerable to

psychosocial risk. When vulnerabilities are identified antenatally, it is important to involve child and family services in care planning to facilitate the relevant community-based services that are to be put in place and a seamless transition of care in the postnatal period.

Systems are to be established to enable services external to AHSs to participate in the team-management approach to care planning when appropriate. It is important that along with the provision of universal child and family health services there are appropriate referral pathways to services such as Brighter Futures, particularly for complex Level 2 and Level 3 cases.

3.4 Determination of level of care

The level of care–service response is determined by considering the risk factors in the context of the strengths of the woman and her family and local resources available. Risk factors are divided into levels (see table 2) that may or may not correspond with level of service response determined by the team. The levels of care–service response are, as indicated in figure 2, categorised in the following way:

- Level 1 – universal services, eg midwifery, early childhood health clinics, parenting groups, community supports, and parent support telephone or web links.
- Level 2 – early intervention and prevention services. Ongoing and active follow-up/review is required, eg day stay clinics, family care centres, specialist support groups and services, general practitioner, paediatrician or psychiatrist referral to 12 sessions of Allied Health assessment and care through 'Better Access Medicare Agreements'.
- Level 3 – complex parenting needs – a coordinated team-management approach is required and referral to relevant needs-specific services such as Brighter Futures.

These levels of care are not independent or distinct categories, but rather form a continuum of service delivery. The level of support offered is to meet the identified needs of the individual family. It is envisaged that families may move into, and out of, the different levels of support as their circumstances change. Families may also require different intensity of interventions within the different levels of care in response to their individual circumstances. This requires the service network to be flexible enough to meet the changing needs of individuals and families.

When deciding the most appropriate level of care, the health worker is to develop the care plan in consultation with their multidisciplinary team and the family, and address the priority issues that have been identified with the family. Health's response should be formulated in the context of, and with consideration to, all maternity and family services available, including those available in the external child and family service network as well as local community supports. When indicated, partnerships are to be formed with other service providers to provide the most appropriate care and level of service to the family.

Figure 2. Levels of care

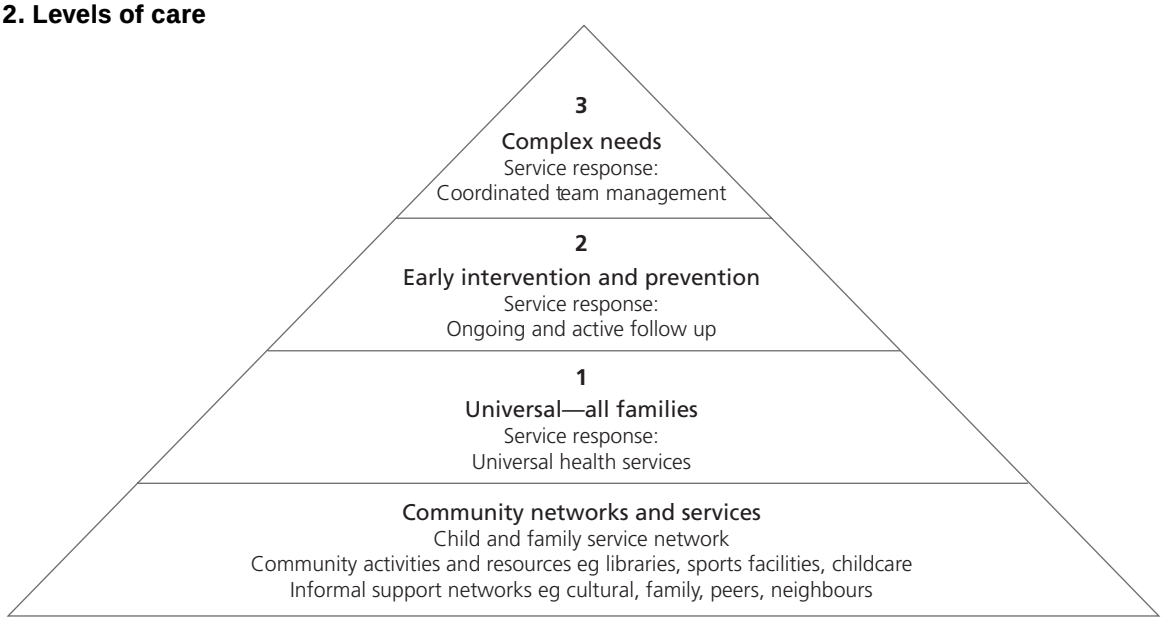


Table 2. Levels of care

General service response	Risk factors	Needs-specific services
Level 1. All (Universal support)		
Routine health services are offered. Local systems are in place to encourage families to: ■ utilise universally available services ■ utilise early childhood health services at key transition points in the child's development ■ link with other services available for families with young children within their local community. Services are delivered in a health promoting, early intervention framework.	No specific risk factors are identified.	Families are encouraged to utilise a range of services and community level supports, depending on their individual needs. These supports can include: ■ Maternity services ■ Early childhood health services, including UHHV, parenting and breastfeeding groups ■ General practitioners ■ Parenting and child development information ■ Parent help lines ■ Community activities, eg playgroups, breastfeeding peer support groups, libraries ■ Childcare, preschools ■ Informal support network, eg family, peers, neighbours ■ Ethno-specific and multicultural support networks
Level 2. Prevention and early intervention		
Ongoing support and active follow-up. Families identified as vulnerable should be: ■ actively followed up and supported with progress reviewed at key transition points ■ linked with and referred to other services as needed ■ encouraged and supported to utilise universally available services. A key worker may need to be identified to coordinate care across services.	■ Young (under 20 years) ■ Unsupported parent ■ Late antenatal care ■ Multiple birth ■ Premature birth ■ Complicated birth ■ Child or parent with disability/ chronic illness ■ Adjustment to parenting issues ■ Mild-to-moderate anxiety ■ Mild-to-moderate depression ■ History of mental health problem or disorder eg eating disorder ■ Grief and loss associated with the death of a child or other significant family member ■ Unresolved relationship issues, including with own parents ■ Financial stress ■ Unstable housing ■ Partner unemployed ■ Isolated, eg geographic, no telephone, lack of support ■ Refugee status, recent migrant, poor English skills.	A range of services can be accessed for consultation or referral to support families identified as vulnerable, depending on their individual needs and priorities. Services to be considered include Level 1 services and may include any of the following: ■ Maternity services – active follow-up ■ Early childhood health services – priority and active follow-up ■ UHHV – priority and active follow-up, and may require a number of home visits over the short-term ■ Sustained health home visiting ■ Family care services – centre-based and outreach ■ Breastfeeding clinics/units ■ Adolescent pregnancy and parenting support services ■ Child and family counselling services ■ Interpreter services ■ Disability services ■ Early intervention services ■ Supported playgroups ■ Residential family care services ■ Counselling ■ Social work ■ 'Allied Health/Counselling' via general practitioner, paediatrician or psychiatrist referral through 'Better Mental Health Access Medicare Agreements' ■ Mental health ■ Drug and alcohol ■ Other Government and NGO programs, eg Family Support Services, Disability Services, volunteer home visiting services, housing ■ Ethno-specific and multicultural support networks.

General service response	Risk factors	Needs-specific services
Level 3. Complex needs		
Coordinated team management. Families identified as having complex needs will require a coordinated team management approach to care. This may also include some families with level 2 vulnerabilities. The plan is developed in consultation with the family. Roles and responsibilities of members of the team will need to be clarified. A key worker will be identified for the coordination role. The family will receive: ■ coordinated care ■ review of progress ■ referral to specialist services.	■ problematic substance use or parent/carer on the opiate treatment program ■ diagnosed mental illness, eg schizophrenia, bipolar disorder ■ current or history of domestic violence ■ known to Department of Community Services ■ current or history of child protection issues.	A range of health and other services will work together to support families with complex issues and will include some or all of the following: ■ Level 1 services ■ Level 2 services Families may also need referral to all or some of the following: ■ Specialist health services – drug and alcohol – mental health including residential and inpatient services – Physical Abuse and Neglect of Children (PANOC) child protection counselling services via DoCS Helpline ■ Drugs in Pregnancy Programs ■ Other Government and NGO programs eg Department of Community Services, Family Support Services, Brighter Futures ■ Domestic Violence Services.

3.5 Review and follow-on coordinated care

The success of primary health care, including health home visiting, in the perinatal period depends on regular review and coordinated and appropriate follow-on care.

3.5.1 Effective programs and interventions

It is clear from the research that early intervention with vulnerable families will improve outcomes across a range of physical, psychological and social indicators.

Interventions and specific programs during the antenatal and early infancy period should aim to enhance the resilience of parents, promote optimal child development, facilitate secure attachment relationships and prevent developmental and emotional disorders. To be effective, these programs should address prevention of risks and the enhancement of protective factors that will strengthen parenting. They should incorporate a focus on the emotional and social development of the infant, and the prevention of adverse mental health outcomes (Mrazek & Haggerty 1994). The provision of services that are universal, voluntary and non-stigmatising is advocated. Programs should have multiple goals, be flexible in intensity and duration, be sensitive to the unique characteristics and circumstances of families, and be provided by well-trained and supported staff.

3.5.2 Coordinated care

There is a need for planning across the continuum of early child development. This is especially so for those families with greater challenges to manage due to their individual, family and/or community circumstances.

Families caring for a new baby require holistic care for the mother, child and family across the transition from maternity services to community-based services. It is acknowledged that the maternity and child and family health service system within each AHS is different. Service planning across the transition from pregnancy to birth to parenthood should be conducted within the context of the services and models that are currently in place in each AHS.

The key elements of coordinating care are:

- integrating and coordinating service development across maternity, child and family health and specialist services within an AHS
- ensuring links to the service network across Health, other government, non-government and community

services available to parents expecting or caring for a new baby.

The processes for review and coordinated follow-on care are to be established and consistently implemented.

The role of the midwife or child and family health nurse

The management of families who require additional support is to be consistent with the clinical skills and abilities of the staff and the local supports and resources that are available.

The role of the midwife or child and family health nurse (C&FHN) is to:

- identify the risks
- identify the strengths and supports that the client/family may already have
- identify the need for ongoing support and where appropriate facilitate client access to needs-specific services
- develop a management plan with the client/family
- when appropriate, support the family as the key primary health care worker and consult with specialist staff or general practitioner as necessary
- provide ongoing midwifery and child and family nursing care to clients.

Transition of care from maternity services to early childhood health services

Ensuring transition of care between maternity services and early childhood health services is important in improving health outcomes for children and providing support to parents.

All parents are to receive information prior to discharge from hospital to home on:

- the services available through the early childhood health service
- a contact for their local early childhood health service should issues arise between discharge from hospital and the Universal Health Home Visit
- the offer of their first early childhood health service within their own home within the first two weeks of their baby's birth
- relevant community peer support groups, eg Australian Breastfeeding Association.

AHSs are encouraged to explore additional strategies to facilitate stronger links between maternity services, early childhood health services, other community health services and general practitioners.

It should be noted that maternity and child and family health staff may be providing care during the same period, each with their own unique focus.

Maternity and neonatal intensive care discharge services

With the introduction of UHHV, it is important that maternity, neonatal intensive care and paediatric discharge services, family care cottages, day stay units and child and family health services work together, complement each other and ensure a continuum of care across this transition. Systems are to be established to ensure that there is effective transfer from the hospital to community health services. It may be appropriate in such circumstances for the child and family health service to visit the family with the maternity or neonatal home visiting service in order to achieve a seamless transition.

The provision of home visiting by a maternity discharge service does not meet the requirement for the offer of a Universal Health Home Visit. It should be noted that a principal objective of the Universal Health Home Visit is to ensure an early introduction to, and connection with, community-based early childhood health services following the birth of a baby, in order for these services to be accessed by the family throughout the early childhood years.

Families identified as vulnerable antenatally

The ongoing care of these families following the birth of the baby is to be determined as part of the team management approach to care planning (refer to section 3.3). A coordinated support plan is to be developed prior to discharge from hospital that addresses the needs of the parents and infant in the early postnatal period.

The local early childhood health service is to be involved in planning for the care of these families. Planning is to involve local maternity, social work and child and family health services. The Universal Health Home Visit is part of this ongoing care.

Transfer of information

In order to promote this transition of care, AHSs will develop systems to ensure the effective flow of information from the maternity service to the early childhood health service. Such a transfer of information will enable support commenced antenatally to be reinforced and strengthened.

Advice regarding the sharing of this information with the community-based child and family health service is to be made available to parents as part of the routine information provided by the hospital on booking-in and again prior to discharge.

To ensure a smooth transition of care from hospital to community-based health services, the following information is to be transferred from the maternity service to the early childhood health service within 48 hours of discharge from hospital:

- MR 44/PR16 or Obstetric discharge summary
- outcomes of the antenatal psychosocial assessment and any follow-up services provided to address the identified issues
- other information about the parents and infant that is required to ensure appropriate care and follow-up
- identification of those families requiring priority follow-up.

Priority follow-up

- The early childhood health service is to be informed by maternity services of the families who require priority follow-up. AHSs are to develop local protocols to ensure these families are referred to the child and family health service for priority follow-up. Indicators for priority follow-up may include but not be limited to risk factors identified in Table 2, Levels 2 and 3.

It is also important to establish cross-border protocols between health services for transfer of information and discharge planning, as well as protocols with private hospitals.

Linking to the service network

All families require social support and connectedness at the neighbourhood and community level. Various health and other services are working to provide supportive networks under *Families NSW*. Health services are to establish systems of liaison, referral, and service agreements where appropriate, with the local service network available for families with young children.

Local mechanisms are to be put in place within each AHS to facilitate and support the linking of families from specialist services back to universal support services, such as early childhood health services and general practitioners.

SECTION 4

Health home visiting

Health home visiting is not delivered in isolation but forms part of the continuum of care and network of services for families with young children. Comprehensive assessment and coordinated care provide the platform for health home visiting.

The literature indicates that home visiting programs that provide support to parents should be offered to all parents with newborns on a voluntary basis. Through the provision of voluntary and non-stigmatising home visiting, those families identified as vulnerable or at risk can be targeted to receive additional support services (Vimpani 2000).

4.1 Universal health home visiting

Universal Health Home Visiting (UHHV) within the context of NSW Health's child and family health service system includes the offer and provision of at least one universal contact in the client's home within two weeks of birth and may also include further home visiting. The child and family health nurse from the early childhood health service conducts the UHHV.

4.1.1 Aim and objectives

The aim of UHHV is to engage all families with newborns and to provide support to parents with young children. UHHV is based on universality of access, assessment and intervention in the context of the client's own environment and the development of partnerships.

The objectives of UHHV are to:

- improve access to services by contacting and offering a home visit to all families with newborns
- introduce families to the concept of health home visiting in a non-stigmatising manner
- actively engage those families that do not traditionally access maternity and early childhood health services and that need extra support
- engage families with the child and family service system and to provide support early, within two weeks of birth
- better determine families' needs for ongoing care by adding depth and context to the assessment by conducting it in the family home and in partnership with the family
- ensure an introduction to, and connection with, community-based child and family services within Health and across other government and community organisations, for families that may not have readily accessed these services.

4.1.2 Organising the initial contact visit

When information is received from the maternity service, the early childhood health service is to establish contact with the family and offer a home visit. When the offer of a health home visit is accepted, the visit is to be provided within the first two weeks of birth. If the family has been identified as vulnerable antenatally, the UHHV is included in the care plan and organised in advance. This constitutes an offer of a UHHV.

When the offer of the home visit is accepted, the parents are to be advised of the purpose of the home visit, the name of the child and family health nurse who will be visiting and a mutually agreed time for the visit.

The child and family health nurse is to ensure there are no threats posed to their safety in undertaking the home visit. A risk assessment is to be completed by the child and family health nurse for each family, prior to the first home visit. This risk assessment is to identify any potentially dangerous conditions and/or situations that may compromise worker safety. Local and NSW Health Occupational Health and Safety (OH&S) policy should be followed for all home visiting (refer to section 5.7).

4.1.3 What happens at the initial postnatal contact visit?

The initial postnatal contact visit is to be driven by the family's needs and conducted at a pace and in a manner suitable for the individual family. It is reasonable to expect that the contact would take a minimum of one hour in order to cover the points set out below. Preferably, this contact will occur in the home and may take more than one visit to complete. Whether it occurs in the clinic or the home, at the initial contact the nurse will:

- establish a trusting relationship based on principles of the Family Partnership model
- review the antenatal comprehensive primary care assessment, or
- conduct a comprehensive primary health assessment with the parents if there is clinical or access concerns (refer to section 3.1 – Assessment)
- provide positive support, affirm and normalise early parenting experiences whilst recognising deviations from the norm
- respond to issues or concerns that the parents may have regarding the health and development of the baby, and conduct the 1-4 week check as per the NSW child Personal Health Record.
- monitor the baby's growth and general progress, and provide information and resources as required
- determine and respond to issues regarding breastfeeding for both the mother and her infant, eg breast care and management, adequate milk intake to meet optimal growth, (refer to NSW Health PD2006_012) or respond to issues associated with other methods of infant feeding
- promote parent–infant bonding and attachment
- identify with parents the conditions and experiences that will promote their baby's health and wellbeing
- provide health education on key issues such as safe sleeping, non smoking, breastfeeding, infant nutrition, infant safety and immunisation
- establish with parents their support needs and identify how these needs can be met
- link parents with other appropriate services and supports, including centre-based early childhood health services and the broader child and family service system. The recommended minimum early childhood health schedule is described within the NSW child Personal Health Record.
- determine the need for further home visiting – it is acknowledged that for some families more than one home visit may be needed and that additional home visits may be needed over the short term to support parents experiencing early adjustment issues, for example, settling and breastfeeding.

4.1.4 Outcomes of universal health home visiting

Health home visiting, within the context of universal Child and Family health services, should contribute to the following outcomes:

- increased appropriate use of services and programs
- improved family relationships
- ability to demonstrate parent craft and child development knowledge and skills
- improved quality of the parent–child interaction
- increased positive health behaviours
- reduced anxiety
- increased confidence
- increased resourcefulness, that is, the ability to identify and garner resources needed for positive health and wellbeing.

The outcomes achieved from the UHHV are dependent on the intervention delivered, the capacity of the client to respond to the intervention and the capacity of the nurse and service to deliver the intervention as illustrated in table 3.

Table 3. Generic model of Universal health home visiting *(Source: Aslam and Kemp 2005)*

Co-dependent aspects of intervention – Create the conditions

Context	Trust relationship	Response		
Integrated into normal activities Integrated in environment Predictable Opportunistically identifying needs Flexible Accessible	Institutional Reliable Non-authoritarian Back-up safety net Agreed boundaries/ expectations Support	**Psychosocial** Affirmation Normalising Empowerment Reflecting behaviour Goal setting	**Instrumental** Information made accessible Resources Linking	**Education** Adaptive parenting/ attachment skills Parent craft skills Child development Health Promotion

Capacity to deliver/respond to intervention (mediating layer)

Client (mother/family)	Nurse	Health service
Resilience Skills Support – personal Stage of change Personal and family strengths	Training Experience Support/supervision Skills and qualities	Staffing Funding Resources Networks Reputation Goals and values Number, length and duration of visits

Correlated outcomes – Generalised and institutional trust

Social resources	Social well-being	Demonstrated knowledge	Emotional well-being	Adaptability
Increased appropriate use of services and programs.	Improved family relationships.	Parent craft. Adaptive parenting. Appropriate developmental expectations. Health behaviours.	Reduced anxiety/stress Increased confidence.	Resourcefulness.

4.2 Targeted home visiting programs

NSW Health provides some isolated targeted programs to support women who are pregnant or caring for a new baby. A range of staff, including midwives, nurses and social workers currently offer targeted home visiting programs. AHSs are to review their existing service models and ensure they reflect this policy and operate in partnership with home visiting services delivered by child and family health nurses.

Some models of targeted home visiting developed in some AHSs include:

- maternity home visiting programs
- early childhood health service home visiting programs
- locally developed home visiting services for culturally and linguistically diverse families
- adolescent pregnancy and parenting support services
- drugs-in-pregnancy services
- mental health services supporting families.

4.3 Specific populations

The implementation of health home visiting programs should be flexible and be conducted in a manner that allows for the needs of specific populations in the community to be met. AHSs are encouraged to work with local communities to develop culturally sensitive and appropriate responses.

4.3.1 Aboriginal families

The health disadvantage of the majority of Aboriginal and Torres Strait Islander people begins early in life and continues throughout their lives. Many Aboriginal people have had negative experiences with mainstream services, and may carry a lot of mistrust and fear and may not readily open their homes to health workers they do not know. Service providers need to be sensitive to the needs of Aboriginal families.

By utilising a primary health care approach which simultaneously addresses health service delivery and the broad social factors affecting Aboriginal communities, it is possible to achieve significant long term improvements in Aboriginal maternal and infant health (NSW Aboriginal Perinatal Health Report 2003).

In order to deliver effective universal child and family health services including home visiting, it is essential that health staff engage with Aboriginal communities and Aboriginal health care providers in their Area. An excellent example of an effective primary health care model for the delivery of Aboriginal services is the Aboriginal Maternal and Infant Health Strategy (AMIHS). More information on the strategy is provided in Appendix 1, 1.1 Maternity Services.

4.3.2 Rural and remote families

It is recognised that providing health home visiting in rural and remote locations requires additional time and resources to accommodate the issue of distance and access to other services. It is also recognised that some of these families may have a heightened need for home visiting support as a result of their geographic isolation.

AHSs may need to explore additional methods of maintaining contact with these families, for example through the use of telephone and email services or group programs that involve several families living in proximity to each other.

4.3.3 Culturally and linguistically diverse families

Services are to be aware and respectful of diverse cultural beliefs and practices. Knowledge of cultural beliefs and issues is essential to inform clinical practice. It is important not to make assumptions about what parents from a particular cultural background require, but rather work in partnership to establish each family's specific needs.

When planning and providing services, including health home visiting, staff are to be aware of the specific issues for parents from culturally and linguistically diverse backgrounds.

The following issues may be encountered.

- Isolation and lack of extended family and social networks. Isolation can be a significant issue affecting the mental health of parents from culturally and linguistically diverse backgrounds, and a major factor contributing to anxiety and depression. Staff require knowledge of multilingual and ethno-specific support groups and networks.
- Settlement problems and socio-economic factors. Settlement problems and socio-economic factors may also affect the coping ability of parents from culturally and linguistically diverse backgrounds.
- Refugee backgrounds. Parents from refugee backgrounds have additional issues related to their experience of trauma, possible sexual assault or torture, or years of deprivation.
- Cultural sensitivity of mainstream services and cross-cultural competencies of health professionals. Antenatal, maternity and child and family health staff require an understanding of different cultural birthing and child rearing practices.
- Language. A family's need for an interpreter service is to be established when a woman is booking in at her first antenatal visit, or at the family's first contact with the health service. Services are to be conducted in the appropriate language. NSW Health funds the Health Care Interpreter Service, which provides both face-to-face and telephone interpreting services. For further information on the use of health care interpreters, please refer to (PD2006_053 Interpreters – Standard Procedures for Working with HealthCare Interpreters). Subject to resource availability, the same interpreter should be utilised for a family to facilitate continuity of care and relationship with the client. Written information should be provided in the appropriate language. The NSW Multicultural Health Communication Service has publications related to pregnancy and child and family health in several languages. These publications are available on the NSW Health website www.mhcs.health.nsw.gov.au/mhcs/index.html. The use of bilingual workers is encouraged.

Consultations with specific communities are to be undertaken as part of each AHS's service development processes.

4.4 Sustained health home visiting

As part of a comprehensive approach to service delivery, families that require additional support may be offered support in their own homes over a two-year time frame, this is known as Sustained Health Home Visiting (SHHV). Where funding has been identified specifically for this purpose, SHHV is integrated into the service network for families with young children.

Health home visiting programs comprising intensive and sustained visits by professionals (usually nurses) over the first two years of life show promise in promoting child health and family functioning, and ameliorating disadvantage.

4.4.1 Aim and objectives

The objectives of SHHV are to:

- actively engage those families who need additional support and may not otherwise access maternity and early childhood health services
- build on existing knowledge and experience of parents
- establish and develop a trusting relationship between the family and nurse
- foster the development of parental self-efficacy, the early attachment relationship and awareness of the developmental needs of the infant in order to enhance the social and emotional development of children
- enhance health, safety and wellbeing of children and families through community-based involvement and family support.

4.4.2 Outcomes of sustained health home visiting

When supported by SHHV, a review of trials (Aslam H & Kemp L 2005) has shown that families with risk factors for adverse child outcomes have:

- significantly improved quality of the home environment, parent–child interaction, child development and family functioning
- higher immunisation rates
- reductions in the numbers of subsequent pregnancies, reliance on welfare support, criminal behaviour and child abuse and neglect.

Systematic reviews have shown that SHHV interventions that include the following elements have greater success:

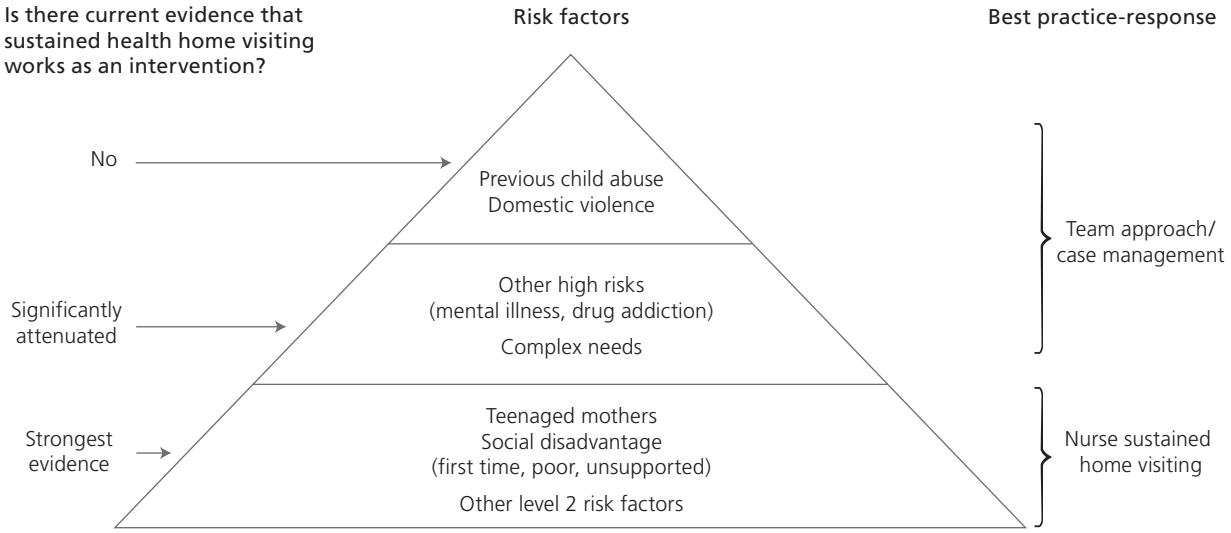
- a universal population approach to enrolment, rather than referral-based enrolment
- services which target populations or families that are vulnerable to poor maternal and/or child outcomes ('at-risk') with the aim of intervening proactively to prevent and minimise risk, eg mothers with, or at risk of, postnatal depression; mothers of lower socio-economic status or teenage mothers
- commence antenatally
- comprehensive interventions including a combination of counselling, problem solving, child growth and development, social support, parenting skills, parent-child interaction and provision of resources, including information and linking to relevant services
- interventions based on respectful parent-nurse partnerships
- proactive interventions based on anticipatory guidance.

Furthermore, these reviews have shown that SHHV interventions with the following characteristics are unlikely to result in successful outcomes for families:

- those that are focussed on relationship building and social support in the absence of other elements of a comprehensive intervention
- services targeting populations or families with multiple, known significant problems (the 'at risk'), requiring a proactive approach to existing problems, eg families experiencing domestic violence, drug and alcohol misuse or engagement with the child protection system. These families require a specialist and continuing support response.

Figure 4 illustrates where the best evidence exists for SHHV as an effective intervention, and the best-practice response in light of this evidence.

Figure 3. Effectiveness of sustained health home visiting programs



4.4.3 Implementing sustained health home visiting

Target group

Families who require additional support do not necessarily use universal services or seek help when problems arise. Where there is specified funding available, a SHHV program can be considered as a possible service response following comprehensive assessment for those families identified with level 2 vulnerabilities. Where a SHHV program exists it is to be provided in the context of universal services, coordinated care and a team-management approach to care planning. Comprehensive assessment and clinical judgement are to be used to determine who will be offered a service in the context of the current service structure, the community profile and the outcome evidence.

Approach to implementing

There are two possible approaches to implementing SHHV as part of the early childhood health service:

1. delivered by the child and family health nurses delivering UHHV and clinic-based services, or
2. delivered as a separate and distinct service in which child and family health nurses are specifically employed to undertake SHHV.

There are benefits and disadvantages to both approaches. For example, there may be benefits in a mixed case load for nurses delivering UHHV, clinic-based and SHHV services, but the nurse is likely to be more easily available to the family in a separate and distinct SHHV service. The approach adopted will also have implications for how the service is structured, skills and knowledge required by nurses, and the provision of clinical supervision and access to multidisciplinary services.

Sustained health home visiting service model

Sustained health home visiting consists of the provision of approximately 20 home visits (actual number of visits determined by need) primarily by the same child and family health nurse during the pregnancy and the first two years post birth. The home visits are to be standardised as follows:

- Antenatal home visits, at least one joint visit with the midwife should be undertaken.
- A postnatal visit within one week of birth, and then visits weekly until six weeks; second weekly till 12 weeks; monthly to 15 months; bi-monthly until two years.
- Individually tailored content of each home visit based on the mother's needs, skills, strengths and capacity. Guided by a strengths-based approach, the nurse will:
  - support and enable the mother and the family to enhance their coping skills, problem solving skills and ability to mobilise resources
  - foster the emotional well-being of the mother
  - foster positive parenting skills

- foster parental skills in supporting optimal child development
- support the family to establish supportive relationships in their community
- mentor maternal-infant bonding and attachment
- provide primary health care and health education, including but not limited to immunisation, Sudden Infant Death Syndrome (SIDS) risk reduction, infant nutrition including breastfeeding, and child safety.

- Facilitated access to other appropriate early childhood and specialist services. Where other childhood, community or specialist services are involved in supporting the family, it may be appropriate for the health home visitor to arrange joint visits.

The SHHV program is to be supported by a systematic program of assessment, monitoring and evaluation of goals and outcomes of the intervention, for each family.

A team approach to supporting vulnerable families

In order for SHHV to be most effective, the home visiting nurse is to be part of a multidisciplinary team. This team will include other health services or teams and identified service partners within the service network. Members of the team are identified to provide a second tier of support for the family. Individuals providing this level of support undertake two roles in supporting the work of the primary child and family health nurse:

- training, consultation, clinical advice and education for the primary child and family health nurse
- direct provision to the family of more specialised services in conjunction with the primary child and family health nurse.

When several workers and services are involved in supporting a family, there is to be regular communication and care planning between these workers. The family is to be informed that services are working together to support them and that information is being exchanged.

When information is to be exchanged with other government and community services, the permission of parent/carer is to be obtained. Consent to exchange information is not required in circumstances such as:

- when making a risk of harm report to DoCS, or a response to a Section 248 request
- when there is a serious and imminent threat to the life, health or safety of the individual or other person (refer *NSW Interagency Guidelines for Child Protection Intervention 2006, NSW Health Privacy Manual V2, 2005*).

SECTION 5

Implementation requirements

5.1 Planning

Planning and coordinating health services that work with children, parents and families is the first step in effective implementation of primary health and home visiting services for families expecting a new baby or caring for young children. AHSs are to collect information regularly on the:

- population of children, including the number of births, the characteristics of families (including the identification of Aboriginal families and culturally and linguistically diverse families) and the local communities in which they live
- range of health services available to parents and families during the pregnancy and first years of the child's life
- range of health services that support vulnerable families
- services available in the broader child and family service network
- staffing and funding for child and family health services
- linguistic/cultural skills of staff involved in the delivery of maternity and child and family health services.

This information is to be used to inform the quality of service provision and to develop a planning framework to identify the mix of clinical, universal and targeted service models needed to support families.

Families and communities are to be involved in these planning processes.

5.2 Staffing

AHSs are to ensure that there are appropriate staffing levels to provide UHHV for the Area's population and characteristics. It is acknowledged that characteristics such as rurality and culturally diverse populations will impact on the staffing levels required.

5.2.1 Ratio for sustained health home visiting

A ratio of one nurse full time equivalent (FTE) position to every 25 families is a guide to the recommended staffing level for sustained health home visiting, where this is specifically funded and delivered as a distinct and separate service by child and family health nurses specifically employed to deliver the service. The guide of one nurse FTE to 25 families is the maximum caseload, assuming circumstances are optimum. The model has not been trialled in rural NSW, however, the ratio for rural areas is less and recommended at one nurse FTE to every 20 families.

5.2.2 Child and family health staff

Qualifications

The recommended minimum qualifications for UHHV staff employed in the early childhood health service to undertake UHHV are registered nurse or midwife with qualifications in child and family health. Other desirable qualifications include Graduate Certificate in Lactation/ International Board Certified Lactation Consultant, Graduate Diploma of Midwifery/Midwifery Certificate, Graduate Diploma in Infant Mental Health, or advanced counselling skills.

It is acknowledged that some AHSs employ registered generalist community nurses to provide early childhood health services and provide training and education through Area in-service programs, including on-the-job mentoring and supervision.

AHSs are encouraged to adopt recruitment policies to employ registered nurses or midwives with qualifications in child and family health. The quality and efficiency of care provided to children and families is dependant on the level of competency of the clinician. For this reason, specialist qualifications in child and family health are considered to be the ideal.

Scope of practice

The Child and Family Health Nurses Association (CAFHNA) identifies the scope of practice for nurses working in the child and family health area as:

- child health and development
- maternal health and welfare
- family health and welfare
- parenting support
- counselling
- health surveillance of infants and children
- community health nursing
- community development and partnerships.

The Competency Standards for Child and Family Health Nurses (Child and Family Health Nurses Association (NSW) Inc., 2000) are based on current best-practice principles for child and family health nursing and provide a guide to determine competencies in this area of nursing practice.

5.3 Training

It is the responsibility of the AHS to ensure that staff delivering maternity, child and family services have adequate qualifications, skills and training. Training and development systems for all staff are to support a multidisciplinary and interagency approach to working with families.

Each AHS is to implement the NSW Health *Families NSW* training that will be developed and delivered as part of a Statewide training project. This training package is designed to support all staff with the implementation of *Families NSW*, this Policy and the Family Partnership Model.

The training incorporates two primary components:

1. The Family Partnership Training.
2. SAFE START psychosocial assessment and depression screening training.

5.3.1 Family partnership training

Family Partnership Training is designed to provide basic training in the Family Partnership Model (refer to Appendix B section 1.4.2). The model has been evaluated in several research projects and is being implemented in a variety of settings, both nationally and internationally (Davis et al. 2002).

Family Partnership Training was first introduced in NSW to underpin the *Families NSW* strategy of UHHV, and particularly SHHV by child and family health nurses. However, it also has relevance for all health professionals who have contact with clients as well as their managers.

Family Partnership Training enables primary health staff, including midwives and child and family health nurses, to feel prepared to deal with parental concerns at an early stage, although referral to a more specialised service may be necessary at a later stage. By identifying and dealing with issues early it is possible to prevent more severe, entrenched problems developing. To do this effectively, staff need managerial support to work in this way, and ongoing supervision, to support them and maintain and enhance their skills.

Family Partnership Training focuses on the importance of developing a relationship, listening effectively to enhance the assessment of the client's needs and developing strategies to assist parents to solve their problems. It helps staff to identify and develop the skills and qualities required to engage with families and develop a basic understanding of Personal Construct Theory, including the awareness that every person is shaped by his or her unique history which influences their constructions or view of the world and events.

The basic course consists of 10 half-day sessions. There are two facilitators and a maximum of 12 participants, and the sessions are best delivered weekly. The course is delivered in an adult learning style that builds the knowledge, skills, strengths and experience of the participants. As the course progresses, a partnership between facilitators and the participants develops that mirrors the partnership that develops between a helper and a client. Learning occurs through reflection, exploration and participation, particularly in skills practice sessions.

5.3.2 SAFE START psychosocial assessment and depression screening training

With a more psychosocial focus to their work, primary health care staff, including child and family health nurses and midwives, require further training and support in psychosocial assessments and dealing with the outcome of these assessments. This training aims to support the Statewide implementation of psychosocial assessment and depression screening by drawing together several components that are essential and complementary for working with families during the perinatal period.

Important areas covered in this training include:

- the concept of an integrated approach for working with families in the perinatal period
- the evidence base including the importance of the early years, rationale for *Families NSW*, the SAFE START model and early intervention and prevention in general
- comprehensive psychosocial assessment processes and the key depression screening tools
- the importance of clinical pathways and community networks for families
- working in partnership with the family to promote strengths and identify vulnerabilities
- assessment of safety of parent and infant.

In addition, attendance at the following existing training opportunities is encouraged: Area drug and alcohol courses; updates on child and family health issues; cultural awareness training; annual education programs; conferences and seminars; and specific courses such as breastfeeding/lactation and infant mental health. Attendance at mandatory training such as suicide risk assessment and management, child protection and domestic violence screening are to be arranged as a priority and before staff conduct psychosocial assessments and depression screening.

5.4 Clinical supervision

Staff working with families are required to exercise professional judgement and make decisions on options for care that have significant consequences for families. Clinical supervision is vital to support the practitioner and maintain a professional service that focuses on the client's needs. AHSs are to ensure that staff receive regular clinical supervision.

Clinical supervision focuses on the health professional, his or her clinical practice and the client. The key function of a clinical supervisor is to provide an environment where the health professional can feel 'safe' to discuss, reflect upon and explore clinical experiences and issues. The supervisor is usually a health professional who is able to provide additional expertise, knowledge and skill. This supervisor should not have direct managerial responsibility for the person whom they are supervising.

Approaches to clinical supervision include:

- Individual – the health professional and the supervisor meet on a regular basis to discuss clinical cases and experiences. This approach will be most appropriate for staff involved in home visiting more complex/vulnerable client groups.
- Group – the supervisor meets several health professionals on a regular basis to discuss clinical cases and experiences. This method of supervision has the added advantage of group members learning from their colleagues' experiences and will be most appropriate for all staff working with families.

Peer support can be used to provide additional opportunities for discussion about clinical practice issues and/or the opportunity to review literature. No formal supervisor is included in this group discussion.

5.5 Service systems to support clinical practice

As part of the Family Partnership Model (Davis et al 2002), primary and community health care services and staff within these services can be categorised according to the type and complexity of service delivered, which can be grouped under generalist and specialist tiers. Within both the generalist and specialist tiers there are two further tiers that reflect the complexity of services provided within these tiers. This results in a four-tier model in which each tier requires its own level of expertise and set of skills and depends on good working relationships and links with the other tiers to enhance the quality of care delivered. These tiers relate to the primary, secondary, tertiary and quaternary levels of service.

Tier 1 (Primary level service) involves direct service provision for clients with low-level and common needs delivered by staff with highly developed generalist skills. For example, within the broad child and family health service system, child and family health nurses can be considered to be Tier 1 staff, delivering Tier 1 service to all children and their families.

Tier 2 (Secondary level service) involves a mixture of direct service provision and consultation, support and training to Tier 1, delivered by staff with more specialised skills. For example, the multidisciplinary team, as described in Sections 3.2 and 3.3, provides elements of Tier 2 service within this team, by providing support and consultation for the Tier 1 staff delivering the primary care.

Tier 3 (Tertiary level service) involves the direct provision of care to clients with specific conditions that require specialised care and support by staff that have specialised, condition-related clinical skills. Access is generally by referral from the generalist tier. Tier 3 services also provide support and consultation to the generalist tiers. Mental Health and Drug & alcohol services are examples of Tier 3 services.

Tier 4 (Quaternary level service) involves intensive short-term care for clients with the most severe, complex and least frequent conditions.

It is important for health services to develop effective partnerships between the tiers, to allow generalist health services to manage ongoing care of clients with specific health problems and be able to access specialised support and effective referral pathways for clients with more acute and complex problems.

Universal maternity, child and family health services are to be underpinned by support from a Tier 2 multidisciplinary team that has four functions:

- participation in multidisciplinary case discussion to determine level of care
- consultation, support and education for Tier 1 primary care workers
- direct service provision to families, as required, in collaboration with Tier 1 staff
- facilitation of referral to Tier 3 and Tier 4 services when required.

The provision of Tier 2 support is essential because it provides an important level of service to people with extra needs that cannot be met adequately by Tier 1 services. Tier 2 support acts as a buffer or filter to the more specialised Tier 3 and Tier 4 services (therefore limiting premature referrals and escalation of cost) and collaborates with Tier 1 staff to provide ongoing care for people with higher level needs. AHSs need to consider the availability and accessibility of all tiers.

5.6 Service networks

Health home visiting may lead to the identification and engagement of more families with a range of problems and issues that will require interventions by several professional groups and services.

AHSs are to ensure there is a directory of services available that outlines what services the AHS and broader child and family service networks provide for families, and the eligibility criteria to access these services.

AHSs are to develop referral protocols both within NSW Health and with other service network partners to facilitate optimal transition between services. The development of protocols to effect the timely and smooth referral of children and families is essential for the effective operation of health home visiting. When appropriate, AHSs should consider developing service agreements or memoranda of understanding.

5.7 Occupational health and safety

Health professionals conducting home visiting are to be aware of the practices and approaches that will reduce the risks to their personal safety and the safety of the family they are visiting. Workers should not place themselves at risk.

The NSW Health Policy directive PD2005_339 should be used as the basis for developing AHS occupational health and safety procedures relating to health home visiting.

AHSs are to establish protocols and procedures that address the following occupational health and safety considerations when implementing health home visiting:

- Risk assessments – to be completed for each family prior to the first home visit to identify any potentially dangerous conditions and/or environmental hazards that may compromise worker safety.
- Precautions – situations in which nurses should not home visit and/or visit alone should be identified. When aggression or violence has been assessed as a potential concern, a home visit should not be conducted and alternative arrangements should be made, for example, contact in a health facility or public place

- Itinerary – systems are in place to monitor staff movements, safety and return, including procedures for late return.
- Procedures – to maximise safety during the home visit and action to be taken when a worker feels at risk during a home visit.
- Communication equipment – all health professionals involved in home visiting are to carry a mobile telephone that is capable of functioning in the geographical area of use, switched on during home visits and carried on the health professional's body (not left in brief case/bag).
- Car breakdowns – access to a mobile phone and clear guidelines on what to do in the event of a breakdown or accident.

5.8 Confidentiality

The sharing and transfer of information are to be conducted with regard to Information Privacy provisions. The NSW Health Policy Directive PD2005_593 is to be referred to.

In general the following should be noted:

- patients/clients are to be advised that access to their health record will be available to the patient's/client's treating health care providers within the public health system
- patients/clients are to be provided with information on how their personal health information will be used within the public health system
- a parent can give informed consent in relation to their child but they cannot give consent on behalf of a partner or other family member
- personal health information is not to be disclosed to third parties without the informed consent of the person to whom it relates unless there is a legal obligation to do so
- under the *Children and Young Persons (Care and Protection) Act 1998* the Department of Community Services can direct agencies including NSW Health to provide information that relates to the safety, welfare and wellbeing of a child or young person (refer to *NSW Interagency Guidelines for Child Protection Intervention 2006* and NSW Health PD2005_299).

Health services are to respect confidentiality and obtain consent when sharing information with services other than those provided by the AHS. Before a referral is made to another agency, written permission is to be obtained from the parent prior to the transfer of that information. Parents are to be informed of the purpose for sharing information, what information will be shared and with whom, and the benefits of sharing information. AHSs will develop local policies and protocols that support sharing information and case coordination across the service network in the context of Information Privacy provisions.

5.9 Resource requirements

The implementation of a home visiting service will require nurses to be mobile and have access to the following equipment.

Motor vehicle

Access to a motor vehicle is essential to the success of health home visiting. Ideally a vehicle should be allocated to each clinician providing home visiting or there should be ready access to a pool vehicle. Staff conducting home visiting need to have access to a motor vehicle that allows opportunistic visits and interactions with families. It is not appropriate for staff to be dropped off when visiting in the home and picked up at a later time as this potentially compromises staff safety.

Mobile telephones

Access to a mobile telephone with appropriate network coverage for the area being serviced is also required for all staff conducting home visits.

Lockable brief case

All staff require a lockable bag to securely transport client records. The locked bag is to be transported in the boot of the car and taken in when visiting a client. Client records are not to be left unattended in a car.

Clinical equipment

Equipment for monitoring the growth and development of the infant is required for home visiting, for example scales, age-appropriate toys. The availability of this equipment will ensure that nurses may undertake opportunistic child health screening and surveillance when required.

Information technology

Access to computers for the provision of data and for access to information necessary to support clinical practice and communicate with the service network is required.

5.10 Funding

AHSs are to ensure that adequate funding is provided for implementation of primary health care and health home visiting services for families expecting a baby or caring for young children.

AHSs have been provided with enhancement funds as part of the Statewide implementation of *Families NSW*. These enhancement funds are to be used in the development of systems to support the implementation of *Families NSW* and health home visiting. AHSs may need to redirect existing resources and re-orient their services to implement health home visiting.

AHSs are required to report annually to the NSW Health Department on the expenditure of the enhancement funds made available for implementing *Families NSW*.

5.11 Evaluation

The implementation of the *Families NSW* strategy across the State will enhance NSW Health's ability to contribute to improving outcomes for the children of NSW. The *Families NSW* Headline Indicators and Outcomes Framework sets out the expected long term outcomes from the strategy, and is one aspect of the overall evaluation strategy for *Families NSW*. These broad, high level outcomes are conceptualised at a population level. When measured and monitored over time they will inform us about the health and wellbeing outcomes for children, families and communities in NSW and whether these outcomes are improving.

Currently, several NSW Health Statewide data sets and systems are in use, or being developed that may contribute to the provision of data for monitoring and evaluation. These include the Midwives Data Collection, the Statistical Inpatient Collection (Health Outcomes Information Statistical Toolkit), and the NSW Health Survey Program.

AHSs are to evaluate their compliance with the practices and procedures outlined in this policy regularly.

5.12 Reporting

An annual report that provides information on AHS *Families NSW* activity including SAFE START, progress on UHHV, financial reporting and major achievements, is to be provided to the NSW Department of Health, at the end of each financial year.

Specific data on UHHV performance is requested by NSW Department of Health on a quarterly basis.

APPENDIX 1

Health care services for mothers, babies and families

NSW Health has a long and successful history of providing health services to mothers, babies and families. Maternity and Child and Family Health Services have demonstrated considerable innovation in delivering flexible and responsive services with a capacity to respond to changing social circumstances. Central to this has been the ongoing commitment and dedication of the health professionals delivering these services.

Universal primary health care services

The platform for the provision of integrated perinatal and infant services is the universal primary health care system.

NSW Health currently provides universal services to families who are expecting or caring for a baby. Maternity and child and family health services are well placed to be the entry point for families into the broader *Families NSW* service network. NSW Health has the capacity to engage with all families following the birth of a baby, and many families prior to birth, and has a key role in providing support for all families expecting or caring for a new baby. Midwives and child and family health nurses adopt a holistic model of care which encompasses medical, physical, psychological, emotional and social aspects and are therefore able to identify the needs of families and facilitate access to the required supports.

This section outlines the range of maternity and early childhood health services currently provided by NSW Health. This is included to ensure that integrated perinatal care, including UHHV, is viewed and implemented as part of the universal service system provided by NSW Health to parents expecting or caring for a baby.

1.1 Maternity Services

Maternity services are the first point of entry to the *Families NSW* service system for most parents expecting a baby in NSW.

NSW Health provides a range of maternity services to the community through metropolitan and rural AHSs. The nature and scope of maternity services available to local populations varies considerably within and between AHSs.

The NSW Framework for Maternity Services (NSW Health 2000) identifies the following services and systems of care that constitute the maternity services of NSW:

- Core services include antenatal, intrapartum, birth and postpartum care. Clinicians include obstetricians, paediatricians, midwives and nurses for both outpatients and inpatients with access to anaesthetic and allied health services.
- Systems and processes within and between primary, secondary and tertiary models of care that are networked to facilitate transfer of care between AHS facilities and the community setting by encouraging effective communication and consumer participation.
- Specific services and programs that provide direct care, information and/or specific education programs that target marginalised or disadvantaged groups of women and their families.
- Non-specific services and programs that provide information and/or education programs for women and their families in the antenatal and postnatal period, ie preparation for parenthood, antenatal and postnatal education classes or group sessions.

Area Health Services are expected to provide continuity of care for all women throughout the antenatal, intrapartum and postnatal periods.

Continuity-of-care models

Continuity-of-care utilises a primary health care philosophy that enables women to develop a meaningful relationship with the same caregiver(s) throughout pregnancy, birth and the postnatal period. Each woman receives care from a primary carer(s) who takes responsibility for ensuring that the care provided to the woman is appropriate, safe and effective, based on her identified needs and individual circumstances.

Maternity home visiting programs

Most AHSs have developed maternity home visiting programs to support women during pregnancy and in the transition from hospital to home.

Across NSW there is wide variation with regard to access, availability, entry criteria and scope of service provision, including duration and timing of visits, for these programs. The aims of postnatal services are to provide early postnatal maternity care and assessment of the woman and baby, with a focus on physical aspects, psychosocial and environmental needs that relate to the transition to home, including the establishment of infant feeding.

Additional services have been developed in some metropolitan tertiary hospitals for the provision of neonatal home visiting services for babies who have been discharged from neonatal intensive care units. These services are restricted to those babies whose conditions meet specific criteria and who reside within set geographical areas.

In some AHSs, additional services are provided for women and their babies with identified problems, to promote effective discharge from hospital and seamless uptake into the community-based child and family health services.

Maternity care for Aboriginal women

The NSW Aboriginal Maternal and Infant Health Service (AMIHS) features a primary health care model of antenatal and postnatal care for Aboriginal women until their baby is 8 weeks old. Within this model, teams of midwives and Aboriginal health workers work with general practitioners and other specialists to provide comprehensive care for Aboriginal women during the antenatal and postnatal period.

The key elements of this model are:

- Continuity of maternity care, providing antenatal and postnatal care
- a partnership between a midwife and Aboriginal health worker/education officer
- a partnership approach between Area Health Services and the Aboriginal community-controlled sector
- community-based, culturally appropriate services, including home visiting and outreach
- the provision of transport
- a training component for midwives and Aboriginal health workers
- an explicit focus on community peer education and community development (in addition to health service delivery)
- participation of Aboriginal families in program implementation and evaluation.

AMIHS includes programs funded by the Australian Government known as Alternative Birthing Services Program (ABSP), and Area Health Services funded programs with the same philosophy and service delivery model.

1.2 Early childhood health services

Early childhood health services form part of the comprehensive network of primary health care services for families and children across NSW. Early childhood health services are provided for children aged zero to five years and their parents/carers. The staff of these services are primarily registered nurses who predominantly have postgraduate qualifications and experience in child and family health nursing and other relevant qualifications, for example midwifery.

NSW Health provides a range of health care services to children and their families. Health services specifically provided for children and their families include:

- Early childhood health services
- Family care centres
- Residential family care centres
- Parent help telephone lines
- Child and family teams in community health services
- Child protection services
- Child and adolescent mental health services
- Children's wards in general hospitals
- Specialist children's hospitals.

General practitioners are major providers of care within the primary health care system. They are key partners in the provision of health services for children and their families. The health system must maintain strong links with other relevant government departments, local government, non-government organisations, health professionals and families to create the best opportunities for improving children's health.

Early Childhood Health Centres are staffed by health professionals (including registered nurses) who specialise in child and family health. The child and family health nurse gives assistance with caring for babies and young children, including information on:

- breastfeeding
- coping with sleeping and crying

- children's growth and development
- immunisation
- safety
- playing with babies or toddlers to stimulate development
- parental wellbeing.

The range of early childhood health services encompasses areas of activity delivered in two main settings – at centres and in the client's home.

Centre based activities

- Early childhood health clinics – services are provided on an appointment or 'drop in' basis within a clinic setting.
- Group programs – programs are conducted for a range of issues including postnatal depression, breastfeeding, sleep and settling and child behaviour. These groups also encourage social interaction amongst parents so that they may develop and utilise their own supportive network of friends. Group programs can also be used at appropriate well child health checks.

Various other services provided from centres are designed to maximise the opportunities for families to network, for example newsletters, pram-walking activities, and coffee mornings.

Home visiting

AHSs have developed specific early childhood health home visiting programs to address local needs. Home visiting is sometimes provided over the short term to address specific health issues, such as breastfeeding, settling or postnatal depression. In some instances, these programs have been available universally and in others they have been targeted to particular groups.

The universal postnatal home visit outlined in the Policy is one component of home visiting that is delivered by child and family health nurses as part of the universal primary health care services provided within the NSW Health system.

APPENDIX 2

Principles underpinning the policy

The integrated approach to perinatal and infant care, as part of the *Supporting Families Early* initiative, aims to achieve the following key results:

1. improved child health and wellbeing
2. enhanced family and social functioning
3. provision of services that meet the needs of children and families
4. improved continuity of care.

Achievement of these results necessitates working within a service framework guided by:

- *Families NSW*
- investment in the early years: NSW Action Plan Early Childhood and Child Care, State Plan and State Health Plan
- equity
- clinical practice principles that include working in partnership with the family and facilitating the development of the parent–infant relationship.

1.1 Families NSW

Families NSW is based on research that demonstrates that the way in which families are supported in the early years of their children's lives has lasting effects on children's development and later education, health and economic outcomes. The two underpinning principles of the *Families NSW* strategy are:

- a strengths-based approach to working with families, inclusive of all cultures and family types
- a planned, coordinated service system that is responsive to the needs of families.

Working with families

Staff can make their interactions with families as valuable as possible if they:

- empower parents to be active in the decisions which affect their lives
- view parents as experts who know what is best for their family
- link families to the services best able to meet their needs
- have a holistic view of each family
- seek and take into account feedback from families about the service they have received
- provide flexible services in convenient settings
- work with families as a team at two levels, within the service itself and across the service network
- have access to opportunities for ongoing training and development.

Service planning

Services will be more effective in helping families if they:

- form part of a network of services which is multidisciplinary and multifaceted
- are built on practices that have proved to be effective
- encourage feedback from communities and families
- are developed locally by families, volunteers and staff
- are appropriate to the needs of different communities (eg culturally and linguistically diverse and Aboriginal communities and communities at different levels of functioning)
- are flexible and accessible to families in convenient settings
- collect and share information and participate in evaluation.

1.2 Investment in the early years

The NSW Government is committed to supporting children and families. It recognises the importance of providing children with a good start in life, to ensure their optimal growth and development. This commitment is a priority in the NSW Action Plan Early Childhood and Child Care, under the Council of Australian Governments, National Reform Agenda, the State Plan (in particular,

F4 embedding prevention and early intervention into Government service delivery in NSW, F6 Increased proportion of children with skills for life and learning, and F7 reduced rates of child abuse and neglect) and the State Health Plan (Strategic Direction 3 Strengthen primary health and continuing care in the community).

The rationale for this investment is supported by economic evidence that investment in the early years is cost effective. Professor James Heckman, a leading US economist and Nobel laureate, promotes investment in the early years as a means to increasing productivity in the economy and society more broadly. Early interventions for disadvantaged children provide the greatest return. Interventions have been shown to promote schooling, improve the quality of the workforce, enhance the productivity of schools and reduce crime, teenage pregnancy and welfare dependency. The interventions evaluated were shown to raise earnings in adulthood and promote social attachment. The return from the dollars invested is as high as 15–17 per cent. Further more, the cost of intervening increases with age (Heckman 2006), making early childhood intervention cheaper and more effective in the long term.

1.3 Equity

The Policy focuses on two key concepts for equity:

- a universal population approach
- working in context to address the social determinants of health.

Universal population approach

A universal population approach aims to improve the health and wellbeing of the whole population. It seeks to influence individual behaviours and lifestyles indirectly by changing social norms and social support (Nutbeam & Harris 1999). Home visiting is most effective when a universal population approach to enrolment is used (Guterman 1999).

Working in context to address the social determinants of health

Maternal and child health is, 'inextricably linked with social factors in our communities' (Tiedje 2000). Primary child and family health care addresses the broader context of family, social system and environment, particularly the social and psychological aspects. This is best achieved by working in the context of the family home, where 'the one-to-one relationship in that private domain, appears to provide the foundation for very individualized care' (Carr 2001).

1.4 Clinical practice principles

Clinical practice principles include working in partnership with the family, the Family Partnership model and the common core of skills and knowledge.

1.4.1 Working in partnership with the family

Working in partnership with the family is supported by a strengths-based model of service delivery.

Professionals who work from a strengths-based perspective focus on what is working in the family rather than what is not. While family issues are not ignored, they are not viewed as pathologies or labelled. The focus is on the qualities that a family may already have that can be drawn on to help them manage the problem.

The family is supported to identify the available resources and skills within the family and community so they can become empowered to use those assets. Family resilience is viewed as an inherent property of families that can be nurtured and mobilised. Practitioners focus on helping families to recognise their strengths in order to increase their resilience.

> *If one studies only family problems, one finds only family problems. When strengths are identified they can become the foundation for continued growth and positive change in a family and a society. (DeFrain 1999).*

1.4.2 The family partnership model

The Family Partnership Model (Davis et al. 2002) is a framework that can be applied within an organisation and within clinical practice to support clinicians to work from a strengths-based perspective, in partnership with their clients. This model was developed to enable all potential helpers engaging with parents to provide a more effective service and work together to enable a more complete system of care.

> *The intention is to enable them (the clinicians) to understand the processes and skills of helping, so that they can use their own technical expertise more effectively by taking into account the interpersonal processes, yet also deal with the psychological and social issues that are invariably present when people have a problem. (Davis et al. 2002).*

The model focuses on skilled practitioners engaging clients in a partnership-based process to enable them to work together on identifying, clarifying and managing problems. The partnership includes the following elements:

- mutual respect and trust – the development of a mutual trusting relationship between the nurse and the family is needed to facilitate change
- effective communication
- working closely together
- sharing power but led by parents
- operating with honesty and flexibility
- identifying and respecting each other's complementary expertise
- establishing parent-directed goals
- presenting ideas as suggestions for consideration and negotiation.

The approach is primarily concerned with fostering the parent–professional relationship and parent-infant relationship so that parents and families are supported to build on their strengths to rectify any health, lifestyle or parenting issues.

The service system – a coordinated, tiered approach

There are high levels of psychosocial problems in some families and the resources available to assist them are limited (Davis et al. 2002). Therefore, to address this need most effectively within the current service system, it is important that there be an interactive and responsive system that relies on all the components of universal and specialised services. The Family Partnership framework identifies a model to explain the relationship between both universal and specialist services. The model consists of coordinated tiers of service ranging from Tier 1 services that deal with all children, to Tier 4 services that are the most specialist level dealing with the comparatively few children and families that have the most complex needs. In this model, services are structured to enable skilled Tier 1 workers to consult with, and be supported by, more specialised Tier 2 staff. This facilitates the provision of effective and efficient support to families, by improving the quality of help available to all families and decreasing the need for referral to specialist services (refer to Section 5.5).

The parent-helper relationship

In the Family Partnership Model the nature of the relationship between the professional and parent is one that regards the parent as the expert in his or her own life. It invites a paradigm shift away from the professional as expert to one of professional and parent in partnership, recognising the complementary expertise of both. Working within a partnership relationship, the professional seeks to help the parent to recognise the aspirations they hold for themselves and their children and then support them to realise these.

Such a relationship is assumed to be the vehicle by which parents may be able to explore difficulties they face, to clarify their situation and to develop the most helpful and effective strategies for optimising the psychosocial development of their children (Davis et al. 2002).

The nature of the relationship between the professional and the parent can be used to model the attachment relationship between the parent and the baby. Parents are encouraged to mirror the nature of this relationship with their infants by following and responding to their infant's cues and providing the infant with the support they need whilst they are learning to master new skills. In both circumstances, the relationship is designed to provide support, rather than encourage dependency.

In the Family Partnership Model, there is a focus on enhancing the parent's ability to:

- effectively deal with circumstances and problems that may interfere with parenting
- relate to and interact with their children appropriately.

The parent-infant relationship

Human development occurs within a relationship context (Donley 1993). It is well recognised that, from birth, nurturing relationships with caring adults are essential to a child's healthy development. From conception, the infant is totally dependent on the environment for survival and is embedded in relationships with caregivers who provide the ingredients to support both physical and psychological growth (Sameroff & Fiesse 2000).

Attachment theory highlights the importance of the relationship between the primary care-giver and infant in the first three years of life in establishing enduring emotional patterns that affect emotional regulation, coping capacities, self-confidence and social interactions throughout the lifespan (Egeland & Erickson 1999). Parenting is an interactive process and the attachment relationship that develops is affected primarily by the parent's interactions with the infant, sensitivity to identifying an infant's needs, and consistency in response to an infant's behaviour.

To provide effective help for parents and their children, clinicians need to understand:

- the nature of the parent–infant interaction

- that a child's behaviour and development is the result of the continuous dynamic interaction between the child and the experiences provided by that child's family.

The Family Partnership Model includes a model of parent–child interaction that mirrors the model of parent–helper interaction. This model has direct implications for helping families with young children, as it will assist clinicians with:

- understanding the basis of parenting
- conducting psychosocial assessments
- promotion, prevention and early intervention
- assisting parents with their understanding of parent-infant interactions and the importance of the early parent-infant relationship for their baby's future health and wellbeing.

The quality and stability of relationships in the first few years form the basis for many later developmental outcomes such as sound mental health, school achievement, and capacity to develop and sustain relationships.

> *Young children experience their world as an environment of relationships, and these relationships affect virtually all aspects of their development – intellectual, social, emotional, physical, behavioural… (Shonkoff 2004).*

1.4.3 *The common core of skills and knowledge*

The Common Core of Skills and Knowledge for the Children's Workforce sets out the basic skills and knowledge needed by people whose work brings them into regular contact with children, young people and families. It enables multi-disciplinary teams to work together more effectively in the interests of the child. The skills and knowledge are described under six main headings:

- effective communication and engagement with children, young people and families
- child and young person development
- safeguarding and promoting the welfare of the child
- supporting transitions
- multi-agency working
- sharing information.

More information on the above can be found at www.everychildmatters.gov.uk/delivering services/commoncore/

APPENDIX 3

SAFE START psychosocial assessment questions

Example of preamble:

In this health service we ask all women the same personal questions about a number of things, including violence at home. We ask about these things because we know that there are some issues for women or their partners that can affect parenting. The answers to these questions can help us to help you and your family to care for your baby.

You don't have to answer the questions if you don't want to. What you say will remain confidential to the Health Service, except where we are seriously concerned for you or your children's safety.

Recommended core psychosocial risk questions

Variables	Psychosocial questions
I Lack of support	1. Will you be able to get practical support with your baby? 2. Do you have someone you are able to talk to about your feelings or worries?
II Recent major stressors in the last 12 months	3. Have you had any major stressors, changes or losses recently (ie in the last 12 months) such as financial problems, someone close to you dying, or any other serious worries?
III Low self-esteem (including self-confidence, high anxiety and perfectionistic traits)	4. Generally do you consider yourself a confident person? 5. Does it worry you a lot if things get messy or out of place?
IV History of anxiety, depression or other mental health problems	6. Have you ever felt anxious, miserable, worried or depressed for more than a couple of weeks? a) If so, did it seriously interfere with your work and your relationships with friends and family? 7 Are you currently or have you in the past, received treatment for any emotional problems?
V Couple's relationship problems or dysfunction (if applicable)	8. How would you describe your relationship with your partner? 9. a) Antenatal: What do you think your relationship will be like after the birth? b) Postnatal (in a community setting): Do you have concerns about how your relationship has changed since having the baby?
VI Adverse childhood experiences	10. Now that you are having/have a child of your own, you may think more about your own childhood and what it was like. As a child were you hurt or abused in any way (physically, emotionally, sexually)?
VII Domestic violence Questions must be asked only when the woman can be interviewed away from partner or family member over the age of three. Staff must undergo training in screening for domestic violence before administering questions.	11. Within the last year have you been hit, slapped, or hurt in other ways by your partner or ex-partner? 12. Are you frightened of your partner or ex-partner? (If the response to questions 11 and 12 is "No" then offer the DV information card and omit questions 13–18) 13. Are you safe: here at home?/to go home when you leave here? 14. Has your child/children been hurt or witnessed violence? 15. Who is/are your children with now? 16. Are they safe? 17. Are you worried about your child/children's safety 18. Would you like assistance with this?
Opportunity to disclose further	19. Are there any other issues or concerns you would like to mention?

APPENDIX 4A

Edinburgh Postnatal Depression Scale

The Edinburgh Postnatal Depression Scale (EPDS) is a well validated universal screening measure originally used to screen community samples of women for depressive symptoms following childbirth. The EPDS has also been found to be useful for screening non-postpartum women and can be reliably used from conception up to 18 months postpartum (Kowalenko et al. 2000). As with all assessment tools, the EDS should be used to complement clinical judgement. The scale helps professionals to identify and assist women who are experiencing distress or depression during the perinatal period and, therefore, who are at significant risk of developing more complex health problems.

The EPDS is a self-report questionnaire that can be completed in two or three minutes.

Scoring the Edinburgh Postnatal Depression Scale

The response categories are scored 0, 1, 2 or 3, according to the order of severity of the symptoms. Some items are scored in reverse order (that is 3, 2, 1 or 0). Adding the scores for the 10 items yields a total score between zero and 30.

Scores are graded as follows (the validated cut off scores that are provided are taken from *Variability in use of cut-off scores and formats on the Edinburgh Postnatal Depression Scale – implications for clinical and research practice*, Matthey et al 2006):

Antenatal period

- 15 or more: probable major depression
- 13 or more at least probable minor depression

Postnatal period

- 13 or more: probable major depression
- 10 or more at least probable minor depression

Things to check:

- inconsistency between low and high scores and the clinical presentation and verbal responses of the woman
- the woman's literacy level and comprehension of the items (this is particularly important if the woman is from a non-English-speaking background)
- cut off scores for women from non-English speaking backgrounds. It is recommended that a thorough search of the literature is undertaken for studies using the EDS/EPDS from the particular culture/ ethnic background being reporting on. If no studies have been conducted, it is recommended that this is mentioned and the rationale is explained for whatever score issued (Matthey et al 2006)
- different cut-off scores are appropriate for different cultural groups
- individual items that received a high score
- a score of 10 or more suggests the need for further assessment. All women expressing a positive response to question 10 require further assessment to determine risk of harm to self or others. Assessment of suicidality also requires an assessment of family safety, particularly the safety of any children or unborn babies. Assessments are based on a combination of the background conditions and the current factors in a person's life and the way in which they are interacting. Further information is available in *NSW Health Framework for Suicide Risk Assessment and Management for NSW Health Staff* September 2004.
- extremely high and low scores, as clinical experience suggests that extremely high scores are achieved by those with severe personality disorders (who may also have a major depressive disorder). A score of zero should also evoke suspicion.

Important note

Remember the Edinburgh Postnatal Depression Scale is a screening tool and scores alone do not represent a diagnosis or an assessment. An appropriate management plan relevant to the client's needs can only be developed after a full assessment.

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Edinburgh Postnatal Depression Scale

Cox JL, Holden JM, Sagovsky R. (1987).

Date_____ Mother's name_____ Age_____

Baby's name_____ Date of birth_____ Sex_____

As you have recently had a baby we would like to know how you are feeling. Please UNDERLINE the answer which comes closest to how you have felt IN THE PAST 7 DAYS, not just how you feel today. Here is an example, already completed.

I have felt happy:

Yes, all the time

Yes, most of the time

No, not very often

No, not at all

This would mean: "I have felt happy most of the time" during the past week. Complete the other questions in the same way.

1. I have been able to laugh and see the funny side of things:
   As much as I always could
   Not quite so much now
   Definitely not so much now
   Not at all
2. I have looked forward with enjoyment to things:
   As much as I always could
   Not quite so much now
   Definitely not so much now
   Not at all
3. I have blamed myself unnecessarily when things went wrong:
   Yes, most of the time
   Yes, some of the time
   Not very often
   No, never
4. I have been anxious or worried for no good reason:
   No, not at all
   Hardly ever
   Yes, sometimes
   Yes, very often
5. I have felt scared or panicky for no very good reason:
   Yes, quite a lot
   Yes, sometimes
   No, not much
   No, not at all
6. Things have been getting on top of me:
   Yes, most of the time I haven't been able to cope at all
   Yes, sometimes I haven't been coping as well as usual
   No, most of the time I have coped quite well
   No, I have been coping as well as ever
7. I have been so unhappy that I have had difficulty sleeping:
   Yes, most of the time
   Yes, sometimes
   Not very often
   No, not at all
8. I have felt sad or miserable:
   Yes, most of the time
   Yes, quite often
   Not very often
   No, not at all
9. I have been so unhappy that I have been crying:
   Yes, most of the time
   Yes, quite often
   Only occasionally
   No, never
10. The thought of harming myself has occurred to me:
    Yes, quite often
    Sometimes
    Hardly ever
    Never

APPENDIX 4B

Edinburgh Postnatal Depression Scale scoring guide

Score for each question has been inserted on the left-hand side of each possible response.
Add the scores for each question to calculate a total score out of a possible 30.

1. I have been able to laugh and see the funny side of things:
   - 0 As much as I always could
   - 1 Not quite so much now
   - 2 Definitely not so much now
   - 3 Not at all

2. I have looked forward with enjoyment to things:
   - 0 As much as I always could
   - 1 Not quite so much now
   - 2 Definitely not so much now
   - 3 Not at all

3. I have blamed myself unnecessarily when things went wrong:
   - 3 Yes, most of the time
   - 2 Yes, some of the time
   - 1 Not very often
   - 0 No, never

4. I have been anxious or worried for no good reason:
   - 0 No, not at all
   - 1 Hardly ever
   - 2 Yes, sometimes
   - 3 Yes, very often

5. I have felt scared or panicky for no very good reason:
   - 3 Yes, quite a lot
   - 2 Yes, sometimes
   - 1 No, not much
   - 0 No, not at all

6. Things have been getting on top of me:
   - 3 Yes, most of the time I haven't been able to cope at all
   - 2 Yes, sometimes I haven't been coping as well as usual
   - 1 No, most of the time I have coped quite well
   - 0 No, I have been coping as well as ever

7. I have been so unhappy that I have had difficulty sleeping:
   - 3 Yes, most of the time
   - 2 Yes, sometimes
   - 1 Not very often
   - 0 No, not at all

8. I have felt sad or miserable:
   - 3 Yes, most of the time
   - 2 Yes, quite often
   - 1 Not very often
   - 0 No, not at all

9. I have been so unhappy that I have been crying:
   - 3 Yes, most of the time
   - 2 Yes, quite often
   - 1 Only occasionally
   - 0 No, never

10. The thought of harming myself has occurred to me:
    - 3 Yes, quite often
    - 2 Sometimes
    - 1 Hardly ever
    - 0 Never

APPENDIX 4C

Edinburgh Depression Scale (Antenatal)

Cox JL, Holden JM, Sagovsky R. (1987).
Cox JL, Holden, JM. (2003)

As you are about to have a baby we would like to know how you are feeling. Please UNDERLINE the answer which comes closest to how you have felt IN THE PAST 7 DAYS, not just how you feel today. Here is an example, already completed.

I have felt happy:

Yes, all the time

Yes, most of the time

No, not very often

No, not at all

This would mean: "I have felt happy most of the time" during the past week. Complete the other questions in the same way.

---

1. I have been able to laugh and see the funny side of things:
   As much as I always could
   Not quite so much now
   Definitely not so much now
   Not at all
2. I have looked forward with enjoyment to things:
   As much as I always could
   Not quite so much now
   Definitely not so much now
   Not at all
3. I have blamed myself unnecessarily when things went wrong:
   Yes, most of the time
   Yes, some of the time
   Not very often
   No, never
4. I have been anxious or worried for no good reason:
   No, not at all
   Hardly ever
   Yes, sometimes
   Yes, very often
5. I have felt scared or panicky for no very good reason:
   Yes, quite a lot
   Yes, sometimes
   No, not much
   No, not at all
6. Things have been getting on top of me:
   Yes, most of the time I haven't been able to cope at all
   Yes, sometimes I haven't been coping as well as usual
   No, most of the time I have coped quite well
   No, I have been coping as well as ever
7. I have been so unhappy that I have had difficulty sleeping:
   Yes, most of the time
   Yes, sometimes
   Not very often
   No, not at all
8. I have felt sad or miserable:
   Yes, most of the time
   Yes, quite often
   Not very often
   No, not at all
9. I have been so unhappy that I have been crying:
   Yes, most of the time
   Yes, quite often
   Only occasionally
   No, never
10. The thought of harming myself has occurred to me:
    Yes, quite often
    Sometimes
    Hardly ever
    Never

APPENDIX 5

Practice checklist for clinicians

Antenatal assessment and coordinated maternity care

- ☐ Assessment provided at the first antenatal visit or booking in (before 20 weeks preferably).
- ☐ Universal assessment offered to all pregnant women.
  - – Core psychosocial assessment.
  - – Administer Edinburgh Depression Scale; record and discuss score with parent.
- ☐ No vulnerabilities detected – care plan developed and maternity care until birth
- ☐ If new vulnerabilities detected.
  - – Identify level of vulnerability (refer to Table 2 and Section 3.2 of the Policy).
  - – Refer for case discussion within multidisciplinary team management approach.
  - – Level of care/service response determined by team and care plan developed in conjunction with mother (refer to Section 3.2 to 3.4 of the Policy).
  - – Case review as determined in care plan.
- ☐ Following birth, transfer of client's information to the early childhood health service within two (2) days of discharge.
- ☐ Ensure a smooth transition of care to early childhood health services.

Postnatal assessment and coordinated care by child and family health

- ☐ Universal Health Home Visit/assessment offered to all families with a new baby and will ideally be provided within two (2) weeks of date of birth.
  - – Preferably assessment will be provided in the home; however, there will be occasions when assessments will need to be provided in the clinic setting.
  - – Review antenatal assessments transferred from maternity services.
  - – Core psychosocial assessment reviewed or where none has been previously attended conduct a primary health care assessment.
  - – Administer Edinburgh Postnatal Depression Scale, if clinical or access concerns; record and discuss score with the parent.
- ☐ No vulnerabilities detected, care plan developed, assessment points as per infant's personal health record ('Blue book') and provision of universal health services.
- ☐ If new vulnerabilities detected.
  - – Identify level of vulnerability (refer to Table 2 and Section 3.2 of the Policy).
  - – Refer for case discussion within multidisciplinary team management approach.
  - – Level of care/service response determined by team and care plan developed in conjunction with client (refer to Sections 3.3 and 3.4 of the Policy).
  - – Case review as determined in care plan.

6 to 8 weeks assessment

In addition to the infant check conducted at 6–8 weeks.

- ☐ Provide parent with Edinburgh Postnatal Depression Scale, readminister in two weeks if score is 13 or above and 0 on question 10.
- ☐ Review postnatal assessments and consider within a team management approach to care.
- ☐ No vulnerabilities detected, assessment points as per infant's Personal Health Record ('Blue Book') and provision of universal health services.
- ☐ If vulnerabilities detected.
  - – Identify level of vulnerability (refer to Table 2 and Section 3.2 of the Policy).

- Refer for case discussion within multidisciplinary team management approach.
- Level of care/service response determined by team and care plan developed in conjunction with client (refer to Section 3.3 and 3.4 of the Policy).
- Case review as determined in care plan

6 months assessment

In addition to the infant check conducted at 6 months.

☐ Provide parent with Edinburgh Postnatal Depression Scale, if a need has been identified. Record and discuss score with parent.

☐ Review postnatal assessments and consider within a team management approach to care, if a need has been identified.

☐ No vulnerabilities detected, assessment points as per infant's Personal Health Record ('Blue Book') and provision of universal health services.

☐ If vulnerabilities detected.

- Identify level of vulnerability (refer to Table 2 and Section 3.2 of the Policy).
- Refer for case discussion within multidisciplinary team management approach.
- Level of care/service response determined by team and care plan developed in conjunction with client (refer to Section 3.3 to 3.4 of the Policy).
- Case review as determined in care plan.

APPENDIX 6

Area health service practice checklist Planning for implementation

Collect baseline information on

- ☐ The population of children and their families, including Aboriginal families and culturally and linguistically diverse families.
- ☐ Health services and programs directed to children and their parents.
- ☐ Staffing and funding provided to child and family health services.

Service network

- ☐ AHSs are to identify the service network for families with young children and establish methods of liaison and referral, and service agreements where appropriate, across the range of government and community organisations in the area.

Support for clinical practice

- ☐ Ensure availability of Tier 2 multidisciplinary support staff for Tier 1 staff.

Health home visiting

- ☐ Review services and programs delivering support to families to incorporate UHHV.
- ☐ Review existing home visiting programs that support families expecting or caring for a baby to ensure that the services provided are consistent with this Policy.
- ☐ Ensure that all families are offered a universal health home visit (UHHV) by the child and family health service and that this is delivered within the first two weeks of birth.

Continuum of care

- ☐ Review clinical pathways to care to ensure consistency with the Policy.
- ☐ Integrate and coordinate service development across maternity, child and family health and specialist services.
- ☐ Develop systems to ensure the effective flow of information from maternity to early childhood health services following the birth of a baby.

Psychosocial assessment

- ☐ Ensure an assessment process is in place in both maternity and early childhood health services that will facilitate universal, systematic exploration of key areas of risk, as per the SAFE START model and the Policy.

Team management

- ☐ Develop a team management approach to collaboratively planning care for families identified as vulnerable.

Referral systems

- ☐ Develop a directory of services and referral protocols within the AHS and with other service network partners, and policies that support sharing of information and case coordination across the service network within the context of information privacy provisions.

Evaluation

- ☐ Ensure evaluation processes are in place.

Qualifications

- ☐ Ensure that staff have qualifications and skills appropriate to the role to work within a multidisciplinary interagency approach supporting families and to deliver primary health care in the perinatal period as outlined in the Policy.

Training

- ☐ Ensure that staff have access to all necessary training as described in the Policy.

Clinical supervision and support

- ☐ Ensure staff receive clinical supervision on a regular basis.

Occupational health and safety

- ☐ Develop Occupational Health and Safety procedures for home visiting based on the NSW Health Policy Directive PD2005_339.

Resource requirements

- ☐ Services – Monitor demand for, and ensure timely access to, interpreter services, specialist consultation and therapeutic services needed to support health home visiting.
- ☐ Equipment – Ensure access to a motor vehicle, a mobile phone and clinical equipment for health home visiting staff.

Funding

- ☐ *Families NSW* enhancement funds have been provided to AHSs and are to be used to employ additional staff to develop systems to support *Families NSW* implementation.

Reporting requirements

- ☐ AHSs are required to report annually to the NSW Department of Health on the implementation of the Policy and the use of *Families NSW* enhancement funds.

Note: Area Health Services are to ensure that families are provided with information on the rationale for change in service provision including health home visiting and are involved in the ongoing planning and evaluation of health home visiting services.

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Websites

www.families.nsw.gov.au – the *Families NSW* website and links to other sites relevant to supporting families.

www.founders.net – comprehensive list of research and articles on prevention and early intervention support for families.

www.health.nsw.gov.au – NSW Health's website

Glossary of terms

Assessment
is an ongoing process beginning with first contact and continuing throughout all involvement with the family. Assessment is based on a range of information sources. It looks at physical, psychological, emotional and social aspects of health and identifies both vulnerabilities and strengths of the family.

Child and Family Health Services
are those health services available to support children and their families and include services such as mental health, drug and alcohol, early childhood health and allied health.

Clinical supervision
is a support mechanism for health professionals within which they can share clinical, organisational, developmental and emotional experiences with another professional in a secure, confidential environment in order to enhance knowledge, skills and reflective practice.

Drug misuse/abuse
is a pattern of drug use that has adverse physical, psychological and/or legal consequences for a person using drugs and/or those living with or otherwise affected by the actions of the person using drugs.

Early Childhood Health Service
is the program of services offered by the child and family health nurses. The role of this service is to provide support to families with children age 0–5 years. It is part of the comprehensive child and family health service.

Early intervention
strategies target people displaying the very early signs and symptoms of an illness. Early intervention also encompasses the early identification of people suffering from a first episode of a problem or disorder. Early intervention may also refer to programs focused on the early years of life.

Family strengths
are characterised by those relationship patterns, interpersonal skills and competencies, and social and psychological characteristics which create a sense of positive family identity, promote satisfying and fulfilling interaction among family members, encourage development of the potential of the family group and individual family members, and contribute to the family's ability to deal effectively with stress and crisis.

Health promotion
is an action to maximise health and wellbeing among populations and individuals.

Health Home Visiting
is defined as the delivery of health services within a client's home, to parents/carers who are expecting or caring for a baby, in order to enhance health and social functioning by responding to the specific need of that family within the family's own environment.

Key worker
is the worker identified by all persons involved in the care of a family as the pivotal support person. The role of the key worker is to ensure good communication between all service providers and the family and to act as the advocate for the family.

Mental health
is the capacity of individuals within groups and the environment to interact with one another in ways that promote subjective wellbeing, optimal development and use of cognitive, affective and rational abilities.

Mental health problem
is defined as diminished cognitive, emotional or social abilities but not to the extent that the criteria for mental illness or mental disorder are met.

Parent
is any person or persons with primary responsibility for the care and welfare of the child.

Perinatal
is defined within the mental health context, as encompassing pregnancy and the first year postpartum.

Postnatal period
is defined by the World Health Organization (WHO) as the period that starts about an hour after the delivery of the placenta and includes the following six weeks. WHO states that the postnatal period represents 'a critical transition for a woman, her newborn and her family at a physiological, emotional and social level and that postpartum care should respond to special needs of the mother and baby.'

Population-based interventions
target populations rather than individuals. They include activities targeting the whole population as well as activities targeting population groups such as Aboriginal peoples.

Prevention
is an intervention that occurs before the onset of the problem or disease and can be designed as a universal (whole population), selective (groups at risk) or indicated (individuals with early signs or symptoms) intervention.

Primary Health Care
NSW Health defines the meaning of Primary Health Care by adopting the definition used by the Australian Health Ministers Council (1998):

> *Primary Health Care seeks to extend the first level of the health system from sick care to the development of health. It seeks to protect and promote the health of defined communities and to address individual and population health problems at an early stage. Primary health care services involve continuity of care, health promotion and education, integration of prevention with sick care, a concern for population as well as individual health, community involvement and the use of appropriate technology.*

Service network
is the group of services, teams or individuals within the local community that supports families.

Strengths-based approach
views a family as resourceful and skilled, setting the agenda and actively engaged in the process of addressing their issues and solving their own problems. The focus is on the available resources and skills within the family and community, and empowering the family and community to use those assets in building resilience. The aim is to facilitate families in the process of identifying their own strengths.

Sustained Health Home Visiting
is a structured program of health home visiting over a sustained period of time, beginning in pregnancy and continuing until the infant is two (2) years old. The aim of this program is to provide a range of support around health and other bio-psychosocial areas of risk and vulnerability.

Targeted programs
identify children and/or groups for intervention who are at higher risk of developing poor social or health outcomes.

Universal Health Home Visiting (UHHV)
includes at least one universal contact in the client's home within two weeks of birth and may also include further home visiting. The child and family health nurse from the early childhood health service conducts the UHHV. A home visit can be classified as a UHHV if it has occurred up to and including four weeks and six days from the birth of the baby.

Universal programs
are characteristically available to all. There are two types of universal interventions – those that focus on particular communities or settings, and those with a whole population focus.

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