

DRAFT

**National Framework for Health Services for
Aboriginal and Torres Strait Islander
Children and Families**

DRAFT

List of Acronyms

ACCHO	Aboriginal Community Controlled Health Organisation
AEDC	Australian Early Development Census
AHEO	Aboriginal Health Education Officer
AHMAC	Australian Health Ministers Advisory Council
AHW	Aboriginal Health Worker
AIFS	Australian Institute of Family Studies
AIHW	Australian Institute of Health and Welfare
ANFPP	Australian Nurse Family Partnership Program
BBV	Blood borne virus
FASD	Fetal Alcohol Spectrum Disorders
GP	General practitioner
NACCHO	National Aboriginal Community Controlled Health Organisation
NGO	Non-Government Organisation
NHMRC	National Health and Medical Research Council
RCT	Randomised Control Trial
STI	Sexually transmissible infection
UN	United Nations
USF	National Framework for Universal Child and Family Health Services
WHO	World Health Organization

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1 EXECUTIVE SUMMARY

The National Framework for Health Services for Aboriginal and Torres Strait Islander Children and Families ('the Framework') articulates a vision and principles for the delivery of child and family health services to Aboriginal and Torres Strait Islander people across Australia. It aims to provide guidance for policy and program design, service development and implementation to address the needs of Aboriginal and Torres Strait Islander children and families.

The Framework has been developed to complement the National Framework for Universal Child and Family Health Services (USF), in recognition that the current child and family health service system, including the provision of universal services, does not currently meet the needs of all Aboriginal and Torres Strait Islander children and families.

The Framework adopts a holistic view of health and wellbeing and seeks to draw on the inherent strengths of Aboriginal and Torres Strait Islander peoples and cultures to inform how high quality, evidence based child and family health services can be delivered to Aboriginal and Torres Strait Islander people.

In recognition of the importance of the early years of child development, the Framework emphasises the importance of supporting healthy in-utero growth and primary preventive programs that support physical, social and emotional wellbeing, in particular the establishment and maintenance of strong relationships between children and their primary care givers.

Building the evidence base and more effectively using available evidence is a key focus of the Framework. All parts of the service system, including policies and funding programs, need to have clear and measurable aims and objectives that reflect the best available evidence about both the risk factors for poorer health and wellbeing outcomes, as well as service responses that have demonstrable impact.

In addition to promoting better use of the available evidence, other key elements of the Framework are:

- Embedding child and family health services in primary health care
- Comprehensive assessment of the needs of individuals and families
- Approaches to care that recognise and respond to the needs and preferences of Aboriginal and Torres Strait Islander families and communities.
- System change through structured place-based planning

A number of factors underpin the Framework that are required to support health services to enable them to meet the needs of Aboriginal and Torres Strait Islander children and families. These include:

- The principles of primary health care: equity, universal access, community participation and inter-sectoral approaches
- Infrastructure to support service delivery
- Skilled and culturally competent workforce
- Policies and operational systems to support monitoring and continuous quality improvement, referral, data collection and information sharing
- Leadership and governance structures including the participation of Aboriginal and Torres Strait Islander people in planning, delivery and review of child and family health services.

The Framework identifies key approaches to care that support culturally appropriate care for Aboriginal and Torres Strait Islander people. Central to these approaches is the importance of cultural competence and the need for individuals and organisations to develop the capacity to work effectively within the cultural context of each client. Other approaches to care identified in the Framework include:

- Family-centred care to identify and respond to the needs and structures of individual families
- Strengths-based approaches
- Continuity of care to support relationship-based care
- Trauma-informed approaches
- Reflective practice
- Multi-disciplinary care.

Key elements of service delivery have been identified to enhance the scope and quality of services for Aboriginal and Torres Strait Islander children and families including:

- Comprehensive, holistic assessment to ensure that families are supported to access the range of services they need including universal and targeted health services as well as other educational and social supports
- Flexible service delivery to facilitate the establishment and maintenance of engagement with Aboriginal and Torres Strait Islander families
- Improving transitions between services.

The Framework sets out key responsibilities of government and policy makers, service organisations and practitioners for implementation of health services.

Key factors affecting Aboriginal and Torres Strait Islander children and families at different stages of development are identified in the Framework along with the implications for service delivery and mechanisms for services to address these needs.

The organisation of services within the broad service system has a considerable impact on accessibility, availability and navigability for Aboriginal and Torres Strait Islander families. The Framework proposes a (local or regional) place-based model for improving collaboration and integration of services to support improved service delivery.

Development of the Framework has been informed by review of relevant literature, extensive consultations and was supported by:

- A Working Group of the Australian Health Ministers' Advisory Council Standing Committee on Child and Youth Health (SCCYH) and the National Aboriginal and Torres Strait Islander Health Standing Committee (NATSIHSC)
- A Cultural Advisory Group of Aboriginal and Torres Strait Islanders with specific expertise and experience in Aboriginal and Torres Strait Islander health; and
- An Expert Reference Group representing organisations with expertise in child and family health.

2 INTRODUCTION

This Framework has been developed to complement the National Framework for Universal Child and Family Health Services (USF)¹ which articulates a vision, objectives and principles for universal child and family health services for all Australian children aged zero to eight years and their families.

All states and territories have a system of universal child and family health services, however the disparity in health outcomes between Aboriginal and Torres Strait Islander people and other Australians remain. While significant improvement has been made towards reducing the gap between Aboriginal and Torres Strait Islander people and other Australians in child mortality and to a lesser extent birthweight, there is slower progress towards reducing other health and developmental disparities.

This Framework has therefore been developed in recognition that the current child and family health service system, including the provision of universal services, does not meet the broad spectrum of needs of Aboriginal and Torres Strait Islander children and families. While the Framework builds on the USF, links to the secondary and tertiary service sectors is fundamental to improving health service delivery, particularly for the most vulnerable families and those with complex needs.

The document aims to provide additional guidance for policy and program design, service development and implementation necessary to address the needs of Aboriginal and Torres Strait Islander children and their families.

3 CONTEXT

This Framework sets out an approach that seeks **to draw on the inherent strengths** of Aboriginal and Torres Strait Islander peoples and cultures to inform how high quality, evidence-based child and family health services can be delivered to Aboriginal and Torres Strait Islander people.

The National Aboriginal Health Strategy has described 'Aboriginal health' as a holistic view of health and wellbeing:

*"Aboriginal health means not just the physical wellbeing of an individual but refers to the social, emotional and cultural wellbeing of the whole Community in which each individual is able to achieve their full potential as a human being, thereby bringing about the total wellbeing of their Community. It is a whole-of-life view and includes the cyclical concept of life-death-life."*²

The health and wellbeing of Aboriginal and Torres Strait Islander children and families is determined by a complex interplay of factors including culture, socioeconomic characteristics, housing and transport, community capacity, behavioural factors, and social and emotional wellbeing. Along with culture, concepts of social justice, equity and rights are central to wellbeing.

Culture is fundamental to health and wellbeing for Aboriginal and Torres Strait Islander children and families and is a source of strength and resilience for many.³ The importance of culture to the health and wellbeing of Aboriginal and Torres Strait Islander children and families needs to be acknowledged and understood by all service providers.

The traumatic legacy of colonisation and ongoing racism have a significant impact on Aboriginal and Torres Strait Islander people, both in terms of their health and wellbeing and in their decisions about where and how they access services. Aboriginal and Torres Strait Islander culture provides a strong foundation for adaptation and survival, in spite of a long history of adversity. It is important for people and organisations at all levels of the health service system to recognise, support and build upon this strength and resilience.

Aboriginal and Torres Strait Islander communities consist of many different groupings based on kinship and language. Within these communities 'family' is defined more broadly than for most other Australians and comprises extended family members and significant others. These relationships define how people relate to each other, and are communicated to children from birth. Unlike many other cultures, child rearing is seen as a family and community concern. Members of the extended family or kinship group may have specific roles and responsibilities for the care and nurture of children. Understanding the particular relationships and responsibilities within Aboriginal and Torres Strait Islander families is critical for ensuring services are appropriately targeted and for maximising access.

Child rearing and parenting practices also differ, both between Indigenous and non-Indigenous families but also between Indigenous communities and families. Many families will develop parenting practices based on a mix of Indigenous and non-Indigenous approaches. Some key attitudes that may underpin Aboriginal and Torres Strait Islander approaches to child rearing include^{4 5 6}:

- Children are seen as independent, autonomous and self-sufficient from birth
- Care is provided on a "child-led" basis rather than using set feeding or sleeping routines
- Children learn to look after younger kin from an early age, encouraging autonomy and early learning
- Non-interference unless a child is in distress or causing distress to others
- Indirect behaviour management such as storytelling, modelling and the use of natural consequences.

Understanding and respecting different child rearing practices is important for planning and delivering services that reflect individual parenting choices and styles.

3.1 The importance of the early years

There is considerable evidence demonstrating the importance of the period from conception through the early years of a child's life to provide strong foundations for lifelong physical, social and emotional wellbeing.^{7 8}

Early childhood experiences – starting in pregnancy with fetal development and continuing through infancy, childhood and adolescence – shape outcomes throughout the lifespan. The role of early childhood experiences in the development of emotional, social and health issues in adulthood are becoming better understood.

Early childhood is a critical intervention point in which the foundation for future health and wellbeing is established.^{9 10} A number of factors shape this foundation, including:

- *Maternal health and behaviours* such as attendance at antenatal care, physical and mental health, tobacco use, alcohol consumption and nutrition
- *Brain development.* From conception, the first three years of a child's life are critical to brain development. Several neural systems necessary for adult functioning are formed in this time period, including auditory and visual perception, mastery of motor skills, language development and self-regulation and control
- *Family and social environment* has a significant effect on brain development, with normal development requiring a high level of sustained stimulation (e.g. being spoken or read to, engaging in play)
- *Relationships with carer(s)* are important for emotional regulation, impulse control and protection against the negative effects of stressful life events. Secure attachments, characterised by high quality carer-child interactions, help to mitigate against the effects of adverse situations
- *Good nutrition* in infancy and early childhood supports healthy development (including brain development), growth and functioning.

Research has demonstrated that programs which are initiated during pregnancy and during the first years of life are more successful at improving core developmental outcomes. The benefits of prevention and early intervention for children and their families are well documented.

3.2 Service structures

Australia has a complex health service structure, involving federal, state/territory and local governments, non-government organisations, Aboriginal Community Controlled Health Organisations (ACCHOs) as well as a significant private sector, each of which contribute to the provision of child and family health services.

Each jurisdiction is responsible for the provision of universal maternal, child and family health services and the way in which these services are funded and delivered varies across Australia. Furthermore a range of other community-based providers, including ACCHOs and general practitioners (GPs) deliver similar services, and all community-based providers interface with the tertiary hospital system where the majority of women give birth. The complexity of the system can lead to fragmentation of services and can make it challenging for families to access the services they need.

Public antenatal care is provided predominantly by midwives working in organisations funded by state and territory governments. Services are either provided through hospital clinics or in community based settings. Many ACCHOs provide antenatal care (either by GPs or midwives), often supported by Aboriginal Health Workers (AHWs). Antenatal care is also provided by GPs, often through shared care arrangements with local hospitals and by private obstetricians on a fee for service basis. There is limited use of private midwives across Australia.

Most women give birth in hospitals. Although birthing services are outside the scope of the Framework, it does encompass services leading up to and after the birth as well as the management of transitions between these services.

The system for the delivery of child health services is more complex. Each jurisdiction has a schedule of universal contacts from birth to school age which are delivered through a variety of models and settings, predominantly by child and family health nurses. GPs provide child health services including health checks and monitoring, immunisation and management of chronic and acute illness. Similarly ACCHOs provide a comprehensive range of child health services through nurses, AHWs, GPs and allied health providers. Families may access child health services from any or all of these providers at different developmental stages and as their needs change.

3.3 Using and building the evidence base

The disparity in health and developmental outcomes between Aboriginal and Torres Strait Islander people and other Australians is based on considerable research and evidence. However the implementation of service responses often has not reflected the same level of evidence. To achieve measurable improvements in Aboriginal and Torres Strait Islander children's health and development, governments need to invest in high-quality evidence-based early childhood services.

The now widely used term *evidence based practice* has its origins in the field of medicine and the use of randomised controlled trials (RCT) in clinical settings. Systematic reviews of RCTs are considered to be the highest level of evidence and sit at the top of evidence hierarchies that set out criteria by which the effectiveness or impact of interventions can be assessed. Figure 1¹¹ shows an example of a research hierarchy, with increasing levels of validity and reliability moving up the triangle.

Figure 1 Hierarchy of Evidence



Evidence hierarchies are useful as a guide to interpreting the relative merits of different studies or research to inform, or evaluate interventions and programs. However assessing the relevance and applicability of evidence to the implementation of a particular program also should involve consideration of the:

- Type or level of evidence
- Quality of the particular study or studies
- Size of the effect demonstrated
- Relevance or generalisability to other locations or populations.

It is important to note that in the “real world” contexts in which child and family health services operate, there is often debate about the relative merits of different evidence, based on the applicability to particular contexts or service environments. The challenge for policy makers and service providers is to interpret and apply the best available evidence to inform policy and program design while at the same time implementing programs in diverse community settings.

It is unrealistic to suggest that all child and family health programs can be based on interventions with RCT level evidence. However all programs should be planned and implemented to incorporate evidence that is applicable to the setting and context. At the same time a stronger evidence base needs to be developed to identify what is working and what is not. This requires attention to the implementation of programs, treatment schedules and protocols to ensure they are administered with fidelity such that the recipient receives the “full dose” of the program or treatment schedule as well as improved data collection and reporting. A greater emphasis needs to be placed on robust evaluation that measures programs against defined outcomes, rather than, as is often the case, relying solely on intermediary or indirect outputs to assess their effectiveness.

3.4 Current policy environment

The policy environment for child and family health services reflects the complexity of the service system described above.

Given that the majority of child and family health services are funded by governments, policy at the national, state and territory, and local levels, has a critical role in driving and shaping service delivery. It is vital, then, that policy is informed by and reflects the best available evidence. Just as service providers are encouraged to collaborate and ensure linkages, governments also need to ensure consistency in policy across portfolios and program areas. This is particularly important where policies intersect across sectors and have direct and/or indirect impacts on other policies.

Table 1 provides a summary of national policies, strategies and frameworks that are relevant to the Framework. It should be noted that while this list was current at the time of developing the Framework, many of the policies are time-limited and may no longer be current. Likewise new policies will be developed over time that may have an impact on the implementation of the Framework.

Table 1 Policy Environment 2014

Policy/Strategy/Plan	Date	Relevance to Framework
United Nations Convention on the Rights of the Child`	1989	<p>The Convention on the Rights of the Child is an international human rights treaty adopted by the UN General Assembly requiring signatories to abide by its 54 Articles under international law, ensuring that their social services, education, health and legal systems are in full compliance. The Convention protects a wide variety of children's rights including;</p> <ul style="list-style-type: none"> • To survive and develop healthily • To live with their parents • To be protected from physical and mental violence or neglect • To enjoy access to health care facilities and the highest attainable standards of health with particular attention to be paid to; <ul style="list-style-type: none"> ○ Reducing infant and child mortality ○ Providing necessary health care to all children, emphasising primary health care ○ Combating disease and malnutrition through available technology, providing nutritious foods and clean drinking water ○ Ensuring prenatal and postnatal health care for mothers ○ Ensuring all segments of society have access to education on child health and nutrition, the advantages of breastfeeding, hygiene and accident prevention ○ Developing preventative health care and parental guidance services. • To enjoy living standards adequate for their physical, mental, spiritual, moral and social development. • To readily accessible education, with the State to take steps to encourage regular attendance and reduce drop-out rates.
United Nations Declaration on the Rights of Indigenous Peoples	2007	<p>The Declaration on the Rights of Indigenous Peoples is a human rights standard adopted by the UN General Assembly. The purpose of the Declaration is not to set firm requirement on member States, but rather to act as an international standard for conduct with regard to Indigenous populations.</p>
Investing in the Early Years: A National Early Childhood Development Strategy	2009	<p>Articulates common goals for governments in early childhood development outcomes by 2020 around health, nurturing environments, development of knowledge and skills, improving social inclusion, educational opportunities, family capability and early childhood development services to support workforce</p>

Policy/Strategy/Plan	Date	Relevance to Framework
		<p>participation.</p> <p>Recognises the need for both universal and targeted strategies for more vulnerable groups.</p>
Protecting Children is Everyone's Business: National Framework for Protecting Australia's Children	2009-2020	<p>Aims to establish a national approach to child protection that will ensure Australia's children are safe and well. Intended outcomes:</p> <ul style="list-style-type: none"> • Children live in safe and supportive families and communities • Children and families access adequate support to promote safety and intervene early • Risk factors for child abuse and neglect are addressed • Children who have been abused or neglected receive the support and care they need for safety and wellbeing • Indigenous children are supported and safe in their families and communities • Child sexual abuse and exploitation is prevented and survivors receive adequate support
National Maternity Services Plan	2010-2015	<p>National framework to guide policy and program development. Four priority areas:</p> <ul style="list-style-type: none"> • Improving access • Improving service delivery • Developing the maternity care workforce • Developing maternity care infrastructure <p>Recognises role of maternity care in closing the gap, culturally competent care and increasing the Aboriginal and Torres Strait Islander maternity workforce</p>
The National Plan to Reduce Violence against Women and their Children	2010-2022	<p>Vision: Australian women and their children live free from violence in safe communities.</p> <p>The Second Action Plan: Moving Ahead 2013-16 contains five National Priorities and 26 actions, which are joint areas of work that all governments agree are critical to moving ahead in reducing violence against women and their children. These are:</p> <ol style="list-style-type: none"> (1) Driving whole of community action to prevent violence (2) Understanding diverse experiences of violence (3) Supporting innovative services and integrated systems (4) Improving perpetrator interventions (5) Continuing to build the evidence base.
National Indigenous Law and Justice Framework	2010	<p>Provides governments with a resource to address Indigenous disadvantage related to contact with the justice system. Five goals:</p> <ol style="list-style-type: none"> 1. Improve all Australian justice systems so that they can comprehensively deliver on the justice needs of Aboriginal and Torres Strait Islander peoples in a fair and equitable manner

Policy/Strategy/Plan	Date	Relevance to Framework
		<ol style="list-style-type: none"> 2. Reduce over-representation of Aboriginal and Torres Strait Islander offenders, defendants and victim in the criminal justice system. 3. Ensure that Aboriginal and Torres Strait Islander people feel safe and are safe within their communities 4. Increase safety and reduce offending within indigenous communities by addressing alcohol and substance abuse 5. Strengthen indigenous communities through working in partnership with governments and other stakeholders to achieve sustained improvement in justice and community safety
AHMAC Clinical Practice Guidelines – Antenatal Care (Module 1)	2012	<p>Advice and recommendations for best practice antenatal care in first trimester including:</p> <ul style="list-style-type: none"> • Woman-centred, culturally appropriate care • Ideal timing and frequency of visit schedules • Clinical assessments to screen for complicating health factors • Providing advice on behavioural considerations e.g. smoking
National Framework for Universal Child and Family Health Services- Secondary and Tertiary Services	Under development	Articulates with the USF outlining secondary and tertiary child and family health services.
National Aboriginal and Torres Strait Islander Health Plan 2013-2023	To be updated and released by the end of 2014	The Health Plan is a 10-year evidence-based framework developed with significant input from Aboriginal and Torres Strait Islander health leaders and service providers. The Health Plan is designed to guide policy and programme development to improve Indigenous health and achieve health equality by 2031. The Plan is being updated to reflect the Government's approach and priorities for Indigenous affairs, to recognise the important links between education, employment, community safety and health.

4 THE FRAMEWORK

4.1 Approach to developing the Framework

The Framework has been informed by a review of relevant literature, scoping of current policies and programs and a consultation process across Australia. A list of organisations and individuals who have participated in the consultation process to date is included at Appendix A. The development of the Framework was overseen by a Working Group of the SCCYH and supported by an Expert Reference Group and an Aboriginal and Torres Strait Islander Cultural Advisory Group.

Following public consultations on the Department of Health website (www.health.gov.au), the Department will collate stakeholder feedback and prepare the document for endorsement by the SCCYH, NATSIHSC, CCPHPC and AHMAC.

4.2 Vision

Aboriginal and Torres Strait Islander children and families access high quality, evidence-based and culturally safe child and family health services to support their health, development and wellbeing.

4.3 Principles

1. *Access:* All Aboriginal and Torres Strait Islander children and families should have access to culturally safe and comprehensive primary health care services that take a holistic approach to meet individual and population health needs and that support optimal health, growth and development.
2. *Equity:* Child and family health services should be planned and delivered to reduce inequalities and address the poorer health status of Aboriginal and Torres Strait Islander people.
3. *Working in partnership:* Aboriginal and Torres Strait Islander people and organisations should be involved in all levels of decision making about local planning and delivery of child and family health services that meet their needs and preferences.
4. *Collaboration and continuity:* Child and family health services are planned and delivered in collaboration with primary, secondary and tertiary health services, including ACCHOs as well as education, social support, child protection, housing and disability sectors.
5. *Evidence-based:* The design and implementation of child and family health services for Aboriginal and Torres Strait Islander people should be based on the best available evidence for improving health and developmental outcomes.
6. *Strengths-based:* Child and family health services should recognise and draw on the strengths of Aboriginal and Torres Strait Islander approaches to parenting and child rearing.
7. *Cultural respect:* All child and family health services should implement policies and practices that are respectful of and responsive to Aboriginal and Torres Strait Islander people and cultures.
8. *Workforce development:* The health and wellbeing of Aboriginal and Torres Strait Islander children and families will be enhanced through an ongoing commitment to the development of a strong Aboriginal and Torres Strait Islander health workforce.

4.4 Overview

The Framework builds on the USF but has an extended scope to include antenatal and pre-conception periods. As summarised in Figure 2, the Framework encompasses universal health services across the continuum from pregnancy to youth/pre-conception as well as highlighting the intersection between health, education and social services and the need for a holistic approach to supporting Aboriginal and Torres Strait Islander families to maximise their health. The Framework also describes the features of a local place-based health service

system that are required to deliver culturally appropriate child and family health services to Aboriginal and Torres Strait Islander people.

The key elements of the Framework are:

- Embedding child and family health services in primary health care
- Effective use of evidence in the design and implementation of services
- System change through structured place based planning
- Comprehensive assessment of the needs of individuals and families
- Approaches to care that recognise and respond to the needs and preferences of Aboriginal and Torres Strait Islander families and communities.

The Framework is underpinned by:

- Infrastructure to support high quality service delivery
- A technically and culturally skilled workforce, supported by appropriate training
- Information sharing to enable seamless movement of the child and family through the service system and access to care
- Supportive and evidence based national and jurisdictional policy
- Strong leadership at a national, jurisdictional and local/regional level.

The model described emphasises the need for local or regionally based system development that:

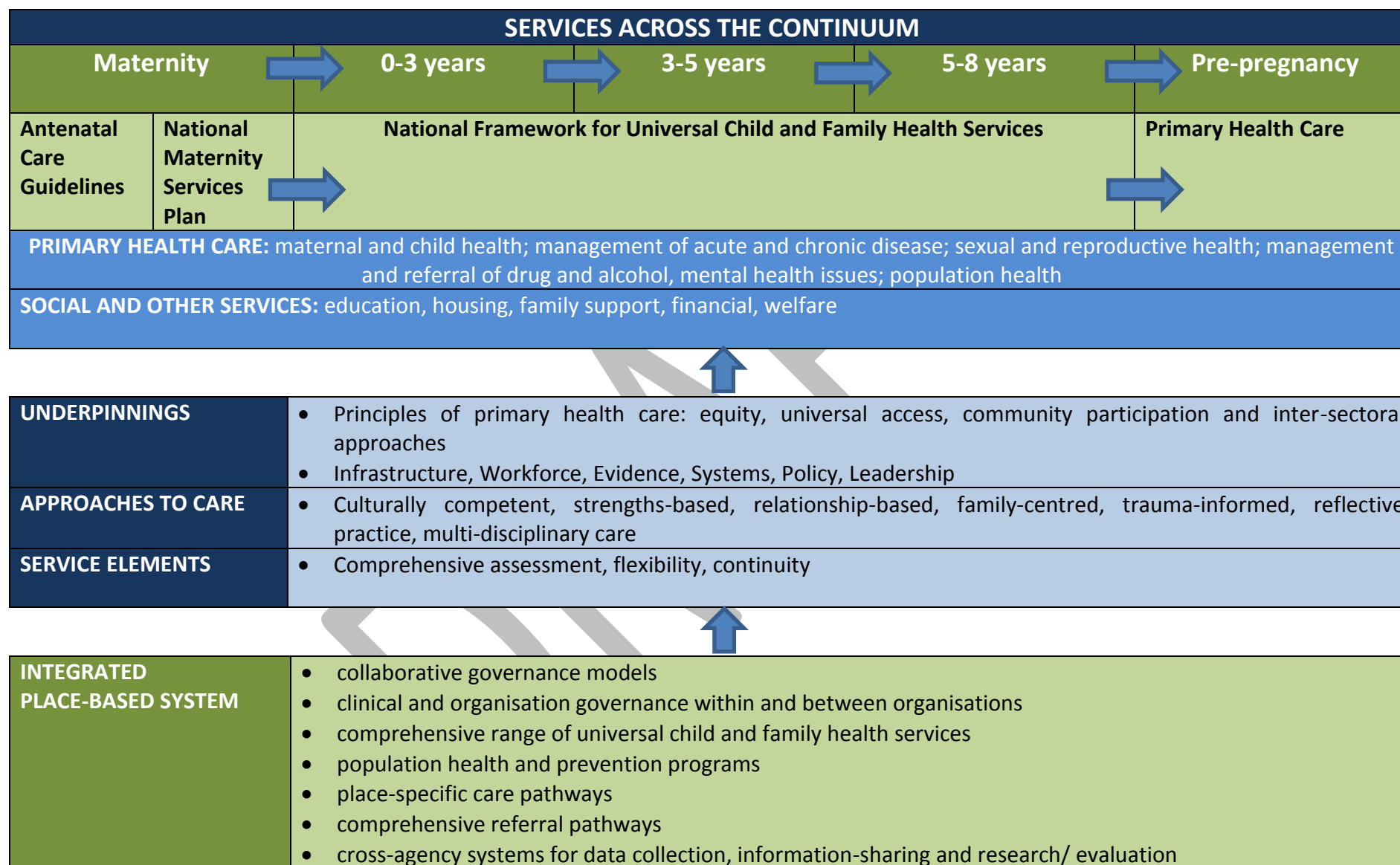
- Recognises and builds on the strengths of Aboriginal and Torres Strait Islander culture
- Acknowledges the need for changes in approach, evidenced by the continuing disparity in health outcomes between Aboriginal and Torres Strait Islander people and other Australians
- Uses the best available evidence to guide decision making about funding, program design and service delivery
- Emphasises the need for joint accountability across the service system, irrespective of how existing programs are funded and managed.

Figure 2 shows a linear model of care, from conception to youth/pre-pregnancy. However it is important to note that families will enter the system at different points and will loop through maternal and child health services with second and subsequent children.

Figure 2: Framework Overview

National Framework for Health Services for Aboriginal and Torres Strait Islander Children and Families	
VISION	
<i>Aboriginal and Torres Strait Islander children and families access high quality, evidence-based and culturally safe child and family health services to support their health, development and wellbeing.</i>	
PRINCIPLES	
<ul style="list-style-type: none"> • Access: All Aboriginal and Torres Strait Islander children and families should have access to culturally safe and comprehensive primary health care services that take a holistic approach to meet individual and population health needs and that support optimal health, growth and development. 	<ul style="list-style-type: none"> • Evidence-based: The design and implementation of child and family health services for Aboriginal and Torres Strait Islander people should be based on the best available evidence for improving health and developmental outcomes.
<ul style="list-style-type: none"> • Equity: Child and family health services should be planned and delivered to reduce inequalities and address the poorer health status of Aboriginal and Torres Strait Islander people. 	<ul style="list-style-type: none"> • Strengths-based: Child and family health services should recognise and draw on the strengths of Aboriginal and Torres Strait Islander approaches to parenting and child rearing.
<ul style="list-style-type: none"> • Working in partnership: Aboriginal and Torres Strait Islander people and organisations should be involved in all levels of decision making about local planning and delivery of child and family health services that meet their needs and preferences. 	<ul style="list-style-type: none"> • Cultural respect: All child and family health services should implement policies and practices that are respectful of and responsive to Aboriginal and Torres Strait Islander people and cultures.
<ul style="list-style-type: none"> • Collaboration and continuity: Child and family health services are planned and delivered in collaboration with primary, secondary and tertiary health services, including ACCHOs as well as education, social support, child protection, housing and disability sectors. 	<ul style="list-style-type: none"> • Workforce development: The health and wellbeing of Aboriginal and Torres Strait Islander children and families will be enhanced through an ongoing commitment to the development of a strong Aboriginal and Torres Strait Islander health workforce.

Figure 2: Framework Overview



4.5 Underpinning Components

UNDERPINNINGS

- Principles of primary health care: equity, universal access, community participation and intersectoral approaches
- Infrastructure, Workforce, Evidence, Systems, Policy, Leadership

The Framework is underpinned by:

- Principles of primary health care to inform the targeting and implementation of services
- Components of the service system that are necessary for it to function effectively.

The World Health Organisation (WHO) Principles of Primary Health Care underscore the importance of addressing the disparity in health outcomes between Indigenous and non-Indigenous children and families. These principles support implementation of programs that complement mainstream approaches in order to deliver services on the basis of need and improving health equity.¹²

4.5.1 Principles of Primary Health Care

Universal access to care and coverage on the basis of need

The Framework supports and builds on the USF which outlines core services that should be available to all Australian children and families. This Framework emphasises the importance of ensuring that all Aboriginal and Torres Strait families have access to culturally appropriate services, both universal and targeted that are appropriate to their level of need. Recognising the considerable heterogeneity of Aboriginal and Torres Strait Islander communities, and families within communities the Framework reflects the need for services to be tailored in scope and approach.

Commitment to health equity as part of development oriented to social justice

Achieving health equity between Aboriginal and Torres Strait Islander people and other Australians necessitates addressing the factors that contribute to the current inequity. In the context of child and family health services this means enabling access to clinical and public health resources needed to improve and maintain health as well as having strategies in place to influence social determinants of health. Importantly the WHO also identifies the need to support empowerment of Aboriginal and Torres Strait Islander people through systemic changes in order to address health inequalities.

Community participation in defining and implementing health agendas

The principle of community participation requires service providers, as well as policy makers, to actively engage Aboriginal and Torres Strait Islander people in the design and delivery of services. How this can be achieved will vary between communities and locations, but should be an essential component of service planning, monitoring and review to ensure services are meeting the needs of their target populations both in scope and approach.

Inter-sectoral approaches to health

Addressing the complex and intersecting risk factors associated with poor health outcomes will never be achieved by the health system in isolation. Systemic responses are required to ensure that inter-sectoral responses are sustained and sustainable, and not reliant only on cooperation or collaboration between individuals.

4.5.2 Workforce

The child and family health workforce is comprised of a broad range of practitioners including maternal, child and family health nurses, generalist nurses, Aboriginal Health Workers, GPs, medical specialists, dentists and allied health providers. In addition to relevant professional competencies all these providers require core competencies to work with Aboriginal children and families that include:

- Knowledge of child development
- Understanding of social determinants of health, and broader outcomes for children and families, including risk factors such as domestic violence and drug and alcohol
- Skills in assessment, monitoring and observation
- Ability to work in multi-disciplinary teams
- Interpersonal and communication skills
- Cultural competence
- Knowledge of relevant ethical guidelines, legislation and policies
- Appreciation of work life balance and providing flexible working arrangements.

Engagement of Aboriginal and Torres Strait Islander families with individual health practitioners and organisations is influenced by the cultural competence of these providers. Approaches that support building and maintaining a culturally competent workforce include:

- Pre-service and ongoing training for all staff about the impacts of colonisation, racism and understanding impacts of inter-generational trauma and how this needs to inform their service delivery and facilitate improved culturally appropriate communication
- Employment of Aboriginal and Torres Strait Islander workers
- Appropriately valuing and using the skill sets of Aboriginal and Torres Strait Islander workers.

Likewise there are several requirements to ensure that the workforce as a whole is appropriately trained, skilled and supported to deliver high quality child and family health services. These include:

- Clinical supervision and support
- Ongoing training and professional development
- Support for staff dealing with complex and challenging situations, e.g. debriefing
- Capacity to work collaboratively and in multidisciplinary teams.

Responsibility for ensuring that the child and family health workforce is both technically and culturally competent is shared. Policies and programs need to reflect the need for a skilled workforce in planning and funding mechanisms and build in appropriate accountability requirements. Service organisations are responsible for the provision of appropriate clinical governance, training and professional development and systems to monitor this. Individual staff are responsible for undertaking appropriate training and development and implementing services in ways that meet clinical governance standards and demonstrate cultural responsiveness.

While workforce planning and development is beyond the scope of this Framework to address, it is important to note that workforce capacity and shortages have a considerable impact on the ability of services to implement appropriate services. A recent review of New Directions Mothers and Babies services¹³ highlighted the difficulties many child and family health services currently have in recruiting appropriately qualified and skilled Indigenous and non-Indigenous staff.

4.5.3 Infrastructure and resources

The provision of child and family health services to Aboriginal and Torres Strait Islander children and families requires resources and infrastructure including:

- Recurrent funding to cover human resources and administration,
- Facilities from which services can be provided
- Clinical equipment
- IT systems and Continuous Quality Improvement (CQI)
- Transport/vehicles
- Educational resources.

The availability of these resources and infrastructure has a direct impact on the capacity of organisations to deliver services.

4.5.4 Evidence

The importance of evidence has been highlighted previously. For there to be improvements in outcomes for Aboriginal and Torres Strait Islander children and families, better use of evidence is foundational to inform policy, planning and delivery of services. Mechanisms to monitor, review and evaluate services and programs are essential to build the evidence base and communicate the effectiveness of programs and interventions

4.5.5 Supportive policy

The vast majority of child and family health services are funded by governments. Government policy directly and indirectly affects the implementation of programs and services. It is vital that policies at all levels reflect the best available evidence and that funded programs are built upon strong program logic and clear accountability requirements.

Just as collaboration and coordination between organisations at the local level is crucial, so too is the need for government policies to support inter-sectoral approaches through:

- Cross-agency coordination to ensure that policies and programs in health and non-health portfolios are mutually supportive and do not have adverse or unintended impacts on health outcomes
- Flexibility in funding mechanisms and enabling policies to facilitate innovative place-based collaborative models of service delivery
- Support for cross agency service models that address the complex social determinants of health and support prevention and early intervention in the early years.

4.5.6 Systems

Service delivery is also underpinned by policies and operational systems that support:

- Identification of Aboriginal and Torres Strait Islander clients
- Ongoing monitoring against agreed outcomes and continuous quality improvement to ensure clients receive all relevant services
- Referral networks, within and between service delivery organisations
- Data collection
- Information sharing between practitioners and organisations.

4.5.7 Governance and Leadership

This Framework identifies the need for change in the way child and family health services are planned and delivered to improve parity in health outcomes for Aboriginal and Torres Strait children. To achieve this requires strong technical and adaptive leadership at a policy level (national and jurisdictional), regional or place level, and organisational level.

A key component of this leadership should come through the participation of Aboriginal and Torres Strait Islander people in planning, delivery and review of child and family health services.

4.5.8 Roles and Responsibilities

Table 2 sets out key roles and responsibilities of governments (national and state/territory), service organisations and individual practitioners in relation to these underpinning elements of the child and family health service system.

Table 2 Roles and Responsibilities - underpinnings

	Government/Policy	Service Organisation	Practitioner
Principles of primary health care	<ul style="list-style-type: none"> Services made available to <i>all</i> Aboriginal and Torres Strait Islander children and families Aboriginal and Torres Strait Islander people engaged in the design of policy and programs 	<ul style="list-style-type: none"> Active identification of Aboriginal and Torres Strait Islander children and families Aboriginal and Torres Strait Islander people engaged in the design and delivery of services Service models designed to reflect best available evidence Flexible service delivery models to promote engagement with, and access by Aboriginal and Torres Strait Islander families 	<ul style="list-style-type: none"> Practice approach includes a holistic view of health, relationship-based and family centred care Practice is based on best available evidence
Workforce – Aboriginal and Torres Strait Islander	Planning and programs to support increasing the Aboriginal and Torres Strait Islander health workforce	Employment of Aboriginal and Torres Strait Islander people including: <ul style="list-style-type: none"> Health professional roles Cultural brokers Training and support to fulfil cultural brokerage role	<ul style="list-style-type: none"> Commitment to ongoing learning. Undertake training to maintain technical and cultural competence
Workforce	Health Workforce policies and programs	Employment of appropriately trained, skilled and culturally competent staff empowered and motivated by management Provision of: <ul style="list-style-type: none"> pre-service and ongoing training and professional development including reflective practice clinical supervision and support policies and procedures that support collaborative and multidisciplinary services 	<ul style="list-style-type: none"> Commitment to ongoing learning Undertake training to maintain technical and cultural competence Develop and maintain collaborative networks to support holistic care for Aboriginal and Torres Strait Islander families

	Government/Policy	Service Organisation	Practitioner
Infrastructure	<p>Policy and programs that provide adequate resources for:</p> <ul style="list-style-type: none"> • program funding • human resources • equipment • facilities <p>Support for systems of health information that promote and support strong communication and sharing of information</p>	<ul style="list-style-type: none"> • Efficient use of available resources. • Development and use of appropriate systems to share information within and between services. 	<ul style="list-style-type: none"> • Use available systems for communication and sharing information within and between services.
Systems	Facilitation of system-wide planning and development	<ul style="list-style-type: none"> • Participation in place-based planning and integrated service development • Communication and referral networks developed including systems to support referral and follow up. 	<ul style="list-style-type: none"> • Understand and utilise referral networks • Ensure all referrals are followed up.
Evidence	<ul style="list-style-type: none"> • Policies and programs that reflect the best available evidence and built on strong program logic. • Accountability mechanisms developed to ensure organisations are funded to provide service models that reflect the best available evidence. • Build the evidence base through high quality research and evaluation to guide policy development and program implementation • Facilitate development of agreed outcome measures 	<ul style="list-style-type: none"> • Service models developed on the basis of best available evidence. • Program logic developed for all programs, identifying expected outcomes, timeframes and monitoring processes. • Implementation of continuous quality improvement processes to ensure and improve adherence to program logic and monitor performance. • Participate in national and jurisdictional data collection 	<ul style="list-style-type: none"> • Maintain knowledge of current evidence and develop practice to reflect evidentiary developments • Commitment to reflective practice • Commitment to clinical data collection, monitoring and review for: <ul style="list-style-type: none"> ✓ Clinical planning ✓ CQI ✓ Service planning • Commitment to program data collection monitoring and review for: <ul style="list-style-type: none"> ✓ CQI ✓ Service and program planning
Leadership and governance		<ul style="list-style-type: none"> • Establish governance structures that support the active involvement of Aboriginal and Torres Strait Islander people. • Strong leadership and empowerment for team care across the organisation 	

4.6 Approaches to care

APPROACHES TO CARE	Culturally competent, strengths -based, relationship-based, family-centred, trauma-informed, reflective practice, multi-disciplinary care
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Approaches to care refers to the way in which services are delivered. These approaches have been highlighted as important ways in which culturally appropriate services can be provided that better meet the needs and expectations of Aboriginal and Torres Strait Islander children and families. It is important to note that the value in these approaches is not exclusive to Aboriginal and Torres Strait Islander people, and have application to socially disadvantaged groups and culturally and linguistically diverse populations.

Cultural competence has been identified as a key strategy to improve access to health services and health outcomes for Aboriginal and Torres Strait Islander people. Cultural competence is defined as:

“a set of congruent behaviours, attitudes, and policies that come together in a system, agency or among professionals and enable that system, agency or those professionals to work effectively in cross-cultural situations. The word ‘culture’ is used because it implies the integrated pattern of human behaviours that includes thoughts, communications, actions, customs, beliefs, values, and institutions of a racial, ethnic, religious, or social group. The word ‘competence’ is used because it implies having the capacity to function effectively.”¹⁴

The cultural competence of individual practitioners needs to be supported at an organisational level, and must be reflected in policies, programs and practices.

“A culturally competent system of care acknowledges and incorporates – at all levels – the importance of culture, the assessment of cross-cultural relations, vigilance towards the dynamics that result in cultural differences, the expansion of cultural knowledge, and the adaptation of services to meet culturally unique needs.”¹⁵

Cultural competence should not be seen as an end point, but an ongoing developmental process seeking to work effectively within the cultural context of the client. Elements of developing cultural competence to work with Aboriginal and Torres Strait Islander families include:

- Understanding the history and impacts of colonisation
- Recognising and understanding the impact of racism
- Learning about Aboriginal and Torres Strait Islander cultures with particular reference to local or regional culture
- Critical self-reflection and the ability to identify and challenge one’s own cultural assumptions, values and beliefs
- Empathy and understanding different ways of viewing the world.

Service systems and practitioners need to understand and value the cultural knowledge and expertise of Aboriginal and Torres Strait Islander workers.

Relationship-based care encompasses key relationships between health professionals, women, their families and the communities in which they live. Relationship-based care supports collaborative, client and family centred approaches, and seeks to improve:

- Quality of care
- Cultural competence

- Capacity of service providers to create a safe environment in which to discuss complex challenges, set goals and implement change
- Experiences of women, children and families' care
- Access and/or utilisation of the health care system
- Retention with the service and practitioner(s).

Family-centred care focuses on the unique needs, expectations, aspirations, and social and emotional environment of each family. It requires building a relationship with each family in order to understand and respond to their need and expectations as well as their cultural and community networks and context. It is underpinned by understanding the familial structure, including the roles and functions of extended family members and kin. Understanding the makeup of each family, and the roles each member has in child rearing enables the targeting of information and messages to the appropriate caregiver and decision-maker within the family.

An important element of family-centred care is the identification and support of the inherent **strengths** of the family allowing for a more balanced understanding of Aboriginal and Torres Strait Islander children and families rather than focusing on deficits/ problems.¹⁶ It requires health professionals to work collaboratively with Aboriginal and Torres Strait Islander families in the identification and strengthening of 'protective factors' such as cultural practices, values and kinship structures which promote child and family wellbeing.¹⁷

Establishing trust and rapport requires time and effort. Aboriginal and Torres Strait Islander people may need multiple visits with service providers to develop trust, and to feel secure. Extended consultations or appointments are important for several reasons:

- Aboriginal and Torres Strait Islander women are more likely than other Australian women to have multiple and complex health needs during pregnancy
- To enable health practitioners to build trusting relationships with individual women, families and children
- To incorporate discussion of both physical and social health issues and to negotiate appropriate service responses
- To develop an understanding of family, kinship and community relationships that provide the foundation for support networks and decision-making processes.

Flexibility to respond and tailor services to the individual needs of Aboriginal and Torres Strait Islander women and their families is fundamental to family-centred care. Providing families with the opportunity to make informed decisions about their care is another important element of relationship-based care including such things as:

- Choices about the type of services they receive
- Which family members participate in the care
- Which professionals are involved in providing care
- Choices about disclosing confidential information to a third party.

Continuity of care is a key element of relationship-based care and supports the building of relationships with children and families across the continuum. The fragmentation of our current system means that most families have to access services from different providers across various developmental stages. Continuity of care aims to break down barriers between services, reduce the number of different service providers, and/or support effective networks for referral and access across services. Therefore it is important that health service providers have developed collaborative relationships with colleagues in the sector and understand the types of services they provide to establish strong referral networks and coordinated care arrangements.

Where aspects of care are provided by various practitioners in different settings, such as maternity care provided by midwives and child health by child and family health nurses, service models can provide continuity by ensuring that the care providers work closely together and share relevant information. The use of the Personally Controlled Electronic Health Record System (eHealth record system), an electronic record for a patient that contains a summary of their health information, for example, enables healthcare organisations to have faster easier access to more health information and facilitates continuity of care.

A **trauma-informed approach** draws on the following guiding principles in the development and delivery of services:

- *Understanding trauma and its impact on individuals, families and communal groups*
- *Promotion of safety* through the provision of physically and emotionally ‘safe spaces’
- *Ensuring the cultural competence* of services and staff
- *Supporting client control*, autonomy and informed decision making
- *Sharing power and governance* across all levels of the organisation
- *Integrating care* by linking all services involved (including trauma-specific services)
- *Supporting relationship building* to assist in healing and recovery
- *Enabling recovery* by empowering individuals, families and communities.¹⁸

Trauma-informed services aim to understand, anticipate and respond to the needs of individuals and families who have experienced trauma while not necessarily specifically addressing the trauma.

The complexities and challenges of working with Aboriginal and Torres Strait Islander families require health professionals to continuously examine and learn from their experiences. **Reflective practice** supports the development of health professionals who are self-aware, and able to engage in self-monitoring and self-regulation. Reflective practice typically involves:

- Critical reflection to achieve deeper understanding, and identify learning needs
- Reflective learning, including consideration of ‘what could have been done differently, to guide future practice
- Reflection-in-action, including informal theories based on knowledge of the individual and their specific situation, which are continuously tested, modified and re-tested.

The literature suggests the provision of health care to Indigenous mothers and children should be **multi-disciplinary** and involve a collaborative, team based approach. Within an Indigenous maternal and child health context, multi-disciplinary teams typically include general practitioners (GPs), nurses, midwives, Aboriginal health workers (AHWs) and allied health professionals.

Enablers of multi-disciplinary care include:

- Clearly defined goals (client-centred and outcome focused)
- Clearly articulated and negotiated roles of each health professional (Mitchell et al, 2008)
- Clear communication pathways and feedback mechanisms
- Ongoing, regular communication and information sharing
- Established guidelines for the provision of multi-disciplinary care to Indigenous mothers and children.

4.6.1 Roles and Responsibilities

Table 3 sets out key roles and responsibilities of governments (national and state/territory), service organisations and individual practitioners in relation to these underpinning elements of the child and family health service system.

Table 3 Roles and Responsibilities - approaches to care

Government/Policy	Service Organisation	Practitioner
Government agencies provide funding for cultural competence training and support	Provide cultural competence training and support for all staff including: <ul style="list-style-type: none"> • Understanding of history of colonisation and ongoing impacts and building this knowledge into service delivery models • Recognising and preventing racism 	Develop cultural competence and understanding of unique cultural protocols of local communities.
Government agencies provide funding for training and support for trauma informed care	Provide trauma informed training and support for all staff covering the guiding principles for a trauma informed approach	Develop an understanding of the impact of trauma on individuals and communities and how this related to the provision of care
	Develop service models that support practitioners to build strong professional relationships with children and families including: <ul style="list-style-type: none"> • Understanding and building on strengths • Allowing time for relationship building • Supporting continuity of care 	Practice built around developing appropriate professional relationships with families and children that are based on trust, respect and understanding. Develop understanding of, and incorporate reflective practice into approach

4.7 Service Elements

SERVICE ELEMENTS

- Comprehensive assessment, flexibility, continuity

This section outlines key elements of service delivery that need to be in place to enhance the scope and quality of services for Aboriginal and Torres Strait Islander children and families.

4.7.1 Engagement and comprehensive assessment

Comprehensive, holistic assessment is a crucial element of ensuring Aboriginal and Torres Strait Islander families have access to the services they need, including universal and targeted health services as well as other educational and social supports. The purpose of comprehensive assessment is to gain an understanding of the family, their kinship networks, their individual needs, expectations and preferences. It is important to understand the circumstances of the child and recognise that where children have been removed, services may be working with caregivers who are not related to that child.

Assessment enables service providers to:

- Gain a thorough understanding of the health and social needs of each family
- Understand family and kinship networks which are important for knowing both how services should be delivered and who should be involved in the delivery of care
- Build trust and rapport to engage families in the service system
- Establish appropriate communication methods
- Understand and discuss expectations and preferences about what and how services should be provided
- Provide information about potential pathways of care to support informed decision making.

While the aim should be to engage with women as early as possible in their pregnancy, it is also important that comprehensive assessment can occur at any point families first engage with the service system, and at other times as circumstances can change.

Assessment should be seen as a process rather than a one off “service”. It may take some time, and possibly multiple visits, to develop sufficient trust and rapport to be able to ask women and their families about personal issues and circumstances. Consideration also needs to be given to who the most appropriate people are to conduct such assessments. While AHWs may have the understanding and capacity to develop rapport, cultural networks or kinship relations may restrict the appropriateness of them undertaking such assessments in some circumstances. It is also essential that AHWs or other cultural brokers are able to communicate well with other health professionals to ensure that cultural integrity can be maintained.

Comprehensive assessment needs to incorporate:

- Understanding of family and kinship networks
- Physical health
- Psychosocial health
- Behavioural/clinical risk factors (e.g. smoking, drug/alcohol consumption, chronic disease)
- Social risk factors (e.g. housing, financial security, child protection)
- Expectations and preferences of the client/family about their health, how services are delivered and preferred communication methods.

The assessment process should include discussion of clinical and social risk factors that may impact on both the nature of services and how they are provided. Communication preferences should be established to

ensure that services understand how best to provide information and reminders to maximise access and engagement.

The capacity and needs of each family needs to be assessed, to ensure the maximum support can be provided to them in establishing and maintaining strong parenting skills. Particular consideration needs to be given to additional parenting support that might be required due to:

- Low literacy and therefore capacity to understand and interpret written material
- Financial stress
- Lack of strong parenting role models

Engaging families in the health system and maintaining that engagement is crucial for the provision of both universal and other services. Some families with complex needs will require a range of support services and it is important for organisations to ensure they provide adequate support for staff working with vulnerable families with complex needs.

4.7.2 Flexible service delivery

Flexible service delivery can facilitate the establishment and maintenance of engagement with Aboriginal and Torres Strait Islander families. Flexible approaches might include:

- Providing services in places that families access for other reasons such as playgroups, childcare centres, children and family centres
- Specialised services e.g. midwifery services working into and with ACCHOs
- Flexibility in appointment times and providing opportunities for drop-in services to enable families to access services when it is convenient for them
- Providing reminders using technology such as text messages
- Providing transport to and from appointments
- Allowing for longer and/or more frequent consultations.

4.7.3 Transitions

Transition between services has been identified as a challenge for many services in maintaining engagement with Aboriginal and Torres Strait Islander families, in particular from maternity services to child health services and the transition between primary health care services and hospitals. These transitions can be exacerbated for women and families who receive services from multiple providers and/or move locations.

Continuity of care is a key element of the Framework and requires services to ensure that these points of transition are smooth and seamless. This requires:

- Good communication and information sharing between service providers
- Established referral pathways and mechanisms for ensuring follow-up
- Effective clinical networks
- Collaborative relationships between service organisations and individual practitioners.

The place-based model seeks to establish these systems and networks to break down the barriers that are reflected in the current fragmented system.

It is important that communication and referral pathways are systematised and do not rely on relationships between individual practitioners.

Examples of current practice that seek to facilitate continuity of care include:

- Co-location of midwives and child health teams
- Joint visits between child health nurses and midwives during pregnancy
- Shared data systems
- Referral networks which provide support and follow-up care.

4.7.4 Roles and Responsibilities

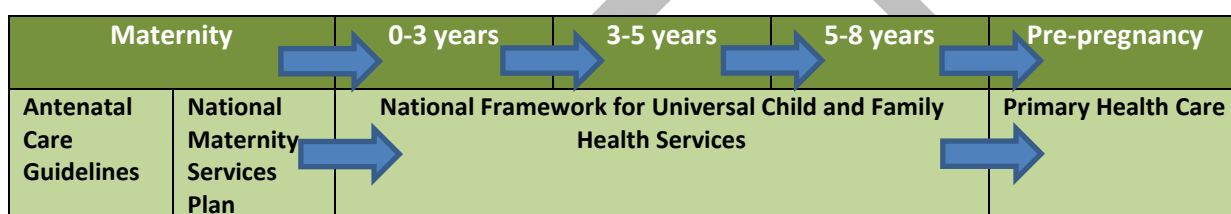
Table 4 sets out key roles and responsibilities of governments (national and state/territory), service organisations and individual practitioners in relation to these elements of care that support the child and family health service system.

Table 4 Roles and Responsibilities - elements of care

	Government/Policy	Service Organisation	Practitioner
Engagement and Assessment	Provide funding for comprehensive assessments	Implement service models that incorporate thorough assessment for every family	<ul style="list-style-type: none"> • Establish contact with relevant family members • Undertake thorough assessments • Undertake opportunistic assessment and intervention without waiting for scheduled visits or screening activities. • Ongoing assessment of the needs of children and families as these change over time. • Support parents and caregivers to reduce exposure to environmental stressors
Flexibility	Implement flexible funding models	<p>Implement flexible service models that allow sufficient time for relationship building</p> <p>Implement flexible service models that are provided in a variety of locations to meet the needs and preferences of families</p>	<ul style="list-style-type: none"> • Provide programs and interventions that actively support the development of strong parent/caregiver relationships and cognitive development • Provide intensive support services for vulnerable families • Provide services to families in places where they are comfortable to meet, such as playgroups or Children and Family Centres • Use culture and cultural events as a mechanism for engaging with families and to deliver health messages • Provide opportunities for parents to interact with their children in a supportive environment, for example supported playgroups where peer support and modelling of positive interaction can occur

	Government/Policy	Service Organisation	Practitioner
			<ul style="list-style-type: none"> Actively seek to involve appropriate family such as aunts or grandmothers who might have responsibility for child rearing and decision-making within wider family networks Identify and respond to community level needs.
Transitions		Build place level referral networks and systems to support referral and follow up	<ul style="list-style-type: none"> Establish referral networks and mechanisms for follow-up Refer and follow up to appropriate services

4.8 Universal Services for Aboriginal and Torres Strait Islander children and families



Along with the USF, the Australian Health Ministers Advisory Council (AHMAC) Antenatal Care Guidelines and the National Maternity Services Plan provide overarching guidance for services about the provision of care across the continuum from conception to eight years of age.

4.8.1 AHMAC Clinical Practice Guidelines for Antenatal Care

Improved health outcomes for Aboriginal and Torres Strait Islander mothers and babies can be achieved through better access to antenatal care. The AHMAC Clinical Practice Guidelines for Antenatal Care¹⁹ were developed to provide a nationally consistent and evidence-based resource for health professionals providing antenatal care in a range of settings.

The first module of the Guidelines deals with the first trimester of pregnancy, providing advice and recommendations for best practice on:

- Delivering care that is woman-centred, culturally safe for Aboriginal and Torres Strait Islander women, and suitable for groups with specific care needs.
- Planning antenatal visit schedules, reflecting current evidence basis for ideal timing and frequency, while recognising the woman's individual circumstances.
- Performing clinical assessments to screen mother and foetus for complicating health factors, such as STIs, congenital abnormalities, mental health problems and psychosocial factors.
- Providing advice to women on lifestyle considerations such as alcohol and tobacco use as well as healthy eating and nutritional supplementation.

The second module is still in development and will cover antenatal care in the second and third trimesters of pregnancy, diabetes screening and caring for women from culturally and linguistically diverse backgrounds.

The Guidelines reflect needs in antenatal care and include explanations on cultural safety, both in general and specifically in the Aboriginal and Torres Strait Islander context, and advise on the provision of culturally responsive care. They also contain information and specific recommendations for health professionals providing care for Aboriginal or Torres Strait Islander women, such as the complicating factors that exist around alcohol and tobacco use, and the greater prevalence of folic acid deficiency and the need for it and other nutritional supplementation.

4.8.2 National Maternity Services Plan

The National Maternity Services Plan²⁰ seeks to consolidate existing work by State and Territory jurisdictions to provide a national framework to guide policy and program development in the area of maternity care.

The plan lays out an agenda for all levels of government over the five year period covering 2010-2015, establishing a timetable and identifying the parties responsible for implementation.

The plan seeks to address four priority areas:

1. **Improving access** to locally-based maternity care, and to objective information on pregnancy outcomes to guide women and their families
2. **Improving service delivery**, through ensuring high-quality evidence-based care, greater cultural competency and accessibility for Aboriginal and Torres Strait Islander people, and services delivering appropriate care for women from vulnerable groups.
3. **Developing the maternity care workforce**, through increasing clinical training placements, improving productivity and retention of the existing workforce, increasing Aboriginal and Torres Strait Islander representation in the maternity workforce, and facilitating a culture of interdisciplinary collaboration.
4. **Developing maternity care infrastructure**, through establishing nationally consistent guidelines, and ensuring maternity service planning reflects community realities and is flexible to the individual needs of women.

While the plan is focused on improving maternity services for all Australian women, it recognises the specific role of maternity care in closing the health gap between the Aboriginal and Torres Strait Islander population and the wider community. The plan includes commitments to expand existing programs exhibiting the characteristics of culturally competent care. The plan also seeks to increase the number and capacity of Aboriginal and Torres Strait Islanders in the maternity care workforce through increasing their access to clinical training places and by continuing to provide funding and other support mechanisms through the Closing the Gap initiatives.

4.8.3 National Framework for Universal Child and Family Health Services

The USF outlines a vision, objectives and principles for universal services for Australian children aged zero to eight.

The USF draws on extensive research and literature to identify the importance of the early years. It identifies core services that are available to Australian families, irrespective of where they live and how they access health care. It seeks to establish a platform for the delivery of evidence based services as described through “core services elements” and provide a consistent approach that is applicable across jurisdictions.

Each jurisdiction has a schedule of periodic contacts from birth to school age, generally timed to coincide with critical periods in development.

4.8.4 Youth health and pre-pregnancy

There is no universal framework or guidelines for the provision of health services to children and young people after the age of eight. While there is a range of short term health promotion programs targeted at this age group, there is no universal approach to meeting their health needs.

This is a notable gap which poses a significant challenge for services aiming to improve the health and wellbeing of young people prior to pregnancy. The evidence emerging from epigenetics research highlights the importance of the physical (in-utero) and social environment for the developing foetus that can be challenged by the complexity of the health concerns facing many Indigenous Australians. Ensuring that young people are healthy prior to conceiving and during pregnancy has the potential to significantly improve long term health outcomes for Aboriginal and Torres Strait Islander children.

Preparation for pregnancy and advice to young people about sexual and reproductive health through school-based programs can potentially improve engagement with health services in the antenatal period, and provide opportunities for health promotion and prevention strategies to be implemented.

While there is no universal approach to meeting young people's health needs, primary health care services are best placed to assist young people achieve their optimal health and wellbeing. Research has shown that young people experience barriers to accessing healthcare and that these barriers exist across both genders and in all socioeconomic groups.²¹ Certain subgroups of young people, such as young men and Indigenous youth may be exposed to a higher risk of poor health outcomes because they are not accessing healthcare.²² Barriers cited by young people include fears about confidentiality and embarrassment about discussing health concerns while barriers cited by health professionals, including GPs including communication difficulties, time and uncertainty about medicolegal status for those under 18 years.²³

To overcome these barriers, seven principles for youth-friendly health services have been proposed.²⁴

1. *Accessibility*: health services should be easily accessible, flexible, affordable, relevant and responsive to the needs of all young people
2. *Youth participation*: young people should be actively involved in developing, implementing, reviewing and evaluating youth services and programs.
3. *Collaboration and partnerships*: service providers develop working relationships with other groups that share similar service goals and target groups.
4. *Professional Development*: developing the workforce's knowledge, skills and attitudes to enable them to work confidently and effectively with young people.
5. *Evaluation*: effective evaluation engages staff, young people using the service or program and other stakeholders in providing feedback and suggesting improvements.
6. *Evidence-based approaches*: considering and learning about what works in responding to young people, meeting their health care needs, and developing approaches to address youth health issues.
7. *Sustainability*: sustainable programs and initiatives become self-maintaining in the long term or can become everyday practice. Sustainable programs support long-term improvements in health and wellbeing for young people.

Other national youth health initiatives include immunisation (e.g. the *National HPV School Vaccination Program*), health checks (e.g. the Medicare Health Assessment for Aboriginal and Torres Strait Islander People or MBS item 715) and mental health and drug and alcohol services (e.g. *headspace*).

There are also a number of programs across Australia that are specifically concerned with preparation for pregnancy such as the Core of Life Program. Often programs for young people are run in conjunction with cultural or sporting activities to improve engagement. However there have been few programs that have been

evaluated and demonstrate improved health outcomes, highlighting the need for greater attention to this stage of development.

A fourth National Aboriginal and Torres Strait Islander Blood Borne Viruses and Sexually Transmissible Infections Strategy has been released. It aims to reduce the transmission of sexually transmissible infections (STIs) and blood borne viruses (BBVs), and the morbidity, mortality and personal and social impacts they cause.

4.9 Embedding the Framework in primary health care

PRIMARY HEALTH CARE: maternal and child health; management of acute and chronic disease; sexual and reproductive health; management and referral of drug and alcohol, mental health issues; population health

“Primary care” and *“primary health care”* are often used interchangeably but in order to clarify the model described in this Framework, it is important to distinguish between these terms.

Primary care is essentially the first point of contact with the health system. Most commonly in Australia this will be a general practitioner although it could be a nurse, allied health provider or pharmacist. Primary care is largely focussed on early diagnosis and timely, effective treatment.

Primary health care is a broader concept that derives from a social model of health encompassing health promotion, illness prevention, treatment, community development, advocacy and rehabilitation. The World Health Organization²⁵ describes primary health care as both a set of core principles and a variable set of activities. The core principles include:

- Universal access to care and coverage on the basis of need
- Commitment to health equity as part of development oriented to social justice
- Community participation in defining and implementing health agendas
- Intersectoral approaches to health.

Core functions of primary health care have been identified as:²⁶

- Clinical services
- Population/public health
- Corporate services and infrastructure
- Advocacy, knowledge and research, policy and planning
- Community engagement, control and cultural safety.

Building the child and family health service system around primary health care:

- Builds on the principles of equity, universal access, community participation, and inter-sectoral approaches
- Emphasises broader population health issues, reflecting and reinforcing public health functions
- Creates the conditions for effective provision of services to the most at risk and vulnerable families;
- Promotes integrated and seamless care, linking prevention, monitoring, acute care and chronic care across the system;
- Provides the basis for evaluation and continuous quality improvement.

In the context of the Framework, taking a primary health care approach aims to address health inequalities, acknowledge the importance of involving Aboriginal and Torres Strait Islander people in the design and

implementation of services and emphasises the importance of engaging across sectors to assist families to address complex health and social issues.

Primary health care is at the centre of life course health care, providing families with management of acute and chronic disease as well as facilitating access to other health services such as substance use, mental health and social and emotional wellbeing services. Comprehensive primary health care includes population health programs that support and complement the delivery of individual health care. In this context, maternity and early childhood services can be seen as a component of the overall primary health care response to meeting the needs of families.

Essentially this means that all child and family health care providers are part of an overall primary health care system, irrespective of the funding mechanisms or employment arrangements determined by existing system structures and emphasises the importance of placing the child and his/her family at the centre of service provision.

4.10 Services across the continuum

The following sections highlight elements of the provision of child and family health services across different stages of child development. Improving and refocussing service delivery in the period from conception to the age of three should be a priority, based on the evidence that demonstrates the critical brain development during this time. Supporting the health and wellbeing of young people prior to pregnancy will also contribute to addressing risk factors associated with poorer health outcomes for Aboriginal and Torres Strait Islander children and families.

4.11 Maternity

Maternity care

Maternity care includes antenatal, intrapartum and postnatal care for women and babies up to six weeks after birth. As described previously this care is provided in a variety of settings by a range of public and private practitioners.

4.11.1 Background

On average Aboriginal and Torres Strait Islander women giving birth are younger than non-Indigenous women. A higher proportion of Aboriginal and Torres Strait Islander women:

- Are aged under 20
- Have previously given birth three times or more
- Report smoking during pregnancy
- Report drinking alcohol during pregnancy
- Experience poor maternal health including anaemia, poor nutrition, hypertension, diabetes or glucose intolerance
- Give birth prematurely
- Give birth to low birth weight babies
- Have higher rates of perinatal mortality.

Chronic overstimulation of the fetal immune system by maternal stress hormones can result in the infant developing an altered immune response, leading to an elevated risk of inflammatory disease in adulthood.²⁷ Both excessive and insufficient maternal weight gain during pregnancy have been found to cause an elevated risk for the child later developing insulin resistance and obesity.²⁸

Aboriginal and Torres Strait Islander women are less likely to access antenatal care in the first trimester of pregnancy and access or receive less antenatal care than non-Indigenous women. Reasons for this might include:²⁹

- Being unsure about being pregnant
- Being anxious about hospitals and/or health services
- Not thinking it was necessary
- Moving around
- Being unhappy about care at previous visits
- Not wanting people to know about the pregnancy
- Being too unwell to get to a service
- Being concerned at the potential removal of the child by child protection services.

Some Aboriginal and Torres Strait Islander women and their families face particular challenges in accessing maternity care. These include:

- Women with complex health needs that may necessitate a greater level of clinical care that cannot be provided as easily in community settings.
- Women from remote communities who have to travel to a larger centre to give birth, usually 2-3 weeks in advance, but sometimes longer depending on clinical indications, weather, accessibility or other factors. Women in this situation face considerable upheaval including social dislocation, having to leave family including other children behind and travelling to often alienating places with little or no family support.

4.11.2 Implications for service delivery

A primary goal of all maternity services should be to ensure that Aboriginal and Torres Strait Islander women are engaged early in their pregnancy and receive the optimal level and type of care according to their individual needs.

Initial assessment is important for identifying needs and risk factors in order to ensure that women receive appropriate clinical care as well as other relevant support. Service models need to particularly focus on identifying and addressing key risk factors including smoking, alcohol consumption and mental health, recognising that doing so necessitates assessment of the underlying contributing factors such as housing, financial security and family context.

Appropriate support through periods of transition is important for Aboriginal and Torres Strait Islander women and their families. Systems need to be in place to ensure smooth transitions for women from community based midwifery services to hospital birthing services and back again, followed shortly thereafter by transition from maternity to child and family health services. This might include:

- Hospital familiarisation visits during pregnancy
- Joint visits with child and family health services during pregnancy
- Support during birthing from community based midwife or AHWs
- Colocation of maternity and child and family health teams and clinics
- Mainstream maternity services working into primary health care services
- Systems to ensure discharge summaries are complete, timely and received by appropriate practitioners.

Taking into consideration appropriate approaches to care, maternity services for Aboriginal and Torres Strait Islander women and families should:

- Wherever possible provide continuity of care and carer, particularly allowing for caseload models of midwifery led care
- Local factors may preclude the above option. In these instances services should, at a minimum, enable continuity of carer to be available throughout the antenatal periods to minimise the number of care-givers that the women meets throughout her maternity experience. When possible these services can explore extending continuity of carer to include the intrapartum and postnatal periods.
- Postnatal care plans should be developed with the woman during the antenatal period
- Conduct thorough assessments for all women at their first visit (where possible) including discussing care pathways and options as well as expectations, preferences and concerns
- Support the employment and training of Aboriginal and Torres Strait Islander people
- Develop service models where non-Aboriginal midwives are supported by Aboriginal or Torres Strait Islander health workers to support cultural safety, community engagement, health literacy, wellbeing and provision of health information
- Provide maternity care in the community
- Provide support for women in accessing hospital services, both in the antenatal period and for birthing
- Deliver antenatal programs that:
 - Are tailored according to language and cultural preferences of local communities
 - Target health promotion and anticipatory guidance based on individual and community level priorities and health needs
 - Incorporate strategies for engaging fathers
 - Use peer support approaches involving other Aboriginal and Torres Strait Islander women providing support and information to each other, with additional support from midwives and health workers as appropriate.

4.12 Birth to three years

0-3 years – critical for brain development

The period from birth to three has been identified as a critical period for brain development and a time where there is significant opportunity for prevention and early intervention programs to impact on health and developmental outcomes. While this section of the Framework separates this period from later periods of childhood development, many of the service responses outlined are applicable across this continuum.

4.12.1 Background

Aboriginal and Torres Strait Islander children are more likely than non-Indigenous children to experience poor health outcomes. A higher proportion of Aboriginal and Torres Strait Islander children experience:

- Infant mortality
- Hospitalisation
- A range of physical health conditions including respiratory disease, asthma, skin disease, otitis media, trachoma, anaemia, malnutrition and dental caries
- Exposure to violence both in homes and in the community
- Poor nutrition
- Exposure to tobacco smoke
- Contact with juvenile justice and child protection systems.

The period from birth to three years of age is critical for brain development. Neural plasticity is at its peak in this period and synaptic connections are readily formed in response to environmental stimuli but can quickly degrade unless stabilised through repeated stimulation. Foundations developed during this period include:

- Executive function which assist in connecting past experience to current action
- Self-regulation or capacity to control one's impulses, both to stop doing something, if needed (even if one wants to continue doing it) and to start doing something, if needed
- Cognitive functions including impulse control, curiosity and attentiveness.

There is evidence that neurological damage experienced due to early childhood adversity can be repaired if intervention occurs before the end of this peak period of neural plasticity. This highlights the importance of this period for the implementation of primary prevention and early intervention programs.

Parental or caregiver relationships are important foundations for the development of capacities needed in later life because they:

- Provide the foundations for social and emotional competencies
- Act as a buffer to environmental stressors, moderating the severity of potentially traumatic experiences
- Play a powerful moderating role over gene expression in the developing brain.

Exposure to excessive or prolonged stress can have a range of negative impacts on infant development including:

- Elevated risk of developing inflammatory conditions such as asthma, diabetes and cardiovascular disease
- Enlarged areas of the brain associated with aggression and impulsivity
- Delays in cognitive development
- Impaired acquisition of healthy coping mechanisms.

While many Aboriginal and Torres Strait Islander children grow up in secure and nurturing environments and experience strong caring relationships with parents or other caregivers, others experience early childhood environments that expose them to multiple risk factors for poor health and developmental outcomes.

4.12.2 Implications for service delivery

Child and family health services need to design service responses that address the complex factors that contribute to health and wellbeing. Key factors for consideration in service design include:

- Ongoing assessment of the needs of children and families as these change over time
- Provision of programs and interventions that actively support the development of strong parent/caregiver relationships and cognitive development
- Supporting parents and caregivers to reduce exposure to environmental stressors
- Provision of intensive support services for vulnerable families
- Providing services to families in places where they are comfortable to meet, such as playgroups or Children and Family Centres. These settings provide the opportunity to provide both physical health monitoring and a range of parenting support and other programs, as well as providing opportunities to observe parents interacting with their children and to identify people who may need additional support
- Using culture and cultural events as a mechanism for engaging with families and to deliver health messages
- Providing opportunities for parents to interact with their children in a supportive environment, for example supported playgroups where peer support and modelling of positive interaction can occur
- Actively seeking to involve appropriate family such as aunts, uncles or grandparents who might have responsibility for child rearing and decision-making within wider family networks

- Undertaking opportunistic assessment and intervention without waiting for scheduled visits or screening activities
- Establishment of referral networks and mechanisms for follow up
- Identifying and responding to community level needs.

NACCHO and the Royal Australian College of General Practice have developed a guide to conducting preventive health assessments for Aboriginal and Torres Strait Islander people.³⁰ Responding to physical health risk factors should include additional screening for Aboriginal and Torres Strait Islander children and families based on a sound understanding of the community in which services operate. Additional screening might include:

- Fetal alcohol spectrum disorders (FASD)
- Family violence
- Anaemia
- Ear disease
- Overnutrition.

Knowledge and understanding of community level needs should provide the platform for opportunistic assessment and responses. For example if it is known that there is a higher incidence of ear disease, practitioners can choose to opportunistically screen or assess children beyond the universal protocols, either routinely or as part of consultations for other health needs.

Anticipatory guidance and health education are key components of supporting parents and the USF outlines a range of topics that are relevant to this early period of development. Particular attention needs to be paid to both the content and delivery of messages for Aboriginal and Torres Strait Islander families. Delivery of health messages need to be relevant and appropriate for the recipients, taking into consideration such things as:

- Language
- Literacy levels
- Cultural context including family structure and child rearing practices
- Skills and experience of parents
- Availability of strong parenting role models
- Access to technology and preferred communication methods.

4.13 Three to Five years

3-5 years

4.13.1 Background

By the age of three, brain connections or synapses are selectively pruned, emphasising the importance of the very early years in child development. From this age it is more difficult for children to take advantage of learning environments at pre-school and school if they have not had an optimal home environment. Access to high quality pre-school programs help children build on the foundations laid down in the period from birth to three.

The Australian Early Development Census (AEDC) is a measure of how young children are developing in Australian communities. The AEDC is a population measure of children's development collected when children enter their first year of formal school. Information for the AEDC is collected by teachers through a checklist that measures five areas of early childhood development. These five areas, are closely linked to the predictors of adult health, education and social outcomes:

- physical health and wellbeing
- social competence
- emotional maturity
- language and cognitive skills
- communication skills and general knowledge.

According to 2012 Australia Early Development Index (AEDC) data, Aboriginal and Torres Strait Islander children are more than twice as likely to be developmentally vulnerable on one or more AEDC domain(s) compared with all other children.³¹

The Footprints in Time Longitudinal Study of Indigenous Children³² identified the factors having the greatest negative impact on Aboriginal and Torres Strait Islander children's social and emotional difficulty scores were:

- Having a close family member arrested, in jail or having problems with the police (in two or three years)
- Being cared for by someone else for at least a week (over three or four years) rather than remaining with their regular carers
- Being scared by other people's behaviour (in three or four years)

4.13.2 Implications for service delivery

Appropriate service models for Aboriginal and Torres Strait Islander children aged three to five and their families should build on those for younger children including:

- Ongoing universal health and developmental checks and monitoring
- Referral to specialised services and follow up as required including co-location or specialised allied health services working into primary health care/ ACCHO settings to promote access
- Support for parents, caregivers and families in providing secure and healthy home environments
- Identifying and responding to community level needs including using the AEDI results in place based approaches to understand the degree and concentration of developmental vulnerability and to develop service responses.

4.14 Five to Eight Years

5-8 years

4.14.1 Background

In the period from five to eight years of age, children are generally engaged in formal schooling. Vulnerabilities that have not been addressed in early childhood will continue to affect the health and development of children at this age.

4.14.2 Implications for service delivery

Health services should aim to ensure that engagement is maintained with both children and families throughout this period. Schools provide a valuable avenue for the implementation of programs such as:

- Health promotion and health education
- Screening
- Nutrition programs such as breakfast clubs
- Health hubs that provide the opportunity for comprehensive health assessments, treatment and referral.

4.15 Youth health and pre-pregnancy

Pre-pregnancy

4.15.1 Background

Young Aboriginal and Torres Strait Islander people experience similar patterns of disease and injury to non-Indigenous young people, however the extent of these problems varies and in some cases can be very high.

AIHW data³³ suggest that 59% of young Aboriginal and Torres Strait Islander people self-reported they had a long term health condition and about 34% reporting they had two or more long term health conditions. Diabetes was less common among Aboriginal and Torres Strait Islander young people, but overweight begins to take hold in this period, which is a major risk factor for Type 2 diabetes.

Young Aboriginal and Torres Strait Islander people have higher rates of hearing impairment and higher rates of hospitalisation for injury, particularly due to assault. They also have higher rates of psychological distress and are more commonly hospitalised for mental and behavioural disorders in particular for schizophrenia, alcohol misuse and reactions to severe stress.

Aboriginal and Torres Strait Islander young people are more likely than non-Indigenous young people to smoke, consume harmful levels of alcohol and to suffer ill health due to harmful use of marijuana, heroin, amphetamines and inhalants. They are also less likely to consume the recommended daily intake of fruit and vegetables.

Higher levels of educational attainment are associated with improved health outcomes.³⁴ Education influences health through income, access to health care and participation in the labour market. Less schooling is also associated with higher rates of risky behaviour such as smoking, being overweight or having a lower rate of physical activity³⁵.

Completing school increases one's earning capacity and one's capacity to purchase better housing, healthier food, better medical care and more education. Education also facilitates healthier behaviour choices through better access to information and assists people to gain social supports that assist in mitigating social stressors.

These factors are important both for the health and wellbeing of young people but also potentially for their children through pregnancy and beyond and provide the basis for further developing strategies to improve the health of young people before they conceive.

4.15.2 Implications for service delivery

Adolescence can be a time of considerable change and, often, stress both for young people and their families. It is a time when patterns of behaviour can begin that potentially have serious implications for both individuals and their children.

As identified earlier in this Framework, there is a lack of a systematic or universal approach to health services for young people, once they pass beyond the universal child health services that typically end at either five or eight years. There are many programs targeted at young people and their health, however these are not universally available and there is a lack of evidence about their impact on measures of health and wellbeing. Evaluation of the impact of these programs should be prioritised to enable sharing of good practice.

Unlike in early childhood, young people do not tend to have regular engagement with health services, except for the treatment of acute illness and injury. Suggestions for promoting and maintaining engagement with Aboriginal and Torres Strait Islander young people include:

- Universal adolescent health checks (including through MBS Item 715)
- Targeted health promotion events and activities for young people
- Youth-friendly GP practices – build rapport and trust and develop a confidentiality policy that is visible to all patients; consider bulk-billing consultations and diagnostic and pathology tests; assist young people to obtain a Medicare card, provide psychosocial screening to identify risk and protective factors, seek feedback from young people, develop and maintain strong collaborative relationships with other local youth services, and train staff in youth friendly healthcare.³⁶

4.16 Social and other service links

SOCIAL AND OTHER SERVICES: education, housing, family support, financial, welfare

Socio-economic factors such as education, employment and income have considerable impact on health and wellbeing. Aboriginal and Torres Strait Islander people have lower retention and attainment rates in education, lower levels of labour force participation and higher unemployment rates than other Australians. A range of other factors impacting on the health and wellbeing of Aboriginal and Torres Strait Islander people include:

- Poor access to functional housing, in particular in remote areas
- Overcrowding
- Homelessness
- Lack of access to transport.

Aboriginal and Torres Strait Islander children are over-represented in the child protection system. Substantiated child protection notifications for Indigenous children were over 7 times the rate for other children. In addition, Indigenous children are more likely to be placed on care and protection orders (9 times more likely), and in out-of-home care (almost 10 times more likely) than non-Indigenous children.³⁷

Relatively high rates of incarceration among Aboriginal and Torres Strait Islander people are likely to affect the health and wellbeing of those imprisoned, and their families and children. Furthermore, incarceration also has the potential to “erode” Indigenous communities through adverse employment outcomes and absence of positive role-models in the community.³⁸

Responding directly to these issues is considered beyond the scope of many health services. However mitigating these psychosocial risk factors is fundamental to improving the capacity of parents and other carers to provide a safe and healthy environment for children, and ultimately child health and wellbeing outcomes.

In order to address wider psychosocial issues, services need to:

- Understand the available evidence of risk factors affecting health and wellbeing and where possible tailor service responses that consider these factors
- Establish and maintain links and referral pathways with the wider social service system to enable complementary health and psychosocial service responses.

4.17 Place based System Development

INTEGRATED PLACE-BASED SYSTEM	<ul style="list-style-type: none">• collaborative governance models• clinical and organisation governance within and between organisations• comprehensive range of universal child and family health services• population health and prevention programs• place-specific care pathways• comprehensive referral pathways• cross-agency systems for data collection, information-sharing and research/ evaluation
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4.17.1 Health systems

According to the WHO³⁹ a health system consists of all organisations, people and actions whose primary interest is to promote, restore or maintain health. The six building blocks are:

- Leadership and governance
- Service delivery
- Information systems
- Workforce
- Financing
- Access to medicines/vaccines/technology.

These building blocks have been identified as key characteristics present in *all* well-functioning health systems, regardless of how they are organised. They define what a health system should have the capacity to do and also provide a means for identifying service and system gaps.

How services are organised within a system has a considerable impact on the accessibility, availability and navigability of the system for families.

4.17.2 Place based systems

At a place (local or regional) level, the universal child and family health service system encompasses a broad range of providers. In order to access the services they need, an individual or family may have contact with a number of providers within that system. Although there may be connections and referral pathways between some of these providers, families are often required to negotiate their own access due to disjointed and fragmented service structures.

The complexity of the system is compounded for families when health services are viewed as a component of the wider service system.

4.17.3 Integrated place based model

This section describes the importance of a place-based planning approach to inform the development of integrated service models for the delivery of child and family health services to Aboriginal and Torres Strait Islander children and families to support implementation of the Framework. This approach presents an opportunity to better address the child and family health needs of Aboriginal and Torres Strait Islander children and families at a place (local, regional, community) level.

The approach as summarised in Figure seeks to ensure that *all* Aboriginal and Torres Strait Islander children and families have access to:

- Universal health services across the continuum from conception to pre-pregnancy
- Targeted health and social services that maximise their broader health and wellbeing
- High quality culturally competent services that reflect the best available evidence and are delivered in ways that meet community and individual level preferences and expectations.

It seeks to address key weaknesses in the current approach to service delivery through:

- Improved use of evidence to drive service delivery and to respond to community need
- Improved collaboration and coordination within the health sector and across sectors
- Increasing effective Indigenous governance.

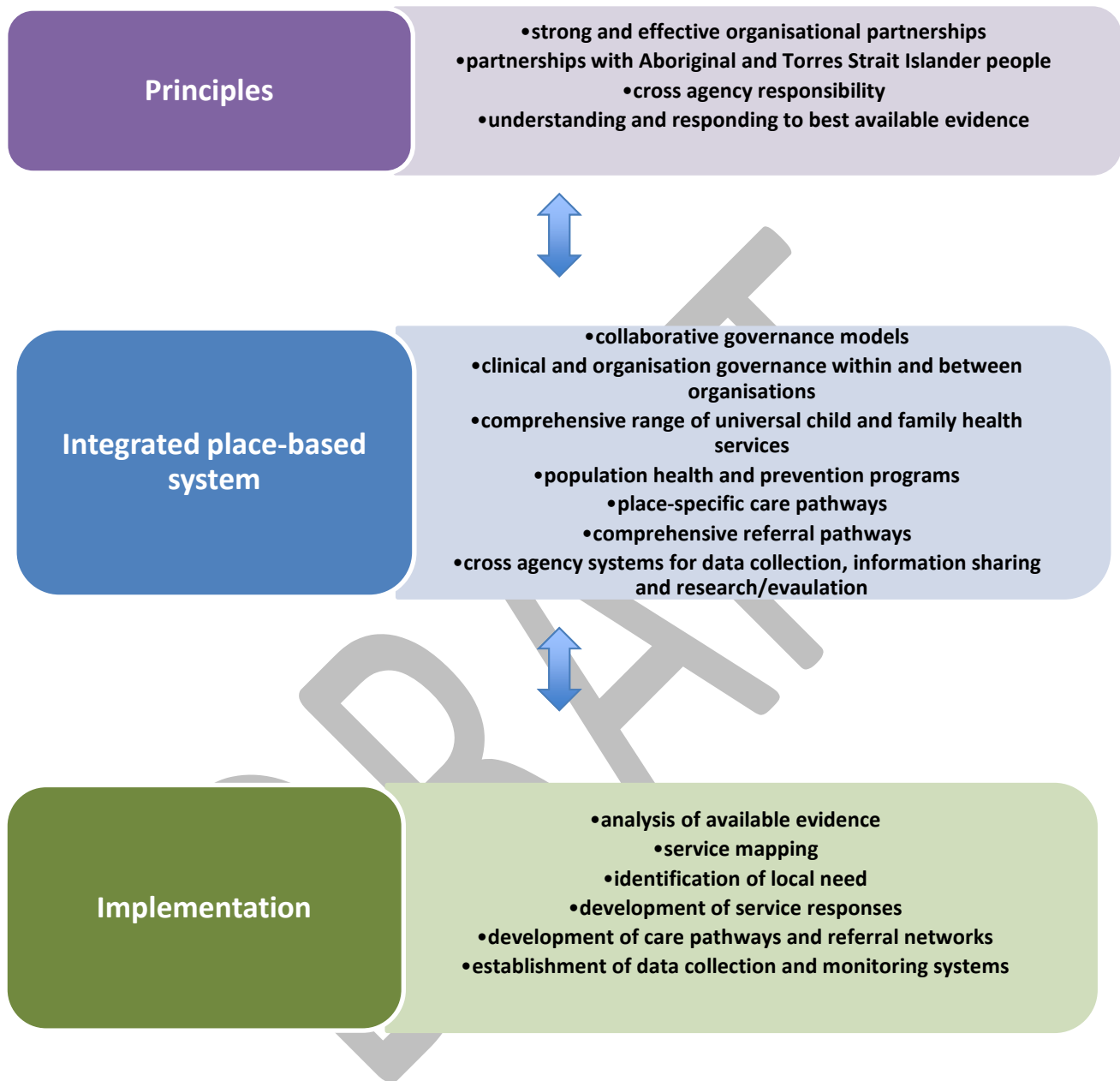
The approach is based on key principles:

- An integrated place-based model founded on strong and effective partnerships between local health networks (including maternity and child and family health services), ACCHOs, general practitioners, relevant primary health care organisations, NGOs and other services including education and social support
- Coordination is a joint responsibility of all child and family health services and providers
- The governance, design and implementation of services need to be built around partnerships with Aboriginal and Torres Strait Islander people.

Collaboration and service redesign should be built around understanding and responding to the best available evidence and knowledge of community needs. Key elements of an integrated place-based system include:

- Collaborative governance models between Indigenous and non-Indigenous people
- Clinical and organisational governance capacity
- Population health and prevention programs
- Comprehensive range of universal and targeted child and family health services
- Community specific care pathways for families with different needs, including comprehensive referral networks
- Coordinated systems for data collection, information sharing and research/evaluation.

Figure 3 Place-based model



5 CONCLUSION

The Framework seeks to describe an effective child and family health service system for Aboriginal and Torres Strait Islander people. Key features of the Framework include:

- Ensuring that the way in which services are delivered are culturally appropriate and reflect a genuine partnership between service providers and Aboriginal and Torres Strait Islander children and families
- Implementing policies and programs that reflect the best available evidence and the need for improved evaluation and research to assess the effectiveness of programs and service models
- Focussing on maternal and very early childhood (0-3 years) health and wellbeing due to the critical brain development and impacts on metabolic functioning in later life during this period and the potential for implementation of primary prevention strategies to support families to have stable, secure and healthy home environments
- Reinforcing the need for processes to support the planning, implementation and review of services
- Taking a life course approach to the delivery of services which is supported by embedding the delivery of child and family health services in primary health care
- Developing service models that focus on responding to child and family health and wellbeing needs rather than on organisational structures and priorities
- Encouraging the use of place-based approaches to redesigning services to better address the health and wellbeing needs of Aboriginal and Torres Strait Islander families.

The Framework has been developed in recognition that, while some progress has been made in areas such as infant mortality, birthweight and life expectancy, existing policies and programs, including universal child and family health services, are not meeting the needs of Aboriginal and Torres Strait Islander families. The principles detailed in this Framework will need to be periodically reviewed, monitored and evaluated to ensure that it meets the needs of Aboriginal and Torres Strait Islander families and children.

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DRAFT

APPENDIX A – ORGANISATIONS AND INDIVIDUALS WHO PARTICIPATED IN CONSULTATIONS

NEW SOUTH WALES/ACT
Maari Ma
Broken Hill Health Service
NSW Health - NSW Kids & Families, AMIHS, Youth Health, Violence Prevention, Child and Family Health
ACT Health
ARACY Australian Research Alliance for Children & Youth
Australian Institute of Health and Welfare
CHETRE Centre for Health Equity Training Research & Evaluation (Liverpool)
Aboriginal Child & Family Health & Midwifery Service, SESIAHS (South East Sydney and Illawarra Area Health Service)
Birra Li Aboriginal Maternal and Child Health Services
Nursing & Midwifery - Tamworth
SESIAS (South East Sydney and Illawarra Area Health Service)
CATSINM (Congress of Aboriginal and Torres Strait Islander Nurses and Midwives)
AIDA (Australian Indigenous Doctors Association)
IAHA (Indigenous Allied Health Association)
NATSIHWA (National Aboriginal and Torres Strait Islander Health Workers Association)
NACCHO (National Aboriginal Community Controlled Health Organisation)
Healing Foundation
VICTORIA
COPE (Centre of Perinatal Excellence)
VACCHO (Victorian Aboriginal Community Controlled Health Organisation)
VACCA (Victorian Aboriginal Child Care Agency Co-Op Ltd)
Commissioner for Aboriginal Children and Young People
VIC - Department of Human Services Aboriginal Outcomes Branch
VIC Department of Health
Murdoch Children's Research Institute
VAEAI (Victorian Aboriginal Education Association Incorporated)
QUEENSLAND
Community Child Health Services – Wynnum
Allied Health & Community Services
Statewide Child and Youth Clinical Network
JTA International
Aboriginal & Torres Strait Islander Health Unit (Metro North Hospital & Health Service) Qld Health
Ngaramma Maternity Service, Metro North Hospital and Health Service, Qld Health
Institute for Urban Indigenous Health
Policy Unit, Qld Dept of Health
Ellen Barron Family Centre, Qld Health
Wuchopperen Integrated Family Services Project
Good Start Program
Inala Community Health Centre

WESTERN AUSTRALIA
Commonwealth Department of Health– OATSIH
Durri Aboriginal Corporation Medical Service
Child and Adolescent Community Health
Aboriginal Maternity Support Services (King Edward Memorial hospital)
Moort Boodjari Mia
COAG Child Health Program
Broome Hospital Midwifery service
Department of Education (Children and Family Centres)
SOUTH AUSTRALIA
SA - Department of Education & Child Development
SA – Department of Health - Aboriginal Health Directorate, Country Health
Aboriginal Health, Country Health SA
Families SA – Child Protection
Women’s and Children’s Health Network SA
Aboriginal Health Council of SA
Department for Education and Child Development
TASMANIA
North West Private Hospital, Burnie
Tasmanian Aboriginal Centre Inc
Tagari lia
TAS - Department of Health & Human Services, Child Health and Parenting Service, Children and Youth Services
SETAC Primary Health Care and Wellbeing Centre
Bridgewater Children and Family Centre
LINC Huon
NORTHERN TERRITORY
Children’s Commissioner NT
NT Department of Health
Department of Health – Alice Springs
Children’s Development Team
Menzies School of Health Research
NT Government including Darwin Midwifery Group Practice, Strong Women Strong Babies Strong Culture program
Central Australian Congress
Danila Dilba
NT Health Development Unit
Department of Health, NT office
NT Medicare Local

Working Group
NSW Department of Health Victorian Department of Education and Early Childhood Development Queensland Department of Health SA Department of Health WA Department of Health NT Department of Health National Aboriginal and Torres Strait Islander Health Standing Committee
Expert Reference Group
ARACY (Australian Research Alliance for Children and Youth) MCAFHNA (Maternal Child and Family Health Nurses Australia) AMLA (Australian Medicare Local Association) NATSISWA (National Aboriginal and Torres Strait Islander Social Worker Association)
Cultural Advisory Group
Dr Tom Calma Dr Mark Wenitong Ms Jane Harrison Professor Juanita Sherwood Ms Adele Cox