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| Enhanced Maternal and Child Health Program |
| **Program Guidelines** Version 2.0 July 2025 |
| OFFICIAL |



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# Document version control

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| **Version no.** | **Date** | **Notes or summary of changes** |
| 1.0 | 2017 | First version of the Enhanced MCH Guidelines published. |
| 1.1 | June 2019 | Reissued to reflect machinery of government changes. |
| 2.0 | July 2025 | * Updated to include legislative changes impacting practice to include MARAM and Child Link. * Updated to reflect family-centred and relational practice as foundational. * Updated to include guidance around recommended foundational training. * Updated to align with best practice guidance around families who choose not to engage with the service. |

# Key terminology

|  |  |
| --- | --- |
| Term | Meaning |
| Aboriginal | Aboriginal and/or Torres Strait Islander people, |
| Clinical supervision | Formal process for reflection on practice with the aim of improved outcomes for families, and support and professional development for the Maternal and Child Health (MCH) nurse. |
| EMCH team member | Any professional, for example MCH nurses, allied health professionals (such as social workers, family violence workers), Aboriginal Health Practitioners and family support workers, who work within the EMCH program directly with families. |
| Family | Inclusive of all parents, carers and family members. |
| Family violence | Any act or behaviour towards a family member that is: physically, sexually, emotionally, psychologically or economically abusive; threatening or coercive; controls or dominates; causes fear for the safety or well-being of themselves or another person. It also refers to behaviour that causes a child to hear, witness, or otherwise be exposed to the effects of any behaviour referred to above. |
| Father | Male caregiver who provides parenting to a child. The definition includes biological and social fathers (such as stepfathers, foster carers, male partners) and father figures such as uncles and grandfathers. |
| MCH Nurse | To practice as a MCH Nurse in Victoria, the MCH Nurse is required to hold current registration with the Australian Health Practitioner Regulation Agency (AHPRA) as:   * a Registered Nurse (Division 1), and * a Registered Midwife.   In addition to above registration hold an accredited postgraduate diploma in Child, Family and Community Nursing (or equivalent). |
| MCH Service | Overarching Victorian MCH service that is delivered statewide by Local Government Authorised MCH services and Aboriginal Community Controlled Organisations across Victoria. The MCH service also includes the 24/7 MCH Line. |
| Mother | Female caregiver who provides parenting to a child. The definition includes biological as well as social mothers (such as stepmothers, foster carers, female partners) and mother figures such as aunts and grandmothers. It is understood that the care of the biological mother includes both antenatal and postnatal assessment, advice and referral. |
| Parent and carer | Person or people who have substantial responsibility for ongoing care and support of the child or infant for whom the EMCH program is being provided. This parent may or may not be the biological parent; they may be a stepparent, foster parent, grandparent, or other carer. |

Table 1: Key terminology

# Purpose

The Enhanced Maternal and Child Health (EMCH) program is part of Victoria’s Maternal and Child Health (MCH) service and is offered to eligible families as an extension of the Universal Maternal and Child Health (UMCH) program. The EMCH program offers a flexible response to families who need extra support.

The purpose of these guidelines is to provide Local-Government Authorised MCH services with the information and resources to maximise support for families who need it most through the EMCH program.

This version of the EMCH Program Guidelines (version 2.0, July 2025) replaces the previous version issued in 2019 (retroactively labelled as version 1.1).

Since these guidelines were previously issued in 2019, multiple relevant policy frameworks and tools have been introduced. These include the Multi-Agency Risk Assessment Management (MARAM) framework, the Child Information Sharing Scheme (CISS) and Family Violence Information Sharing Scheme (FVISS) and Child Link digital tool. These frameworks, tools and reforms are included in these guidelines.

The updated guidelines incorporate feedback from a range of stakeholders including an expert working group of MCH nurses. They have been informed by *The Evaluation of the Expanded Enhanced Maternal and Child Health Program: Final report 2021* (Jennings et al, 2021) and recommendations from the evaluation have been considered.

Additionally, the updated guidelines also address feedback received from parents, grandparents and carers in 2024 through a series of roundtable discussions held by the Minister for Children and the MCH service survey. Both the roundtables and statewide MCH survey highlighted the importance of ensuring that all MCH services are delivered in partnership with families, utilising a strengths-based approach that centres around the expertise of the family. These important foundations for practice have been embedded in these guidelines.

# How the EMCH program supports families

Responding early to health and development issues can help a child thrive. Extra support through the EMCH program can help parents and carers respond to any issues to give their child the best start in life.

**What is the EMCH program?**

The EMCH program provides free extra support to Victorian families:

* with children from 0 to 3 years
* who are experiencing two or more challenges or factors that impact their role as parents or carers.

The EMCH program:

* works in partnership with families
* builds on the Universal MCH program and provides extra hours of support for families who need it
* is delivered in a family’s home, local MCH centre or another community location.

**What support is available?**

The EMCH program can provide families with extra support with their parenting. This may include:

* building their confidence as a parent or carer
* improving their relationship with their child
* exploring different ways parents can work together
* strategies to help children play, grow and learn
* developing strategies to respond to their child’s cues and needs
* working through the impact of family violence and how to plan the next steps
* linking them to local parent and family support services (such as disability support)
* referrals for specialist assessment or intervention.

**Who is the EMCH program for?**

Families experiencing challenges impacting their role as parents or carers may benefit from the EMCH program. This may include:

* difficulties bonding or developing a strong relationship with their child
* significant child behaviour problems
* issues with their child’s health and development (such as not reaching milestones)
* involvement of Child Protection or family services
* being a young parent/carer (under 20 years)
* family violence and safety
* a parent/ carer or child have a disability or complex medical needs
* a parent/ carer has a health condition or mental health condition (including substance abuse)
* a parent/ carer is at risk of homelessness or unemployment
* the family is struggling to engage with and/or access with the MCH service, for example due to rural/ regional isolation.

Priority access is given to Aboriginal and Torres Strait Islander families, those needing interpreter/language support and children in Out-of-Home Care (OoHC). MCH services should consider the age of the child with respect to risk and vulnerability.

# EMCH Program overview

| Feature | Description |
| --- | --- |
| About the program | * The EMCH program is an outreach program led and primarily delivered by MCH nurses. The EMCH program may also include other practitioners and allied health professionals including mental health practitioners, drug and alcohol workers, bilingual workers, Aboriginal Health Practitioners, psychologists and social workers, whose skill and knowledge complements the work of MCH nurses. * It works in partnership with families who are experiencing two or more challenges or vulnerabilities that may impact on their parenting. The EMCH program provides extra support to parents and families in a setting that works best for them, such as their home, an MCH centre or another community location. * [**Appendix 1**](#_Appendix_1:_EMCH) provides a detailed representation of the EMCH program logic. |
| Tiered service model | * The EMCH program builds on the Universal MCH (UMCH) program and provides extra support for families who need it. It forms part of the early parenting care available in Victoria that also includes the MCH Line and Early Parenting Centres (EPCs). |
| Entry criteria | * Child aged between birth and three years of age. * Experiencing two risk factors - [**Appendix 3A**](#_Appendix_4A:_Protective) provides further detail. * A clear role for the EMCH program in relation to the child and family’s needs. * Priority access for Aboriginal and Torres Strait Islander families, those needing interpreter/language support and children living in OoHC. * There is no cost to families and no Medicare or visa requirements. |
| Program capacity | * 15% of Victorian population aged 0-3 years for up to 20 hours (22.67 hours in regional/rural areas). * The number of service hours provided is dependent on child / family’s level of need and program capacity. |
| Program entry | * Referrals can be made by UMCH, Aboriginal MCH, EMCH in other areas, maternity services, Family Services, Child Protection, family violence services, The Orange Door, homelessness services, early education services, supported playgroups, GPs, allied health and other social services. |
| Culturally responsive and inclusive practice | * The EMCH program works in partnership with a wide range of families and seeks to provide culturally sensitive and responsive care to all. * The important role of caregivers is acknowledged by the EMCH program. * The EMCH program recognises the diversity that exists within contemporary families and aims to provide a respectful environment to support everyone who may be caring for children in Victoria. |

Table 2: Program overview

## Victorian MCH Service

The Victorian MCH service is a free universal primary health service available for all Victorian families with children from birth to school age, regardless of Medicare, visa status or other circumstances.

The MCH service is inclusive and works in partnership with all families. The term ‘families’ is inclusive of mothers, fathers, parents and carers and recognises that all families are different and unique. The MCH service promotes healthy outcomes by working with children and families to identify and manage physical, emotional and social factors that may affect their health, wellbeing and development.

The Victorian MCH service comprises the:

**Universal MCH program** - a free primary health service in local communities that helps every Victorian child to be healthy, ready to grow, learn and thrive and to support the health, wellbeing and parenting journey of mothers, fathers, parents, carers and families. The UMCH program has contact with all Victorian children from birth to school age, through 10 key age and stage (KAS) consultations and the provision of first-time parent groups, sleep and settling outreach support, family violence consultations and other targeted community strengthening activities.

**MCH Line** -a free and confidential 24/7 telephone service where MCH nurses provide information, advice, support and referrals to Victorian families with children from birth to school age. The MCH Line is integral in linking families to the UMCH program, Aboriginal MCH services and to other community, health and support services.

**Aboriginal MCH program** - embedded in self-determination and culture and supports access to care that is tailored to meet the needs of Aboriginal families. It is delivered by Aboriginal Community Controlled Organisations (ACCOs) and strengthens access to culturally responsive MCH services for Aboriginal families. The Aboriginal MCH program is delivered flexibly by ACCOs to responsively meet the individual needs of Aboriginal families. As Aboriginal MCH services do not receive funding to deliver EMCH, it is critical that MCH services including Local Government work in partnership with Aboriginal MCH service providers to ensure priority access for Aboriginal families to culturally safe care through the EMCH program.

**Enhanced MCH program** - providing extra support to families who are experiencing two or more challenges. Referral criteria and eligibility are outlined in [Appendix 3A](#_Appendix_3A:_Protective) and [Appendix 3B](#_Appendix_3B:_Risk) and may relate to long- and short-term physical, emotional and social vulnerabilities. A wide body of evidence recognises the importance of addressing health inequalities in early childhood and further evidence that working alongside families and communities, building on their strengths and empowering them to provide the conditions in which their children can flourish is the best way to do this (Moore, 2024).

The EMCH program was first established in 1999/2000 and expanded in 2018. The program is intended to be available to 15 per cent of Victorian families with children from birth to three years of age, with up to 20 hours (22.67 for regional/rural areas) of support for each child/family. Additional funding for EMCH nurse participation in clinical supervision was included as part of the expansion (Department of Health, 2024).

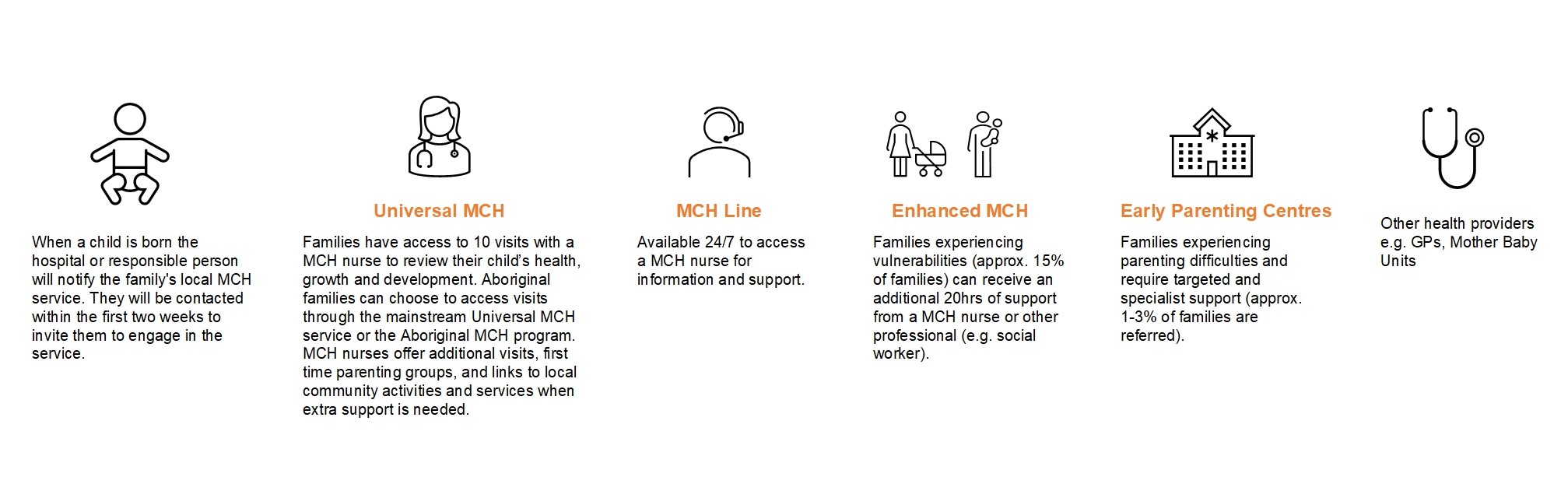


Figure 1: Victorian MCH program and early years supports

## Guiding principles

The guiding principles of the EMCH program are:

**Child-centred, maternal, parent, carer and family-focused**

* child-centred, maternal, parent, carer and family-focused practice is designed to respond holistically to the needs of the family based on their current circumstances

Connection with parents as partners

* follows a family-centred, strengths-based approach, with families always involved in decision making
* responds to families in a respectful, non-judgemental manner, and maintains each child and family’s privacy in line with relevant legislation

Health promoting, early intervention and preventative health activities

* focuses on the importance of keeping the child in mind and promoting child/infant mental health
* follows the principles of health promotion, prevention and early intervention

Equitable, flexible and inclusive

* is flexible and provides outreach support in a variety of settings, including the family’s home, the local MCH centre or another location within the community
* follows a place-based approach. Whilst the EMCH program is consistent across the state, service delivery may be delivered flexibly between local communities in response to differences in population, community needs, and rurality and remoteness
* supports Aboriginal families by working with Aboriginal workforces and/or service providers, wherever possible
* responds assertively to the needs of infants, children and families where there are multiple complexities, by providing a more intensive level of support in addition to the UMCH program

Coordinated, collaborative and prioritises partnership

* provides supportive care coordination where necessary, in the absence of another suitable care coordinator
* actively involves and collaborates with other services including family services, maternity services, Child Protection, specialist family violence services, The Orange Door and other social and health supports
* utilises clinical supervision, reflective practice and continuous improvement to support the provision of high quality, safe care for families and the workforce.

## 

## EMCH Program eligibility

MCH services are free for all families. There is no cost to parents to access MCH services, including the EMCH program. Parents/carers who are not enrolled in Medicare are eligible to access all MCH services.

Families should meet **three** key requirements to be considered for entry into the EMCH program.

**1.Child’s age**

The child is under three years of age. While priority for services is given to families with a child under three years of age, the aim is to provide additional support to families presenting with multiple risk factors. MCH services have the discretion to include families with children over three years of age where capacity exists.

**2.Risk factors**

Families experiencing challenges or vulnerabilities, with two or more risk factors being present. In addition, families are considered high risk if they have insufficient protective factors. Refer to [[Appendix 3A](#_Appendix_3A:_Protective).](#_Appendix_4A:_Protective)

**3. EMCH program can respond effectively**

There is a clear role for the EMCH program to provide intervention(s) and support to meet the child and family’s needs, and the EMCH program has the capacity and skill set to provide the necessary support to the family.

## Priority of access

MCH services at the local level should triage EMCH program referrals based on eligibility and priority. The EMCH program has the capacity to provide service to approximately 15 per cent of the statewide population aged from birth to three years of age. If services experience a period when demand for EMCH exceeds service capacity, MCH services should have processes in place to triage appropriately based on need, risk factors and priority access. MCH services should also consider the age of the child with respect to risk and vulnerability.

Services should ensure families are adequately supported whilst waiting for the EMCH program, for example by providing additional UMCH support or other referrals, such as to Early Parenting Centres, until EMCH is able to engage with the family.

[Appendix 3A](#_Appendix_3A:_Protective) provides details on risk and protective factors and [Appendix 3B](#_Appendix_3B:_Risk) provides details on risk factors mapped to CDIS referral reasons.

**Children in Out-of-Home Care**

Children in OoHC are at greater risk for having poorer physical, developmental and social/emotional health outcomes than their peers (McLean, 2022).

MCH services have a responsibility to ensure that all young children in OoHC are engaged in MCH services and referred into an EMCH program if not already engaged with a UMCH program or when additional support is required.

Where EMCH services are aware that a child is in OoHC and living in their area, services must seek to engage that child’s carer in the MCH service. When MCH services become aware that a child who was in their service has moved into OoHC in another area, services must contact the relevant MCH provider to ensure that MCH care is continued for that child.

Supporting documents:

* Out-of-Home Care: [Child protection - DFFH Services](https://services.dffh.vic.gov.au/child-protection) (Department Families Fairness and Housing, 2022) <https://services.dffh.vic.gov.au/child-protection>
* [Early Childhood Agreement for Children in Out-of-Home Care](https://www.education.vic.gov.au/Documents/childhood/professionals/health/ecagreement.pdf) <https://www.education.vic.gov.au/Documents/childhood/professionals/health/ecagreement.pdf> (Department of Education and Traninng, 2019).

**Aboriginal and Torres Strait Islander families**

Aboriginal families may choose to access the UMCH program, or an Aboriginal MCH program if it is available in their area. If a more intensive level of service is needed by a family, they will be prioritised within the EMCH program.

EMCH respects the strength of Aboriginal child-rearing and family practices and the centrality of culture to this strength. EMCH team members recognise a family’s right to self-determination and will be guided by the family and Community on how to support a family to draw on their strengths. EMCH will work in partnership with parents and carers (as defined by the family) to facilitate culturally safe care, support and service linkages to enhance family resilience.

**Families needing interpreter/language support**

**Families who speak a language other than English and need interpreter or language support and are eligible for EMCH will be prioritised for support. This includes refugee and asylum seeker families.**

**EMCH will utilise professional interpreting services and provide culturally sensitive and appropriate support to ensure that the needs of all families are addressed.**

## Workforce and modes of delivery

**Workforce**

MCH service providers are responsible for the recruitment, management and professional development of the EMCH workforce.

The **EMCH program is led and primarily delivered by MCH nurses** who meet the registration and qualification requirements for Victoria (Department Health and Human Services, 2011, reissued 2019).

The EMCH program is led and primarily delivered by MCH nurses, but EMCH teams may be multidisciplinary and may include MCH nurses, social workers, family support workers, mental health practitioners, Aboriginal Health Workers and Practitioners, bilingual workers and other relevant practitioners. A multidisciplinary workforce can complement the skills of MCH nurses and strengthens the capacity of the EMCH program to assess families experiencing challenges, support child and family health and wellbeing and refer families to appropriate services in a timely manner.

Multidisciplinary staff must hold appropriate tertiary qualifications and demonstrated expertise in risk assessment and management to ensure safe, responsive, and effective service delivery. They should work in partnership with MCH nurses, who provide guidance and clinical oversight to ensure safe, quality care. All staff must work within their own scope of practice and where relevant, have professional registration and maintain the requirements of that professional registration (Department of Health, 2019, reissued 2021).

MCH service providers must:

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

**Modes of delivery**

Flexible modes of service delivery may be used in the EMCH program based on the identified needs of children and families.  These may include:

* home visits
* parenting/carer programs, including education, training, support and skills training
* parenting/carer programs can be delivered in several formats (individual, groups and self-directed) and in a range of settings, with varying intensity and duration. Parenting/carer programs are usually based on:
  + relationships – linking attachment theory and psycho-dynamic approaches (example program: Circle of Security)
  + group activities for specific communities such as adolescent parents, Aboriginal families and culturally and linguistically diverse families (e.g., Supported Playgroups)
* centre based visits
* telehealth (Department of Health, 2022)
* referral pathways to link infants/children and families with other primary or secondary services for longer term intervention, support and safety
* integrated service provision at various levels, with:
  + maternity services for high-risk pregnancies including perinatal service provision
  + local service providers including drug and alcohol, family violence, mental health, preventing homelessness, family support, early intervention, Supported Playgroups, kindergarten and Child Protection services
  + liaison with acute service providers such as the Royal Children’s Hospital, Monash Children’s Hospital, GPs, paediatricians, and primary health care.

## Clinical supervision

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

Clinical supervision is coordinated by the MCH coordinator and is delivered in a way that is tailored to the local needs of EMCH nurses on a monthly basis or accumulated on a pro-rata basis. Recommended best practice principles is that clinical supervision is provided by a supervisor who has attended training in clinical supervision and who receives clinical supervision themselves, is structured, guided by the supervisor who is not a direct line manager. Supervisory agreements formalise the supervisory relationship, agreed goals and purposes and acknowledge the implicit confidentiality that underpins the supervisory relationship.

# EMCH Model of Care

The EMCH Model of Care (MoC) recognises that the EMCH program is a step-up level of support offered to families whose needs cannot be adequately accommodated by the UMCH program. Families receiving support from the EMCH program continue to receive the UMCH program and have access to the MCH Line. They may also receive support from other external support services during their engagement with the EMCH program.

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

The EMCH program supports parent-child interactions by providing more focused and intensive MCH support when parents are experiencing significant early parenting challenges. Recognising the significance of social determinants of health, the program may also work alongside specialist services to address parent/carer or family risk factors that affect child development or the capacity of the family such as parent emotional wellbeing, homelessness, poverty, trauma, family violence and drug and alcohol use.

The EMCH program is a child and family centred program that prioritises the child’s experience of the world and works in partnership with families to address factors than can impact upon this.

The EMCH program MoC is shown at **Figure 2** and inputs, outputs and outcomes from the MoC are shown in a program logic diagram in [Appendix 1](#_Appendix_1:_EMCH).

## **EMCH Program objectives**

1. Work alongside maternity and other support services to commence care planning for pregnant women with identified risk factors during the antenatal period.
2. Conduct relevant assessments of infant/child, maternal, parent, home and environmental protective and risk factors.
3. Deliver targeted actions and early interventions for infants/children, mothers, parents, carers and families to improve child health, wellbeing, safety, learning and developmental outcomes.
4. Assist parents/carers to build on strengths and protective factors to manage risk factors, increasing capacity, responsiveness and ability to keep the child in mind at all times.
5. Facilitate the parent/carer’s ability to engage in their community as a key protective factor.
6. Ensure appropriate and timely referral of infants, children, mothers, carers and families to a range of services to further enhance health, wellbeing, learning and development.
7. Use a place-based approach to contribute to the development of a local system of care to promote the health, wellbeing, safety, learning and development outcomes for children and families.

In providing the EMCH program, it is recognised that changing the experience and life trajectory of children and families with additional needs or concerns is a shared responsibility across community, government, service providers and individuals.

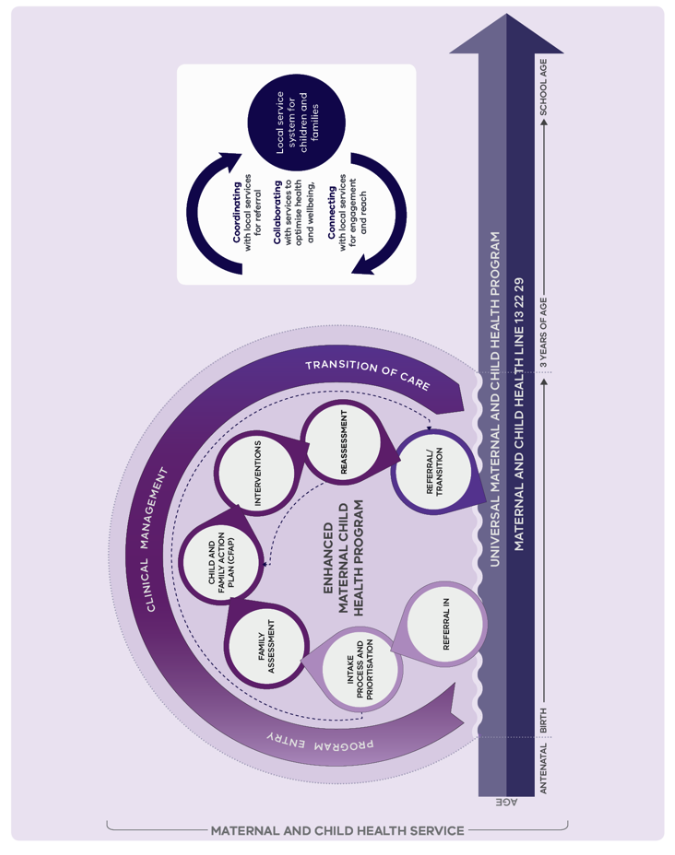
## Coordination of care and information sharing

Coordination of ongoing care and collaborative communication between EMCH, UMCH and other service providers is critical.

EMCH team members are responsible for working collaboratively with others involved in the current or future care of the family, communicating effectively and sharing relevant information to support safe and effective integration of care. This may include care coordination for families with higher levels of need to support their engagement with other support services.

Families may also be involved with other services in the broader service system. In this case, EMCH team members should ensure that all professionals are aware of the involvement of EMCH and that regular updates and communication between services occurs. This may include requesting information, responding to requests or proactively sharing information using Family Violence Information Sharing and Child Information Sharing Schemes.

Information sharing scheme resources for MCH services can be found on the [Municipal Association of Victoria’s (MAV) website](https://www.mav.asn.au/what-we-do/policy-advocacy/social-community/children-youth-family/maternal-and-child-health-children-0-6-years/maternal-and-child-health-resources/information-sharing-schemes-resources). <https://www.mav.asn.au/what-we-do/policy-advocacy/social-community/children-youth-family/maternal-and-child-health-children-0-6-years/maternal-and-child-health-resources/information-sharing-schemes-resources>.



**Figure 2: Enhanced Maternal and Child Health Model of Care**

# Putting the Model of Care into practice

The EMCH program and MoC is typically implemented in three stages.

* **Stage 1: Program entry** - Referral pathways, assessment and intake process.
* **Stage 2: Clinical management** - Engagement, assessment, child and family action plan (CFAP), actions and interventions and review.
* **Stage 3: Transition of care.**

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

* initial and ongoing assessment and screening
* partnering with families to create their CFAP to enable them to reach their goals
* delivery of evidence-informed interventions to meet specific family needs
* building trust and relationships with families who are not currently engaged with the MCH service to facilitate their engagement and connection with the UMCH and/or EMCH program
* care coordination for families with higher levels of risk to support their engagement with other support services
* collaboration and engagement with, and referral to, other services.

In practice, the MoC is delivered flexibly to respond to families’ needs and can vary to reflect the diversity of service delivery across metropolitan, regional and rural areas in Victoria.

## Program entry

### **Referral pathways, assessment and intake process**

**Internal referrals from within a local MCH service**

Children and families may be referred into the EMCH program when a family requires intensive support that cannot be provided by the UMCH program alone.

Each service may set procedures around how referral information is relayed to the EMCH team for assessment. Once accepted into the program, the adult/parent becomes the lead client.

**Transferring of EMCH clients to a new MCH Service**

When a family currently receiving the EMCH program is moving to a new location / local government area they can access the EMCH program in their new place of residence. The family’s consent should be obtained and the new MCH service is contacted directly to support continuing care within the EMCH program.

**MCH Line**

The MCH Line may initiate a referral to the local MCH service who may then decide to refer to EMCH program.

**External referrals**

External referrals into the EMCH program can be received from a range of services and professionals such as:

* Child Protection
* social workers
* hospitals
* GPs
* The Orange Door
* maternity services/maternity care providers
* family violence services
* refuges and hostels.

For pregnant mothers who would benefit from support from the EMCH program, the referring service (e.g., maternity services, Koori Maternity Service or GP) can initiate the referral prior to the birth of the baby.

The EMCH Referral Form at [Appendix 4](#_Appendix_4:_Draft) can assist external referring practitioners to identify specific area/s of need and can be used by the MCH service when making an initial assessment of the family’s suitability for the EMCH program.

Refer to the [CDIS Enhanced MCH Guide on the Department of Health’s website](https://www.health.vic.gov.au/maternal-child-health/child-development-information-system) for details of processes within the electronic client management system <https://www.health.vic.gov.au/maternal-child-health/child-development-information-system>.

## **Assessment and intake**

All referrals to the EMCH program should be received at a central point determined by each MCH service. The assessment and intake process must be led and undertaken by a MCH nurse. While this process may be tailored to suit local service needs, the process outlined below is documented to form baseline best practice guidance.

### Assessment and intake process

During the assessment and intake process the MCH nurse Coordinator/ Team Leader or EMCH nurse should:

* establish the family’s level of need
* assess the risk and protective factors present
* determine the appropriate service response
* consider how the program will support the safety, wellbeing and development of the child/ren and their family
* give thought to the diversity and background of the family
* access Child Link for each child under 6 years in the family being referred to the EMCH program to gain an understanding of services the family is connected to and to support risk assessment.

The EMCH nurse may contact the family to discuss the referral and may also contact the referrer if further information gathering is required.

The referrer should be informed of the outcome of the EMCH program referral.

The EMCH nurse/team may also be available to provide secondary consultation and advice to UMCH nurses to explore the most appropriate referral and support pathways for families.

When a family has been accepted into the program, the EMCH nurse should perform a search on Child Link for each child under 6 years of age in the family. This will support risk assessment and enable the EMCH nurse to further understand the other services currently and previously supporting the family. This information should be shared with the allocated team member.

### Non-eligible families

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

* they do not meet the eligibility criteria
* the family is already receiving adequate care / support via another service or program (such as family support services / allied health services), and the family is receiving concurrent support from UMCH program
* acceptance of the family into the program would pose an unacceptable risk to the safety of the EMCH staff member. In this case consultation and referral should be undertaken with the family and other services to ensure that the parent/ carer and child are safe and that the MCH service is made available to them in another capacity
* the EMCH program does not have capacity or skill set to provide the family with the required support.

If a family is assessed as not meeting eligibility criteria, the EMCH nurse should contact the referring professional to inform them of the decision. They should discuss the family’s needs and alternative support options with the referrer and this should be documented.

### Consent

Enrolment and informed consent to the EMCH program and to information being collected and stored on the electronic client management system is not required again if it has already been established in line with the MCH service processes, recognising that the EMCH program is part of the statewide MCH service. However, the referrer should ensure the client is provided with information about the program and is aware of and consents to the referral.

## Working with the family

### **Engagement**

Investing time in establishing a trusting and respectful partnership with a family is critical. The parent-professional relationship has been identified both by research and families as central to the effectiveness of other interventions that build parental capacity and create change (Jennings, 2021). Feedback from families about the MCH service consistently highlights the importance of trusting relationships and strengths-based, non-judgemental support.

The following evidence-based approaches and skill sets are recommended as foundational for EMCH staff to establish authentic engagement with families:

* **Culturally safe practice** - Respecting cultural values and practices is critical when working with Aboriginal and Torres Strait Islander families as well as those from refugee and culturally diverse backgrounds. Aboriginal families should be offered the choice to have an Aboriginal MCH service and/or Aboriginal EMCH practitioner involved in their care if available.
* See the Department of Health’s [webpage on Aboriginal and Torres Strait Islander Cultural Safety](https://dhhsvicgovau.sharepoint.com/sites/MCH-Program-and-Governance-DH-GRP/Shared%20Documents/General/Programs/EMCH/EMCH%20guidelines/Program%20Guidelines/–%09https:/www.health.vic.gov.au/health-strategies/aboriginal-and-torres-strait-islander-cultural-safety) <https://www.health.vic.gov.au/health-strategies/aboriginal-and-torres-strait-islander-cultural-safety>.
* **Trauma-informed practice** - Trauma-informed care or practice is an approach that understands that trauma is common and seeks to understand how it might affect people’s lives. It is holistic, empowering, strengths-focused, collaborative and reflective. It promotes physical, emotional, spiritual and cultural safety.
  + See the [DFFH Framework to Trauma Informed Practice](https://www.dffh.vic.gov.au/sites/default/files/documents/202302/Framework-for-trauma-informed-practice.pdf) <https://www.dffh.vic.gov.au/sites/default/files/documents/202302/Framework-for-trauma-informed-practice.pdf>
* **Family Partnership Model** - The Family Partnership Model enables practitioners and families to develop a shared understanding of the family’s needs and priorities and to combine their knowledge, skills and experience to achieve their goals.
  + See the [Centre for Community and Child’s Health training on the Family Partnership Model](https://ccch.org.au/learn/?topic=1675) <https://www.rch.org.au/ccch/research-projects/family-partnership/>
* **Motivational interviewing** - Motivational interviewing is a counselling method that involves enhancing a parent’s motivation to change. It provides a framework for the EMCH nurse to build engagement and conversation with the parent/carer leading to establishing collaboration and trust.
* See the [Australian Family Physician article on Motivational Interviewing Techniques](https://www.racgp.org.au/afp/2012/september/motivational-interviewing-techniques) <https://www.racgp.org.au/afp/2012/september/motivational-interviewing-techniques>.

A family’s experience of working on goals and engaging in the EMCH program is often dynamic and not linear. **Figure 3** below is a representative model of this process that can be used by staff members during the engagement period.

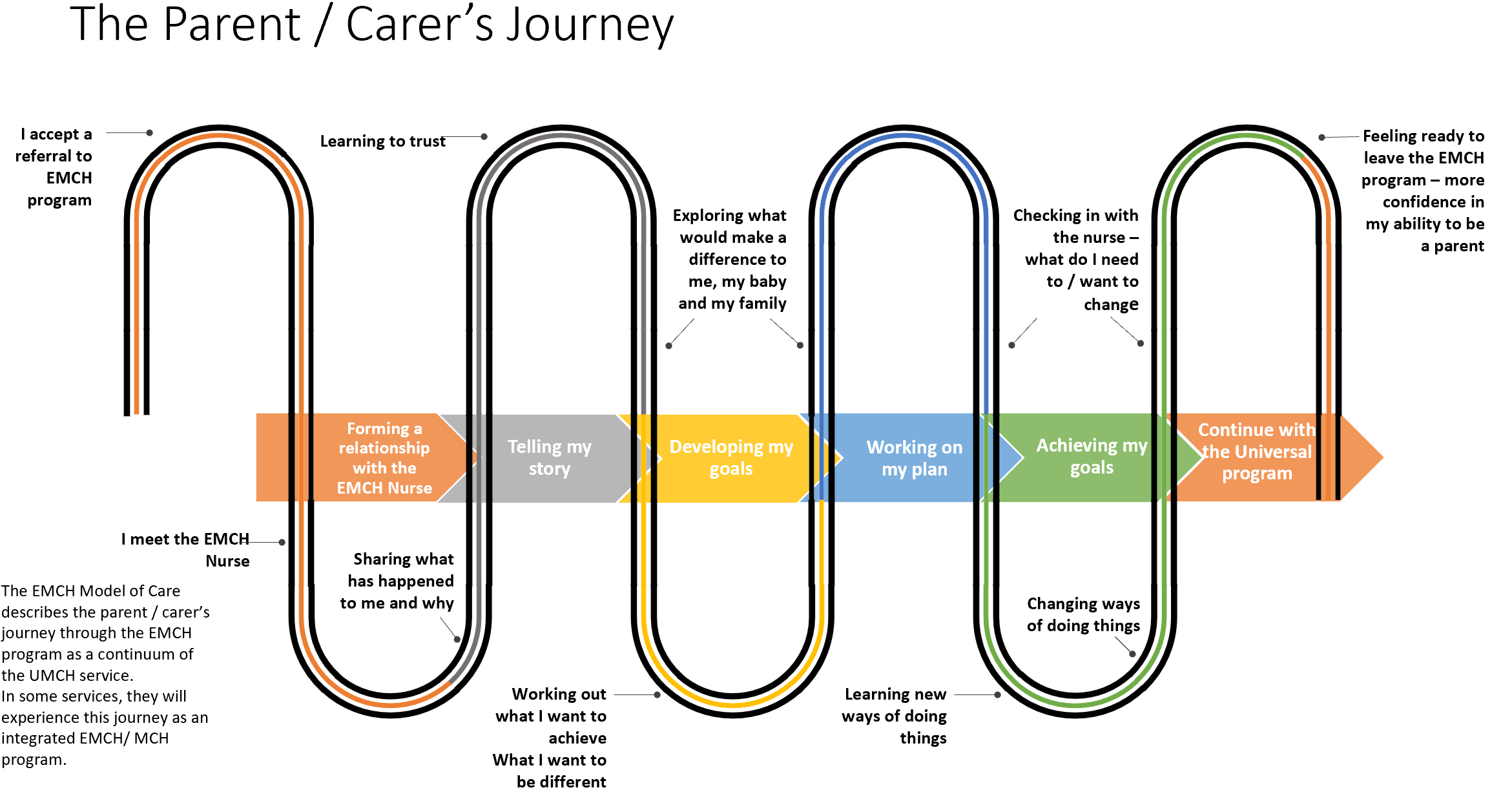


Figure 3: The Parent/ Carer’s Journey

## **Assessment**

Child and family assessment within the EMCH program is a dynamic and ongoing process. It may be a collaborative process involving more than one EMCH team member, depending on the needs of the family and the skill mix within the team.

The EMCH team member will use a range of clinical skills and formal tools to build a detailed understanding of the child and family.

The assessment process will assist the EMCH team member to:

* understand the child’s needs in the context of the broader family environment
* analyse the nature and level of any risks of harm facing the child or parent/carer as well as identifying strengths and protective factors
* recognise any concerns about development requiring further intervention and/or referral
* plan and provide suitable interventions to address short term and medium-term goals
* coordinate, or deliver, and monitor a suite of flexible services
* record goals, objectives and the tasks required to achieve these.

**Table 3** shows some of the tools commonly used by MCH services. Tools and techniques (e.g., Ecomaps, genograms) are used in building a visual representation of child and family function and environment. More details on the tools are provided in [Appendix 5](#_Appendix_5:_Overview).

|  |  |
| --- | --- |
| Domain | Commonly used by MCH services |
| Child health, wellbeing, safety learning and development | * Parents’ Evaluations of Development Status (PEDS) or PEDS-R * Brigance Early Childhood Screening tools * KAS assessments * MARAM * Newborn observations * Social Attention and Communication Surveillance (SACS) * Sleep Pathways Assessment form |
| Parenting/carer capacity | * Clinical observation * Parent and carers psychosocial tool * Brigance parent – child interaction scale |
| Parent/family health, wellbeing and safety | * Edinburgh Postnatal Depression Scale (EPDS) * MARAM * Genogram * Ecomaps |
| Environmental factors | * Home Visit Safety Assessment (CDIS) * Home Safety Checklist (Kidsafe) * Safe Sleeping Checklist |

Table 3: Overview of assessments and tools

### **Developing the Child and Family Action Plan in partnership with the parent/carer**

Care planning is a dynamic process that occurs in partnership with the family and utilises the Child and Family Action Plan (CFAP). The CFAP documents the parent’s goals and what they want to achieve. The CFAP is developed using the parent/carer’s words, is tailored to their unique circumstances, and builds on their strengths. For Aboriginal families, these include strong connection to culture, kinship and Community.

Setting a goal provides the parent/carer with a sense of direction and ownership of their desired outcomes. The goals are flexible, evolve over time as the parent/carer’s circumstances change and they reflect on the infant/child’s cues and response to the interventions. Goal setting may be a new experience for a family, and they may require time and exploration to assist them to identify what they want to achieve.

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

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

The CFAP includes a discharge plan to prepare the family to exit the EMCH program and is used for EMCH program closure or to identify the need for further assessment or service provision to support the child and family. The CFAP is closed only at the transition back to the UMCH program.

## **Actions and interventions**

When the assessment of the family has been completed and a CFAP has been developed, specific strategies, professional-led actions, interventions and referrals to specialist supports are provided in response to identified needs and to meet the goals agreed in the CFAP. **Table 4** outlines some of the interventions and strategies commonly used within the EMCH program.

Interventions should:

* be evidence informed
* build on strengths and protective factors identified in the child and family assessment, including Aboriginal cultural identity and connection
* increase parental knowledge and capacity to address a specific need as identified in the CFAP
* improve parenting confidence and aim to create sustainable change
* be responsive to the needs and issues that the family has identified.

| Domain | Commonly used by MCH services |
| --- | --- |
| **Child health, wellbeing, safety learning and development** | * Monitoring of child development and KAS assessments * Assisting child to learn and communicate from birth (child literacy, language, nonverbal cognitive ability and home literacy environment) * Breastfeeding support program * Sleep and settling family centred support * INFANT program * Newborn observations * Opportunistic immunisation or linkage with immunisation services |
| **Parenting/ carer capacity** | * New parent and other supportive group sessions * Building parenting capacity to keep the child in mind at all times * Infant mental health and attachment education * Assistance with building self-management * Play and art therapy * Motivational interviewing and support * Provision of advice and support to assist the parent to provide appropriate nutrition for the child * Circle of Security * Behavioural approaches such as:   + cognitive behaviour or social learning theories   + effective across universal and targeted populations (example programs and practices may be Triple P, Keys to Caregiving, Supported Playgroups) |
| **Parent / family health, wellbeing and safety** | * Maternal antenatal and postnatal assessment and support * Parent health assessment and support * Parent mental health assessment and support including the use of mobile phone apps e.g. iCope, MumMoodBooster or DadBooster. * Referral to specific groups e.g. transition to parenthood and Supported Playgroup * Family violence risk assessment and risk management, including safety planning * Assistance to improve social connectedness * Health promotion activities |
| **Environmental factors** | * Creating and maintaining a safe home environment * Creating and maintaining a safe sleeping environment * Creating and maintaining a home learning environment that supports the child’s growth and development |

Table 4: Examples of interventions

## Reassessment, reflection, collaboration and review

Reassessment of the family’s goals and objectives, and progress towards these occurs continually throughout a family’s engagement with the EMCH program and is responsive to changing priorities. Reassessment occurs in collaboration with the family, in response to information learned from other services, after clinical supervision and reflection or when the family start or stop receiving support from another service. Reassessment should be discussed with the family and reflected in the CFAP.

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

## Transition of care

Transition of care from the EMCH program is a crucial activity and continuity of engagement should be maintained. All MCH services should have clearly documented transition practices. All goals should be reviewed, and the outcome documented in consultation with the parent.

Transition of care means the family has been successfully linked to the UMCH program, if the EMCH program is not integrated, and acknowledgement of this has been received by the EMCH program based on local service processes.

### Returning to the Universal MCH program

If there is no identified ongoing role for the EMCH program the transition back to the UMCH program only, can commence, guided by the CFAP.

Families who have been transitioned to the UMCH program only can return to the EMCH program if additional needs/risks are later identified or if previously experienced vulnerabilities re-occur.

If the family do not attend the scheduled UMCH appointment, the EMCH service should be consulted and best practice guidance to support parent, carer and family active engagement in MCH services should be followed and documented. For practice guidance please refer to the [Department of Health’s Practice Note for MCH services](https://www.health.vic.gov.au/publications/parent-carer-and-family-active-engagement-practice-guideline) <https://www.health.vic.gov.au/publications/parent-carer-and-family-active-engagement-practice-guideline>.

### Remaining with the EMCH program

The EMCH staff member may identify that:

* families would benefit from further interventions through the EMCH program
* the family is at risk of not engaging with the UMCH program on transition of care from the EMCH program
* the UMCH program is unable to meet the needs of the family.

Concerns should be discussed with the MCH Coordinator/ Team Leader and the family. Where ongoing care is required, the EMCH program continues. This may present an opportunity to review the family’s goals. The aim is that the family continues to receive support from the MCH service.

### Parent choice to exit the EMCH program

Participation in the EMCH program is voluntary. The parent/carer may choose to exit the EMCH program at any point while maintaining their engagement with UMCH.

The EMCH staff member will explore with the parent/carer options to enable them to remain engaged with the EMCH program or to support their transition of care. The plan may include actions such as a facilitated link to continue engagement with the MCH service through the UMCH program, links to other professionals or support services, a list of contact numbers and anticipatory guidance relating to important milestones of the child’s development. It should also include information regarding the availability of the MCH Line and the option to re-engage with MCH services at any time.

All other professionals and service providers including Child Protection (if applicable) that the family are involved with should be notified of the family’s decision and this should be clearly documented.

In cases where a family cannot be contacted, best practice guidance should be followed to support parent, carer and family active engagement in MCH services. Please refer to the [Department of Health’s Practice Note for MCH services](https://www.health.vic.gov.au/publications/parent-carer-and-family-active-engagement-practice-guideline) <https://www.health.vic.gov.au/publications/parent-carer-and-family-active-engagement-practice-guideline>.

# Legislative context

## ****Multi-Agency Risk Assessment and Management Framework (MARAM)****

MARAM aims to increase the safety and wellbeing of Victorians by ensuring relevant services can effectively identify, assess and respond to family violence risk including information sharing and working collaboratively.

MARAM practice guides and resources can be accessed on the [Victorian Government website](https://www.vic.gov.au/maram-practice-guides-and-resources): <https://www.vic.gov.au/maram-practice-guides-and-resources>.

EMCH team members are required to respond to families at risk of or experiencing family violence in alignment with the responsibilities specific to their role function, as outlined in the [MARAM Framework](https://www.vic.gov.au/sites/default/files/2019-01/Family%20violence%20multi-agency%20risk%20assessment%20and%20management%20framework.pdf).

Where appropriate, referrals to specialist family violence services, such as The Orange Door, should be actively facilitated and supported. EMCH staff may continue to be involved with the family, providing ongoing EMCH support and assisting them in navigating the specialist service system

**The Orange Door** provides specialist family violence services across Victoria. For further information visit [The Orange Door website](https://www.orangedoor.vic.gov.au) <https://www.orangedoor.vic.gov.au/>.

## **Information Sharing Schemes**

MCH services are prescribed Information Sharing Entities (ISEs) under the Child and Family Violence Information Sharing Schemes. These reforms allow professionals to make requests, respond to requests and proactively share information under specified circumstances.

### Child Information Sharing Scheme (CISS)

Under CISS, Information Sharing Entities (ISEs) can share confidential information with other ISEs for the purpose of**promoting the wellbeing or safety of a child or group of children**, if, in their view sharing the information could assist the receiving ISE to:

* make a decision, assessment or plan
* start or conduct an investigation
* provide a service, and/or
* manage any risk

relating to a child or group of children. This is known as the threshold.

For more information on information sharing for wellbeing, refer to [Understanding child wellbeing](https://www.vic.gov.au/child-wellbeing) <https://www.vic.gov.au/child-wellbeing>.

If the threshold for sharing is met, ISEs can share information:

* in response to a request and/or
* proactively (‘voluntary sharing’)

in a manner consistent with the legislative principles.

Confidential information may only be shared to the extent necessary to promote the wellbeing or safety of a child or group of children, consistent with their best interests.

Information must be shared in a timely manner. As the purpose of the Schemes is to allow early identification and supports, ISEs do not have to wait until they are sure of an issue or risk. They can and should share before that time, as long as the requirements of the Schemes are met.

ISEs can also share confidential information about any person, from any source, with a child, a person who has parental responsibility for the child, and/or a person with whom the child is living, to manage a risk to that child’s safety.

Please refer to [Chapter 1 of the CISS Guidelines](https://www.vic.gov.au/child-information-sharing-scheme-ministerial-guidelines/chapter-1-sharing-information-under-scheme) for more information about when information can be shared.

Further information is available on the [CISS webpage for Qualified Professionals](https://www.vic.gov.au/child-information-sharing-professionals) <https://www.vic.gov.au/child-information-sharing-professionals>.

### Family Violence Information Sharing Scheme (FVISS)

The FVISS enables authorised organisations and services to share information to facilitate assessment and management of family violence risk to children and adults.

There are two purposes for which information can be shared between ISEs under FVISS:

* **Family violence assessment purpose**: is to establish whether family violence risk is present, assessing the level of risk the perpetrator poses to the victim survivor, and correctly identifying the perpetrator and victim survivor (note that only Risk Assessment Entities [RAEs] can request information for this purpose – see the [Frequently Asked Questions](https://www.vic.gov.au/frequently-asked-questions-about-information-sharing-and-maram#who-can-share-and-request-information-under-the-schemes) < https://www.vic.gov.au/frequently-asked-questions-about-information-sharing-and-maram#who-can-share-and-request-information-under-the-schemes>
* **Family violence protection purpose**: is to manage the risk of the perpetrator committing family violence, or the risk of the victim survivor(s) being subjected to family violence. Managing risk involves removing, reducing or preventing the escalation of risk. This includes information sharing to support ongoing risk assessment.

All ISEs can also share information for a family violence assessment purpose with an RAE, including information about an alleged perpetrator.

All ISEs can share information for a family violence protection purpose with other ISEs either voluntarily or in response to a request.

Only information that is relevant to assessing or managing a risk of family violence can be shared under FVISS. In determining what information is relevant, practitioners should use their professional judgement and refer to the MARAM Framework to determine what constitutes family violence risk.

Risk should be understood as both:

* risk of harm to the victim survivor from past and future family violence incidents
* future risk of family violence occurring.

The MARAM Framework provides guidance on family violence risk and can be found on the [MARAM practice guides and resources](https://www.vic.gov.au/maram-practice-guides-and-resources) page <https://www.vic.gov.au/maram-practice-guides-and-resources>.

If information is not relevant to the assessment and management of family violence, that information should not be shared under FVISS.

Refer to [Chapter 1 of the FVISS Guidelines](https://content.vic.gov.au/sites/default/files/2021-04/Ministerial%20Guidelines%20-%20Family%20Violence%20Information%20Sharing%20Scheme_1.pdf) for further information about when you can share information under the Scheme.

For more information is available on the [FVISS webpage](https://www.vic.gov.au/family-violence-information-sharing-scheme) <https://www.vic.gov.au/family-violence-information-sharing-scheme>.

The proactive use of CISS and FVISS facilitates a collaborative approach to early intervention and promotes the safety and wellbeing of families and children. Both information-sharing schemes enable information sharing without consent where a child is involved. A child’s right to safety and wellbeing is paramount. The schemes give precedence to the child’s right to safety and wellbeing over any individual’s right to privacy (State of Victoria, 2020).

## **Child Link**

[Child Link](https://www.vic.gov.au/childlink) <https://www.vic.gov.au/childlink> is a digital tool that displays information about a child to authorised key professionals including MCH nurses, who have responsibility for child wellbeing and safety. Child Link shows limited but critical information, such as a child’s participation in key early childhood and education services.

By providing information, Child Link helps authorised key professionals to:

* collaborate with other services and professionals working with the child and their family
* identify needs, issues and vulnerabilities that may be present earlier and provide the support necessary to prevent an escalation of harm
* make more informed decisions about the wellbeing, safety and support needs of a child in their school or service.

EMCH services should utilise Child Link for every child under 6 years of age in a family that is referred to the service to support assessment of risk and gain understanding of supports currently and previously involved.

All MCH services have been provided with access and training to use Child Link. Services should prioritise nurses working in EMCH to undertake Child Link training.

Information about accessing the Child Link training can be found on the training page of the [Information Sharing and MARAM website](https://www.vic.gov.au/training-for-information-sharing-and-maram) <https://www.vic.gov.au/training-for-information-sharing-and-maram>.

## Children, Youth and Families Act 2005

The *Children Youth and Families Act 2005* provides the legislative basis for an integrated system of services for children experiencing vulnerability, young people and their families. The legislative context promotes the safety, stability and healthy development of children. It also places a strong emphasis on the need to consider the impacts of cumulative harm and to preserve cultural identity.

In Victoria, nurses are mandated reporters under the *Children, Youth and Families Act 2005* (s182)**.**

Under the Act, mandated reporters must make a report to child protection if they form a belief (on reasonable grounds) that a child needs protection from physical injury or sexual abuse. To form a belief, the reporter must be aware of matters, and hold any opinions in relation to those matters, that lead them to reasonably believe a child needs protection (s. 186).

Further information regarding mandatory reporting can be found on the MAV website on the [Mandatory Reporting MCH and Early Years Fact Sheet](https://www.mav.asn.au/__data/assets/pdf_file/0005/35960/Mandatory-Reporting-Fact-Sheet.pdf) <https://www.mav.asn.au/\_\_data/assets/pdf\_file/0005/35960/Mandatory-Reporting-Fact-Sheet.pdf>.

## Child Safe Standards

The current [Child Safe Standards](https://ccyp.vic.gov.au/child-safe-standards/new-child-safe-standards-now-apply/) <https://ccyp.vic.gov.au/child-safe-standards/new-child-safe-standards-now-apply/> came into effect on 1 July 2022. All MCH services must comply with the Standards. The Commission for Children and Young People (CCYP) have resources available to support organisations to implement the standards.

Further information is available on the standards is available on the [CCYP website](https://ccyp.vic.gov.au/child-safe-standards/the-11-child-safe-standards) <https://ccyp.vic.gov.au/child-safe-standards/the-11-child-safe-standards/>.

For further policy and legislative context refer to [Maternal and Child Health Service Guidelines](https://www.health.vic.gov.au/publications/maternal-and-child-health-service-guidelines) (Department of Health, 2019, reissued 2021) <https://www.health.vic.gov.au/publications/maternal-and-child-health-service-guidelines>.

# Funding, monitoring and quality improvement

## Roles and Responsibilities

The Department of Health (the department) is responsible for system stewardship and policy development of the Victorian MCH service, including the EMCH program.

Funded organisations are responsible for providing the EMCH program in accordance with these program guidelines and complying with the requirements of their service agreement with the department.

Documents that guide the Victorian MCH service include:

* [Maternal and Child Health Program Standards](https://www.health.vic.gov.au/publications/maternal-and-child-health-program-standards) <https://www.health.vic.gov.au/publications/maternal-and-child-health-program-standards> (Department Health and Human Services, 2011, reissued 2019)
* [Maternal and Child Health Service Guidelines](https://www.health.vic.gov.au/publications/maternal-and-child-health-service-guidelines) <https://www.health.vic.gov.au/publications/maternal-and-child-health-service-guidelines>  
  (Department of Health, 2019, reissued 2021)
* [Maternal and Child Health Practice Guidelines](https://www.health.vic.gov.au/publications/maternal-and-child-health-service-practice-guidelines) <https://www.health.vic.gov.au/publications/maternal-and-child-health-service-practice-guidelines> (Department of Health, 2009, reissued 2019).

## Funding

The department provides full funding for the EMCH program. Funding of the EMCH program is allocated and managed by the department and communicated to MCH services through their Service Agreement.

Funding is allocated to local government authorised MCH services using a statewide funding formula and is based on an average of 20 hours of service delivery per child/family (22.67 hours for regional and rural areas) for 15% of the 0–3-year-old population statewide.

The funding allocation to each MCH service is based on:

* data for socioeconomic disadvantage as a percentage share calculated on the number of Family Tax Benefit recipients per local government area.
* rurality, using the Accessibility Remoteness Index of Australia (ARIA).

Funding is subject to services achieving the performance targets specified in Schedule 2 of the Service Agreement.

MCH services funded to deliver the EMCH program are required to:

* deliver the service in accordance with these guidelines
* meet the performance measures outlined in their Service Agreement
* provide an EMCH annual report to the department.

## Performance monitoring

### Service delivery

Each MCH service is required to report annually on EMCH program performance measures. Performance measures and targets are included in the Service Plan. The Service Plan is a component of the Service Agreement between MCH service and the department.

The key performance measure is the **number of service hours**. The hours of service are defined as follows:

* **direct care** includes face to face and telehealth care
* **indirect care,** includes all client related activities, client-specific team discussions and debriefs,
* travel time.

#### Note: When two EMCH staff attend a joint consultation to a family, the data entry should reflect the consultation hours of both staff.

### Clinical supervision

Each EMCH service is required to collect data on the number of EMCH nurses:

* offered clinical supervision
* undertaking clinical supervision.

The total number of hours of clinical supervision administered is required to support acquittal of EMCH program clinical supervision funding.

## Quality improvement

Data collection is used to monitor outcomes for children and families and service quality and supports a culture of continuous improvement. Data can be used to demonstrate the achievements and gaps in the provision of the EMCH program and progress towards achieving agreed outcomes.

As a tier of support that complements the UMCH program, the primary focus of the EMCH program relates to achieving improved outcomes for children and families in the following areas: child development, parent-child interaction, and parent/ carer/family and environmental factors. Indicative outcomes are provided in Table 5.

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

Table 5: Indicative outcomes for the EMCH program

## Outcome measures

Outcomes are monitored through the family’s CFAP and recorded in the client management system. **Table 6** outlines the priority outcomes and indicators. Sign-off on the CFAP at point of transition of care involves confirming with the parent/carer if the outcomes have been achieved. This data is also recorded in the client management system.

| **Domain** | **Priority Outcome** | **Goal / Target** | **Indicators** | **Source of information** |
| --- | --- | --- | --- | --- |
| 1.0 Child health, wellbeing, safety learning and development | 1.1 KAS completed for age of child and growth and developmental concerns are identified | All children enrolled in EMCH program at completion of cycle / transfer of care have KAS completed for age.  Where required secondary screening and/ or referral  are completed. | KAS results  PEDS pathways  Brigance screens completed  Referrals completed | Client management system |
| Appropriate and timely referrals as an outcome of the KAS and assessments | Number of referrals from growth and developmental assessments  Number of children eligible for Supported Playgroups who have been referred  Number of children eligible for kindergarten who have been referred | Client management system |
| 1.2. The parent/carer / child agrees to attend appointments / groups / early years programs | Families are supported to attended referral appointments / groups / early years programs | Referral completed  Attendance is noted | Outcome noted in CFAP |
| 1.3. Immunisation up to date for age of child | 100% of all children enrolled in EMCH program at completion of cycle / transfer of care are up to date for their immunisation | Immunisation status | Immunisation status is noted in CFAP  Parent/carer reported / noted in the child health record /  Australian Immunisation register report (AIR) |
| 2.0 Parenting capacity | 2.1 Achievement of individual parenting goals  2.2 Improvement in parenting knowledge, skills and confidence | Parent/carers have achieved their parenting goals at the end of cycle / transfer of care    Parent/carers report an increase in their parenting knowledge, skills and confidence | Parent/carer response as noted in goals review in CFAP, and EMCH outcomes at end of cycle / transfer of care  Parent/carer reported measure (CFAP notes parenting capacity if goal identified) | Client management system    Client management system |
| 3.0 Parent / family health, wellbeing and safety | 3.1 A family violence risk assessment and or safety plan is completed for parent / care giver and child/ren identified at risk or experiencing family violence | All parents / care giver identified to be at risk or experiencing family violence have a completed family violence risk assessment and safety plan | Number of parents / care giver identified to be at risk or experiencing family violence with a completed family violence risk assessment and safety plan | Client management system |
| 3.2 Parent/carers are aware of and have increased knowledge of available local supports and services. They are willing and confident to access them | The parent/carer is confident to access local health and support services | Number of new protective factors identified | Client management system |
| 3.3 Percentage of families referred to universal, secondary and tertiary services | Where identified an appropriate and timely referral is made | Number of referrals generated | Client management system |
| 4.0 Environmental factors that supports a child’s growth and development | Improved ability of family to maintain a:  4.1 Safe sleeping environment | A safe sleeping assessment is completed and enacted as required  Anticipatory guidance is provided to maintain a safe sleeping environment | Number of safe sleeping assessments completed | Client management system |
| 4.2 Safe home environment  (KidSafe checklist) | A safe home environment assessment is completed and enacted as required  Anticipatory guidance is provided to maintain a safe home environment | Number of home safe assessments completed | Client management system |
| 4.3 Home learning environment | The child is read to each day | Parent/carer report that, every day they read a book to the child | Client management system |

Table 6: Priority outcomes and indicators

# Appendices

## EMCH Program logic showing the input, activities, outputs, short term outcomes, medium term outcomes and long term outcomesAppendix 1: EMCH program logic

## Appendix 2: Child and Family Outcomes

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

## Appendix 3A: Protective and risk factors

| Domain | Protective factors | Needs / Risk Factors |
| --- | --- | --- |
| Child heath, wellbeing,  safety,  learning and development | Breast feeding established early | Child health, wellbeing, safety, learning and development |
| Full immunisation | Premature infants, slow weigh gain |
| Social skills | Complex feeding or sleep issues |
| Secure attachment | Children with poor social or emotional wellbeing (e.g., withdrawal, anxiety, behavioural issues, delayed communication |
| Easy temperament, active, alert and affectionate | Children with a developmental delay or disability |
| Attachment to family | Children with chronic health conditions (often with multiple comorbidities) |
|  | Children with serious injury due to falls, accidents, assault, accidental poisoning and intentional self-harm |
|  | Children affected by family violence |
|  | Children expressing symptoms of trauma |
|  | Child in Out of Home Care |
| Parenting Capacity | Strong attachment to child | Parent is not able to keep the child in mind most of the time |
| Knowledge of parenting and child development | Multiple birth |
| Parenting self-efficacy | Significant parent-child bonding issues |
| Parenting capacity | Significant parent-child attachment issues |
| Parental resilience | Inadequate parenting skills (e.g., warmth/ nurturing, ability to provide home structure, communication) |
| Strong reflective functioning | Lack of engagement with UMCH program |
| Parent / family health and wellbeing | Parental self-esteem | Parent mental health issue (e.g., anxiety and/or depression) |
| Family cohesion | Parent with an intellectual or physical disability |
| Family functioning | Parent with a chronic illness/unexpected illness |
| Connection to culture | Recent relationship breakdown/separation |
| Two-parent household | History of trauma having a current family impact |
| High level of education | Financial distress, low income or partner unemployed |
| Employment | Parent affected by family violence |
| Supportive grandparents or extended kinship network | Families currently known to Child Protection or currently have a child in kinship or out of home care |
|  | Parent with substance misuse |
|  | Contested custody/access to infant/child |
| Environmental factors | Positive social connection and support | Social or geographical isolation |
| Access to health and social services | Housing issues or homelessness |
| Neighbourhood social capital |  |
| Adequate housing |  |
| Socio-economically advantaged |  |

## Appendix 3B: Risk factors mapped against CDIS referral

| Cohort | Risks | CDIS risk factors mapped to CDIS referral reasons |
| --- | --- | --- |
| Parent/s | Mother or parent aged 20 years or under | EMCH: Mother/parent is less than 20yrs of age |
| At risk of, or experiencing challenges, such as social isolation, housing, transport, employment, financial concerns, refugee status | EMCH: Family is socially isolated (housing, cultural group, transport, unemployment) |
| Parent expresses and / or demonstrates poor attachment towards their infant/child. | EMCH: Parent expresses and/or demonstrates poor attachment towards their infant/child. |
| Trauma and/or mental health concerns impacting parenting capacity. | EMCH: Trauma and/or mental health concerns impacting parenting capacity. |
| Intellectual disability or cognitive impairment impacting parenting capacity. | EMCH: Intellectual disability or cognitive impairment impacting parenting capacity. |
| Mother experiencing a high-risk pregnancy. | EMCH: Concern on the part of the assessing nurse |
| Substance abuse related issues impacting parenting capacity | EMCH: Substance abuse related issues currently impacting parenting capacity. |
| Family violence currently impacting safety, parenting, and infant/child development | EMCH:  Family violence currently impacting safety, parenting and infant/child development. |
| Current or previous involvement with or known to child protection or currently have a child residing in out of home care and not engaged with UMCH | EMCH: Current or past intervention from Child Protection or residing in Out of Home Care. |
| Relationship breakdown | EMCH: Concern on the part of the assessing nurse |
| Parent has a physical disability. | EMCH: Concern on the part of the assessing nurse |
| Parent unable to prioritise child needs and safety. | EMCH: Parent expresses and/or demonstrates poor attachment towards their infant/child. |
| Multiple birth | EMCH: Concern on the part of the assessing nurse |
| Child | Premature infant | EMCH: Infant/ child with complex growth health and or development issues |
| Faltering growth | EMCH: Infant/ child with complex growth health and or development issues |
| Complex feeding or sleep issues | EMCH: Infant/ child with complex growth health and or development issues |
| Poor social or emotional wellbeing (e.g., Withdrawal, anxiety, behavioural issues, delayed communication) | EMCH: Infant/ child with complex growth health and or development issues |
| Developmental delay or disability | EMCH: Infant/ child with complex growth health and or development issues |
| Chronic health conditions | EMCH: Infant/ child with complex growth health and or development issues |
| Serious injury due to an accident (unintentional) or intentional injury | EMCH: Infant/ child with complex growth health and or development issues |
| Expressing symptoms of trauma including being affected by family violence | EMCH: Expressing symptoms of trauma including being affected by family violence |
| Child currently residing in kinship and or out of home care and carers not engaged with the UMCH program | EMCH: Current or previous intervention with Child Protection |
| Current or previous involvement with child protection | EMCH: Current or previous intervention with Child Protection |
| Environmental | Social or geographic isolation including families living in regional and or remote areas where support services are difficult to access | EMCH: EMCH: Family is socially isolated (housing, cultural group, transport, unemployment.) |
| Concern on the part of the assessing nurse | EMCH: Concern on the part of the assessing nurse |

## Appendix 4: Draft EMCH Program Referral Form

**For use by external professionals**

|  |  |
| --- | --- |
| Consent | This referral has been completed with the family’s consent   Yes / No |

*Insert logo*

|  |  |  |  |
| --- | --- | --- | --- |
| Referral Information | | | |
| Referred By: |  | Date: |  |
| Job Title: |  | Phone: |  |
| Organisation: |  | Email: |  |

|  |  |  |
| --- | --- | --- |
| Parent/carer details | Parent/Carer 1 | Parent/Carer 2 |
| Given name |  |  |
| Family name |  |  |
| Relationship to child |  |  |
| Date of birth | \_\_/\_\_/\_\_ | \_\_/\_\_/\_\_ |
| Gender |  |  |
| Address |  |  |
| Phone number |  |  |
| Email address |  |  |
| Interpreter required |  |  |
| If yes, language / dialect |  |  |
| Country of birth |  |  |
| Aboriginal or Torres Strait Islander |  |  |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Child / children details | | | | | | |
| Surname | **First names** | **DOB** | **Age** | **Gender** | **Aboriginal / Torres Strait Islander** | **Lives with client** |
|  |  |  |  | M/F | Yes / No | Yes / No |
|  |  |  |  | M/F | Yes / No | Yes / No |
|  |  |  |  | M/F | Yes / No | Yes / No |
| Are there any court orders / custody arrangements in place?  If yes, please attach a copy if available. | | | | | | Yes / No |

**Eligibility**

The EMCH program works with children and families to address an increased need due to factors currently impacting on child development, parenting capacity, or family wellbeing. To be eligible for the program the family need to meet **two or more of the below eligibility criteria**.

|  |  |  |
| --- | --- | --- |
| Please tick relevant factors | |  |
| * Mother/parent is less than 20 years of age | * Family violence currently impacting safety, parenting and infant/child development | |
| * Infant/child is identified as being an Aboriginal or Torres Strait Islander descent and is not actively attending the UMCH program | * Current intervention from Child Protection | |
| * Family is socially isolated (housing, cultural group, transport, unemployment) | * Infant/child born with congenital abnormalities | |
| * Mental health issue currently impacting parenting capacity | * Infant/child born with complex growth, health and development issues | |
| * Parent expresses and/or demonstrates poor attachment towards their infant/child | * Concerns on the part of the assessing MCH nurse | |
| * Substance abuse related issues currently impacting parenting capacity | * Families who are not currently engaged with the UMCH program | |
| * Child residing in OoHC | * Family requiring language/ interpreting support | |

|  |  |
| --- | --- |
| Please tick which agencies are involved in the care of the family | |
| * Child Protection | * Family violence services |
| * Family services | * Mental health services |
| * Family Preservation and Reunification Response | * Disability services |
| * GP /Paediatrician | * Housing services |
| * Drug and Alcohol services | * The Orange Door |
| * Other (please list) | |

**Please provide a short summary of your expectation of the EMCH program.**

**What is the parent/carer’s expectation of the EMCH program?**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Please tick all of the factors that are relevant to the family | | | | | |
| Child Health and Development | **Parent Family Health & Safety** | | **Environmental Factors** | | **Parenting capacity** |
| * Premature Infant | * Mental health concerns  1. (e.g. Anxiety or depression) | | * Housing issues | | * Parent/carer is not able to keep the child in mind most of the time |
| * Faltering growth | * Intellectual or physical disability | | * Homelessness | | * Multiple birth |
| * Social or emotional wellbeing of child (e.g. withdrawal, anxiety, delayed communication) | * Chronic illness / unexpected illness impacting the family | | * Limited access to health services | | * Significant parent-child bonding issues |
| * Injuries – falls, accidents, assault | * Drug, substance or alcohol issues | | * Limited access to social services | | * Significant parent-child attachment issues |
| * Chronic health conditions | * Financial distress / unemployment | | * Geographical isolation | | * Difficulty with parenting skills (e.g., warmth/ nurturing, ability to provide home structure, communication) |
| * Affected by family violence | * Family violence | | * Social isolation | | * Lack of engagement with UMCH program |
| * Expressing / displaying symptoms of trauma | * Child Protection intervention | | * New settler / refugee | |  |
| * Out of Home Care placement | * Relationship breakdown | | * Limited social connection / support | |  |
| * Significant behaviour issues | * Contested custody / access to child | | * Poor antenatal attendance | |  |
| * Developmental delay | * History of trauma currently impacting the family | | * Parent/ carer <20yrs | |  |
| * Intellectual or physical disability |  | | * Significant financial distress | |  |
| Protective factors present in the family | | | | | |
| Parenting Capacity | | **Family Health & wellbeing** | | **Environmental Factors** | |
| * Strong attachment to child | | * Parental self esteem | | * Positive social connection and support | |
| * Knowledge of parenting and child development | | * Family cohesion | | * Access to health and social services | |
| * Primary caregiver feeling supported | | * Family functioning | | * Parental resilience | |
| * Parenting capacity | | * Connection to culture | | * Adequate housing | |
| * Strong reflective functioning | | * Employment | | * Level of education | |

## Appendix 5: Overview of Assessments and Tools

| **Assessment tool** | **Further information** |
| --- | --- |
| [Brigance Parent- Child Interaction Scale](https://www.health.vic.gov.au/publications/parent-child-interactions-scale) (BPCIS) | <https://www.health.vic.gov.au/publications/parent-child-interactions-scale> |
| [Brigance Screen](https://brigance.com.au/splash/) | <https://brigance.com.au/splash/> |
| [Brigance: Self- Help and Social- Emotional Scales](https://brigance.com.au/splash/) | <https://brigance.com.au/splash/> |
| [Edinburgh Postnatal Depression Scale](https://www.health.vic.gov.au/publications/perinatal-mental-health-and-psychosocial-assessment) (EPDS) | <https://www.health.vic.gov.au/publications/perinatal-mental-health-and-psychosocial-assessment> |
| [Key Ages and Stages](https://www.health.vic.gov.au/publications/maternal-and-child-health-service-practice-guidelines) | <https://www.health.vic.gov.au/publications/maternal-and-child-health-service-practice-guidelines> |
| [Multi-Agency Risk Assessment and Management Framework](https://www.vic.gov.au/family-violence-multi-agency-risk-assessment-and-management) (MARAM) | <https://www.vic.gov.au/family-violence-multi-agency-risk-assessment-and-management> |
| [Parenting capacity clinical observation](https://www.health.vic.gov.au/publications/parent-child-interactions-scale) | Brigance Infant and Toddler  <https://www.health.vic.gov.au/publications/parent-child-interactions-scale> |
| [Parents’ Evaluations of Development Status](https://www.rch.org.au/ccch/peds/For_Practitioners/) (PEDS) | <https://www.rch.org.au/ccch/peds/For\_Practitioners/> |
| [Play Learn and Grow](https://www.education.vic.gov.au/Documents/childhood/professionals/support/Using%20the%20Play,%20Learn,%20Grow%20resources%20in%20the%20Maternal%20and%20Child%20Health%20Service.pdf) | <https://www.education.vic.gov.au/Documents/childhood/professionals/support/Using%20the%20Play,%20Learn,%20Grow%20resources%20in%20the%20Maternal%20and%20Child%20Health%20Service.pdf> |
| [Sleep and Settling assessment form](https://www.health.vic.gov.au/publications/sleep-pathways-assessment-form) | <https://www.health.vic.gov.au/publications/sleep-pathways-assessment-form> |
| [Social attention and communication surveillance (SACS) tool](https://www.latrobe.edu.au/otarc/research/autism-detection-diagnosis/social-attention-communication) | SACS Assessment 12, 18 months and 2 years  <https://www.latrobe.edu.au/otarc/research/autism-detection-diagnosis/social-attention-communication> |
| [TEN 4 FACES](https://www.rch.org.au/vfpms/guidelines/Bruising/) | <https://www.rch.org.au/vfpms/guidelines/Bruising/> |

## Appendix 6: List of Abbreviations

|  |  |
| --- | --- |
| **Acronym** | **Meaning** |
| ARIA | Accessibility Remoteness Index of Australia |
| AHPRA | Australian Health Practitioner Regulation Agency |
| CDIS | Child Development Information System |
| CFAP | Child and Family Action Plan |
| MARAM | Multi Agency Risk Assessment Management |
| EMCH | Enhanced Maternal and Child Health |
| EPDS | Edinburgh Postnatal Depression Scale |
| KAS | Key Ages and Stages |
| LGA | Local Government Areas |
| MAV | Municipal Association of Victoria |
| MCH | Maternal and Child Health |
| MoC | Model of Care |
| OoHC | Out-of-Home Care |
| PEDS | Parents’ Evaluations of Developmental Status |
| PEDS-R | Parents’ Evaluations of Developmental Status - Revised |
| UMCH | Universal Maternal and Child Health |

## Appendix 7: Examples of EMCH program support

| Domain |  | Challenges that the child/parents/carers may experience | Support for child/parents/carers |
| --- | --- | --- | --- |
| Child health, wellbeing, safety learning and development |  | Child has not had opportunity to receive universal growth and developmental screening. | Growth and developmental screening undertaken at a time and place that suits families. |
|  | Child has not had opportunity to be immunised. | Immunisation services provided at a time and place that suits families. |
| Parenting Capacity |  | Becoming a parent under the age of 20 years. | Supporting young parents in their parenting journey. |
|  | The parent/carer is unsure about developing a strong relationship or bond with their child. | Improving their relationship with their baby/child.  Using different approaches to respond to their baby/ child's cues.  Exploring different ways that parents can work together as parents. |
|  | Supporting parent/carers living with a disability that impacts on their ability to parent their child. | Exploring different approaches to respond to their baby’s needs. |
|  | The parent/carer is struggling with their child’s feeding / sleep / behaviour patterns.  Concerned about their child’s development or illness. | Using different approaches to respond to their baby / child’s cues.  Exploring how to respond to the baby / child’s needs. |
| Parent/family health, wellbeing and safety |  | Family violence is impacting the safety and parenting of the child. | Understanding the impact of family violence on the baby/child and next steps. |
|  | Health conditions such as their (or their partner's) mental health and/or substance use that is impacting their ability to parent their child. | Understanding the impact of their mental health or substance use on the baby / child and the next steps.  Understanding the impact of the baby / child not meeting their development milestones and the next steps. |
|  | The parent/ carer is at risk of homelessness and or unemployment and is impacting the children. | Ensuring that families are linked to local and specialist services. |
|  | The parent/ carer is struggling to engage with the MCH service. | Providing long term follow up to parents. |
| Environmental factors |  | Unsafe sleeping environment. | Safe sleeping environment improved with safe sleeping messages and access to Nursery Equipment Program. |

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