



Australian Government

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



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ARTWORK: THE CULTURE OF HEALING

The artwork for the Department of Health 'The Culture of Healing' brings together many people from Government to community all across Australia to address the theme of health and wellbeing for all Aboriginal and Torres Strait Islander peoples.

The foundation of the artwork is set in a grid pattern. Each area consists of different cultural markings and motifs from the Torres Straits and across mainland Australia. These markings are the tracks left by the Rainbow Serpent, the Creation Spirit, and they represent the diversity of country. The lines that make up the grid formation are the navigational pathways and meeting places. Three stars represent these navigational pathways for Government and for Aboriginal and Torres Strait Islander peoples.

The plant and animal motifs represent traditional health and wellbeing – 'bush tucker'. The central figures represent Aboriginal and Torres Strait ancestors who teach us the traditional ways so we can keep our culture strong today and into the future.

The circular motif towards the bottom of the artwork represents Government and communities coming together in discussion, working together to create better health outcomes for Aboriginal and Torres Strait Islander peoples. The inner circle represents the Government from the Minister, to staff and other stakeholders and moving outwards to the Communities. The 'U' shaped motifs represent people seated in discussion, or a 'Yarning Circle'.

The pathways that lead out from these people represent the expertise and cultural knowledge and understanding that each individual brings to the table of their family, their community and their people and how the 'Health Plan' can best benefit them for a happier, healthier and brighter future together.



This original artwork was produced by Gilimbaa. Gilimbaa is an Indigenous creative agency accredited by Supply Nation.





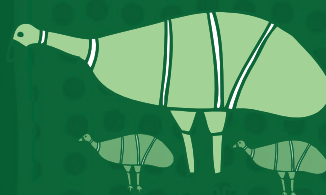
National Framework for Health Services for Aboriginal and Torres Strait Islander Children and Families

List of Acronyms and Terms

ACCHO	Aboriginal Community Controlled Health Organisation
AEDC	Australian Early Development Census
AHMAC	Australian Health Ministers' Advisory Council
AIHW	Australian Institute of Health and Welfare
ATSIHP	Aboriginal and/or Torres Strait Islander Health Practitioner
ATSIHW	Aboriginal and/or Torres Strait Islander Health Worker
family	The word 'family', as used in this Framework, is inclusive of carers as well as parents. This is consistent with the terminology used in the National Framework for Universal Child and Family Health Services and the National Framework for Child and Family Health Services – <i>secondary and tertiary services</i> .
GP	General Practitioner
health	Where this Framework refers to Aboriginal and Torres Strait Islander health, it is intended that this incorporates not just the physical wellbeing of an individual but also the social, emotional and cultural wellbeing of the whole community in which each individual is able to achieve their full potential as a human being ¹ . This is consistent with the <i>National Aboriginal and Torres Strait Islander Health Plan 2013-2023</i> .
Health Plan	National Aboriginal and Torres Strait Islander Health Plan 2013 – 2023
NACCHO	National Aboriginal Community Controlled Health Organisation
NGOs	Non-government organisations
Framework	National Framework for Health Services for Aboriginal and Torres Strait Islander Children and Families
Universal Services	National Framework for Universal Child and Family Health Services Framework

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1. Executive Summary

This National Framework for Health Services for Aboriginal and Torres Strait Islander Children and Families (the Framework) articulates a vision, principles and approaches for the delivery of child and family health services to Aboriginal and Torres Strait Islander people. It aims to provide guidance for policy and program design, and for the development and implementation of services.

The Framework has been developed to complement the *National Framework for Universal Child and Family Health Services* (the Universal Services Framework), the *National Framework for Child and Family Health Services – secondary and tertiary services* and the *National Aboriginal and Torres Strait Islander Health Plan 2013 – 2023* (the Health Plan).

As with the Universal Services Framework, the core elements of health services for Aboriginal and Torres Strait Islander children and families are:

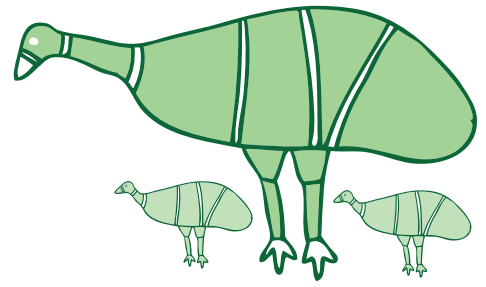
- health and developmental surveillance;
- health promotion;
- early identification of family need and risk; and
- responding to identified need.

However, the Framework recognises that the child and family health service system does not currently meet the needs of all Aboriginal and Torres Strait Islander children and their families. A more holistic approach to health and wellbeing that draws on the strengths of Aboriginal and Torres Strait Islander peoples and cultures must inform how high quality, evidence-based child and family health services are delivered to Aboriginal and Torres Strait Islander people.

The Framework describes:

- a **vision** for health services for Aboriginal and Torres Strait Islander families that focuses on children and families accessing high quality, evidence-based and culturally-safe child and family health services to support optimal health, development and wellbeing; and
- nine **principles** relating to: access; equity; Aboriginal and Torres Strait Islander leadership and partnership in the planning and delivery of child and family health services; collaboration between all levels of government, between health service providers and other sectors; an evidence and strengths-based approach to the funding, design and delivery of child and family health services; cultural respect; workforce development; and accountability.

A number of structural factors underpin the Framework, and are required to enable health services to meet the needs of Aboriginal and Torres Strait Islander children and families.



These **system enablers** include:

- a culturally respectful and non-discriminatory health system (which is also a priority of the National Aboriginal and Torres Strait Islander Health Plan 2013 – 2023);
- access to care based on proportionate universalism;
- commitment to health equity, and addressing the social determinants of health. Strong and sustainable health outcomes cannot be achieved without recognition of the impact of colonisation, interpersonal and institutional racism, and the resulting health and social impacts of poverty, trauma, addiction, housing shortages, poor education, unemployment, and the lack of social supports;
- evidence-based practice that is informed by researchers and the experience of Aboriginal and Torres Strait Islander families;
- a focus on the cultural safety and development of the Aboriginal and Torres Strait Islander health workforce at all levels of governance and service delivery;
- governance structures that support Aboriginal and Torres Strait Islander people in leadership roles and ensure the participation of Aboriginal and Torres Strait Islander people in planning, delivery and review of child and family health services; and
- supportive Government policy and funding. The vast majority of child and family health services are funded by governments. Government policy directly and indirectly affects the implementation of programs and services. It is vital that funded programs are built upon strong program logic, and that there is joint accountability and funding continuity (where possible) across the service system, irrespective of how existing programs are funded and managed. Funding must align with the principles of proportionate universalism with an expectation of delivering equitable health outcomes for Aboriginal and Torres Strait Islander peoples.

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

- family-centred care to identify and respond to the needs and structures of individual families;
- relationship-based care;
- a focus on social and emotional wellbeing; and
- strengths-based approaches.

It is acknowledged that many Aboriginal and Torres Strait Islander people have complex systems of family relationships. Children are often the responsibility of the entire extended family, rather than the biological parents alone². As such, the term family, as used in this Framework, is inclusive of carers as well as parents. Similarly, this Framework covers all families where a child or children are of Aboriginal and/or Torres Strait Islander descent, regardless of either of their parents' heritage. In this sense, it places the child and their needs at the centre of the family.



Key elements of service delivery have been identified to enhance the scope and quality of services for Aboriginal and Torres Strait Islander children and families. By contrast to the approaches to care that focus on how service providers engage with clients, the elements of service delivery focus on ensuring that the client, in this case children and their families, remain at the centre of considerations, and thus experience integrated services. These elements of service delivery include:

- building services around a primary health care model;
- a multi-disciplinary, collaborative team-based approach;
- a well-resourced, highly-skilled, and culturally competent workforce;
- continuity of care;
- comprehensive, holistic assessment which ensures that children and their families are supported to access the range of services required to meet their needs and aspirations. This includes not only universal and targeted health services but comprehensive educational and social support services, tools, and other resources;
- flexible service delivery; and
- a (local or regional) place-based model for collaboration and integration of services.

Different factors affect Aboriginal and Torres Strait Islander children and families at different stages of development. This has implications for service delivery, and for developing mechanisms to address these needs. This is explored in Part 8 of the Framework.

Finally, the Framework describes **key roles and responsibilities of government** and policy makers, peak bodies, service organisations, practitioners and communities in implementing these principles, approaches and service delivery elements.

As noted above, the Framework complements and builds on the Universal Services Framework, the Health Plan and the *National Framework for Child and Family Health Services – secondary and tertiary services*. The intent of the Framework is to highlight those areas of service design, delivery and evaluation that require different or additional considerations in order to ensure that the needs of Aboriginal and Torres Strait Islander children and families are met, and that health outcomes are ultimately improved.

It is expected that stakeholders (governments, peak bodies, service providers and practitioners) will develop their own policies, systems and processes to reflect the principles and approaches described in the Framework. Consistent with the principles, it is critical that this be done in a collaborative manner, and that scalable learnings are shared in order to support continuous improvement.

2. The Framework

2.1 Purpose of the Framework

The Framework articulates a vision and principles for the delivery of child and family health services to Aboriginal and Torres Strait Islander people across Australia. It aims to provide guidance for policy and program design, and for the development and implementation of services to meet the needs of Aboriginal and Torres Strait Islander children and families.

The Framework has been developed to complement:

- the Universal Services Framework which articulates a vision, objectives and principles for universal child and family health services for all Australian children aged zero to eight years, and their families (as described at Attachment A);
- the *National Framework for Child and Family Health Services – secondary and tertiary services*. This Framework serves as a guide for government and non-government agencies in responding to the health needs of children and their families, especially those requiring complex, specialised care. It articulates the vision, objectives and principles of secondary and tertiary health services in improving the health, development and wellbeing of children and their families. It identifies system enablers, and outlines targets for monitoring child and family health outcomes, in alignment with the *Healthy, Safe and Thriving: National Strategic Framework for Child and Youth Health*; and
- the Health Plan which describes a vision, principles and priorities for tackling Aboriginal and Torres Strait Islander disadvantage, and for closing the health gap between Aboriginal and Torres Strait Islanders and other Australians (as described at Attachment B).

Why is a specific, additional Framework needed for health services for Aboriginal and Torres Strait Islander children and their families?

Each of the Frameworks and Plans detailed above acknowledge that there are significant disparities between Aboriginal and Torres Strait Islander, and other, children and their families in relation to health outcomes, including life expectancy at birth, birth weight, child hospitalisation, youth trauma and rates of chronic disease.

This Framework has been developed in recognition that the current child and family health service system does not equitably meet the needs and aspirations of Aboriginal and Torres Strait Islander children and their families.



A different approach is needed that recognises:

- the fundamental importance of culture to health and wellbeing for Aboriginal and Torres Strait Islander children and families, including as a source of strength and resilience for many³;
- the complex interplay of factors that influence health and wellbeing, including socioeconomic characteristics, housing and transport, community capacity, education, literacy, health literacy, social and emotional wellbeing, social justice and equity;
- the traumatic legacy and ongoing effects of colonisation, the removal of Aboriginal and Torres Strait Islander children from their families, persisting interpersonal and institutional racism, and the impact these have on the health and wellbeing of Aboriginal and Torres Strait Islander people, and their decisions about where and how they access services. In 2012-13, 48% of Aboriginal and Torres Strait Islander adults reported that either they, or their relatives, had been removed from their natural family. Levels of high or very high psychological distress were significantly more common among Aboriginal and Torres Strait Islander adults who had been removed from their family⁴;
- the importance of well-coordinated, holistic, culturally competent and culturally safe services that support and build upon the strengths of Aboriginal and Torres Strait Islander children and families; and
- the different child-rearing and parenting practices of many Aboriginal and Torres Strait Islander communities and families. Within Aboriginal and Torres Strait Islander communities, 'family' is defined more broadly than for many other Australians, and comprises extended family members and significant others. Understanding and respecting different child-rearing practices is important for planning and delivering services that reflect individual parenting choices and styles.

This Framework aims to provide additional guidance for policy and program design, service development and implementation that reflects the factors detailed above, and enhances the scope and quality of services for Aboriginal and Torres Strait Islander children and their families.

2.2 Scope of the Framework

The Framework focuses on pre-conception, maternity services, and, as central to the Framework, services for children (birth to age eight) and their families.

Birthing services are beyond the scope of the Framework.

2.3 Approach to developing the Framework

The Framework has been informed by a review of relevant literature, and the scoping of current policies and programs.

National face-to-face consultations with a broad range of Aboriginal and Torres Strait Islander stakeholders including a Cultural Advisory Group were complemented by an online consultation phase.

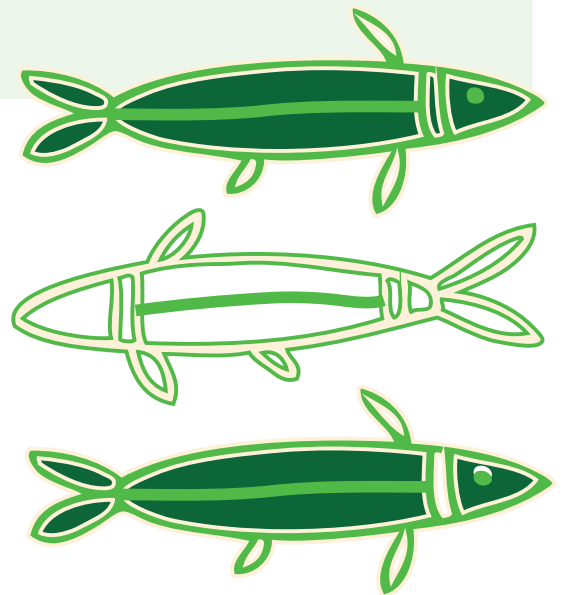
The development of the Framework was also informed by a Working Group of the Standing Committee on Child and Youth Health, and the National Aboriginal and Torres Strait Islander Health Standing Committee. The Framework has been endorsed by the Australian Health Ministers' Advisory Council.

The consultations provided valuable advice about how peak bodies, service providers and practitioners are already implementing many of the principles and approaches outlined in this Framework. The Framework includes some of these practical suggestions and ideas. These are not exhaustive or definitive lists but are examples of some of the practical ways that the approaches and service elements can be implemented.

Note

A wide range of resources have been used in drafting this Framework, and has informed the development of the "In practice" sections throughout the document. The practice examples are not intended as a direction, nor to be prescriptive for service providers. Rather, they simply highlight some practices that are already being implemented by service providers (noting that not all of these have been evaluated).

Throughout the Framework, reference has been made to relevant statistics. In most cases, national data has been used. However, it is acknowledged that there is variability across States and Territories.





3. Context

3.1 The importance of the early years

There is considerable evidence demonstrating the importance of the period from conception through the early years of a child's life in providing strong foundations for lifelong physical and mental health, and social and emotional wellbeing^{5 6}.

Early childhood experiences, starting in pregnancy with foetal development and continuing through infancy, childhood and adolescence, shape these outcomes throughout the lifespan.

Early childhood is a critical stage at which the foundation for future health and wellbeing is established⁷. A number of factors shape this foundation:

- Maternal health and behaviours such as attendance at antenatal care, breastfeeding, physical and mental health, tobacco use, consumption of alcohol or other drugs and nutrition. Antenatal care may be especially important for Aboriginal and Torres Strait Islander women, as they are at a higher risk of giving birth to low birthweight babies, and have greater exposure to other risk factors such as anaemia, poor nutritional status, hypertension, diabetes, genital and urinary tract infections and smoking⁸.
- Brain development. From conception, the first three years of a child's life are critical to brain development, as several neural systems necessary for adult functioning are formed. These include auditory and visual perception, mastery of motor skills, language development and self-regulation and control.
- Family and social environment has a significant effect on brain development, with normal development requiring a high level of sustained stimulation (e.g. being spoken or read to, engaging in play).
- Relationships with carer(s) are important for emotional regulation, impulse control and protection against the negative effects of stressful life events. Secure attachments, characterised by high quality carer-child interactions, help to mitigate against the effects of adverse situations; and
- Good nutrition in infancy and early childhood supports healthy development (including brain development), growth and functioning.

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

3.2 The Australian health service system as it relates to children and families

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

Each jurisdiction is responsible for the provision of universal maternal, child and family health services. Hence, the way in which these services are funded and delivered varies across Australia. Furthermore, a range of other community-based providers, including ACCHOs and general practitioners (GPs), deliver similar services, and all community-based providers interface with hospitals. The complexity of the system can lead to fragmentation of services, making it challenging for families to access the services they need, when they need them. The responsibility for ensuring improved access to appropriate health services for Aboriginal and Torres Strait Islander children and their families is shared by mainstream service providers, in addition to those who provide services specific to Aboriginal and Torres Strait Islander people. Additionally, all health care services are responsible for providing continuity of care for children and their families.

For example:

- public antenatal care is provided predominantly by midwives working in organisations funded by state and territory governments. Services are either provided through hospital clinics or in community-based settings. Many ACCHOs provide antenatal care through midwives, Aboriginal and/or Torres Strait Islander Health Workers (ATSIHWs) or Aboriginal and/or Torres Strait Islander Health Practitioners (ATSIHPs). Antenatal care is also provided by GPs, often through shared care arrangements with local hospitals, and by private obstetricians on a fee for service basis. There is limited use of private midwives across Australia;
- birthing services are predominantly provided through hospitals; and
- child health services are delivered through a range of public and private mechanisms. For example, each jurisdiction has a schedule of universal contacts from birth to school age which are delivered through a variety of models and settings, predominantly by child and family health nurses. GPs provide child health services including health checks and monitoring, immunisation and management of chronic and acute illness. Similarly, ACCHOs provide a comprehensive range of child health services through nurses, ATSIHWs/ATSIHPs, GPs and allied health providers. Families may access child health services from any or all of these providers at different developmental stages, and as their needs change.

3.3 The health service system and Aboriginal and Torres Strait Islander children and families

Aboriginal and Torres Strait Islander people share a continuing legacy of resilience, strength and determination, even though their health and wellbeing has been, and continues to be significantly impacted by dispossession, interruption of culture and intergenerational trauma.

While some health gains are being realised, Aboriginal and Torres Strait Islander children still face large disparities in nearly every measured health outcome – including birthweight, mortality rate for children aged 0-4 years, ear and eye disease, dental health and general nutrition⁹.

Aboriginal and Torres Strait Islander children are not only more likely to be afflicted with a range of health-related conditions as children, but are also less likely to have access to resources and services that reduce the risk of health issues later in life.

While the Universal Services Framework is designed to meet the needs of all Australian children, this Framework is aimed at identifying ways in which health services might be better planned, delivered and evaluated in order to meet the specific needs and expectations of Aboriginal and Torres Strait Islander people.



4. Overarching vision and principles

4.1 Vision

As noted previously, this Framework complements other important documents including the Universal Services Framework and the Health Plan.

The **vision** of the Universal Services Framework is:

All Australian children benefit from quality universal child and family health services that support their optimal health, development and wellbeing.

The **vision** of the Health Plan is:

The Australian health system is free of racism and inequality and all Aboriginal and Torres Strait Islander people have access to health services that are effective, high quality, appropriate and affordable. Together with strategies to address social inequalities and determinants of health, this provides the necessary platform to realise health equity by 2031.

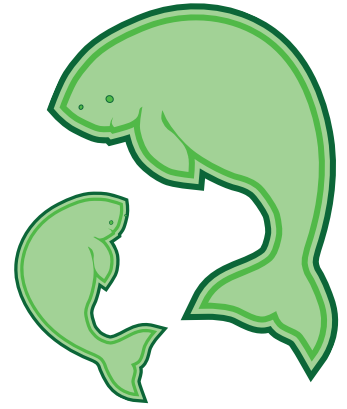
Drawing on these overarching visions, the vision of this Framework is:

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

4.2 Principles

The principles underpinning this vision (and also building on the principles described in other documents) are:

1. **Access:** All Aboriginal and Torres Strait Islander children and families should have access to culturally safe, close to community and community-led, comprehensive primary health care services that take a holistic approach to meet individual and population health needs.
2. **Equity and equality:** Child and family health services should be planned and delivered to meet the diverse needs of Aboriginal and Torres Strait Islander children and families of all backgrounds and locations, to eliminate inequities and improve the health status of Aboriginal and Torres Strait Islander people.
3. **Leadership and partnership:** Aboriginal and Torres Strait Islander people and organisations should either lead, or be actively involved in, decision-making about the planning and delivery of child and family health services that meet the needs of individuals and families.



4. Collaboration: Child and family health services are planned and delivered in collaboration with primary, secondary and tertiary health services, including ACCHOs, sexual health services and mental health and social and emotional wellbeing services. Relevant linkages and integration also occurs with other social supports, education, child protection, justice and employment sectors, and housing and disability sectors.
5. Evidence-based: The funding, design and delivery of child and family health services for Aboriginal and Torres Strait Islander people should be based on the best available evidence for improving health and developmental outcomes.
6. Strengths-based: Child and family health services should recognise and draw on the strengths of Aboriginal and Torres Strait Islander approaches to parenting and child-rearing, including traditional healing and cultural models of care.
7. Culturally safe and competent services: All child and family health services should implement policies and practices that respect the cultural values of, and are responsive to all Aboriginal and Torres Strait Islander people.
8. Workforce development: The health and wellbeing of Aboriginal and Torres Strait Islander children and families will be enhanced through a strengthened and enduring commitment to the development of the Aboriginal and Torres Strait Islander health workforce, alongside work to ensure that the non-Indigenous health workforce delivers equitable care to Indigenous children and their families.
9. Accountability: Structures should be in place for the regular monitoring and review of implementation as measured against indicators of success, with processes to share knowledge of what works. Progress targets will be specific, measurable, achievable and realistic. There must be joint accountability across the service system, irrespective of how existing programs are funded and managed.



5. System enablers

5.1 Context

Achievement of the vision depends on a number of systemic or structural factors. These factors will ultimately be as influential as the specific approaches to care, and to service delivery that are articulated in Parts 6 through 8.

These systemic or structural health enablers include:

- a culturally respectful and non-discriminatory health system;
- access to care based on proportionate universalism;
- commitment to health equity and addressing the social determinants of health;
- evidence-based practice;
- supporting the cultural safety and development of the Aboriginal and Torres Strait Islander workforce and the cultural competence of the broader workforce;
- Aboriginal and Torres Strait Islander leadership and participation in design, development, implementation, delivery and evaluation of health services; and
- supportive Government policy and funding.

5.2 A culturally safe and non-discriminatory health system

As noted in the Health Plan:

Racism is a key social determinant of health for Aboriginal and Torres Strait Islander people, and can deter people from achieving their full capabilities, by debilitating confidence and self-worth which in turn leads to poorer health outcomes. Evidence suggests that racism experienced in the delivery of health services contributes to low levels of access to health services by Aboriginal and Torres Strait Islander people.

There are a number of pathways from racism to ill-health – experiences of discrimination, linked with poor self-assessed health status, psychological distress, depression and anxiety, and health risk behaviours such as smoking and alcohol and substance misuse.

Experiences of racism are compounded by the traumatic legacy of colonisation, forced removals and other past government discriminatory policies. The consequences of these events have been profound, creating historical disadvantage that has been passed from one generation to the next.

Cultural safety, and non-discriminatory service systems and practices, are essential to the improvement of Aboriginal and Torres Strait Islander health outcomes.



5.3 Access to care based on proportionate universalism

The Framework supports and builds on the Universal Services Framework, which outlines core services that should be available to all Australian children and families based on proportionate universalism. Proportionate universalism is the resourcing and delivery of universal health services at a scale and intensity proportionate to the degree of need¹⁰. This Framework also emphasises the importance of ensuring that all Aboriginal and Torres Strait Islander children and their families have access to culturally appropriate services, both universal and targeted, that are appropriate to their needs. Recognising the considerable diversity of Aboriginal and Torres Strait Islander communities (and families within communities), the Framework reflects the need for services to be tailored in scope and approach.

5.4 Commitment to health equity and addressing the social determinants of health

Achieving health equity between Aboriginal and Torres Strait Islander people and other Australians necessitates addressing the factors that contribute to the current inequity. In the context of child and family health services, this means enabling access to clinical and public health resources needed to improve and maintain health, as well as having strategies in place to influence social determinants of health.

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

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

- poor access to functional housing, in particular in remote areas;
- overcrowding;
- homelessness;
- lack of access to transport;
- high rates of incarceration. This affects the health and wellbeing of those imprisoned, and their families and children. It increases stress, affects relationships and has adverse employment and financial consequences¹¹; and
- over-representation in the child protection system. Substantiated child protection notifications for Aboriginal and Torres Strait Islander children are 6.6 times the rate for other children (noting that there are jurisdictional variations). In addition, there has been a steady increase in the number of Aboriginal and Torres Strait Islander children on care and protection orders over the period 2009-2013, while the rate for other Australians has remained relatively stable¹².

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

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

- understand the available evidence of risk factors affecting health and wellbeing, and where possible, tailor service responses that consider these factors; and
- establish and maintain links and referral pathways with the wider social service system to enable complementary health and psychosocial service responses. For example, services should seek opportunities to ensure that young people are informed about, and able to access, sexual and reproductive health services.

5.5 Evidence-based practice

For there to be improvements in outcomes for Aboriginal and Torres Strait Islander children and families, policy, planning and delivery of services must be informed by evidence about what works and what does not work. Mechanisms to monitor, review and evaluate service and program outcomes are essential to build the evidence base, and to communicate the effectiveness of programs.

While the disparity in health and developmental outcomes between Aboriginal and Torres Strait Islander people and other Australians is well documented, the service responses have generally not been evaluated over time. As a result, key lessons have not been shared, and evidence about the effectiveness of various strategies has not been rigorously analysed.

To achieve measurable improvements in Aboriginal and Torres Strait Islander children's health and development, there needs to be a commitment to, and investment in, identifying what is working and what is not. Specifically:

- research to inform program development and service delivery;
- timely, quality evaluation of policy approaches, programs and services. In particular, a greater emphasis on robust evaluation that measures programs against defined outcomes, rather than, as is often the case, relying solely on intermediary or indirect outputs to assess effectiveness; and
- interpreting and applying the best available evidence to inform policy and program design, and service delivery. This must recognise the setting and context.

Importantly, evaluation of policies, programs, services and service providers must be informed through consultation with the children and families accessing those services. The evaluation must be informed by the experience of Aboriginal and Torres Strait Islander people.

5.6 Supporting the cultural safety and development of the Aboriginal and Torres Strait Islander workforce and the cultural competence of the broader workforce

Major challenges to the provision of quality health services to Aboriginal and Torres Strait Islander families are workforce shortages (particularly in rural and remote areas), and the provision of culturally safe services.

Aboriginal and Torres Strait Islander health professionals are important to the delivery of culturally safe care, and for the engagement of Aboriginal and Torres Strait Islander people in their own health. Aboriginal and Torres Strait Islander health professionals also contribute to the development and maintenance of culturally safe workplaces which contribute positively to workforce retention and assists in addressing institutionalised racism.

This is recognised in the Health Plan. One of the key strategies for improving workforce capacity is the continued implementation of the National Aboriginal and Torres Strait Islander Health Workforce Strategic Framework, which includes support for the take-up of health careers, and support for people working in the health and healing professions.

In addition to supporting the training, development and employment of Aboriginal and Torres Strait Islander health professionals, there must continue to be a focus on training and developing non-Indigenous staff in the delivery of culturally appropriate health services. This is discussed in more detail, in relation to approaches to care and key service elements, in Parts 6 through 8.

5.7 Aboriginal and Torres Strait Islander leadership and participation

In order to achieve positive change in the way child and family health services are planned, developed and delivered, there must be strong Aboriginal and Torres Strait Islander leadership at a policy level (national and jurisdictional), regional or community level, and organisational (service delivery) level.

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

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

5.8 Supportive government policy and funding

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

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

- cross-agency coordination to ensure that policies and programs in health and non-health portfolios are mutually supportive, and do not have adverse or unintended impacts on health outcomes;
- flexibility in funding mechanisms and enabling policies to facilitate innovative, place-based, collaborative models of service delivery; and
- cross-agency service models that address the complex social determinants of health.

There must be joint accountability across the service system, irrespective of how existing programs are funded and managed.





6. Approaches to care

6.1 Context

‘Approaches to care’ refers to the way in which services are delivered in order to meet the needs, circumstances and expectations of Aboriginal and Torres Strait Islander children and their families. Central to these approaches to care are children and consideration of their health care needs and best interests.

This section describes the importance of, and strategies for, achieving:

- culturally safe and appropriate care;
- relationship-based care;
- family-centred care; and
- a focus on social and emotional wellbeing.

6.2 Culturally safe and appropriate care

Culturally safe, appropriate and competent care is a key strategy for improving access to health services and also health outcomes for Aboriginal and Torres Strait Islander people.

Cultural competence and cultural safety go beyond cultural awareness and acknowledgement of difference. Cultural competence focuses on the skills, knowledge and attitude of practitioners. Cultural safety is the outcome experienced by those who receive the service, and by Aboriginal and Torres Strait Islanders working for health services.

Key elements of cultural competence include:

- respecting Aboriginal and Torres Strait Islander self-determination;
- working in partnership with Aboriginal and Torres Strait Islander community-controlled organisations – as service partners, not service competitors;
- engaging with Aboriginal and Torres Strait Islander communities and their organisations in respectful and culturally appropriate ways; and
- supporting Aboriginal and Torres Strait Islander staff in organisations, and creating culturally supportive workplaces¹³.

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

“A culturally competent system of care acknowledges and incorporates – at all levels – the importance of culture, the assessment of cross-cultural relations, vigilance towards the dynamics that result in cultural differences, the expansion of cultural knowledge, and the adaptation of services to meet culturally unique needs¹⁴.”

The cultural competence of staff should not be seen as an end point, but as an ongoing process for facilitating strong relationships with children and families. Developing cultural competence should include:

- continuing self-assessment;
- careful attention to the dynamics of difference and power;
- adapting services to meet the diverse needs of families and their children;
- recognition and respect for Aboriginal and Torres Strait Islander knowledge and practice within health services. Service systems and practitioners need to understand and value the cultural knowledge and expertise of Aboriginal and Torres Strait Islander health professionals;
- understanding the history and impacts of colonisation and racism;
- learning about Aboriginal and Torres Strait Islander cultures with particular reference to local or regional culture;
- critical self-reflection including understanding one's own intrinsic biases, and the ability to identify and challenge one's own cultural assumptions, values and beliefs; and
- empathy and understanding for different ways of viewing the world.

In practice

A culturally safe service could be fostered by:

- ensuring that staff are culturally competent;
- utilising the knowledge and expertise of Aboriginal and Torres Strait Islander staff and community members in planning and delivering care;
- ensuring a service environment that welcomes family groups, and is responsive to community expectations for separate areas for men and women (where appropriate); and
- displaying posters and signs in service locations that acknowledge traditional owners of the land on which the service is located, and feature Aboriginal and Torres Strait Islander topics and people.

Examples of some of the ways that the cultural competence of staff may be improved include:

- a weekly in-service for staff to learn important words or phrases from the local language/s;
- staff participation in cultural training;
- if appropriate, staff participating in local Aboriginal and Torres Strait Islander community events and celebrations; and
- staff building skills in effective cross-cultural communication. This requires a sound knowledge of the diversity of Aboriginal and Torres Strait Islander communities, families and people. While there is no formula for good communication, there are some basic principles that may be used as a foundation. These are articulated in the SNAICC Working and Walking Together publication and include: understanding indirect communication; communicating with honesty and openness; avoiding leading questions; and understanding the importance of non-verbal communication, and the use of silence and indirect eye contact.

6.3 Relationship-based care

Relationship-based care incorporates a consciousness of the dimensions of health and healing - placing relationships and caring at the core of service delivery.

Relationship-based practice challenges a tendency to understand human behaviour narrowly with bureaucratic responses to complex problems. Practitioners engaged in relationship-based practice are instead encouraged to respond to the uniqueness of each community, family and individual and to design care around these relationships. Key relationships are between health professionals, children and their families and the communities in which they live.

Relationship-based care supports collaborative, child-centred and family-centred approaches, and seeks to improve:

- the quality of care;
- the capacity of service providers to create a safe environment in which to discuss complex challenges, set goals and implement change;
- the experiences of children, women, men and families' care;
- access and/or utilisation of the health care system; and
- retention with the service and practitioner(s).

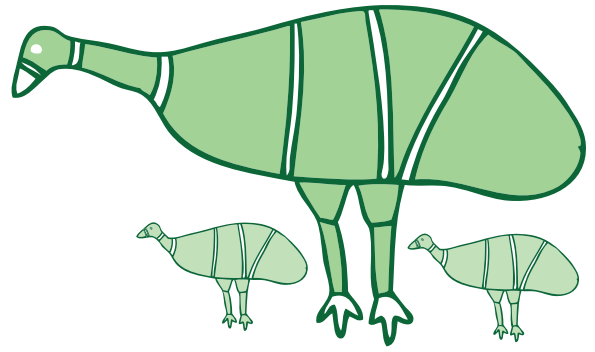
In practice

Building relationships and partnerships takes investment of time and perseverance. Strategies for initiating, developing and strengthening relationships with children and families, other health professionals and organisations may include: getting to know the local community (attending local activities, events and working groups); staying in regular contact with other organisations that are also providing support to children and families; and regular contact with families to develop respect and trust.

Providing families with the opportunity to make informed decisions about their care is an important element of relationship-based care.

Examples of matters that could be discussed with families include:

- giving families adequately informed choices about the type of services they receive;
- supporting family members to identify health and wellbeing goals and actions that are valued as highly as clinical goals identified by health professionals;
- encouraging children and family members to participate in their care by giving them practical examples of how they might do this and providing the necessary tools and supports to enable this; and
- giving families an opportunity to decide which professionals are involved in providing care.



6.4 Family-centred, strengths-based care

Family-centred practice includes three key elements: an emphasis on strengths, not deficits; promoting family choice and control over desired resources; and the development of a collaborative relationship between families and professionals¹⁵.

Family-centred care focuses on the unique needs, expectations, aspirations, and social and emotional environment of each family. It requires building a relationship with each family in order to understand and respond to their needs and expectations as well as their cultural and community networks and context. It is underpinned by understanding the familial structure, including the roles and functions of extended family members and kin.

Family and kinship define obligations and responsibilities for many Aboriginal and Torres Strait Islander people, and are important elements in child-rearing. Understanding the makeup of each family, and the roles each member has in child-rearing enables the targeting of information and messages to the appropriate caregiver and decision-maker within the family.

Cultural practices and societal roles affect the role that fathers play in the development of the child. It is important for services to acknowledge and include males in the raising of children in a culturally appropriate way.

An important element of family-centred care is the identification and support of the inherent **strengths** of the family allowing for a more balanced understanding of Aboriginal and Torres Strait Islander children and families, rather than focusing on deficits or problems¹⁶. It requires health professionals to work collaboratively with Aboriginal and Torres Strait Islander families in the identification and strengthening of 'protective factors' such as cultural practices, values and kinship structures which promote child and family wellbeing¹⁷.

Establishing trust and rapport requires time and effort. In some cases, children and their families may need multiple visits with service providers to develop trust, and to feel secure. Extended consultations or appointments are important for several reasons:

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

Flexibility to respond and tailor services to the individual needs of Aboriginal and Torres Strait Islander women and their families is fundamental to family-centred care.

In practice

A family-centred approach relies on identifying key relationships and connections between the mother, father and/or partner, grandparents, aunties, uncles and others. Some specific methods that may be used by service providers to engage the men that make up an extended family might include:

- promoting programs in spaces traditionally frequented by men;
- enabling flexible service delivery outside of business hours;
- promoting positive images of men and fathers in promotional material, showing that the service welcomes men and recognises their importance;
- providing hands-on learning opportunities for fathers, and also for grandparents, aunties and uncles where they are also caring for the child;
- building staff capacity to engage with fathers and extended family members or other carers (i.e. eliminating stereotyping, and focusing on inclusion); and
- adopting a strengths-based approach that focuses on sharing information about how fathers (or other family members or carers) already contribute, and how they can contribute further to the wellbeing of the family, resisting an 'expert' approach.

The above examples have been drawn from the Community and Families Clearinghouse Australia practice sheet, which builds on the Engaging Fathers study¹⁸.

6.5 A focus on social and emotional wellbeing

Social and emotional wellbeing is a holistic concept that recognises the importance of connection to land, culture, spirituality, ancestry, family and community, and how these affect the individual¹⁹. Social and emotional wellbeing focuses not just on the wellbeing of the individual, but also the wellbeing of their family and community.

An approach focused on social and emotional wellbeing aims to understand:

- life stressors, including trauma, grief and loss, and the impact on individuals, families and communal groups; and
- the influence of geographical and cultural dimensions on individuals and communities.

Such an approach also draws on the following guiding principles in the development and delivery of services:

- promotion of safety through the provision of physically and emotionally 'safe spaces';
- ensuring that services and staff are culturally respectful and competent;
- provision of support programs for Aboriginal and Torres Strait Islander staff;
- supporting client control, autonomy and informed decision making;
- sharing power and governance across all levels of the organisation;
- integrating care by linking all services involved (including trauma-specific services);
- supporting relationship building to assist in healing and recovery; and
- enabling recovery by empowering individuals, families and communities²⁰.

Mental health and social and emotional wellbeing have been identified as key priorities of the Health Plan.

The *National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing* is currently being finalised. In this Framework, mental health and social and emotional wellbeing are addressed together in an integrated approach adapted from the spectrum of interventions within the Australian mental health system encompassing promotion, prevention, detection, treatment and recovery.

7. Key Service Elements

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

In summary these essential service elements include:

- building the child and family health service system around primary health care;
- utilising a multi-disciplinary, collaborative, team-based approach;
- building a skilled and culturally competent workforce;
- continuity of care;
- comprehensive holistic assessment;
- flexible service delivery; and
- an integrated, place-based approach.

Please note that while each of these service elements has been dealt with separately, they are all inter-related. For example, an integrated place-based approach is founded on strong and effective partnerships between health services (including maternity and child and family health services), ACCHOs, GPs, relevant primary health care organisations, NGOs and other services including education and social support. Likewise, continuity of care depends on these strong partnerships, networks and referral pathways.

There is also overlap with the approaches of care discussed in the previous Part. For example, a focus on social and emotional wellbeing (discussed in the previous Part) is also an important element of primary health care (discussed in this Part).

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

Primary care is essentially the first point of contact a person has with the health system. Most commonly this will be with a GP, although it could be with an ATSIHW/ATSIHP, nurse, allied health provider or pharmacist. Primary care is where the majority of health issues are treated and is the basis of a health care system.

Primary health care is a broader concept that derives from a social model of health encompassing health promotion, illness prevention, treatment, community development, advocacy and rehabilitation. The World Health Organization²¹ describes primary health care as both a set of core principles and a variable set of activities. The core principles include:

- universal access to care and coverage on the basis of need ;
- commitment to health equity as part of development oriented to social justice;
- community participation in defining and implementing health agendas; and
- intersectorial approaches to health.



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

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

In the context of the Framework, taking a primary health care approach aims to address health inequalities, acknowledge the importance of involving Aboriginal and Torres Strait Islander people in the design and implementation of services, and emphasises the importance of engaging across sectors to assist families to address complex health and social issues.

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

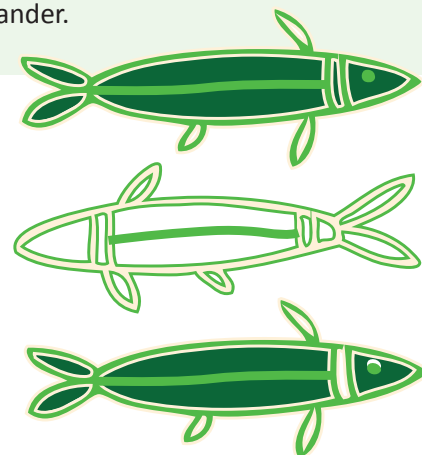
Essentially this means that universal child and family health services are part of an overall primary health care system, irrespective of the funding mechanisms or employment arrangements determined by existing system structures.

In practice

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

- mainstream primary, secondary and tertiary health services engaging meaningfully with local/regional Aboriginal and Torres Strait Islander groups/peak bodies/Elders, and considering social determinants of health in designing and implementing systems and services;
- support for, and collaboration with, ACCHOs; and
- promoting wellbeing and illness prevention as well as management of existing health problems.

Given the well-documented under-identification of Aboriginal and Torres Strait Islander people accessing health and human services, service providers should also explicitly ask whether or not parents and their children identify as Aboriginal and/or Torres Strait Islander.



7.2 A multi-disciplinary, collaborative, team-based approach

The provision of health care to Aboriginal and Torres Strait Islander children and their families should be multi-disciplinary, and involve a collaborative, team-based approach.

Within an Aboriginal and Torres Strait Islander maternal and child health context, multi-disciplinary teams typically include GPs, nurses, midwives, ATSIHWs/ATSIHPs and allied health professionals.

In practice

Enablers of multi-disciplinary care include:

- clearly defined goals (client-centred and outcome-focused);
- clearly articulated and negotiated roles of each health professional;
- clear communication and referral pathways and feedback mechanisms;
- ongoing, regular communication and information sharing;
- established guidelines for the provision of multi-disciplinary care to Aboriginal and Torres Strait Islander children and families; and
- ongoing participation in inter-professional education and training.

7.3 Building a skilled and culturally competent workforce

The child and family health workforce comprises a broad range of practitioners including maternal, child and family health nurses, generalist nurses, midwives, ATSIHWs, ATSIHPs, Aboriginal community workers, Aboriginal cultural brokers, GPs, medical specialists, dentists and allied health providers.

In addition to relevant clinical competencies, all of these providers require core competencies to work with Aboriginal and Torres Strait Islander children and families. These include:

- knowledge of child development;
- understanding of social determinants of health, and broader outcomes for children and families, including risk factors such as domestic violence and exposure to (or use of) alcohol and other drugs;
- skills in assessment, monitoring and observation of behavioural and environmental risk factors;
- ability to work in multi-disciplinary teams;
- interpersonal and communication skills;
- cultural competence; and
- knowledge of relevant ethical guidelines, legislation and policies.

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

- pre-service and ongoing training for all staff about the impacts of colonisation, racism and inter-generational trauma, and how this needs to inform their service delivery, reflective practice, and facilitate culturally safe communication;
- employment of Aboriginal and Torres Strait Islander staff in a culturally safe work environment; and
- appropriately valuing and using the skill sets of Aboriginal and Torres Strait Islander workers.

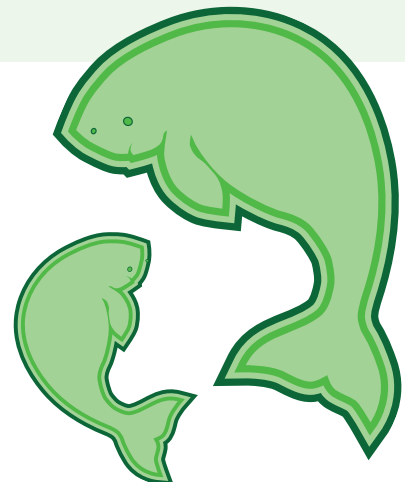
Cultural competence is a broader concept than cultural knowledge. Cultural competence allows individuals and organisations to work appropriately with people from other cultures. It is essential that practitioners in the child and family health workforce have both cultural competence and cultural knowledge.

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

In practice

In order to support Aboriginal and Torres Strait Islander and non-Indigenous staff in providing culturally appropriate care, service providers may consider:

- utilising ATSIHWs/ATSIHPs as care coordinators or case managers;
- supports for staff dealing with complex and challenging situations, e.g. debriefing, implementing burnout interventions and staff-centred stress reduction programs;
- ongoing training, professional development, clinical supervision and support;
- engaging Aboriginal and Torres Strait Islander mentors from outside the organisation to support all staff;
- using resources developed by Aboriginal and Torres Strait Islander organisations to support staff training;
- ensuring job descriptions do not inadvertently discriminate (e.g. requiring tertiary qualifications when direct experience can in fact provide the necessary skills); and
- Aboriginal and Torres Strait Islander community members having a role on selection panels for staff.



7.4 Continuity of care

The fragmentation of our current system means that most families have to access services from different providers across various developmental stages. Even within each developmental stage, there can be a different health professional attending to a family on each visit to a service. Continuity of care aims to break down barriers between services, reduce the number of different service providers, and/or support effective networks for referral and access across services. Therefore, it is important that health service providers have developed collaborative relationships with colleagues in the sector, and understand the types of services they provide, in order to establish strong referral networks and coordinated care arrangements.

Where aspects of care are provided by various practitioners in different settings, such as maternity care provided by midwives and child health by child and family health nurses, service models can provide continuity by ensuring that the care providers work closely together and share relevant information.

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

Continuity of care requires services to ensure that these points of transition are smooth and seamless. This requires:

- good communication and information sharing between service providers. For example, the use of electronic health records to enable health services to have easy access to a person's health information and facilitate continuity of care;
- established referral pathways and mechanisms for ensuring follow-up. It is important that communication and referral pathways are systematised, and do not rely on relationships between individual practitioners;
- effective clinical networks; and
- collaborative relationships between service organisations and individual practitioners.

In practice

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

- utilising ATSIHWs/ATSIHPs as care coordinators or case managers;
- co-location of midwives and child health teams;
- joint visits between child health nurses and midwives during pregnancy;
- support for, and increased access to, continuity of midwifery care models;
- client-held records that include history, health assessment findings, goals of care and progress towards goals;
- shared data systems; and
- referral networks which provide support and follow-up care.

Aboriginal and Torres Strait Islander children and families should have the option to access culturally safe mainstream services and/or Aboriginal and Torres Strait Islander specific services, depending on their preferences.

7.5 Comprehensive holistic assessment

Comprehensive, holistic assessment is crucial for ensuring Aboriginal and Torres Strait Islander children and families have access to the services they need, including universal and targeted health services, as well as other educational and social supports.

The purpose of comprehensive, holistic assessment is to gain an understanding of the child and family, their kinship networks, their individual needs, expectations and preferences.

Comprehensive, holistic assessment enables service providers to:

- gain a thorough understanding of the health and social needs of each child and their family;
- understand family and kinship networks which are important for knowing both how services should be delivered, and who should be involved in the delivery of care;
- build trust and rapport to engage children and families in the service system;
- establish appropriate communication methods;
- understand and discuss expectations and preferences about what and how services should be provided; and
- provide information about potential pathways of care to support informed decision making.

While the aim should be to engage with women in antenatal care as early as possible in their pregnancy, it is also important that comprehensive, holistic assessment can occur at any point that families first engage with the service system. Reassessment may be required as circumstances change.

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

Comprehensive, holistic assessment should incorporate:

- understanding of family and kinship networks;
- physical health;
- psychosocial health;
- behavioural/clinical risk factors (e.g. smoking, alcohol/drug use, chronic disease);
- social risk factors (e.g. housing, financial security, child protection);
- expectations and preferences of the client/family about their health, how services are delivered and preferred communication methods; and
- individual and family ability to access services.

The assessment process should include discussion of clinical and social risk factors that may impact on both the nature of services and how they are provided. Communication preferences should be established to ensure that services understand how best to provide information and reminders to maximise access and engagement.

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

- low literacy, and therefore capacity, to understand and interpret written material;
- financial stress; and
- lack of strong parenting role models.

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

In practice

Examples of comprehensive, holistic assessment might include:

- adapting intake/assessment documentation to be more holistic, and reflect community needs and child-rearing practices;
- home visits by the care team (including ATSIHW/ATSIHP) to facilitate assessment; and
- meeting/consulting with extended family.

Special consideration needs to be given to the circumstances of children whose caregivers are not related to the child, or while related, are not of Aboriginal or Torres Strait Islander descent, including because the child is receiving out-of-home care as the result of a substantiated child protection notification. Internalised trauma may be expressed by individuals in various ways including psychological distress and destructive behaviours²². Children who have suffered neglect and trauma are also likely to have more complex health (including social and emotional) needs. The experience of children in out-of-home care has a significant impact on how culturally appropriate and family-centred care should be delivered.



7.6 Flexible service delivery

Flexible service delivery is about developing and testing innovative approaches to ensure a responsive, evolving service system. It is also about planning and implementing practices that focus on person-centred and restorative care.

Despite being innovative, flexible service delivery should continue to draw on the best available evidence and data collection to ensure the highest quality service

In practice

Examples of flexible approaches might include:

- working outside the clinic or traditional service location to maximise engagement, and to challenge subtle power differences;
- providing services in places that children and families access for other reasons such as playgroups, childcare centres, children and family centres;
- flexibility in appointment times, and providing opportunities for drop-in services to enable children and families to access services when it is convenient for them;
- providing reminders using technology such as text messages;
- providing transport to and from appointments;
- allowing for longer and/or more frequent consultations; and
- allowing for consultations with multiple family members at a single visit.

7.7 Integrated, place-based approach

In order to access the services they need, an individual or family may have contact with a number of providers within the health system (and also the broader service system). Although there may be connections and referral pathways between some of these providers, families are often required to negotiate their own access due to disjointed and fragmented service structures.

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

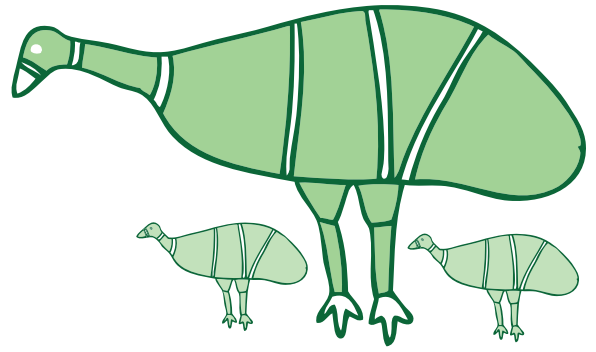
An integrated place-based approach seeks to address weaknesses in the current approach to service delivery by focusing the services around the child and their family such that the service is organised to respond to needs in specific family and community contexts.

As noted by the Lowitja Institute:

Integrated systems pursue positive outcomes for children and families as a goal rather than service outputs, and typically seek to intervene early, prevent family breakdown and promote wellbeing.

An integrated place-based model is founded on strong and effective partnerships between health services (including maternity and child and family health services), ACCHOs, GPs, relevant primary health care services, NGOs and other services including education and social support:

- coordination is a joint responsibility of all child and family health services and providers; and
- the governance, design and implementation of services need to be built around partnerships with Aboriginal and Torres Strait Islander people.



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

- clinical and organisational governance capacity;
- population health and prevention programs;
- comprehensive range of universal and targeted child and family health services;
- community specific care pathways for families with different needs, including comprehensive referral networks; and
- coordinated systems for data collection, information sharing and research/evaluation.

Place-based approaches can be an appropriate response where an area is experiencing multiple issues and there are a range of community members and agencies with different strategies and possible solutions to them. They bring the players together to work collaboratively towards making a difference.

In practice

Some of the important elements of a place-based approach include:

- engaging stakeholders across all sectors in collaborative decision-making. Place-based approaches do not focus solely on health and wellbeing, but also include actions that target housing, employment, transport and social inclusion, that are all likely to have flow-on effects for health and wellbeing. A place-based approach encourages collaborative action by crossing organisational borders and interests;
- collaborative governance. A place-based approach relies on a strong system of inclusive and collaborative governance and shared responsibility for decision making;
- utilising ATSIHWs/ATSIHPs as care coordinators or case managers;
- involving extended family where possible;
- seizing opportunities, particularly local skills and resources and knowledge;
- comprehensive service planning based on service mapping and identification of local need;
- developing place-specific care pathways and comprehensive referral networks; and
- cross agency systems for data collection, information sharing and research/evaluation.





8. Service delivery at different stages of child development

The purpose of this Part is to describe some of the service delivery issues that require consideration at various stages of child development.

Pre-conception

8.1 Background

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

- are aged under 20²³;
- have previously given birth three times or more;
- report smoking and/or drinking alcohol during pregnancy;
- experience poor maternal health including anaemia, poor nutrition, hypertension, diabetes or glucose intolerance; and
- experience adverse perinatal outcomes including increased maternal mortality (four times that of other women), pre-term birth (13.5% versus 8.0%), low birth weight (12.0% versus 6.0%) and fetal deaths (11.1 versus 7.1 per 1,000 births)²⁴.

The evidence emerging from epigenetics research highlights the importance of the physical (in-utero) and social environment for the developing foetus. This is an important consideration given the complexity of the health concerns facing many Aboriginal and Torres Strait Islander people. Ensuring that women are healthy prior to conceiving, and during pregnancy, has the potential to significantly improve the long-term health outcomes for Aboriginal and Torres Strait Islander children. It is also important to equip men and women of child-bearing age (including young people) with strategies to address sexual and reproductive health needs that are appropriate to their individual circumstances. To this end, education of (and anticipatory guidance for) young men and women about health risks that may impact on an unborn child can significantly improve health and developmental outcomes for their children.

8.2 Implications for service delivery

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

There are also a number of programs across Australia that are specifically concerned with preparation for pregnancy. Often these programs are run in conjunction with community events such as cultural or sporting activities to improve engagement.

Supporting the health and wellbeing of potential parents will contribute to addressing risk factors associated with poorer health outcomes for Aboriginal and Torres Strait Islanders.

While there is no universal approach to meeting young peoples' health needs, research has shown that young people experience barriers to accessing healthcare and that these barriers exist across both genders and in all socioeconomic groups²⁵. Barriers cited by young people include fears about confidentiality and embarrassment about discussing health concerns. Barriers cited by health professionals include communication difficulties, time, and uncertainty about the medico-legal status of those under 18 years²⁶.

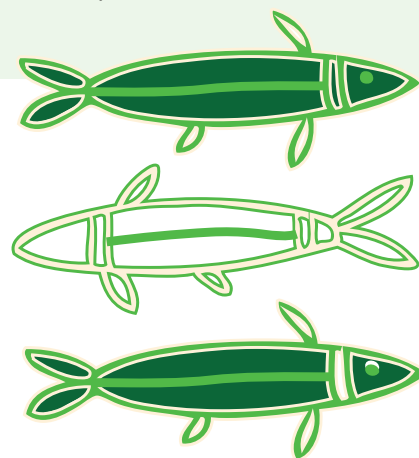
Some proposals for overcoming these barriers include²⁷:

- ensuring that health services (and sexual and reproductive health support services) are easily accessible, flexible, affordable, relevant and responsive to the needs of young people;
- actively involving young people in developing, implementing, reviewing and evaluating youth services and programs;
- developing the workforce's knowledge, skills and attitudes to enable them to work confidently and effectively with young people;
- engaging young people who use services or programs in providing feedback and suggesting improvements; and
- considering and learning about what works in responding to young people, meeting their health care needs, and developing approaches to address youth health issues including youth pregnancy.

In practice

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

- universal adolescent health checks including through the Medicare Health Assessment for Aboriginal and Torres Strait Islander people;
- targeted health promotion events and activities; and
- youth-friendly GP and other health practices. For example, service providers could: develop a confidentiality policy that is visible to all patients; assist young people to obtain a Medicare card; provide psychosocial screening to identify risk and protective factors; seek feedback from young people; develop and maintain strong collaborative relationships with other local youth services; and train staff in youth friendly healthcare²⁸.



Maternity care

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

8.3 Background

Aboriginal and Torres Strait Islander women are less likely to access antenatal care in the first trimester of pregnancy, and overall access less antenatal care visits than non-Indigenous women. Reasons for this might include²⁹:

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

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

- women with complex health needs who need a greater level of clinical care than can be provided in a community setting; and
- women from remote communities who have to travel to a larger centre to give birth, usually 2-3 weeks in advance, but sometimes longer depending on clinical indications, weather, accessibility or other factors. Women in this situation face considerable upheaval including social dislocation, having to leave family, including other children, behind and travelling to often alienating places with little or no family support.

Chronic overstimulation of the fetal immune system by maternal stress hormones can result in the infant developing an altered immune response, leading to an elevated risk of inflammatory disease in adulthood³⁰. Both excessive and insufficient maternal weight gain during pregnancy have been found to cause an elevated risk for the child later developing insulin resistance and obesity³¹.

8.4 Implications for service delivery

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

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

Taking into consideration appropriate approaches to care, maternity services for Aboriginal and Torres Strait Islander women and families should provide continuity of care and carer, particularly allowing for caseload models that are midwifery led. When local factors preclude this, services should (at a minimum) enable continuity of care to be available throughout the antenatal periods to minimise the number of care-givers that the woman meets throughout her maternity experience. When possible, these services can explore extending continuity of carer to include the intrapartum and postnatal periods.

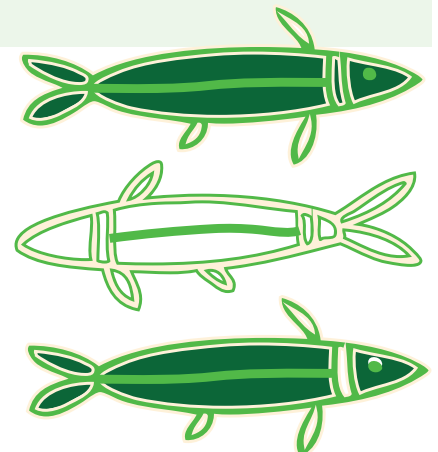
Wherever possible:

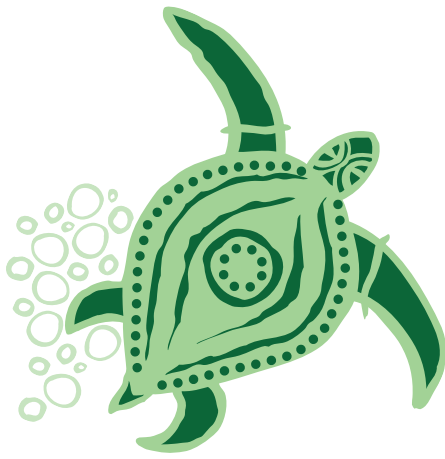
- thorough assessments should be conducted for all women at their first visit, including discussing care pathways and options as well as expectations, preferences and concerns. Service providers should explicitly ask whether or not parents (or carers) and their children identify as Aboriginal or Torres Strait Islander;
- service models should be developed where non-Indigenous midwives are supported by ATSIHPs/ ATSIHWs to support cultural safety, community engagement, health literacy, wellbeing and provision of health information;
- antenatal programs should be delivered that:
 - are tailored according to language and cultural preferences of local communities and families;
 - target health promotion and anticipatory guidance based on individual and community level priorities and health needs;
 - incorporate strategies for engaging fathers and/or partners; and
 - use peer support approaches involving other Aboriginal and Torres Strait Islander women providing support and information to each other, with additional support from midwives and health workers as appropriate;
- support should be provided for women in accessing hospital services, both in the antenatal period and for birthing; and
- postnatal care plans should be developed with the woman during the antenatal period.

In practice

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

- hospital familiarisation visits during pregnancy;
- joint visits with child and family health services during pregnancy;
- support during birthing from community based midwife or ATSIHWs/ATSIHPs;
- colocation of maternity and child and family health teams and clinics;
- mainstream maternity services working in primary health care services; and
- systems to ensure discharge summaries are complete, timely and received by appropriate practitioners.





0-3 years

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

8.5 Background

The first prevention activity a mother can undertake for a newborn child is breastfeeding. Breastfeeding has positive effects on nutritional, physical and psychological wellbeing of infants and where environmental conditions may be less than ideal, breastfeeding provides optimum protection against infection and under-nutrition. As such, it is recommended that infants are exclusively breastfed to around six months of age and that mothers then continue breastfeeding with the addition of appropriate foods until one year of age, and beyond if both mother and infants wish³².

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

- executive function, which assists in connecting past experience to current action;
- self-regulation or capacity to control one's impulses, both to stop doing something, if needed (even if one wants to continue doing it) and to start doing something, if needed; and
- cognitive functions, including curiosity and attentiveness.

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

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

- elevated risk of developing inflammatory conditions such as asthma, diabetes and cardiovascular disease;
- enlarged areas of the brain associated with aggression and impulsivity;
- delays in cognitive development; and
- impaired acquisition of healthy coping mechanisms.

Fortunately, there are indications that much of the neurological damage incurred due to early childhood adversity can be repaired if effective action is taken before the end of the period of peak neural plasticity. One approach which has seen some success (in terms of protecting against some of the significant later-life outcomes of a poor start to life) is the Abecedarian approach. This approach is based on the idea of 'enriched caregiving'. Some strong examples of the Abecedarian approach include those implemented through the Central Australian Aboriginal Congress and through the Gumala Early Childhood 3A (Abecedarian Approach Australia) Project³³.

Each stage of learning and cognitive development in later life is built on the foundational capacities developed in infancy and early childhood. As well as ensuring a solid foundation for later learning, the value of investment in early intervention will be multiplied across the individual's lifetime.

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

- provide the foundations for social and emotional competencies;
- act as a buffer to environmental stressors, moderating the severity of potentially traumatic experiences; and
- play a powerful moderating role over maladaptive gene expression in the developing brain.

8.6 Implications for service delivery

The design of child and family health services needs to address the complex factors that contribute to health and wellbeing. Key factors for consideration in service design include:

- providing preventative health assessments. NACCHO and the Royal Australian College of General Practice have developed a guide to conducting preventive health assessments for Aboriginal and Torres Strait Islander people³⁴;
- ongoing assessment of the needs of children and families including health and developmental checks and monitoring, as these change over time (including ongoing and clear plans for follow-up to ensure that any adverse findings are addressed and monitored);
- supporting parents and carers:
 - by providing programs that actively support the development of strong parent/caregiver relationships and cognitive development;
 - by providing anticipatory guidance and health education;
 - to reduce exposure to environmental stressors; and
 - by providing opportunities for parents and carers to interact with children in a supportive environment, for example supported playgroups where peer support and modelling of positive interaction can occur;
- providing intensive support services for vulnerable families;
- providing services to families in places where they feel comfortable, such as playgroups or child and family centres. These settings provide the opportunity to provide both physical health monitoring and a range of parenting support and other programs, as well as providing opportunities to observe parents interacting with their children and to identify people who may need additional support;
- using cultural events as an opportunity for genuine engagement with children and families and if appropriate use the occasion to provide practical information about health issues;



- actively seeking to involve appropriate family members such as older siblings, aunts, uncles or grandparents who might have responsibility for child-rearing and decision-making within wider family networks;
- undertaking opportunistic assessment and treatment (where necessary) without waiting for scheduled visits or screening activities;
- establishing referral networks and mechanisms for follow up. Where screening occurs there should be clear plans for follow up and management of adverse findings, including functioning recall systems and clear continuous quality improvement processes to ensure quality care is provided; and
- identifying and responding to community needs. Knowledge and understanding of community needs should provide the platform for opportunistic assessment and responses. For example, if it is known that there is a higher incidence of ear disease in a community, practitioners can choose to opportunistically screen or assess children beyond the universal protocols, either routinely or as part of consultations for other health needs.

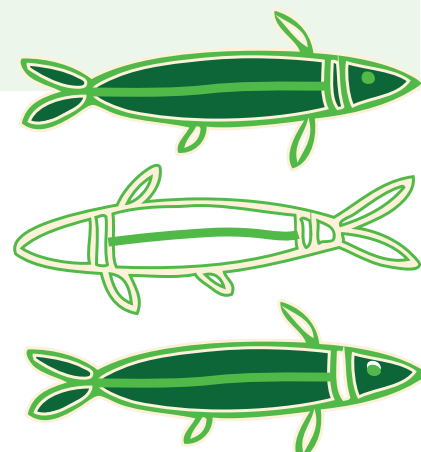
The Universal Services Framework outlines a range of topics that are relevant to this early period of development. Particular attention needs to be paid to both the content and delivery of messages. Delivery of health messages needs to be relevant and appropriate for the recipients. They need to be developed in partnership with communities and take into consideration such things as:

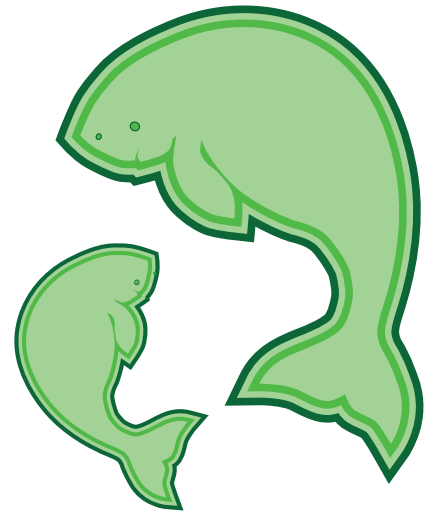
- language;
- literacy levels;
- health literacy levels;
- cultural context including family structure and child-rearing practices;
- skills and experience of parents;
- availability of strong parenting role models; and
- access to technology and preferred communication methods.

In practice

When child and family centres are supported by a range of freely available on-site allied health services, delivered through strong partnerships with other service providers, there is an opportunity for a holistic service to be provided to children and families. Examples of children and family health services that can complement each other include:

- speech and occupational therapy;
- immunisations;
- psychology;
- paediatric services, including child hearing assessments, 'blue book' health checks and coordination of GP assessments; and
- antenatal maternal health assessments³⁵.





3-5 years

8.7 Background

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

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

According to 2012 AEDC data, Aboriginal and Torres Strait Islander children are more than twice as likely to be developmentally vulnerable on one or more AEDC domains compared with all other children³⁶.

The Footprints in Time Longitudinal Study of Indigenous Children³⁷ identified life events having the greatest negative impact on Aboriginal and Torres Strait Islander children's social and emotional difficulty scores. Further analysis was conducted on whether the number of years these events were experienced made a difference to the children's social and emotional difficulty scores. These life events which had a negative impact were:

- having a close family member arrested, in jail or having problems with the police (where children experienced it in two or three years);
- being cared for by someone else for at least a week rather than remaining with their regular carers (where children experienced it over three or four years); and
- being scared by other people's behaviour (for children who had experienced it in three or four years).



8.8 Implications for service delivery

- Appropriate service models, for Aboriginal and Torres Strait Islander children aged three to five and their families, should build on those for younger children including:
- ongoing universal health and developmental checks and monitoring. Where screening occurs there should be clear plans for follow up and management of any adverse findings;
- anticipatory guidance and brief interventions including around nutrition and monitoring of growth;
- referral to specialised services and follow up, as required, including co-location or specialised allied health services working in primary health care/ACCHO settings to promote access;
- support for parents, caregivers and families in providing secure and healthy home environments; and
- identifying and responding to community level needs, including using the AEDC results in place-based approaches to understand the degree and concentration of developmental vulnerability and to develop service responses; and
- responsive early childhood development and stimulation.

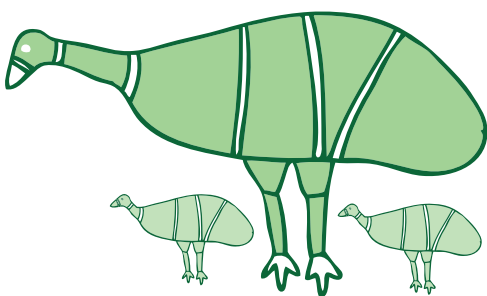
5-8 years

8.9 Background

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

8.10 Implications for service delivery

Health services should aim to ensure that engagement is maintained with children and families throughout this period. Schools provide a valuable avenue for the implementation of programs such as health promotion and health education, hearing assessments, nutrition programs such as breakfast clubs and health hubs that provide the opportunity for comprehensive health assessments, treatment and referral.



9. Summary of roles and responsibilities

One of the objectives of this Framework is to highlight the importance of (and seek to increase and improve) collaboration and cooperation in the delivery of Aboriginal and Torres Strait Islander children and family health services.

To this end, this section details the key roles and responsibilities of governments, service organisations, individual practitioners, communities (including Elders) and children and their families in relation to children and family health services.

It is recognised that these roles shift over time and may vary from state to state, region to region or community to community. The list of stakeholders and their roles is not intended to be exhaustive, but rather to provide an indication of key responsibilities in relation to the delivery of the Framework.

Governments

The Australian Government and State and Territory Governments are broadly responsible for policy and program design and funding in relation to health services for Aboriginal and Torres Strait Islander children and families.

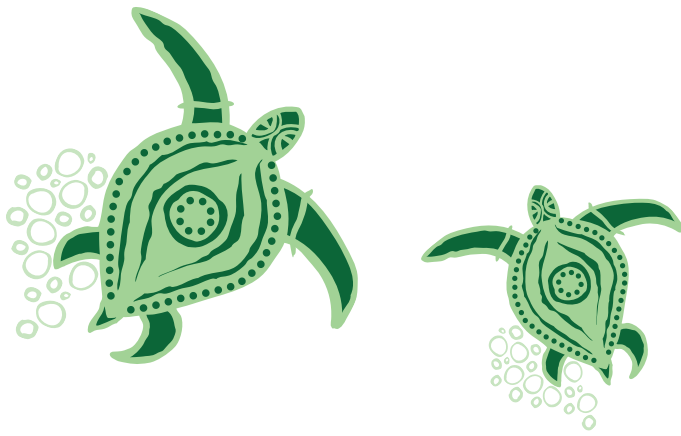
As the vast majority of child and family health services are funded by Governments, it is vital that funded programs are built upon strong program logic and that there is joint accountability and funding continuity (where possible) across the service system, irrespective of how existing programs are funded and managed.

All Government actions should reiterate and contribute to the vision of this Framework – building a health service for Aboriginal and Torres Strait Islander children and their families that focuses on accessing high quality, evidence-based and culturally safe child and family health services to support optimal health, development and wellbeing.

As detailed in this Framework, Governments have a responsibility for ensuring that:

- adequate and sustainable resources are made available to support the provision of multi-disciplinary, family-centred care, including cultural competence training and support;
- Aboriginal and Torres Strait Islander people are engaged in (and, where possible, lead) the design of policy and programs, and the delivery and review of child and family health services;
- program planning increases the Aboriginal and Torres Strait Islander health workforce;
- support is provided for systems of health information that promote and support strong communication and sharing of information;
- policies and programs reflect the best available evidence and are built on strong program logic;
- accountability mechanisms are developed to ensure organisations are funded to provide service models that reflect the best available evidence; and
- the evidence base is built through high quality research and evaluation to guide policy development and program implementation.





Peak bodies

The principal role of peak bodies is an advocacy one, through the development and provision of resources, information and support for the sector in relation to health services.

Peak bodies advocate the importance of the principles in the Framework, through their resources and information channels, promoting the value of:

- access;
- equity and equality;
- leadership and partnership;
- collaboration;
- evidence-based and strengths-based approaches;
- cultural safety and respect;
- workforce development; and
- accountability.

Service organisations

The broad aim of service organisations is to provide well-coordinated, holistic, clinically and culturally competent services that support and build upon the strengths of Aboriginal and Torres Strait Islander children and their families.

The systems and processes put in place by service organisations must enable the delivery of:

- clinically and culturally safe care. This must include a commitment to building the Aboriginal and Torres Strait Islander workforce within services and to embedding systems (including training and other supports) to ensure that all staff adopt practices that reflect cultural awareness, cultural respect, cultural responsiveness and cultural safety;
- family-centred and relationship-based care which is responsive to the needs of individual children and families;
- services that are built around primary health care and incorporate a social and emotional wellbeing component;
- evidence-based and strengths-based approaches;
- coordination and collaboration with other service providers in order to ensure continuity of care and an integrated, place-based approach. This includes developing and using appropriate systems to share information within and between services; and
- ensuring there is strong engagement with ACCHOs (key deliverers of primary health care services to Aboriginal and Torres Strait Islander communities); peak bodies; community members including Elders; and Aboriginal and Torres Strait Islander children and their families.

Flexible service delivery models should promote engagement with, and access by Aboriginal and Torres Strait Islander families, right from the program design stage, through to delivery and evaluation.

Practitioners

At an individual level, practitioners are responsible for ensuring that their practice approach includes a holistic view of health, relationship-based and family-centred care and is based on best available evidence.

As reiterated in this Framework, cultural competence for practitioners in working with Aboriginal and Torres Strait Islander people in health services is essential and an understanding of cultural competence and how to put it into practice, includes:

- continuing self-assessment;
- careful attention to the dynamics of difference and power;
- adapting services to meet the diverse needs of children and their families;
- recognition and respect for Aboriginal and Torres Strait Islander knowledge and practice within health services;
- learning about Aboriginal and Torres Strait Islander cultures with particular reference to local or regional culture;
- critical self-reflection and the ability to identify and challenge one's own cultural assumptions, values and beliefs; and
- empathy and understanding for different ways of viewing the world.

Practitioners play a key role in providing families with the opportunity to make informed decisions about their care, and this is an important element of relationship-based care, as described in this Framework.

Communities, Elders, children and their families

The Aboriginal and Torres Strait Islander communities of children and families, including Elders, play a critical part in how the approaches described in this Framework are further developed, applied and evaluated. The experience, knowledge and opinions of Elders, community members, families and children are valued and respected, and must inform policy and program design and practice. Where possible, Aboriginal and Torres Strait Islander children, particularly older children, should be age-appropriately engaged in health service planning and consultation processes.





10. Conclusion

The Framework seeks to describe an effective child and family health service system that meets the needs of Aboriginal and Torres Strait Islander children and their families, and ultimately improves health outcomes.

The Framework does not include specific targets or performance measures. This is because it complements and builds on the Universal Services Framework and the Health Plan, both of which include (or reference) relevant targets. The Health Plan is also supported by an Implementation Plan and goals that build on existing arrangements that form part of the Closing the Gap effort. Rather than duplicate existing targets and implementation plans, the Framework is designed to be used as a practical resource for stakeholders to assist them in achieving the overarching targets relating to the improvement of Aboriginal and Torres Strait Islander health and wellbeing.

It is expected that stakeholders (governments, peak bodies, services providers and practitioners) will develop their own policies, systems and processes to reflect the principles and approaches described in this Framework.

Attachment A – National Framework for Universal Child and Family Health Services

Vision

All Australian children benefit from quality universal child and family health services that support their optimal health, development and wellbeing.

Objectives

1. To promote health, wellbeing and development in children and families.
2. To enhance the confidence and capabilities of parents, families and carers in the parenting role, and promote the relationship between the parent/carer and the child.
3. To engage with parents and carers in the early identification of their children's physical, developmental, social and emotional needs and enable access to timely and appropriate interventions and supports.
4. To support parents and carers in meeting their own and their children's needs during key transition times especially at birth and the transition to school.
5. To provide early support to families with identified needs.
6. To promote population health through preventing avoidable illness, injury and disease.
7. To enhance community capacity to provide support to parents, carers and families.
8. To work collaboratively with other services to support children, parents, carers and communities.

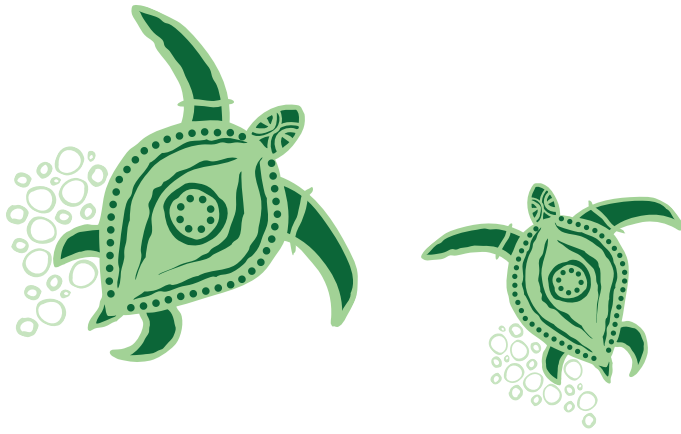
Principles

Access

- Services are universally available, free, appropriate, and accessible for all children and families and articulated where possible with other children's services.
- Services are delivered flexibly how and where the family needs it. Some families will need help to access services.

Equity

- Services seek to improve the health of the whole population as well as reducing inequalities between population groups.
- Universal services work with appropriate targeted responses directed to the families that need them most.
- Service design and delivery is innovative and is informed by and is responsive to the social determinants of health, paying particular attention to the needs of Aboriginal and Torres Strait Islander children, families and communities.
- Services actively ameliorate the poorer health and wellbeing of Aboriginal and Torres Strait Islander children, families and communities.



A focus on promotion and prevention

- The primacy of health promotion, prevention and early intervention is recognised in service delivery.

Working in partnership with families

- Services work in partnership with families, developing an ongoing relationship with parents/carers focusing on strengths and building capacity.
- The central role and expertise of families in influencing and supporting the health, wellbeing and development of children is recognised and parents are enabled in this role.
- Families and communities participate in service design and delivery.

Diversity

- The diversity of Australian families and communities is valued and services are sensitive and responsive to family, cultural, ethnic and socioeconomic diversity.

Collaboration and continuity

- Universal child and family health services work in partnership with primary, secondary and tertiary health services and the education, welfare and disability sectors to provide coordinated, multidisciplinary care and integrated service delivery.
- Continuity of care at transition points is 'seamless.'
- Services maximise opportunities for families to develop sustained relationships with health, education, welfare and disability service providers.

Evidence-based

- Services reflect the best evidence or harness practice wisdom where evidence is not available.
- Continuous improvement and evaluation of services promotes better outcomes for children and families.

Attachment B – National Aboriginal and Torres Strait Islander Health Plan 2013-2023

Vision

The Australian health system is free of racism and inequality and all Aboriginal and Torres Strait Islander people have access to health services that are effective, high quality, appropriate and affordable. Together with strategies to address social inequalities and determinants of health, this provides the necessary platform to realise health equality by 2031.

PRINCIPLES	HEALTH EQUALITY AND A RIGHTS BASED APPROACH	ABORIGINAL AND TORRES STRAIT ISLANDER COMMUNITY CONTROL AND ENGAGEMENT	PARTNERSHIP	ACCOUNTABILITY
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PRIORITIES



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