



GUIDELINE	
Partnership - child health service	
Scope (Staff):	Community health staff
Scope (Area):	CAHS-Community Health

This document should be read in conjunction with this [DISCLAIMER](#)

Aim

To guide staff in supporting children and families with complex concerns with the aim of optimising a child’s health, development, psychosocial health and behaviour.

Risk

Non-adherence to this guideline may result in missed opportunities to improve health and developmental outcomes of children at risk of ongoing adverse experiences.

Background

The Australian Health Ministers’ Advisory Council documents *Healthy, Safe and Thriving: National Strategic Framework for Child and Youth Health* and the *National Framework for Child and Family Health Services – secondary and tertiary services*, aim to improve the health, development and wellbeing of children and families, through a model of progressive universalism.^{1, 2} This acknowledges providing support for all families and recognising more support will be required by those with greater needs.

The *Western Australian Metropolitan Birth to School Entry Universal Health Service Delivery Model – Review of evidence with recommendations for an improved service delivery model* provides the evidence base for a child health service program based on progressive universalism.³ The Child and Adolescent Health Service-Community Health (CAHS-CH) *Child health services* policy describes the following service levels offered as:

- Universal services include a schedule of community health nurse contacts and assessments offered for all children and families.
- Universal Plus services offer additional and flexible contacts providing support to help families manage or resolve a particular concern or issue. Additional contacts provide opportunities for ongoing monitoring, minimising risk factors for children and building protective factors and resilience in families.² Community health nurses (CHN) provide this level of service.
- Partnership services are for children and families who require help to manage or resolve increasingly complex physical, developmental, psychosocial, behavioural and health concerns, which may be complicated by socioeconomic, social and environmental factors.² In addition, there is a level of risk for children, if concerns are not addressed.^{1, 2} Clinical nurse specialists (CNS) will act as care coordinators and work in collaboration with relevant agencies (and families). Clients in the Partnership level of service are offered all elements of Universal services, in conjunction with additional contacts for comprehensive assessments and targeted

care planning. These contacts are timely, ongoing and where indicated, sustained.³ The CNS will deliver this level of service.

Note: Currently, the Partnerships level of service is not offered within the CAHS–CH Aboriginal Health Team. Refer to the *Aboriginal – child health service* policy for more information on delivering child health services with Aboriginal families.

Children require a safe and nurturing home environment to establish secure child parent relationships and to achieve optimal health and developmental outcomes.¹ Some parents may have difficulties providing their children with these opportunities. In these instances parents require early, intensive and individualised support to address issues that may be impacting on their capacity to parent. Interventions aimed at promoting attachment are pivotal for these families, with maternal sensitivity and responsiveness considered a critical outcome.⁴ In addition, child focused outcomes of emotional and behavioural functioning, and developmental status emphasising mental and motor development, are important in relation to family functioning.⁴

Results from a systematic review of interventions that include working with parents and infant together, with the aim of influencing parent infant relationships and promoting infant attachment, demonstrated improved infant attachment security in high-risk families.⁵ The *Circle of Security – Parenting* group is an example of an attachment based intervention, where facilitators use a manual and prepared video segments for discussion with participants. The aim is to enhance the quality of relationships, build self-reflection, increase empathy, help parents manage emotions and promote secure attachment in children.⁶

Children and their families with complex needs will frequently require support from a number of service providers to achieve best outcomes for the child and family. The CNS working in this area require knowledge of available services, skills to assure continuity of services and experience in evaluating outcomes in order to act as care coordinators. Through care coordination, the CNS can assist families to understand and obtain services which may be beneficial to the family and support the navigation of the multiple teams involved. Benefits of care coordination include care planning developed with the family's participation, continuity of care, coordination of community resources, improved information sharing and active monitoring and evaluation of care.²

Key Points

- The child is the primary client and is the centre of care.
- Whilst children from birth to four years will be eligible for Partnership level of service, engagement within the *'first 1000 days'* (conception to two years of age) is recommended, where possible.
- The CNS and clients will work together for the shared understanding of family concerns and resilience, and the establishment of goals to facilitate change for modifiable concerns.
- *Family Partnership Model* principles, child and family centred and strength-based approaches will be used to influence client involvement, commitment and participation.
- The *Guidelines for Protecting Children 2015* (revised May 2017) will guide clinical practice, where relevant.
- The CNS is supported to work within the boundaries of their professional practice, and to recognise the scope of practice for individual CHN may vary.

- The CNS is encouraged to be aware of the availability of local resources, for timely interventions and/or referrals to respond to client concerns.
- The CNS supporting families with complex needs should regularly consult with the line manager, attend clinical supervision sessions, practice self-care and seek support through the employee assistance program, when required.
- Service provision includes coordination and collaboration with internal and external services, and valuing the knowledge, experience and expertise of a multidisciplinary approach, to optimise support for families with increasingly complex concerns.
- Service delivery is culturally secure, ensuring cultural diversity, rights, views, values and expectations of Aboriginal people and those of other cultures are honoured; with the exception of particular issues identified in the *Guidelines for Protecting Children 2015* (revised May 2017).

Partnership service entry considerations

Not all families with complex concerns will require Partnership services, as the presence of protective factors may reduce adversity and increase resilience. Where no risks for child and family functioning have been identified, Universal Plus services offered by the CHN may be appropriate.

It is recognised that the compounding effect of a number of concerns may increase the level of risk for children and increase a family's vulnerability to negative outcomes.⁷ These families would benefit from the services offered by CNS in the Partnership level of service.

A family's commitment to engage with the service and participate in addressing identified concerns is essential to reduce risk factors and improve the daily lives of their children. In instances where a family does not engage with the service, discuss with the line manager and refer to the *Guidelines for Protecting Children 2015* (revised May 2017) for additional information.

Process

Steps	Additional Information
<p>Client with increasingly complex concerns identified by the CHN</p> <ul style="list-style-type: none"> • The CHN shares relevant client information with the CNS. • Shared decision making will identify the appropriate level of service to respond to client concerns, which may include: <ul style="list-style-type: none"> ○ Universal Plus offered by the CHN, with CNS support as required ○ Partnership offered by the CNS. • The CHN will be responsible for notifying the Clinical Nurse Manager (CNM) with the outcomes of the discussion that took place with the CNS. 	<p>Staff discussions will consider client circumstances including:</p> <ul style="list-style-type: none"> • Risk factors • Protective factors • Child health and development • Child parent attachment • Difficulties that may impact on parents' capacity to respond to their child • Family functioning • Level of risk for child if family concerns are not addressed. <p>The <i>Indicator of Need</i> resource provides more information about risk and protective</p>

Steps	Additional Information
<ul style="list-style-type: none"> • Clients requiring Partnership level of service will be referred by the CHN via the Child Development Information System (CDIS) • The CNS will assume responsibility for the client and will request the transfer of the client's record (paper file) to a relevant site. The CNS will amend the Paper File Location in CDIS on receipt of the client's file. • The client will be added to the <i>Clients of concern communication tool</i>, according to local processes. 	<p>factors.</p> <p>Discussion may also involve the CNM when considering the scope of practice of the individual CHN, including knowledge, skills and competency, when making decisions regarding clients receiving appropriate care.</p> <p>Refer to the <i>Record (client) transfer guideline</i> for more information.</p> <p>Refer to the <i>Clinical Handover Nursing procedure</i> for more information.</p> <p>Refer to the <i>Clients of concern management protocol</i> for more information.</p>
<p>Preparation for the initial Partnership client interaction</p> <ul style="list-style-type: none"> • Prior to contacting the client, review client information including the CHN referral and any additional information, if available. Verify that the client's contact details are correct. • Service provision in client homes is preferred, however, it is acknowledged that other venues may be more appropriate to meet individual client circumstances and where staff safety is required. • Complete the <i>Risk Assessment and Home Visiting Checklist</i>, according to the <i>Home and Community Visits</i> procedure. • Document client appointment details using the CDIS calendar. 	<ul style="list-style-type: none"> • Information from other sources may include child health records of any previous children and/or services that that the client may have received. • Undertake a risk assessment to determine the appropriateness of home visiting the client. • Refer to the <i>Universal initial contact interaction, Home and Community Visits and Working Alone</i> guidelines for more information. • When the client contact is taking place in a location that is different to the address that is recorded in CDIS, the CNS will discuss with their line manager the location and rationale for this, and seek consent. • In these instances, a <i>Client not present (CNP)</i> will be completed in CDIS, identifying where the contact will occur.
<p>Client assessment</p> <p>Clients receiving Partnership level of service require comprehensive assessments, to gain a greater understanding of child and family concerns impacting on the child's health, development and family functioning. In addition, an assessment for any immediate safety concerns for the child is undertaken.</p>	<p>Refer to the <i>Universal contact</i> guidelines for more information related to assessing:</p> <ul style="list-style-type: none"> • Family health and wellbeing • Maternal health and wellbeing <ul style="list-style-type: none"> ○ Child Parent attachment ○ Lactation

Steps	Additional Information
<p>A holistic assessment will include undertaking a systematic enquiry of parent concerns, gathering information about child and family functioning and completing age appropriate observations and assessments. This will also include reviewing previous health professional assessments if available, use of appropriate tools and acting on professional judgement.</p> <p>The following tools are used in accordance with the relevant policy to guide assessments, care planning decisions and to inform documentation:</p> <ul style="list-style-type: none"> • <i>Acuity tool</i> • <i>Ages and Stages Questionnaire</i> • <i>Ages and Stages Questionnaire: Social-Emotional</i> • <i>Breastfeeding Assessment Guide</i> • <i>Child Wellbeing Guide</i> • Centre of Perinatal Excellence (COPE) <ul style="list-style-type: none"> ○ <i>Assessing mother-infant interaction and safety of the woman and infant</i> ○ <i>Antenatal (Psychosocial) Risk Questionnaire (ANQR) – Client with postnatal items</i> • <i>Edinburgh Postnatal Depression Scale (EPDS)</i> • <i>Family and Domestic Violence (FDV) Screening</i> • <i>Genogram</i> • <i>Indicators of Need.</i> 	<ul style="list-style-type: none"> • Child health and wellbeing <ul style="list-style-type: none"> ○ Feeding assessment ○ Physical assessment ○ Growth assessment ○ Developmental assessment. <p>The COPE tools provide prompts and questions to explore child mother (parent) attachment, partner relationships, stressors/losses, maternal pregnancy and birthing experience, and FDV. These tools can be used to assist with the understanding of psychosocial factors that may be impacting on family functioning.</p>
<p>Client care planning</p> <ul style="list-style-type: none"> • All elements of Universal service provision will be undertaken by the CNS. • Additional contacts will focus on family goal-setting, managing risks and minimising the impact of identified concerns. 	<p>Refer to <i>Universal contact</i> guidelines for information related to anticipatory guidance, parent education and resources, and care planning.</p> <p>Additional contacts will be timely with ongoing, targeted, intensive interventions. Proactive outreach may be required, when client engagement and participation is</p>

Steps	Additional Information
<p><u>Goal setting</u></p> <ul style="list-style-type: none"> Following the shared identification of parental concerns, explore goal setting and goal reaching with clients. It is important to determine what the client wants to prioritise, as this will contribute to a sense of ownership and motivation to reach their goals. It is desirable for clients to set one or two goals that they consider achievable. The CNS will use relevant <i>Family Partnership Model Practice Resources</i>, to help parents change so that they can reach their desired outcomes. The <i>Goal Setting Agreeing Change for the Future: Making SMARTER Goals</i> template will be completed to document the shared understanding of client goals. The CNS will use a corporate device (mobile phone with security controls) to photograph the completed <i>Making SMARTER Goals</i> document, for attaching into the client's CDIS record as soon as possible. Provide the client with the original copy of the completed <i>Making SMARTER Goals</i> document. A CNP will be completed, noting that a <i>Making SMARTER Goals</i> document has been attached into the client's CDIS record. In instances where subsequent <i>Making SMARTER Goals</i> document are completed, attach into the client's CDIS record, as previously described. 	<p>reduced.</p> <p>It is unnecessary to set goals to address risk factors which are unlikely to be modifiable.</p> <p>The CNS will undertake <i>Family Partnership Model</i> training, which provides essential knowledge about the background, content and use of the resources.</p> <p>The <i>Goal Setting Agreeing Change for the Future: Making SMARTER Goals</i> includes:</p> <ul style="list-style-type: none"> How clear are you about your goal? Which area/s do you want to work up into a goal? When will you reach your goal? How realistic and achievable is this goal? How easy will it be for you to reach it? How important and valuable is reaching this goal for you? How much do you feel involved and in control of choosing this goal? When and how shall we review the progress? <p>The following steps describe how to attach the photograph of the completed <i>Making SMARTER Goals</i> document into the client's CDIS record:</p> <ul style="list-style-type: none"> Email the photograph to the relevant CNS CAHS-CH email address, selecting <i>Large image size</i> on the mobile phone Save the photograph onto your computer desktop and rename with the: <ul style="list-style-type: none"> Date the photograph was taken Name of the attached document Name of the client (child) <p>For example:</p> <p>19-04-25 – Goals – Bobbie BROWN</p> Attach the photograph into the client's

Steps	Additional Information
	<p>CDIS record</p> <ul style="list-style-type: none"> Delete the photograph from the mobile phone and from the computer desktop. <p>Refer to CDIS information in CAHS-CH Common Folders, or contact CDIS Helpdesk for attaching photographs, if required.</p>
<p>Client interventions</p> <ul style="list-style-type: none"> Establish with parents if any existing support or services are already in place, to avoid duplication. Determine the client's uptake of existing support or services and the suitability in meeting client needs. Anticipatory guidance will include: <ul style="list-style-type: none"> Early infant care Nutrition Expected infant and child physical, social and emotional development Illness and injury prevention Immunisation Sensitive parental responses to infant and child cues, and the development of secure child parent attachment Development of healthy relationships between parents. Interventions may include practical guidance such as role modelling, demonstration, parenting skills practice, encouragement and coaching.⁸ Interventions may be targeted to assist clients with making progress towards achieving their goals. Clients identified as having concerns with child parent attachment, and who would be suitable to attend a group, will be offered a referral to a <i>Circle of Security – Parenting</i> group. 	<p><u><i>Circle of Security - Parenting groups</i></u></p> <p>It is recommended that the CNS determine a client's suitability to attend a group, as family circumstances may impact on their capacity or readiness to participate in group sessions.</p> <p>Clients will be offered a group that is accessible to meet their individual preferences. This may include referring clients to groups offered by CAHS-CH staff or groups offered by external providers.</p> <p><i>Circle of Security – Parenting groups</i>, through the use of a manual and prepared video segments, assist parents with:</p> <ul style="list-style-type: none"> Improving their understanding of what their child's behaviour means Improving how they nurture their child, including when their child is distressed Responding positively to cues and expressions of their child's feelings Understanding their own feelings when nurturing their child. <p>The <i>Circle of Security – Parenting</i> group provide opportunities for the CNS to:</p> <ul style="list-style-type: none"> Highlight parental sensitivity, responsiveness and communications Emphasise parental strengths Acknowledge positive changes in behaviour of the parents and child.^{4, 9, 10} <p>Document referrals to a <i>Circle of Security – Parenting</i> group in CDIS. Refer to CDIS information in CAHS-CH Common Folders, or contact CDIS Helpdesk for support, if</p>

Steps	Additional Information
<ul style="list-style-type: none"> • Referral to services specialising in child parent relationships, as required. • Where there are concerns about FDV impacting on the health and wellbeing of infants, children and adults, a safety plan may need to be developed. • Where there are concerns for the child's safety, or where abuse or neglect is suspected, has taken place or the child is currently at clear risk, refer to the <i>Guidelines for Protecting Children 2015</i> (revised May 2017) for taking action. 	<p>required.</p> <p><u>Child Parent relationship services</u></p> <p>Consider referral to services specialising in child parent relationships for clients who:</p> <ul style="list-style-type: none"> • May not be suitable to attend a <i>Circle of Security – Parenting</i> group • Decline attending a <i>Circle of Security – Parenting</i> group • Have demonstrated limited improvement in child parent relationships following attending a <i>Circle of Security – Parenting</i> group. <p><u>Safety plan development</u></p> <p>When a safety plan does not exist, either assist the client to develop a safety plan and/or liaise with specialist services for guidance. The Women's Domestic Violence Helpline and/or the Men's Domestic Violence Helpline can provide support with safety plan development. Refer to the <i>Family and domestic violence</i> protocol for more information.</p>
<p>Client referral</p> <p>Referral to relevant services within Child and Adolescent Health Service (CAHS) may include:</p> <ul style="list-style-type: none"> • CAHS-CH Child Development Service • CAHS-Mental Health • Child Protection Unit - Perth Children's Hospital <p>Referral to external relevant health and social service support agencies, and professionals, according to client need.</p> <p>For additional resources and referral options, refer to the <i>Family and domestic violence</i> protocol, <i>Vulnerable populations</i> policy and the <i>Guidelines for Protecting Children 2015</i> (revised May 2017).</p> <p>Complete clinical handover, according to the <i>Clinical Handover Nursing</i> procedure.</p>	<p>Relevant agencies or professionals include:</p> <ul style="list-style-type: none"> • Child and Adolescent Community Mental Health Services • Circle of Security – Parenting • Day care programs or services • Department of Communities Child Protection and Family Services • Drug and Alcohol Services • Family Support Network • Family and domestic violence services • Legal Aid Western Australia • Mental Health Services • Mental Health Emergency Response Line • General Practitioner • Men's Domestic Violence Helpline

Steps	Additional Information
	<ul style="list-style-type: none"> • Ngala • Non-government agencies offering family support • Women's Domestic Violence Helpline • Women's Health & Family Services.
<p>Client review</p> <p>Develop and document a follow up plan in consultation with the client to revisit goals and measure progress.</p> <p>Liaise with relevant health professionals and services that may be involved with the family, to share information regarding client progress, as required.</p>	<p>Additional contacts will be responsive to client needs and will involve the CNS reviewing progress and revisiting goals, as required. The follow up plan will include dates, time and a venue mutually agreed on by the client and the CNS.</p> <ul style="list-style-type: none"> • Where the venue is to be different to the address recorded in CDIS, the CNS will seek line manager consent and record the location in a CDIS CNP.
<p>Client care coordination duties</p> <p>The CNS will be responsible for acting as care coordinators to assist families to understand and obtain services which may be beneficial to the family, and support the navigation of the multiple teams that may be involved.</p> <p>Care coordination requires working collaboratively with internal and external services, and valuing the knowledge, experience and expertise of a multidisciplinary approach, to optimise support for families with increasingly complex concerns.</p>	<p>The CNS will share relevant client information in accordance with the <i>Consent for release of client information</i> procedure, and progress with internal and/or external health and social service support agencies involved with the family.</p> <p>In instances where staff may have difficulties obtaining information from CPFS, complete a <i>Request to Department for Child Protection and Family Support (CPFS) to provide relevant information to WA Health</i> form. For more information refer to the <i>Guidelines for Protecting Children 2015</i> (revised May 2017).</p>
<p>Partnership service exit considerations</p> <ul style="list-style-type: none"> • Client care is transferred to the CHN in the child health setting when: <ul style="list-style-type: none"> ○ Achievement or adequate resolution of identified client goals. ○ Risks to the child have been mitigated and/or are stable with no actual risk of harm. ○ Clients are actively engaging with health and social service support agencies. ○ Clients are not committed to 	<p>When client care is transferred from the CNS to the CHN in the child health setting, the CNS will be responsible for providing a clinical handover. The CHN will be responsible for undertaking relevant universal contacts and planning ongoing client care. The client's paper file will be transferred to the relevant child health centre the client is active for.</p> <p>In instances where client care is transferred from the CNS to the CHN in the school health setting and/or school student service team, the CNS will be responsible for providing a clinical handover. The CHN in</p>

Steps	Additional Information
<p>addressing concerns and/or implementing strategies.</p> <ul style="list-style-type: none"> • Client care is transferred to the: <ul style="list-style-type: none"> ○ CHN in the school health setting ○ A local or interstate health service. • Client declines further involvement with CAHS-CH services. 	<p>collaboration with the Department of Education staff will be responsible for planning ongoing client care.</p> <p>The CNS will discuss with the line manager whether escalation to CPFS is required, for clients declining involvement with CAHS-CH services. Refer to the Guidelines for Protecting Children 2015 (revised May 2017) for additional information.</p> <p>Clinical handover and the use of the Clinical Handover/Referral form (CHS663) will be completed, according to the <i>Clinical Handover Nursing</i> procedure.</p>

Leadership and consultancy

The CNS will support the CNM and the CHN working with clients with complex needs in the Universal Plus services through:

- Discussing client concerns and assisting with appropriate client care planning
- Attending client contacts with the CHN (home visits and/or centre based), as requested
- Collaborating with the CNM at the Client of concern meetings, including providing guidance with clinical issues, as required.

Documentation

The outcomes of client contacts will be documented in the client's CDIS record.

The client's paper file will be used to store completed forms, including the:

- Tools used for assessments
- Health professional or related forms and reports relevant to the client.

Health outcomes

The Partnership level of services is expected to contribute to improvement in the following outcomes:

- Children's health and development
- Children's social and emotional development
- Children's behavioural functioning
- Quality of child parent relationship
- Wellbeing and quality of life for children and parents
- Mental health problems in children and parents
- CPFS involvement.

Suggested quality measures for CAHS-CH services may include:

- Proportion of families engaged with Partnership level of service following referral from community health nurses.
- Proportion of families engaged with Partnership level of service with a completed *Making SMARTER Goal* document.
- Proportion of families engaged in Partnership level of service completing Universal contacts.
- Proportion of families engaged with Partnership level of service referred to Circle of Security - Parenting groups.
- Proportion of families engaged with Partnership level of service with improvements in EPDS.
- Proportion of families engaged with Partnership level of service where a notification to CPFS is made.

CNS skills and education

The CNS will comply with the *Mandatory Training and Practice Frameworks – Child Health Nurse*. In addition, the CNS will demonstrate expertise and and/or competence in:

- Circle of Security – Parenting
- Clinical supervision
- Community needs assessment – identification of available local services and resources
- Department of Communities Child Protection and Family Support processes
- Family Partnership Model training

CNS support

CAHS-CH Directors North and South will provide support for the individual CNS through regular meetings (and as required) to:

- Ensure client load, and client goals and progress are carefully managed
- Support with the development of client care coordination duties
- Support with the development of leadership and consulting duties
- Ensure clinical supervision opportunities are being accessed, in accordance with local processes.

References

1. Australian Health Ministers' Advisory Council. Healthy, safe and thriving: National strategic framework for child and youth health. Australia: 2015.
2. Australian Health Ministers' Advisory Council. National Framework for Child Health and Family Services - secondary and tertiary services. Australia: 2015.
3. Edmond K. The Western Australian Metropolitan Birth to School Entry Universal Health Service Delivery Model. Review of evidence with recommendations for an improved service delivery model. Western Australia: 2015.
4. The British Psychological Society & The Royal College of Psychiatrists. Children's attachment: Attachment in children and young people who are adopted from care, in care or

at high risk of going into care. 2015.

5. Barlow J, Bennet C, Midgley N, Larkin S, Wei Y. Parent-infant psychotherapy for improving parental and infant mental health (Review). 2015.
6. Circle of Security International. Circle of Security Parenting [cited 2018 26 October]. Available from: <https://www.circleofsecurityinternational.com/circle-of-security-parenting>.
7. Bromfield L. The role of services in assisting vulnerable children and young people. 2018.
8. Engle P, Fernald L, Alderman H, Behrman J, O'Gara C, Yousafzai A, et al. Strategies for reducing inequalities and improving developmental outcomes for young children in low-income and middle-income countries. *The Lancet*. 2011;378(9799):1339-53.
9. National Institute for Health and Care Excellence. Children's attachment. United Kingdom: 2016.
10. National Institute for Health and Care Excellence. Children's attachment: attachment in children and young people who are adopted from care, in care or at high risk of going into care. United Kingdom: 2015.

Related policies, procedures and guidelines

The following documents can be accessed in the **Community Health Manual** via the [HealthPoint](#) link or the [Internet](#) link

Acuity tool

Ages and Stages Questionnaires

Breastfeeding deviations from normal

Child health services

Children in care – conducting an assessment

Children in care – managing referrals

Family and domestic violence

Groups for parents

Growth faltering

Clients of concern management

Perinatal and infant mental health

Physical assessment 0 – 4 years

Overweight and obesity

Universal contact guidelines

Vulnerable populations

The following documents can be accessed in the [CACH Operational Manual](#)

Clinical Handover Nursing
Home and Community Visits
Media Management (under development)
Mobile phones
Record (client) transfer
Working Alone
The following documents can be accessed in the CAHS Policy Manual
Photography and Video/Audio Recording CLINICAL
Photography and Video/Audio Recording NON CLINICAL

Related CAHS-CH forms
The following resources and forms can be accessed from the CAHS-Community Health Forms page on HealthPoint
Antenatal (Psychosocial) Risk Questionnaire (ANQR) – Client with postnatal items
Assessing mother-infant interaction and safety of the woman and infant
Breastfeeding Assessment Guide
Child Protection Concern Referral form
Clinical Handover/Referral Form
Edinburgh Postnatal Depression Scale
Family and Domestic Violence – Screening, Assessment and Referral
Genogram
WHO charts 0-6 months

Related CAHS-CH resources
The following resources and forms can be accessed from the CAHS-Community Health Resources page on HealthPoint
Child Development Information System (CDIS) information is available from CAHS-CH Common Folders.
Family Partnership Model - The <i>Goal Setting Agreeing Change for the Future: Making SMARTER Goals</i> template is available from the CAHS-CH Learning and Development

Workspace page. Contact CAHS-CH Learning and Development for access.
Hearing Surveillance Screening for Universal Contacts
How Children Develop – 0-12 years Resource
Indicators of Need
Vision Surveillance Screening for Universal Contacts

Related external resources
Australian Breastfeeding Association
Breastfeeding Centre of WA
Centre of Perinatal Excellence
Child Protection Unit – Perth Children’s Hospital
Child Wellbeing Guide – Available from the Statewide Protection of Children Coordination Unit on the Child and Adolescent Health Service intranet
Circle of Security
Department of Communities Child Protection and Family Support
Guidelines for Protecting Children 2015 (revised May 2017)
Guidelines for Responding to Family and Domestic Violence 2014
Healthy WA website
Information Sharing for the Protection of Children – Available from the Statewide Protection of Children Coordination Unit on the Child and Adolescent Health Service intranet
Infant Feeding Guidelines – Information for health workers
Kidsafe
Ngala
Playgroup WA
Raising Children Network
Red Nose

This document can be made available in alternative formats on request for a person with a disability.

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