Maternal, Child & Family
Health Nurses Australia

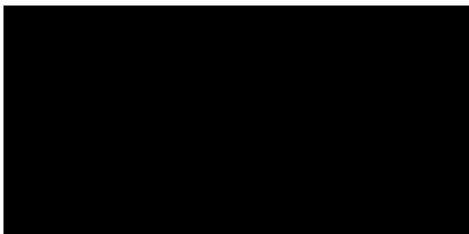
MCAFHNA SUBMISSION

The Maternal, Child and Family Health Nurses Australia (MCaFHNA) organisation is the national peak professional body for nurses working in the field of maternal, child and family health. We promote and advocate for the optimal health and well-being of young children and their families in their communities through the specialty of maternal, child and family health nursing.

We thank you for the opportunity to provide this submission to the Commonwealth Early Years Strategy.

Please note – While acknowledging the Strategy's vision is to '*encompass aspirations for children across all aspects of their lives'*, MCaFHNA submission is specific to the early years in the context of Child health programs.

Warm Regards



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a. Proposed structure of Early Years Strategy

The proposed structure of the Strategy includes a vision, outcomes, policy priorities and indicators that will measure success against each of the outcomes and priority reform areas. It is proposed that indicators will be developed after the policy priorities are established. A diagram of the proposed structure is in Attachment B.

Implementation Action Plans will be developed after the Strategy is finalised and will set out what will be done to respond to the priority reforms. An Outcomes and Evaluation Framework will also be developed to monitor performance.

QUESTION 1. Do you have any comments on the proposed structure of the Strategy?

It is noted that the proposed structure provides, for the first time, 'a national overlay in the early years with policies and programs that cover many areas of early childhood health, development and education' (pp.5). This national overlay is a step towards national consensus in all activities in universal child health assessments, mapping outcomes against domains identified in the Early Childhood Development [ECD] Outcomes Framework (Australian Institute of Health and Welfare [AIHW], 2011) which can then inform progress towards the National Early Childhood Development Strategy (Council of Australian Governments [COAG], 2009;) and the proposed Early Years Strategy.

It is hoped that this new structure will break down traditional State and Territory program silos to avoid infants and toddlers 'falling through gaps' and not reaching their full potential prior to 3 years.

Maternal Child and Family Health Nurses Australia (MCaFHNA) supports this approach.

b. Vision

The Strategy's vision will describe the Commonwealth Government's aspirations and ambitions for children in the early years. The Strategy's vision will describe how we want the next generation of Australians to experience their first five years of life. It will be informed by what we hear from the Australian community about what they want for young children in Australia, especially in the critical years from before birth to age five.

Note: the vision for the Strategy is intended to be broader than the vision for the ECEC sector that the Commonwealth Government is developing in collaboration with State and Territory Governments. The Strategy's vision should encompass aspirations for children across all aspects of their lives.

QUESTION
2. What vision should our nation have for Australia's youngest children?

The provision of universal well-child health and development programs, to meet the fundamental needs of all children, is generally recognised as central to the improvement of most population outcomes across Australia and many other developed countries (Robinson, Silburn, & Arney, 2011; Australian Government Department of Health [DoH], 2013; McLean et al, 2014; Newham et al, 2020). The importance of this approach is demonstrated by the implementation of guidelines that aim for a universal reach approach seeking to maximise health, development, and well-being outcomes for children (Australian Health Ministers' Advisory Council, 2011; COAG, 2009; McLean et al, 2014).

One of the essential criteria is to be able to identify a problem prior to it causing symptoms. Recent models of universal well-child health and development programs have evolved from an emphasis on monitoring growth and screening for physical disorders to evidence supporting early intervention which includes comprehensive surveillance of development and health together with health promotion activities (Oberklaid et al, 2002; Department of Health and Human Services [DHHS], 2019a). Current models now seek to enable early identification and management of problems, promote protective factors, and identify and ameliorate risk factors (Rossiter et al, 2018). The National Framework for Universal Child and Family Health Services (Australian Health Ministers' Advisory Council, 2011) supports this process as offering opportunities to positively impact the growth and development of children.

Central to providing a program that is responsive to the needs of families, a universal framework should integrate current evidence into a schedule of periodic visits with targeted interventions such as additional consultations; telephone consultations; groups; and community-strengthening activities. This program should also provide flexibility in service delivery (Rossiter et al, 2018; DHHS, 2019a, Pote et al, 2019).

c. Outcomes

An outcome should describe what the Strategy will achieve. There are a range of outcomes that children need to do well in life. The Strategy will identify the most important short, medium and long term outcomes to support the early years.

The type of outcomes the Strategy could include might be statements about children being physically and emotionally healthy, learning and developing, being safe or having a positive sense of identity. It could also include references to meeting basic needs or having opportunities to participate in social and community activities, acknowledging culture or ensuring that the early years are inclusive of different families and their needs.

There are many interconnected factors that contribute to good outcomes in the early years. This question asks you to think about the outcomes that should be included in the Strategy.

QUESTION
3. What mix of outcomes are the most important to include in the Strategy?

MCaFHNA puts forward the following outcomes for consideration:

1. Child Health programs are standardised across all States and Territories

With evidence demonstrating that more effective and systematised child health services are required to deliver measurable improvements in the outcomes for children (United Kingdom Department of Health, 2013), standardisation in the delivery of a routine child health program is required, which incorporates current evidence, to provide a more effective, efficient, and systematised child health program.

Although Australia has a universal health care system, there is no standardisation in the **content** or **context** of state and territory child and family health programs. This issue extends further to include the **number of contact visits** required to achieve outcomes as well as the **'what' within those contact visits**.

Currently each State/Territory also have their own version of the Parent held Child Health Record Book. In addition to this print version, providing a digital copy of a national Child Health Record would enable health practitioners to complete information for the caregiver irrespective of whomever attends the visit with the infant and whether they have the print version of the child's book with them.

When a program aims to 'improve outcomes for all children' and, importantly, to 'reduce inequalities in outcomes between groups of children' (Council of Australian Governments, 2009), the use of different well child health assessments and schedules across States and Territories, create a lack of consistency in what constitutes 'best practice' in child health services and for families about what is most important in terms of health care for infants, toddlers and young children.

Equity is widely acknowledged to be an important policy objective in the health care field and equality should feature prominently in health policy decisions. Differences between child health programs create barriers. Standardization in child health programs will ensure equality is achieved by providing all children with a standardised program through a key contacts schedule. In this way, equity can only be realised if equality is achieved first, i.e., all children have access to the same standardised program, irrespective of where they live.

Randomised clinical trials have repeatedly found that while development of a positive alliance (therapeutic relationship) is one of the best predictors of outcomes (Kopta, Leuger, Saunders, & Howard, 1999), establishing a therapeutic alliance or relationship takes time. Therefore, the majority of occasions of service or schedules

visits/assessment should occur within the first 12 months after birth. The remainder of the key contacts should occur at 6 monthly intervals which enables the therapeutic relationship to continue as well as facilitates surveillance of 'well child' growth and development: parenting education and support, and health promotion (Leitner, 2001; Hagan, Shaw and Duncan, 2017). With anticipatory guidance underpinning this framework, it reinforces that families are primarily responsible for raising their children and that health services support this process.

2. Child Health key milestone checks are mandatory.

Child Health services are a key component of Primary Health Care. Based on evidence that the foundations for lifelong health, productivity and wellbeing are laid in childhood, the health sector has an important role to ensure that children not only survive but thrive (World Health Organization and the United Nations Children's Fund (UNICEF), 2021).

Currently attendance/engagement with Child Health Services across Australia are voluntary (unless there is Child Protection Service involvement). With an outcome to "children being physically and emotionally healthy", having key milestone checks made mandatory provides the best opportunity to build strong foundations for optimal development and early identification of risk and protective factors known to influence health outcomes and implementing early interventions for maximising healthy development. (Department of Health, 2019; Moore, Arefadib, Deery & West, 2017).

Participation in child health services can be an important protective factor in the lives of vulnerable children. Child vulnerability is not caused by a single contributing factor, but the interaction of several over time. Children who are developmentally vulnerable can be found across the entire socioeconomic spectrum. In addition to supporting the health and development of children, child health services also act as an important gateway to other secondary and tertiary services, informal supports and services i.e., supported playgroups – all which play an important role in identifying vulnerable children (State of Victoria, 2013).

It is globally recognised that children who start school with developmental vulnerability have lifelong consequences. With AEDC scores, nationally showing the percentage of children who were on track in 5 domains decreased for the first time since 2009 and around 1 in 5 children were developmentally vulnerable in one or more domains (Australian Early Development Census, 2022) the need for early intervention is critical.

Like the Australian Immunisation program, key milestone checks could be linked to family assistance payments such as Family Tax Benefit (Part A) and Child Care Subsidies.

3. National Child Health Information System database is created (or ability to interact with each other)

With all States and Territories using different child health information systems, there is currently no effective means to collect relevant outcome data i.e., national breastfeeding rates, developmental assessment results etc.

The Victoria Department of Health and Human Services MCH Service Guidelines

(2019) has a mission "to engage with all families [in Victoria] with children from birth to school age to take into account their strengths and vulnerabilities, and to **provide timely contact** and **ongoing primary health care** in order to improve their health, wellbeing, safety, learning and development" (pp.5). When contact history is unable to be shared across jurisdictions, vulnerability is increased.

4. National minimum standard (i.e. qualifications) to practice as a Maternal Child Family Health Nurse[1] is established.

Children, caregivers and their families have the right to equal access to high-quality services and care. MCaFHNA recognises that maternal, child and family health nursing require a highly specialised skill set gained only through practice as a registered nurse (RN). It is MCaFHNA position that this minimum qualification of a Bachelor of Nursing or equivalent is foundational, with completion of a further postgraduate qualification, through a recognised tertiary institution, to maintain a Maternal, Child and Family Health Nurse (MCFHN) position. Further, families who utilise child health service expect to receive care commensurate with these qualifications. Unfortunately, across States and Territories, there is no minimum standard to practice as a Maternal Child Family Health Nurse in Australia, only that there is current registration with Australian Health Practitioner Regulation Agency (AHPRA). AHPRA, through the Nursing and Midwifery Board of Australia, works to ensure that Australia's nurses and midwives are suitably trained, qualified and safe to practice and only recognise nursing and midwifery qualifications.

For example:

NSW Health Local Health Districts (LHD) advertise CFHN positions to include the RN with evidence of current APHPRA registration and recency of practice, however, there are some LHD's who do not identify the specific CFHN qualification within the advertisement and will accept an RN. Some of the advertisement wording may include- 'willingness to complete a CFHN qualification', however completion of this qualification is not always reviewed or followed up.

[1] MCaFHNA recognises that different jurisdictions across Australia have different titles for Maternal Child and Family Health Nurses (MCaFHN) i.e., VIC, ACT - Maternal and Child Health Nurse; NSW, SA, NT, TAS - Child and Family Health Nurse; QLD, WA - Child Health Nurse. For the purpose of this submission, the title MCFHN is used to encompass all titles.

In both South Australia and Queensland, registered nurses can hold the title "Child and Family Health Nurse" but not necessarily have (or required to obtain) a postgraduate qualification that supports the title.

In the ACT, the MACH (Maternal and Child Health) nurse must be a registered nurse, with further post-graduate qualifications in the specialty of child and family health nursing. The mandatory minimum qualification in the ACT is a Graduate Certificate in Child and Family Health Nursing; however, a Graduate Diploma is preferred qualification to prepare nurses for the complexity and breadth of the MACH role.

In Western Australia, essential criteria for working as a 'Child Health Nurse' include registration in the category of Registered Nurse by the Nursing and Midwifery Board of Australia and a child health postgraduate certificate or equivalent. However, in remote/regional areas; "Possession of or substantial progress towards the attainment of a certificate in Child & Community Health Nursing through an accredited institution' is sometimes desirable not essential criteria.

In Northern Territory (NT), the requirements to hold a Child Health Nurse title are current registration as a Registered Nurse with postgraduate qualifications in Child and Family Health or working towards. In recognition that many remote and extremely remote localities are not serviced by specialist Child & Family Health Nurses (CFHN), the current NT Child Health Program (Healthy Under 5 Kids-Partnering with Families -HU5K-PF) is highly manualized and standardised to enable Remote Area Nurse (RAN's) and Aboriginal Health Practitioners to safely practice with support or in consultation with an outreach Child Health Nurse.

Victoria is the only state who has legislation that requires that to practice as a Maternal and Child Health Nurse (MCH), an MCH nurse is required to hold current registration with AHPRA as a Registered Nurse (Division 1); a Registered Midwife, and in addition to the above registrations, hold an accredited postgraduate degree/diploma (or equivalent) in maternal and child health nursing.

The National Standards for Practice of Maternal, Child and Family Health Nurses in Australia (Grant, Mitchell, & Cuthbertson. 2017), recognise the unique qualities of practice in each jurisdiction to maintain quality and safety in practice. The Standards of Practice for MCFHN's also articulate that the qualification of Registered Nurse (RN) is the foundational qualification needed to be able to care for infants, children and families (including a variety of caregivers) from birth to school entry.

With the aim of Maternal Child and Family Health nursing being to optimize the health, development and wellbeing of young children - then infants, children and families are entitled to, and should, expect to receive the highest quality care from appropriately qualified staff.

5. MCFHN become (limited) eligible health professionals recognised for Medicare services

MCFHN's do not have the ability to apply for a Medicare provider number as an eligible health professional recognised for Medicare services.

Currently, the only way a MCFHN can refer to a specialist (i.e., Paediatrician) is through a General Practitioner. This pathway can cause unacceptable delays in referral if a family does not have access to a General Practitioner (GP).

For example, rural, remote and very remote locations where timely access to a General Practitioner is challenging. Of greater concern, is when GPs dismiss the concern held by the MCFHN and do not progress the referral.

In addition, there is also a financial burden to families in this process, especially with the current contraction of bulk billing services (these are only available to Health Card Concession-HCC- holders) i.e., families who do not have a Medicare card (Visa status, refugee etc.), or middle/lower income who are ineligible for a HCC. Without recognition of MCHFNs as an eligible health professional (recognised for Medicare services), families must pay the full fee of a specialist appointment as there is no Medicare rebate available to them.

Families are wanting to act on a MCFHN concern and referral. In most jurisdictions, waiting lists are prohibitive and as families also need to go through a GP to access a referral, this delay is lengthened further. Enabling MCFHNs to become eligible health professionals recognised for Medicare services, to directly refer to a Paediatrician where a developmental delay has been identified through an appropriate screening tool - either ASQ3 or Brigance (Australian Health Ministers' Advisory Council, 2011) - is crucial for early diagnosis and intervention.

6. Address barriers for accessing NDIS, between States and Territories.

Ensure access for early intervention is accessible in all jurisdictions and within a timely manner (i.e. within 3 months) for all children under school age). A consistent approach to early intervention services.

d. Policy priorities

For the Strategy to be effective, it is important to identify specific areas (policy priorities) where the Government should focus its efforts.

One area that the Government has already identified as a priority is for the Commonwealth Government to address and break down silos. If there is not a coordinated, joined up approach across Government, there is a lack of ultimate responsibility and accountability for Australia's children. A siloed approach also risks duplicating functions, unnecessary competing for resources and missing opportunities to work collaboratively to improve outcomes.

Some priorities will emerge as the vision and outcomes for the Strategy take shape. We welcome early ideas on priorities for the Strategy.

QUESTIONS
4. What specific areas/policy priorities should be included in the Strategy and why?
5. What could the Commonwealth do to improve outcomes for children—particularly those who are born or raised in more vulnerable and/or disadvantaged circumstances?
6. What areas do you think the Commonwealth could focus on to improve coordination and collaboration in developing policies for children and families?

4. What specific areas/policy priorities should be included in the Strategy and why?

MCaFHNA seeks to have the following recognised as areas of priority (further information including rationale - See Q3)

Child Health Program

- Child Health programs are standardised across all States and Territories, including national agreement of key milestone checks:
  - Based on Early years evidence i.e., most appts in first year of life, tapering off to minimum of 6 monthly from 2 yrs.
  - that they incorporate pathways that are easily accessible with affordable early intervention when it is needed.
- Key milestone checks are mandatory.
- Common data system –critical for documentation of infants and children across States and Territories (vulnerable children/families can be followed and supported irrespective of where they live in Australia) both for undertaking assessments and documenting finding and for obtaining program outcomes.

Workforce

- Minimum standard of qualifications to practice as a Maternal, Child and Family Health Nurse
- MCFHN becomes eligible health professional recognised for Medicare services

5. What could the Commonwealth do to improve outcomes for children—particularly those who are born or raised in more vulnerable and/or disadvantaged circumstances?

- Standardise child health programs and make them mandatory to attend.
- Ensuring that Child Health Programs (Universal) explicitly follow the child not the parents i.e., the child is the primary client, not the parent/caregiver.

  This is of particular importance for Children in Out of Home Care (OOHC)

  - These children are extremely vulnerable and are often associated with child protection.
  - Training for OOHC caregivers - children rely on their appointed caregiver, who may not have any children themselves, and are often not aware of key milestone checks nor the importance of having them done.
  - Due to changes in jurisdiction and caregivers, they do not receive the same quality of health care and quantity of checks.
- Improve access (waiting lists) to allied and tertiary services when physical or developmental concerns are identified.

6. What areas do you think the Commonwealth could focus on to improve coordination and collaboration in developing policies for children and families?

   The commonality in themes will cross jurisdictions i.e.

   - Early intervention
   - Developmental delay
   - Partnerships
     - Providing services/intervention where children are i.e. Early Learning Centre's (ELC); Home day Care 3 yr Kindergarten,
     - Hub model to provide specialist services i.e. Paediatrician, Speech Pathology, Psychology, Physiotherapy – bulk billed – based on vulnerability, not income/socioeconomic status
     - Key initiatives delivered through place-based programs i.e., through hospitals in the antenatal period, through Maternal Child Family Health services, through childcare, through kinder, primary, and secondary schools.
     - Use partnerships between key organizations to deliver a stronger message.

   Media Campaigns funded for nationwide promotion of key messages i.e.,

   - breastfeeding messages – normalisation of breastfeeding an infant as well as the health benefits to women in later life (health adverse effects if not breastfeeding – i.e., childhood obesity, increase risk of some cancers etc)
   - normalising infant development – sleep and feeding, the introduction of solids, infant movement (rolling, sitting, crawling, walking)

e. Principles

A set of principles will be developed to guide policy and implementation under the Strategy.

Guiding principles could include things such as being child and family centred, listening to the views of children and families, and being inclusive of diverse children and families. They could also consider the needs of children and families across the service system and over time.

QUESTION
7. What principles should be included in the Strategy?

Cohort-specific, responsive and targeted interventions and universal services – all tailored to the specific needs of a particular life stage that is equity-sensitive and gender-responsive.

Uniformity of Child Health Services across States and Territories

f. Evidence-based approach

Researchers and practitioners have developed many frameworks to guide policy and practice for the early years. These models or frameworks highlight how different parts of a child's life work together to contribute to positive childhood outcomes. Some of these are described below.

The purpose of these frameworks is similar – to put children at the centre of all policy development and show the interconnections and important elements of early childhood development. These frameworks may help shape the Strategy. Examples include the public health model, ecological systems theory, the Australian Research Alliance for Children and Youth child wellbeing framework (the Nest), and the Organisation for Economic Cooperation and Development (OECD) well-being frameworks. Further information about example frameworks is listed below. It's important to note these frameworks are not the only source of evidence and data that will be drawn upon. The Strategy will recognise the importance of Aboriginal and Torres Strait Islander knowledge bases, recognising there are gaps in current evidence and data, a key priority under the current Closing the Gap Agreement.

- The public health model identifies areas of risk in children's development and prevents problems before they occur by addressing that risk. The model provides different levels of support, from universal services available to everyone to highly targeted offerings. Universal services include things like our health and education systems; targeted (or secondary) services include policies such as parental leave; and tertiary services address acute issues such as child protection[xxi].

- The ecological systems theory developed by Urie Bronfenbrenner shows

a child's development is influenced by their surrounding environment, which ranges from a child's immediate environment, through their family, community, and up to the influence of society[xxii].

- The Nest conceptualises wellbeing as six interconnected domains that support each other to help children both thrive in childhood and reach their full potential as they grow. To have optimal well-being, a child needs to have their needs met in all six domains, in an ecological model based on Bronfenbrenner's[xxiii].

- The OECD has two key frameworks for measuring well-being. The first is a general well-being model that considers diverse experiences and living conditions of people and is built around three components, including current well-being, inequalities in wellbeing outcomes and resources for future wellbeing (Figure 1). A second more recent framework developed by the OECD is an aspirational model to pinpoint the aspects of children's lives that should be measured to best monitor their well-being (Figure 2). It is centred on the idea that children should be able to both enjoy a happy childhood and develop skills and abilities that set them up for the future[xxiv].

QUESTION
8. Are there gaps in existing frameworks or other research or evidence that need to be considered for the development of the Strategy?

In the Guide to the National Quality Standard (Australian Children's Education and Care Quality Authority (Australian Children's Education and Care Quality Authority [ACECQA], 2013), there is an acknowledgement that the drive to change the focus to the early years is based on clear evidence that this period of children's lives is very important for their present and future health, development and wellbeing.

Theories provide a framework for the development of interventions. However, theories taken alone without connection are of little value to practice and single theories will inevitably focus attention on just part of the set of influences that shape the health and well-being of the developing child (Olds, 2005). To fully appreciate and make effective use of these theories, they must be understood as both individual conceptual constructs and also as bodies of thought that are inter-influencing, interconnecting, and interlocking. It is not possible to separate theory (concept) from practice (action) so to be effective, theory and practice must be interconnected (Turner, 2011).

There are three main foundational theories of human development. These theories form the framework that strengthens the capacity and parenting practices of caregivers by emphasising the importance of child development and wellbeing. As such, all are considered critical in Child Health programs.

These three theories are:

- Attachment theory - emphasises interaction and changes between caregiver and children.

  John Bowlby's theory of attachment is now accepted as a vital component of social and emotional development in the early years (Zeanah & Smyke, 2008). Research on attachment indicates that infants are biologically preprogramed to attach but it is the quality of that attachment that is crucial to emotional development of the infant and young child.

  Attachment and bonding are both phrases used to describe the early intimate interactions between caregiver/s and the infant. However, attachment is not bonding. Simply, bonding refers to a caregiver's response to the infant versus attachment, which refers to the infant's relationship with the caregiver (Kruske & Donovan, 2009). This distinction is important as bonding has not been shown to predict any later child outcomes, whereas attachment is a powerful predictor of a child's later social and emotional outcomes (Benoit, 2004).

- Self-efficacy theory - emphasises processes and change that occur within the caregiver.

  Albert Bandura's Self-efficacy theory argues there is a single process which underlies all behaviour change: the changing of efficacy expectations. Self-efficacy is an individual's belief in their ability to accomplish certain tasks (efficacy expectations) and that doing so will lead to a desired outcome (outcome expectations). Bandura (1977, p.193) described efficacy expectations as the individual's" conviction that one can produce the behaviour" while outcome expectations are the individual's belief that a "given behaviour will lead to certain outcomes".

  According to Bandura (1977), self-efficacy is a constantly evolving process with these beliefs begin to form in early childhood through a wide variety of experiences, tasks, and situations and continue to evolve throughout life as individuals acquire new skills, experiences, and understanding and become more confident that they can accomplish a task (Ainsworth, 1979; Bandura, 1986).

- Human ecology theory - emphasises the reciprocal relationships between individuals and the multiple environments in which they live.

  Bronfenbrenner (1977, p.525) also suggests that within these complex systems of influence and changes are windows of opportunity that he calls "ecological transitions". These windows occur when there are changes in an individual's social position, resulting from a change in either role or environmental setting. Further, these periods of transition instigate further development or can be consequences of new development.

  The importance of these periods of transition in child health programs is that it

is during this time of developmental change that the child’s caregiver may be more open to support which can then lead to behavioural change.

Reference List

Ainsworth, M. D. S. (1979). Infant-Mother Attachment. American Psychologist, 34(10), 32-937.

Australian Children's Education and Care Quality Authority. (2013). Guide to the National Quality Standard. Sydney: Australian Children's Education and Care Quality Authority.

Australian Institute of Health and Welfare 2011. *National outcome measures for early childhood development: development of an indicator-based reporting framework*. Cat. no. PHE 134. Canberra: AIHW. Retrieved from: <https://www.aihw.gov.au/getmedia/4b41f3af-33aa-4ad7-b867-fe4f9ef51a6e/12424.pdf.aspx?inline=true>

Australian Government Department of Health (2013) *National Framework for Universal Child and Family Health Services*. Retrieved from: <https://www1.health.gov.au/internet/publications/publishing.nsf/Content/nat-fram-ucfhs-html~framework~health-development>

Australian Health Ministers' Advisory Council. (2011). National Framework for Universal Child and Family Health Services. Canberra: Australian Government Department of Health and Ageing. Retrieved from: <http://www.health.gov.au/internet/main/publishing.nsf/Content/AFF3C1C460BA5300CA257BF0001A8D86/$File/NFUCFHS.PDF>

Bandura, A. (1977). Self-efficacy: Toward a unifying theory of behavioral change. Psychological Review, 84(2), 191-215.

Bandura, A. (1986). Social foundations of thought and action: A social cognitive theory. Englewood Cliffs: Prentice Hall.

Benoit, D. (2004). Infant-parent attachment: Definition, types, antecedents, measurement and outcome. Paediatric Child Health, 9(8), 541-545.

Bronfenbrenner, U. (1977). Towards an experimental ecology of human development. American Psychologist, 32(7), 513-531.

Council of Australian Governments. (2009). *Investing in the Early Years-A National Early Childhood Development Strategy*. Canberra: Commonwealth of Australia. Retrieved from: <https://www.startingblocks.gov.au/media/1104/national_ecd_strategy.pdf>

Department of Education (2022) Australian Early Development Census. Canberra, Australian Government. Retrieved from: <https://www.education.gov.au/child-care-package/early-childhood-data-and-reports/australian-early-development-census-aedc#toc-key-findings-for-the-2021-aedc

Department of Health. National Action Plan for the Health of Children and Young People 2020-2030. Department of Health. Australia. 2019.

Department of Health and Human Services (2019a). *Maternal and child health program standards*. Melbourne: Victorian Government. Retrieved from:

<https://www2.health.vic.gov.au/about/publications/policiesandguidelines/maternal-child-health-service-guidelines>

Department of Health and Human Services (2019b). Maternal and Child Health Service Guidelines. Melbourne: Victorian Government. Retrieved from: <https://www2.health.vic.gov.au/about/publications/policiesandguidelines/maternal-child-health-service-guidelines>

Grant, J., Mitchell., C & Cuthbertson, L. (2017). National Standards of Practice for Maternal, Child and Family Health Nursing Practice in Australia, Adelaide, Flinders Press. Retrieved March 2023 from https://www.mcafhna.org.au/public/138/files/National%20Standards%20of%20Practice%20for%20MCaFHNA%20(1).pdf

Hagan JF, Shaw JS, Duncan PM, eds. (2017) Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents. 4th ed. Elk Grove Village, IL: American Academy of Pediatrics.

Kopta, S. M., Leuger, R. J., Saunders, S. S., & Howard, K. I. (1999). Individual psychotherapy outcome and process research: Challenge leading to great turmoil or positive transition? *Annual Review of Psychology, 50*(2), 441-469.

Kruske, S. & Donovan, J. (2009). Healthy Under 5 Kids Program Education Package. Darwin: Department of Health and Families and Charles Darwin University.

Leitner, L. M. (2001). The Humanistic Psychologist, 29 (1), 98-113. doi: 10.1080/08873267.2001.9977009.

McLean, K., Goldfeld, S., Molloy, C., Wake, M., & Oberklaid, F. (2014). *Screening and surveillance in early childhood health: Rapid review of evidence for effectiveness and efficiency of models*. Haymarket: The Sax Institute.

Moore T, Arefadib N, Deery A, West S. (2017). The First Thousand Days: An Evidence Paper. Victoria. Centre for Community Child Health, Murdoch Children's Research Institute..

Newham, James. J., McLean, Karen., Ginja, Samuel., Hurt, Lisa., Molloy, Carly., Lingam, Raghu. And Goldfeld, Sharon. (2020). *Brief evidence-based interventions for universal child health services: a restricted evidence assessment of the literature*. BMC Public Health 20:993 <https://doi.org/10.1186/s12889-020-09104-7>

Oberklaid, F., Wake, M., Harris, C., Hesketh, K. and Wright, M. (2002). *Child Health Screening and Surveillance: A Critical Review of the Evidence*. Canberra, ACT: National Health and Medical Research Council. Retrieved from: <https://www.rch.org.au/uploadedFiles/Main/Content/ccch/EY_mod3_Ob.pdf>

Olds, D. (2005). The Nurse-Family Partnership Foundations in Attachment Theory and Epidemiology. In L. J. Berlin, Y. Ziv, L. Amaya-Jackson, & M. T. Greenberg (Eds.), Enhancing Early Attachments: Theory, Research, Intervention and Policy (pp. 217-249). New York: Guilford Press.

Pote, I., Doubell, Lara., Brims, Lucy., Larbie, Judy., Stock, Laura and Lewing, Ben. (2019). *Engaging disadvantaged and vulnerable parents An evidence review*. London: Early Intervention Foundation. Retrieved from: <https://www.eif.org.uk/reports/engaging-disadvantaged-and-vulnerable-parents-an-evidence-review>

Robinson, G., Silburn, S. R., & Arney, F. (2011). A population approach to early childhood services: Implementation for outcomes. Topical paper commissioned for the public consultations on the Northern Territory Early Childhood Plan. Darwin: Northern Territory Government.

Rossiter, Chris., Fowler, Catherine., Hesson, Amiee., Kruske, Sue., Homer, Caroline. S.E., and Schmeid, Virginia. (2018). *Australian parents' use of universal child and family health services: a consumer survey*. Health & social care in the community, 27(2), 472–482. <https://doi.org/10.1111/hsc.12667>

State of Victoria, (2013). Victoria's Vulnerable Children; our shared responsibility, Melbourne: State of Victoria.

Turner, F. J. (Ed.). (2011). Social work treatment: Interlocking theoretical approaches. New York: Oxford University Press.

United Kingdom Department of Health. (2013) *Improving Children and Young People's Health Outcomes: a system wide response.* London: United Kingdom Department of Health. Retrieved from: <https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/214928/9328-TSO-2900598-DH-SystemWideResponse.pdf

World Health Organisation. Investing in our future: a comprehensive agenda for the health and well-being of children and adolescents. Geneva: World Health Organization and the United Nations Children's Fund (UNICEF), 2021. Licence: CC BY-NC-SA 3.0 IGO. Retrieved from <https://www.who.int/publications/i/item/9789240037793>

Zeanah, C. H., & Smyke, A. T. (2008). Attachment disorders in family and social context. Infant Mental Health Journal, 29(3), 219–233.