Australian Nursing Federation (Victorian Branch)

Submission to the Parliament of Australia:

Senate Inquiry into Commonwealth Funding and Administration of Mental Health Services

5 August 2011

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Recommendations

1. The Senate committee should recommend that the Australian Government collaborate with stakeholders, including ANF, to ensure all investments in the Mental Health Sector results in greater transparency and accountability in funding, to ensure that every dollar spent is focused on the quality of care for all Australians, and to ensure that the problems in the Aged Care Sector are not replicated within mental health.

2. The Senate Committee should recommend that wherever evidence exists regarding Health Professional Workforce requirements to deliver the new initiatives, these must be implemented. National investment should not result in the substitution of qualified health professionals with those who are not regulated by the Health Practitioner Regulation National Law Bill 2009.

3. Nurses and Midwives must be represented by ANF in relation to planning and implementation of the Federal Budget 2011 Mental Health initiatives.

4. ATAPS initiatives enable crucial treatment services to be provided to people in the community. These are provided by mental health nurses and other allied health professionals. The increased investment to this model must be widely implemented.

5. The Mental Health Commission is proposed to "provide leadership, drive a more transparent and accountable mental health system and give mental health national prominence"(Budget 2011-2012 Delivering better hospitals, mental health and health services page 11). The Senate Committee should recommend that all health professions are involved, with at least one position within the Commission being allocated to the ANF to represent nurses and midwives.

6. ANF urges the Senate Standing Committee on Community Affairs to recognise and value the unique contributions of all Health Professionals, including nurses and midwives, throughout any proceedings related to the Inquiry into Commonwealth Funding and Administration of Mental Health Services.

Introduction

Established in 1924, the Australian Nursing Federation (ANF) is the largest professional and industrial organisation in Australia for nurses, midwives and assistants in nursing with over 205,000 members. The ANF has Branches in each State and Territory of Australia. ANF participates in the development of policy relating to nursing and midwifery practice, professionalism, regulation, education, training, workforce, and socio-economic welfare, health and aged care, community services and primary health care including reform agendas, veterans' affairs, occupational health and safety, industrial relations, social justice, human rights, immigration, foreign affairs and law reform.

The core business for the ANF is the professional and industrial representation of our members who actively contribute to a vision for all communities to have improved access to quality nursing care and advocate for the right balance of nursing skills and services across all sectors.

The ANF Victorian Branch (VB) has more than 61,000 members statewide. Our nurses and midwives work across all areas of healthcare and community services, including but not limited to, public and private specialist mental health services, alcohol and other drug services and programs, rehabilitation and sub acute care, prisons and the justice system, primary and secondary schools, primary health including general practice clinics, district nursing and community health centres, maternal and child health, and hospitals inclusive of emergency departments, medical, surgical, other specialist services such as oncology, palliative care, aged care and midwifery. The diversity of our member's workplaces highlights the wide range of settings where registered nurses and midwives are providing health services to people experiencing an alteration in mental health. At any time, nursing practice can incorporate dimensions of health promotion; preventative approaches; early intervention across the lifespan; assessment; nursing diagnosis and the provision of evidence based treatments for illnesses.

ANF (VB) welcomes the opportunity to provide a submission for the consideration of Senators in reference to the Inquiry into Commonwealth Funding and Administration of Mental Health Services. Members are generally supportive of the Federal Budget announcements to increase funding into the sector and recognise that many of the initiatives will require the direct support and involvement of the nursing profession for such visions and reforms to be delivered to the Australian community successfully.

Nurses have a strong history of contributing to reforms, and remain passionate about their commitment to the community, including improvements which are designed to facilitate better outcomes for all people accessing mental health care.

The ANF (VB) has lobbied for and achieved direct involvement in policy development, required legislative changes and consulted on planning related to Mental Health reform within this state. Robust workforce strategies were required. ANF (VB) actively represented the nursing profession in the development of Victorian Strategies for the Victorian Mental Health Workforce[1]. We recognise workforce forms part of the scope established by the Senate Standing Committee on Community Affairs. This submission focuses on the areas within the terms of reference that relate directly to Nurses and Midwives.

Brief Background to the Nursing and Midwifery Workforce

The nursing profession forms the largest health professional group in Australia, providing healthcare to people throughout their lifespan, and across all geographical areas of Australia. Nurses and midwifery professions constitute more than half the health and aged care workforce in Australia[2]. Nurses and midwives, as part of self-regulated health professions, are autonomous providers of nursing care as legislated under the *Health Practitioner Regulation National Law Bill 2009*[3] and regulated in accordance with the Australian Health Practitioner Regulation Agency (AHPRA) by the Nursing and Midwifery Board of Australia (NMBA). This means that they have independent authority to act within their scope of practice and they are accountable for their own clinical decision-making and the outcomes of their actions when providing healthcare.

Registered nurses and midwives undertake a minimum three year undergraduate education program in the university sector which leads to registration. A national project was established in 2005 to improve the future delivery of mental health content in undergraduate/pre-registration nursing courses in Australia, with an agreed intention to increase all nurses' fundamental knowledge and skills in relation to mental health and well being. The final report was published in March 2008, by the Mental Health Nurse Education Taskforce[4]. When all of the recommendations are implemented, it is anticipated nurses in the future will have an increased understanding, knowledge and skill set in foundational mental health.

Following this initial preparation, there are a plethora of post graduate programs which can be undertaken by nurses and midwives which enhance their ability to provide safe and competent care. Specialisation pathways result in highly qualified, skilled and experienced Registered Nurses working within a range of health care settings. Additional qualifications specific to mental health nursing are available via postgraduate studies commencing from certificate level to doctorate qualifications. In addition, all nurses and midwives must engage in continuing professional development activities to maintain competence and this is now recognised under the NMBA Continuing Professional Development Registration Standard[5] for the purposes on ongoing annual registration.

In 2008 the ANF, in conjunction with the Australian Practice Nurses Association, the Australian College of Nurse Practitioners, Royal College of Nursing, Australia and the Australian College of Mental Health Nurses, developed a consensus statement in relation to the role of the registered nurse and nurse practitioner in primary health care[6]. This statement has some pertinent points to make about the role of registered nurses in the health workforce and can be located in Appendix 1.

Mental Health Nursing

Mental health nursing is one of the specialties of nursing, with a focus on Mental, Physical and Spiritual Health utilising pharmacological, therapeutic and social interventions. ANF members report that this specialty has moved beyond the traditional work practices, where the focus was on *psychiatric symptoms*, to encompassing the totality of an individual's mental health and wellbeing across the lifespan. The Australian College of Mental Health Nurses (ACMHN) defines a mental health nurse as 'a Registered Nurse who holds a recognised specialist qualification in mental health nursing"[7]

Mental health nurses have specific qualifications and expertise directly related to the provision of clinical mental health care. Modern mental health nursing care must be evidence based, therapeutic and purposeful to the consumer, and can fall into a continuum ranging from psychiatric illness to mental health. It incorporates collaborative evaluations of interventions, ensuring that therapeutic change and recovery can be achieved. In clinical practice, mental health nurses are required to utilise nursing theory, inclusive of the psychiatric/mental health paradigms when commencing individual assessments, formulating mental health care and recovery plans and initiating and providing specialist nursing interventions.

In Victoria, mental health nurses represent more than 65% of the clinical mental health workforce[8]. Mental health nurses also utilise approaches that may be targeted towards health promotion, illness prevention, early intervention (across all age groups) and acute intervention and recovery. Work environments are diverse and span across private and public health settings and community organisations. People may engage with mental health nurses within hospitals, emergency departments, residential or sub acute care settings, community based programs, schools, homeless persons outreach programs, Divisions of General Practice or medical clinics, adolescent health and HEADSPACE centres, primary health care environments including community health centres and more recently, within private practice suites as mental health nurses attempt to increase the communities access to their expertise.

Senate Inquiry Terms of Reference

This submission does not respond to all elements within the terms of reference. We have focussed our contributions to those which directly impact on members of the nursing profession.

The Government's funding and administration of mental health services in Australia, with particular reference to:

A) The Government's 2011-12 Budget changes relating to mental health;

ANF (VB) applauds the announcements for $2.2billion over 5 years which incorporate new initiates equivalent to $1.5 billion over 5 years. In relation to the nursing profession, ANF (VB) provides the following comments:

I. $343.8 million has been announced for *better coordination and more services for the severely mentally ill.* ANF seeks for this funding to be allocated in accordance with evidence related to similar programs. International approaches have demonstrated that Enrolled Nurses have been most appropriate health professionals to undertake these new roles.

II. Nurses welcome the announcements regarding *improved admission and discharge processes from Emergency Departments*. Our members have continued to lobby for this within Victoria, and believe that immediate measures to implement this are available to government nationally. At a minimum,

implementation must ensure that every major emergency department has designated mental health nurses on staff, which are in addition to, and work in collaboration with hospital Psychiatric Consultation Liaison Nurses (PCLN) within all major health services.

III. Improved screening for toddlers and children including the proposed *Universal 3 year old health and well being check*. We note that these announcements suggest that an expert group will be established to advise on the implementation of this announcement. Our members are concerned that this component of the budget only attracts $11 million over 5 years, therefore actually provides very limited funding, which should not be spent on forming 'expert groups'. Instead, it must be directed to service delivery which are based on existing services provided for by maternal and child health nurses. ANF (VB) strongly supports that our Victorian Maternal and Child Health Nurses should retain such roles, rather than creation of any 'new worker' to undertake what is part of nurse and midwife care. Victorian Maternal and Child Health Nurses already conduct a series of key neonate/baby or young child assessments in accordance with the *Maternal and Child Health Service: Practice Guidelines 2009* (Department of Education and Early Childhood Development Victoria, 2009). Senators can refer to our attached submission 'Protecting Victoria's vulnerable children inquiry' for more background on this matter, as per Appendix 2.

IV. Announcements regarding an additional 30 *Headspace centers*, aims to increase the overall number to 90 nationally over the coming five years, and the additional $222 million over five years for up to 12 *youth psychosis sites* are welcomed. ANF (VB) is mindful of the important contribution the nursing profession makes to young peoples mental health and wellbeing. Industrially, we are aware of members' entitlement to have certainty regarding their employment within any Headspace centre which must be, as a minimum, consistent with employment provisions for mental health nurses in the public health settings.

B) changes to the Better Access Initiative;

The nursing profession was excluded from these funded arrangements', thereby limiting the communities' access to highly qualified and specialist mental health nurses.

C) The impact and adequacy of services provided to people with mental illness through the Access to Allied Psychological Services (ATAPS) program;

ATAPS is a component of the Better Outcomes in Mental Health Care (BOiMHC) Program which was introduced in 2003 to:

- *Produce better outcomes for consumers with common mental disorders of mild to moderate severity through offering evidence based short-term psychological interventions within a primary care setting;*
- *Offer referral pathways for GPs to support their role in primary mental health care;*
- *Offer non-pharmacological approaches to the management of common mental disorders; and*
- *Promote a team approach to the management of mental disorders.*[9]

ATAPS initiatives include crucial treatment services to people in the community, which are able provided by mental health nurses and other allied health professionals. Our members who currently work with the community under this arrangement welcome the increased investment to this service model. In addition, they are seeking for ANF to be directly involved in the National project related to implement the expansions of this funding.

E) Mental health workforce issues, including workforce shortages;

ANF (VB) has provided the Senate Committee our recommendations which were provided to the Victorian Government. Most of these, with regards to the nursing profession, were agreed and directly converted into the state Shaping the Future: the Victorian Mental Health Workforce Strategy: Final Report released in September 2009. **1**

The focus area of workforce is key to the reforms. Victoria has a registered nursing workforce of 87,700 registered nurses. Approximately 3,000 of these work in specialised mental health. We recommend a range of strategies to strengthen this critical mass of specialised nurses, and to address anticipated attrition rates over the next ten years as a result of retirement of those aged 50 plus.

1. We recommend that the contribution (both actual and potential) of the remaining 84,000 nurses who work in non specialist mental health settings be recognised and promoted. These nurses, by virtue of their underpinning knowledge and the context of their work, provide non-specialist mental health care as part of holistic nursing care.

   This is particularly apparent in specialties such as midwifery, maternal and child health, rural and remote, school nursing, drug and alcohol, emergency, medical, surgical, rehabilitation, palliative care, aged care, district nursing, general practice clinics, community health, prisons and the justice system, occupational health and those working with the Homeless Persons Programme, auspiced by the Royal District Nursing Service, and similar programs through the Royal Children's Hospital. However, we contend all nurses regardless of setting undertake non-specialist mental health nursing, and provide a great opportunity for the integration of mental health care. Such a workforce needs access to evidence based mental health promotion and early intervention to ensure maximum effectiveness.

   We recommend funding be allocated to enable all nurses to have access to education to enable them to undertake mental health assessments, provide initial interventions and ensure referral/access to specialist mental health services when required.

2. Changes in the scope of practice of Enrolled Nurses (EN) must be facilitated. Those ENs with medication endorsement can take on a wider role and the utilisation of these ENs in all areas of Mental Health requires further implementation and evaluation.

3. The existing Government financial incentives for encouraging nurses back into the workforce should be the subject of a renewed campaign particularly in relation to Mental Health. Those nurses who have previously worked in Mental Health or those with Mental Health qualifications should be directly approached with a view to encouraging them to return.

4. An increase in undergraduate University places for nursing and increased clinical placements within mental health services is required.

5. Strategies arrived at improving the conditions/working arrangements of staff in Mental Health are vital in attracting staff to the sector. Attention needs to be given to adequate remuneration as well as the national implementation of mechanisms to ease workload pressures including mandated nurse to patient/client ratios and reasonable caseloads in the community settings.

6. Full fee paying scholarships to:
   a. Enable mental health nurses to upgrade their qualifications to Graduate Diploma and Masters, including Nurse Practitioner,
   b. Enable enrolled nurses to undertake undergraduate study leading to registration as a Registered Nurse, and
   c. Enable nurses not currently employed in Mental Health to obtain specialist mental health qualifications.

7. With respect to the issues of attracting more nurses working in rural areas, some of the abovementioned scholarships could be targeted specifically for work in rural locations.

8. A structured paid undergraduate employment model (based on the ANF Victorian Branch Student Fellowship Agreement) must be available in the mental health sector. The purpose of this scheme is to improve mechanisms for nursing workforce supply, and foster ongoing relationships between the profession and health services at an earlier point than previously possible.

9. Strengthened career opportunities through further career education and training will help retain nurses in mental health. This needs to be facilitated by enhanced professional development time

and a whole of mental health focused training and development program. The option of providing a State-wide Training and Development Units which align to all nationally co-ordinated approaches must be considered.

10. There needs to be an increase in the number of Psychiatric Consultation Liaison Nurses. These highly qualified and skilled mental health nurses work in general hospitals providing advice, support and direction for nurses caring for patients in those facilities who have mental health problems. They provide the link between these services and require an increase in resourcing to facilitate timely advice to nurses and midwives in general hospitals thus meeting the objective of early intervention.

11. Specialist mental health nurses need to be available as consultants for nurses and others working in residential aged care so that they are better able to meet the mental health needs of their residents.

12. Encouragement should be given to the movement of nurses between the various areas within mental health, to foster career development and prevent burnout. Integral to this must be a genuine commitment from the mental health services to enable more experienced nurses to teach/preceptor the less experienced (within guidelines, which include provisions for the experienced preceptor to have a reduction in their clinical load to genuinely increase their availability to preceptor the future workforce).

13. Research needs to be undertaken with respect to the reasons nurses have for leaving mental health. Armed with such data, remedial action can be taken to put in place strategies to overcome the stated reasons revealed in the research.

14. Specific funding and employment support for nurse practitioner candidature is required. Currently, there are only four endorsed Mental Health Nurse Practitioners in Victoria.

15. Ensure clinical supervision is available for nurses working in mental health.

16. Greater integration of health services, to ensure that clients can easily access both physical and mental health services, thereby providing 'the right service at the right time'.

Integration must occur across all sectors, with specialist mental health services, PDRSS, primary care services (both mental health and non mental health), secondary and tertiary health care services. To implement this, ANF offers the following recommendations:

17. Further expansion of mental health services within the general hospitals, commencing with increased and dedicated funding to health services to ensure Psychiatric Consultation and Liaison Nurses are employed

18. Health services encouraged to provide opportunities for graduate nurses to experience working within inpatient and community mental health settings.

19. The provision of combined professional development programs that span across all specialties of health.

20. Continuation of the partnerships between PDRSS and acute health services, incorporating the nursing profession.

21. Build on the strengths of the Primary Care Partnerships, with recognition of the services that have already built successful alliances between the Area Mental Health Services, such as North East Victoria (Wodonga, Wangaratta and Beechworth) and those services that have partnerships between clinical services and PDRSS (about 80). Following this, areas for improvement and further reform may be identified.

22. Evaluation of the integrated Community Mental Health Team Models.

23. Consideration of co-location of some clinical community mental health teams alongside other community health services.

24. Mechanisms are needed to facilitate Primary Mental Health Early Intervention teams working alongside other community nurses, to decrease duplication of effort, and increase continuity of care.

25. Support for the expansion of services for people with eating disorders, and suggest that any further improvements continue to integrate the physical and mental health services for this group. The Royal Children's Hospital has an integrated model which could be applied to other settings.

26. Review documentation requirements, which are sometimes onerous and time consuming, especially when a client moves between services.

27. Good quality, client centred care is resource intensive. Commitment and funding are required for this to occur. We support the notion that when a person is acutely unwell, the role of the clinician should be emphasised.

28. There needs to be a commitment to building capacity within acute areas, as a precursor to any expectation that clinicians increase services in prevention and early intervention

29. We support the initiatives regarding moves to create safety and reduce seclusion within acute inpatient units, and encourage application of these practices to all units and health care environments.

30. Nursing staff working within Community Care Units (CCU) see the need to remain aligned to the health care services. However, there is acknowledgement that some sub-acute mental health services have attempted to decrease the mental health nursing component within them. Improvement in social and housing services for people with mental health needs may see an improvement in the use of CCU's with a greater ability to be a community based mental health service. However, any changed staffing arrangements may have detrimental effects on the ability to retain existing health professionals in the CCU component of the mental health service. ANF (VB) supports the views of mental health nurses that better outcomes for clients are achieved when there are adequate, qualified and specialist nurses working within this community health care setting.

31. ANF seeks an evaluation of the PARC models of care. Nurses working within the specialist services maintain that more clinical staff are required before further expansion of 'step-up' units can be implemented.

32. A better understanding of the legislation in both mental health and the justice system is required by those involved in mental health as well as those working in forensic health. Professional development programs could be developed to achieve this.

Early intervention for all must be a core factor in the reform strategies, not merely for children, young people and their families. Nurses are under utilised in terms of the prevention and early intervention role they could play. Funds need to be allocated to enable early intervention to become a priority and to ensure opportunities for early detection and intervention are not wasted.

33. An increase in Practice Nurses within GP clinics is required. These nurses focus on holistic health assessments, and may provide early intervention in addition to complementing an overall health promotion strategy.

34. Review of Community Treatment Orders with greater emphasis on human rights, ensuring that expectations with regard to rights, equity and respect are met.

G) The delivery of a national mental health commission;

Mental health nurses have long recognised the need for some National co-ordination of investment into Mental Health. ANF (VB) understands the importance for our members to have ANF directly involved with such an initiative, particularly given the intention for the role of leadership and policy directions. Nurses and midwives seek the Senate Committee recommend that all health profession are involved, with at least one position being allocated to the ANF to represent the nursing and midwifery professions.

References

[1] Mental Health and Drugs Division, Department of Health. 2009. *Shaping the Future: The Victorian Mental Health Workforce Strategy Final Report.* Victoria.

[2] Australian Institute of Health and Welfare. 2010. *Australia's Health 2010.* Canberra: AIHW. P 448.

[3] Health Practitioner Regulation National Law Act 2009. (QLD). Available at http://www.legislation.qld.gov.au/publications/index.cfm/title/12017

[4] Mental Health Nurse Education Taskforce (MHNET). 2008. Final report: Mental Health in Pre-Registration Nursing Courses, Melbourne

[5] NMBA CPD Registration Standard

[6] Consensus Statement. 2008. *Registered nurse and nurse practitioner role in primary health care.* Available at www.anf.org.au

[7] Australian College of Mental Health Nursing, 2007, Constitution, Canberra.

[8] Department of Human Services. 2005. Victoria's direct care mental health workers: the public mental health workforce study 2002-04 to 2011-12, State Government of Victoria, Melbourne.

[9] Department of Health Australia. 2011. Discussion Paper Flexible Care Packages For People with Severe Mental Illness: The Access to Allied Psychological Services Component of the Better Outcomes in Mental Health Care Program accessed via the departments website www.health.gov.au

APPENDIX 1

CONSENSUS STATEMENT IN RELATION TO THE ROLE OF THE REGISTERED NURSE AND NURSE PRACTITIONER IN PRIMARY HEALTH CARE

Registered nurses are self-regulated health care professionals who provide care in collaboration with other health professionals and individuals requiring nursing care. Legislation and regulation guide nursing practice. Registered nurses, as qualified licensed professionals, are accountable and responsible for their own actions.

Nurses are entitled to identify the nursing care which they are educated, competent and authorised to provide. Nurses are held accountable for their practice by the nurse regulatory authorities [now NMBA], whose role is to protect the public, as is the case for all other regulated health professions.

As regulated health professionals, registered nurses are not 'supervised' nor do they provide care 'for and on behalf of' any other health care professional. Nurses acknowledge that all health care is a collaborative endeavor focused on positive outcomes for individuals and groups.

Registered nurses are prepared for advanced practice through post registration education, and accept responsibility for complex situations which may encompass clinical, managerial, and educational and research contexts. They provide leadership, initiate change and practise comprehensively as an interdependent member of the team. These nurses have particular breadth and depth of experience and knowledge in their field of practice. Where appropriate, these advanced registered nurses may seek authorisation or endorsement as a nurse practitioner.

The nurse practitioner role is differentiated by their expert practice in clinical assessment, prescribing, referral and diagnostics. These broader practice modalities are enshrined in state and territory legislation [now also national law]. While there are around 300 [now 538] authorised or endorsed nurse practitioners in Australia, only around half of these nurses are employed in nurse practitioner positions and even less are practising to the full scope of their role. Some of the restrictions on nurse practitioner practice are the lack of positions, an

inability for patients to receive subsidised medicines if prescribed by a nurse practitioner (as distinct from a medical practitioner) or rebates from Medicare for nurse practitioner services, limiting their practice and reducing patients' access to affordable, high quality health care.

The numbers of endorsed Nurse Practitioners have almost doubled in the last three years and legislative amendments have allowed for Nurse Practitioners and eligible midwives to access Medicare Benefits Schedule (MBS) rebates and Pharmaceutical Benefits Scheme (PBS) subsidies for the people for whom they provide care.

APPENDIX 2

Australian Nursing Federation (Victorian Branch)

ANF (Vic Branch) Submission to the
Protecting Victoria's Vulnerable Children Inquiry

10 May 2011

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Recommendations

Recommendation 1

ANF (Vic Branch) recommends that in developing policy to prevent and reduce child abuse and neglect government:

- Recognise the crucial significance of the early years of a child's life in respect of future health and behavior outcomes
- Recognise the imperative of early intervention in preventing and reducing child abuse and neglect
- Enhance the capacity of existing primary, secondary and tertiary health and support services to reduce child abuse and neglect through early intervention

Recommendation 2

ANF (Vic Branch) recommends that:

- Specific course content in respect of matters relating to Child Protection be developed and standardised and included in the curriculum of all undergraduate nursing courses or direct entry mental health or midwifery courses
- Inclusion of standardised Child Protection course content be required for course accreditation by the Australian Nursing and Midwifery Accreditation Council (ANMAC)

Recommendation 3

ANF (Vic Branch) recommends that education and professional development opportunities continue to be provided to all maternal and child health (MCH) nurses regarding child protection in Victoria, thereby assisting them to prevent, identify and make effective early intervention around child neglect or abuse.

Recommendation 4

ANF (Vic Branch) recommends that government provide funding to enable full implementation of the measures and strategies to improve collaboration amongst health professionals, health and support services who provide care to vulnerable children as outlined in the ANF (Vic Branch) Submission to the *Protecting Victoria's Vulnerable Children Inquiry*, and as detailed in the Continuity of Care Reference Group document titled *A Framework for communication between Victorian maternity and newborn services, the MCH service, and other service providers.*

Recommendation 5

ANF (Vic Branch) recommends that MCH nurses are deployed in sufficient number at each MCH centre to match demand, thereby ensuring safe workloads and enabling MCH nurses to provide timely and quality care and early interventions to children and families at risk.

Recommendation 6

ANF (Vic Branch) recommends that:

- Funding for the enhanced MCH nursing service be increased through review of the existing funding formula to ensure all families and children identified at risk - or in need of more intensive MCH service - have access to timely and quality care from the enhanced MCH service

- Funding for the enhanced service not be confined to children aged under one year

Recommendation 7

ANF (Vic Branch) recommends that funding of the MCH Line service be increased to ensure sufficient numbers of appropriately qualified MCH nurses are available to provide timely and expert advice to families in need.

Recommendation 8

ANF (Vic Branch) recommends that additional funding be provided to early parenting centres to enhance their ability to provide timely support and intervention, and to better meet increasing demand of families at children at risk in metropolitan Melbourne and throughout rural Victoria.

Recommendation 9

ANF (Vic Branch) recommends that additional funding be provided to mental health mother and baby units to: enhance their ability to provide timely support and intervention; to better meet increasing demand of families experiencing mental ill health; to prevent and provide early intervention of child abuse; and to improve access throughout metropolitan Melbourne and rural Victoria.

Recommendation 10

ANF (Vic Branch) recommends that:

- Qualified maternal child health nurses - who are preferably of Aboriginal or Torres Strait Islander descent – be employed at every Aboriginal Community Controlled Health Organisation (ACCHO)

- Government introduce recruitment and retention measures to increase the number of MCH nurses of Aboriginal or Torres Strait Islander descent through:

  - Providing enhanced scholarships to nurses or midwives of Aboriginal or Torres Strait Islander descent wishing to undertake MCH programs of study

  - Providing MCH nurses and midwives within such services competitive salaries and employment entitlements

- MCH nurses be provided accredited education and professional development in Aboriginal and Torres Strait Islander cultural awareness to ensure they provide culturally competent MCH nursing care and thereby increase engagement of MCH nursing services by mothers and families of Aboriginal and Torres Strait Islander descent

Recommendation 11

ANF (Vic Branch) recommends that additional Primary School Nursing Program (PSNP) nurses be employed within Victorian Primary Schools to: reduce existing PSNP workloads; and enable nurses within the PSNP greater opportunity for direct contact and intervention with children and families at risk.

Recommendation 12

ANF (Vic Branch) recommends that a registered nurse be allocated and employed in every Victorian secondary school as recommended in the *Review of the Secondary School Nursing Program- Final report (2009)* undertaken by KPMG.

Recommendation 13

ANF (Vic Branch) recommends that government, the Department of Education and Early Childhood Development (DEECD) and Municipal Association Victoria (MAV) expand upon initiatives that enhance the retention and recruitment of Victorian MCH nurses through:

- Continuing to require that Victorian MCH nurses be registered with the Australian Health Practitioner Regulation Agency (AHPRA) as nurses and midwives and have successfully

completed post graduate or masters level MCH programs of study that contain comprehensive child protection content

- Increasing the quantum and total number of scholarships for MCH programs of study
- Providing competitive salaries and attractive employment entitlements to MCH nurses
- Providing ongoing opportunities for professional development to MCH nurses

Recommendation 14

ANF (Vic Branch) recommends that:

- Resourcing of Child Protection Services be significantly increased to enable it to provide quality and timely support and intervention
- Government consider employing experienced and appropriately qualified MCH nurses within Child Protection Services to provide quality intervention and support to families with complex issues and at significant risk of harm

Introduction

The Australian Nursing Federation (ANF) was established in 1924. The ANF is the largest industrial and professional organisation in Australia for nurses and midwives, with Branches in each state and territory of Australia.

The ANF (Victorian Branch) represents in excess of 59,000 nurses, midwives and personal care workers (the latter predominantly in the private residential aged care sector). Our members are employed in a wide range of enterprises in urban, rural and community care locations in both the public and private health and aged care sectors.

The core business for the ANF is the representation of the professional and industrial interests of our members and the professions of nursing and midwifery.

The ANF participates in the development of policy relating to nursing and midwifery practice, professionalism, regulation, education, training, workforce, and socio-economic welfare; health and aged care, community services, veterans' affairs, occupational health and safety, industrial relations, social justice, human rights, immigration, foreign affairs and law reform.

Nurses and midwives are integral to the provision of primary, secondary and tertiary care to young infants, children and adults, providing holistic care in a vast range of settings that are particularly relevant to the Protecting *Victoria's Vulnerable Children Inquiry.* These settings include antenatal, neonatal intensive care, maternal and child health, school nursing, community health, accident and emergency, paediatrics, and mental health. As such, nurses and midwives are in a strong position to identify children suffering or at risk

of abuse or neglect, and to make timely referral to health professionals and support services. Moreover, nurses and midwives are uniquely positioned to implement care and interventions that may circumvent, prevent or reduce the risk of child neglect or abuse occurring. (Parry, Maio–Taddeo, Arnold and Nayda, 2009)

The ANF (Victorian Branch [Vic Branch]) is delighted to make comment to the State Government consultation being undertaken by the *Protecting Victoria's Vulnerable Children Inquiry*.

Our submission is structured around the *Protecting Victoria's Vulnerable Children Inquiry, Guide to Making Submissions* (the Guide), and provides detailed response to a limited number of terms of reference from this Guide relevant to the ANF (Vic Branch) nursing, midwifery and MCH membership.

1. *The factors that increase the risk of abuse and neglect occurring, and effective preventative strategies.*

1.1.1 What are the key preventative strategies for reducing risk factors at a whole or community or population level?

There are several key preventative strategies for reducing risk factors of child abuse and neglect. These include:

- Recognition that the first three years of a child's life are a critical period in a child's physical, social and psychological development, and that these early years set the foundation for health outcomes and behaviors into adulthood. (Baldwin, 2001;Tomison and Poole, 2000)

  This period therefore represents an enormous opportunity for health and support services to make their most significant difference, and conversely is a period when babies and young children are most vulnerable and at greatest risk of suffering enduring detrimental effects of child abuse or neglect.

  Given the plethora of research indicating the formative nature of a child's early years in respect of future health outcomes and behaviors, it is crucial that significant priority be placed on enhancing primary, secondary and tertiary health and support services to provide care, support and intervention during these early years.

- Recognition of the radiant benefits of preventing or making early interventions around child abuse and neglect.

  Significant attention must therefore be focused on strategies, services and programs that have the capacity to prevent child abuse or neglect from occurring, or that circumvent such abuse or neglect from escalating. Resourcing services or programs to achieve this will reap lasting benefits for children and families at risk, and result in cost savings. The Child Protection System must therefore be proactive and not reactive, through enhancing primary, secondary and tertiary health and support services to make interventions that prevent or circumvent child abuse and neglect.

- Effective preventative strategies or interventions must focus and go to the core of risk factors that may contribute to or increase the risk of child abuse and neglect including:
    - Social isolation/loneliness/and lack of support - leading to a lack practical help, mentoring or guidance that may otherwise be provided by family and friends to help new parents adjust to the challenges of a new born baby or child
    - Lack of parenting skills or knowledge on the needs and demands of a new born baby or child
    - Low parental self esteem or self confidence
    - Incidence of parental mental or physical ill health - eg post natal depression
    - Stress caused by raft of factors such as sleep deprivation or financial strain
    - Poverty
    - Unemployment
    - Acrimonious marital breakdown
    - Domestic violence
    - Inadequate housing
    - Parental alcohol or drug abuse
    - Unreasonably high expectations of the developmental stages of the new born baby or child
    - Inability to establish breastfeeding creating maternal fatigue and stress
    - Traumatic or distressing birth leading to maternal stress
    - Abuse of parent as a child - ie "intergenerational" pattern of abuse
      (Department of Human Services Victoria, 2001; Department of Communities, Queensland. 2011; Royal Australian Nursing Federation, Infant Welfare Special Interest Group, 1980)

Whilst this submission will focus on strategies limited to health and support services, ANF (Vic Branch) is cognizant the prevention of child abuse and neglect demands a whole of community response and is significantly dependent upon policy and strategy that:

- Ensures every family has access to safe, affordable, comfortable and secure housing
- Promotes optimal employment
- Reduces poverty and socioeconomic disadvantage

Recommendation 1

ANF (Vic Branch) recommends that in developing policy to prevent and reduce child abuse and neglect government:

- **Recognise the crucial significance of the early years of a child's life in respect of future health and behavior outcomes**
- **Recognise the imperative of early intervention in preventing and reducing child abuse and neglect**
- **Enhance the capacity of existing primary, secondary and tertiary health and support services to reduce child abuse and neglect through early intervention**

1.1.3 What are the most cost effective strategies for reducing the incidence of child abuse in our community?

A study completed in Michigan USA comparing the costs associated with child abuse with the costs arising from measures to prevent child abuse, found that interventions aimed to prevent child abuse were significantly more cost effective (Caldwell, 1992). Additionally research has indicated that for every dollar invested in the early care of young children, a further $17 can be saved in later years as a result (Blakester, 2006). Therefore strategies aimed at the early years of a child's life - and that promote prevention or early intervention - have the most enduring outcomes and are the most cost effective means to reduce child abuse.

The ANF (Vic Branch) supports the view that this can be best achieved through investment in primary preventative health services such as the universal maternal and child health (MCH) service, and the secondary and tertiary services that also have a strong preventative and early intervention function, including the enhanced MCH nursing service, the MCH Telephone Line [the MCH Line], early parenting centres, and specialist mental health mother and baby units.

Whilst we acknowledge measures must also be targeted at antenatal and maternity services, school nursing and across adult mental health or primary and acute care services, the ability and enormous capacity of the universal MCH nursing service to prevent and make early interventions around child abuse cannot be overstated. The critical function of the universal MCH nursing service and its enormous capacity to make a significant difference to child abuse and neglect will be explored under terms of reference 2.

Importantly, we support the government investing in the capacity of existing health and support services to better enable them to meet the needs of those at risk and contend such investment is a sensible and cost effective strategy to reduce child abuse and neglect. Furthermore we know that where there are universal MCH services and secondary and tertiary health services - such as the enhanced MCH service, MCH Line and early parenting centres already - they enjoy unparalleled traction with their communities. The highly qualified MCH nurses and health professional workforce

within these services have the invaluable knowledge, clinical skills and professional expertise in respect of strategies that engage their community and make a meaningful difference for those at risk. As such, these services have unmatched potential to provide support and intervention to families during their children's most formative years. Put simply government must focus on measures that enhance the capacity of these services to meet the existing and projected demand, rather than attempting to re invert the wheel.

At the same time government must give significant priority to ensuring that these services – as those that best equipped to prevent or circumvent child abuse or neglect from occurring – are well resourced to prevent child abuse and neglect, and thus avoid having to direct funding and resources to manage the consequences that flow from a lack of appropriate support or timely and quality intervention.

2. Strategies to enhance early identification of, and intervention targeted at, children and families at risk including the role of adult, universal and primary services. This should include consideration of ways to strengthen the capability of those organisations involved.

2.1 What is the appropriate role of adult, primary and universal services in responding to the needs of children and families at risk of child abuse and neglect? Please provide comment in relation to any of the services listed below or any additional services that you regard as relevant to this Term of Reference.

2.1.1 Universal and primary children's services such as general medical practitioners, antenatal services, maternal and child health services, local playgroups, early childhood education and care services, primary schools, secondary schools, and telephone and internet based services for children and young people seeking information and support.

MATERNAL AND CHILD HEALTH (MCH) NURSING SERVICE

The universal MCH nursing service plays a pivotal role in the primary prevention and early intervention of child abuse and neglect. MCH nurses are uniquely positioned to equip new mothers and families with the skills and knowledge required to competently care for their babies or young children. In doing so MCH nurses have significant potential to prevent - or make early intervention - around the known risk factors of child neglect and abuse as outlined in section 1 of this submission.

At the same time MCH nurses are perfectly positioned in the early childhood development space to identify children and families at risk, and to provide inter-professional referral as appropriate to secondary and tertiary health care services such as the Enhanced Nursing Service, early parenting services, including specialist mental health services, or other health and support services.

This MCH service is provided by maternal and child health nurses with comprehensive educational preparation. Victorian MCH nurses are registered with the Australian Health Practitioner Regulation Agency (AHPRA) as registered nurses and registered midwives and possess accredited post graduate qualification in maternal and child health nursing, or qualification at masters level.

The comprehensive and specialist educational preparation of MCH nurses provides them necessary professional skills and knowledge to carry out, in consultation with the mother and family, appropriate assessment, planning, delivery, ongoing monitoring and evaluation of maternal and child health care.

Historically the Maternal and Child Health (MCH) nursing service has been developed significantly from its original inception in 1917 to provide health supervision and education on nutrition, hygiene and 'mother craft' skills to mothers with new born babies. (Royal Australian Nursing Federation, Infant Welfare Special Interest Group, 1980).

Today the MCH service plays a crucial role in promoting and maintaining optimal health of neonates, babies, young children and mothers. This is achieved through the provision of a universal MCH service that is available to all families with young babies from birth to 5 years.

The Role Of The MCH Nurse

MCH nurses conduct a series of key neonate/baby or young child assessments in accordance with the *Maternal and Child Health Service: Practice Guidelines 2009* (Department of Education and Early Childhood Development Victoria, 2009). These assessments commence with an initial MCH nurse home visit immediately after the birth of a child - and subsequent discharge of the mother and baby from a maternity service - and continue at set intervals up to when the child reaches school age. With the exception of the initial home visit, assessments occur via scheduled visit by the mother or family and child to the MCH nursing centre which is located in the community.

The recently revised *Competency Standards for the Maternal and Child Health Nurse in Victoria* (The Victorian Association of Maternal and Child Health Nurses [VAMCHN], ANF (Vic Branch) 2010) provide a very useful description of overarching principles of the MCH nursing service which broadly speaking require MCH nurses to promote and optimise child and family health and wellbeing.

Of particular relevance to the *Protecting Victoria's Vulnerable Children Inquiry* the *Competency Standards for the Maternal and Child Health Nurse in Victoria* (VAMCHN, 2010) outline that MCH nurses are required to:

- Assess and monitor the health, growth and development of children from birth to school age through:
  - Collecting a comprehensive medical, obstetric and family history;
  - Identifying protective and risk factors in the child's environment;
  - Identifying the child at risk of or experiencing neglect and abuse and acting on professional observation and judgment;
  - Responding to the child at risk of or experiencing abuse, and making notification in accordance with the Children Youth and Families Act 2005.

- Undertake physical and developmental assessment of the child
- Promote, protect and support breastfeeding, through providing support, education and referral to mothers
- Promote appropriate nutrition through education and guidance on optimal nutrition
- Promote maternal physical and emotional health and well being
- Assess the emotional and mental health of the child
- Facilitate community linkages and support, such as provided by new parent groups, to reduce social isolation and improve social connectedness
- Promote effective and safe parenting styles and assists parents to understand the needs of their infant or child in relation to their child's stage of development
- Promote the role of the family in the health and development of the child
- Provide health promotion and health education (Pages 13 to 18)

The broad requirements outlined above are not exhaustive in terms of the comprehensive requirements of MCH nurses, however demonstrate that MCH nursing practice involves making interventions that go to the heart of recognised risk factors of child abuse and neglect. For this reason, improving the capacity of MCH nurses must sensibly focus greatly in any measures to prevent and reduce child abuse and neglect.

ANTE NATAL SERVICES – MIDWIVES

Through provision of ante natal care, registered midwives can play a crucial role in the prevention and early identification of risk factors that may otherwise contribute to child neglect or abuse.

Depending on the particular model of midwifery care, midwives may commence their involvement in a mother's care early in a women's pregnancy. Midwives develop a professional caring relationship with women and their partners throughout pregnancy, labour and birth and are therefore well positioned to undertake screening of women and families to identify those at risk of child abuse and neglect. Moreover midwives have a critical capacity to make early interventions and referral to primary, secondary or tertiary health services and community supports that in turn can intervene to prevent of circumvent child abuse or neglect.

As will be discussed throughout this submission the capacity for midwives to identify risk factors in-utero, and to implement early intervention measures can reduce the likelihood of identified risk factors or behaviors escalating into actual child neglect or abuse.

THE MATERNAL AND CHILD HEALTH LINE

The MCH line provides an important role in preventing child abuse and neglect through providing professional advice and support to parents in need, 24 hours a day, 365 days of the year.

This service is provided by appropriately qualified MCH nurses who offer direct advice, referral information and support to mothers and families in need. Queries to the MCH hotline include issues relating to:

- Breastfeeding
- Nutritional queries
- Crying or unsettled infants
- Medical advice
- Maternal ill health
- Maternal depression
- Infant or child ill health or behaviors of concern
- Accidents
- Immunisation
- Families in crisis
- Emergency Formula provision.

Key features that distinguish the MCH line from other universal MCH services are that it:

- Is provided 24 hours a day , 365 days year
- Offers parents or families the opportunity to access advice and information anonymously
- Caters extensively for non English speaking callers and those who are deaf

As a consequence of our role in review of the MCH Line Review in 2000, the ANF (Vic Branch) is in possession of an unpublished document titled *The Maternal and Child Health Line Annual Report July 2000 to June 2001.* This document supports that the MCH Line is highly valued by mothers and families, and that the service is enhanced by the expertise and professional knowledge base of qualified MCH nursing staff.

Unfortunately, there appears to be no published or publically available documents since this time that would otherwise highlight the effectiveness of the service. ANF (Vic Branch) see considerable benefit to making such documents publically available, and recommends that this occur.

Nonetheless ANF (Vic Branch) considers MCH nurses make a huge contribution to this service. They play an important part in prevention of child abuse and neglect through providing professional support and referral to mothers and families that may improve their capacity to parent effectively. The service can prevent known risk factors of child abuse and neglect from escalating and in turn mitigates the likelihood of child neglect or abuse. Consequently, MCH nurses must remain at the forefront of these services.

PRIMARY SCHOOL NURSING PROGRAM (PSNP)

The PSNP plays an important role in the identification of children at risk, and intervention and referral to health and support services, or the Child Protection System. The PSNP is a universal service provided to all children attending government, Catholic or independent primary school sectors and English language centre schools.

The program is designed to offer:

- A health assessment of all prep children. This is conducted via a School Entrant Health Questionnaire (SEHQ) which the primary school provides to every family of a new prep student to complete
- Advice and information to parents and teachers on children's health
- Development of strategies to assist families to access local family support centres
- Referral to specialist services if required
- Health promotion and education

Whilst the PSNP offers enormous potential to assess the health and well being of young children, and identify those at risk of or suffering abuse or neglect, the capacity of the program to fully realise functions beyond screening for children at risk, is severely limited by existing funding.

Perhaps as a consequence of the limited public funding for such services - and the manifest benefits that nurse can nonetheless bring - some independent schools may also choose to employ a primary school nurse whose role may include:

- Health assessment
- First aid

- Education of parents, teaching staff and students in respect of health promotion, nutrition and wellbeing

- Promotion of student well being

- Referring to other health services or specialists as required

- Assisting schools to develop policy and procedure that promotes optimal health (eg management and prevention of anaphylaxis

Nurses within the PSNP are well positioned to develop trusting relationships with their individual students and are therefore well positioned to make timely and accurate health and risk assessments. As detailed under term of reference 2.2, however, further investments must be made in the PSNP for PSNP nurses to move beyond their screening and referral function - to fully engage with families, teaching and pastoral care staff - and ultimately improve their capacity to implement interventions or referrals that may reduce or prevent child abuse or neglect.

SECONDARY SCHOOL, NURSING PROGRAM (SSNP)

Similarly the SSNP plays an important role in the identification of children at risk and intervention through referral to health and support services, or the Child Protection System.

This program is operated through the Department of Education and Early Childhood Development (DEECD) and has broad objectives to:

- Reduce the negative health outcomes of risk taking behaviors amongst young people such as drug or alcohol abuse, smoking, eating disorders, obesity , depression, suicide and injuries

- Prevent ill health and by ensuring co-ordination between the school and community based health and support services

- Support the school and community to address contemporary health or social issues facing young children

- Provide primary health care through professional clinical nursing such as assessment, care, referral and support

- Assist in the transition form primary to secondary school

The specific role of the nurses within the SSNP may include:

- Individual health counseling

- Health promotion and planning
- Small group work focusing on discussion and education with students
- Providing a resource and referral system for students, teachers and families

Nurses operating within the SSNP are well positioned to develop relationships of trust with their students and are therefore well positioned to not only identify instances of child neglect or abuse, but also to implement strategies to reduce or prevent such abuse or neglect from occurring or continuing.

Unfortunately however, funding to this service is limited to provide 100 nurses to 199 *vulnerable* schools across Victoria (Education and Training Committee, Parliament of Victoria 2010). The program does not therefore extend into every government secondary school leaving well over 100 secondary schools without dedicated funding for a secondary school nurse or the SSNP. This represents a significant shortfall of the service which will be explored later in this submission.

Many schools also see the value of the school nurse and employ them independently to enhance the provided services.

2.1.2 Targeted child and/or family services such as enhanced maternal and child health services, children's disability services, specialist medical services, child and adolescent mental health services, family support services, family relationship counseling services and Aboriginal managed health and social services.

THE ENHANCED MATERNAL AND CHILD HEALTH SERVICE

The Enhanced Maternal and Child health Nursing Service plays a critical role in the prevention and early identification of child abuse and neglect through:

- Providing significant support for families experiencing significant early parenting difficulties
- Improving family functioning and the health and well being of vulnerable children and families
- Promoting early identification and intervention particularly for children and families at risk, improve linkages with other early childhood support systems including maternity services, family support and early intervention services
- Providing more inclusive services for fathers

(Department of Education and Early Childhood Development, 2003)

Additionally *The Enhanced Maternal and Child Health Service Guidelines, 2003 – 2004* (DEECD, page 7, 2003) outline that the Enhanced Maternal and Child Health Service is now *directed towards families who are experiencing significant risk issues and/or multiple risk factors given the potential for a significant impact upon the health and well being of children within these families.*

Identified users of the service vulnerable families with one or more risk factors including:

- Drug and alcohol issues
- Mental health issues
- Family violence
- Families known to Child protection
- Homelessness
- Unsupported parents/under the age of 24 years
- Low income, socially isolated, single parent families
- Significant parent/baby bonding and attachment issues
- Parent with an intellectual disability
- Children with a physical or intellectual disability
- Infants at increased medical risk due to prematurity, low birth weight, drug dependency and failure to thrive

It is important to highlight that in an evaluation of the original initiative completed in 1998 by the Royal Melbourne Institute of Technology University (which comprised outreach, day stay and centre based programs) it was found that the service:

- Was preferred by Koori families and adolescent mothers who either did not use or underused the universal MCH service
- Mothers reported significant improvement in maternal health and well being including post natal depression
- Highlighted and demonstrated the importance of early intervention and appropriate referral to prevent further escalation of needs

- Day stay services combined with follow up outreach were effective in improving significant early parenting difficulties
  (Department of Early Childhood Education and Development, Victoria, 2003)

The positive and enduring benefits to the health of and wellbeing of mothers, families and their young babies and children that flow from an in reach service provided by Maternal and Child Health nurses with the appropriate educational underpinning, is also well documented in literature. In an article titled *Effects of Home Visits to Vulnerable Young Families* (Kearney, York and Deatrick, 2000) it was found that:

> *Mothers' psychological status, including depression, anxiety, stability, psychological distress and perceived mastery, was positively affected by nurses home visiting in three of the 4 studies in which it was measured* (page 372)

Given that mothers can be the cornerstone of healthy families (Lawn, Tinker, Munjanja and Cousens, 2006) and be instrumental in their child's development, the enduring positive effects that a MCH home visiting or in reach program can bring to maternal and child health can not be overstated. It is therefore imperative that reform in respect of the prevention of child neglect and abuse strengthen the capacity of existing programs - such as the enhanced MCH nursing service which is proven to be effective - to meet the demands of their clients, and thus prevent known risk factors of abuse or neglect from escalating.

In providing a more focused and intensive level of support for vulnerable families experiencing early parenting difficulties - and children identified as being at risk of harm - the enhanced MCH service therefore performs a critical function in the prevention and early intervention of child neglect and abuse, and must feature significantly in reform aimed to improve child protection.

EARLY PARENTING SERVICES/'MOTHER AND BABY UNITS

Early Parenting Centres (EPCs) including Mercy Health O'Connell Centre, Queen Elizabeth Centre and Tweedle and Family Health Service provide a critical role in the prevention and early identification of child abuse and neglect. These services are mostly provided by registered health professionals including nurses, midwives, MCH nurses and mothercraft nurses. They provide practical support and education to parents - who may have been identified as requiring more intensive support than provided under the universal MCH or enhanced nursing service - and equipping them to become competent and confident parents who are able to provide for their child's care or manage challenging behavior more effectively. In doing so they make interventions that directly mitigate the likelihood of known risk factors including:

- Low parental self esteem
- Lack of parenting skills or knowledge
- Stress

- Sleep deprivation
- Post natal depression
- Unreasonable high parental expectations regarding the developmental stages of their infant or child
- Inability or difficulty in breastfeeding, from escalating and otherwise leading to the incidence of child neglect or abuse. These services can be the linchpin of prevention - and or early intervention - of child abuse and neglect and should feature significantly in any reform measures to improve child protection within Victoria

To illustrate the positive role that such services play, it is worthwhile examining programs offered by the Queen Elizabeth Centre which include:

- Day Stay. This program assists parents to learn new parenting strategies and to address areas such as feeding, sleeping problems and managing toddler's difficult behavior
- 5-day residential stay. This program provides more intensive parenting education and support for parents experiencing more complex challenges with their infants or young children. The program is intended to improve early parenting skills and practices, promote positive family interactions and support equip parents with strategies and skills in respect of managing feeding and sleeping difficulties
- Home visiting services. These are available for families who may experience difficulty in attending residential or day stay programs
- Parenting Skills Development services. In addition to providing support education and assistance to parents in respect of effective parenting skills, the QEC also offers more intensive assistance to parents via a 10-day residential stay or via the *Parenting Plus Home Based Program*
- Residential or home based parenting assessment and skills development service (PASDS). This program is available to families who may have been referred by Department of Services, Child Protection unit and provides assessment of parenting skills, together with education, support and referral as appropriate

(http://www.qec.org.au/what-we-do.php?id=26 last accessed 3/05/11)

It is also critical to highlight that the programs offered by Queen Elizabeth Centre are known to have demonstrable and measurable success in improving outcomes relating to maternal health, stress, depression and self esteem as reported in the *Evaluation of the Queen Elizabeth Centre's 5-day Residential Program* which found that:

> *Symptoms of depression, anxiety and stress were all reduced after parents completed the program…and parental sense of efficacy and satisfaction increased over the measurement*

period, and improvements were seen in parent's caregiver behavior when interacting with their children…(Treyvaud, Rogers, Matthews and Seymour 2006, Page 5)

Similarly in the *Report to the Queen Elizabeth Center on the Evaluation of the Queen Elizabeth Day Stay Program for Mothers with Infants and Toddlers* Hayes and Matthews report:

That mothers who attended the Queen Elizabeth Day Stay program reported improvement in their psychosocial well being and parental satisfaction…(and) improvement in their child's problematic behavior , such as night walking, settling and behavioral difficulties, with decreases in problem behavior severity, and decreases in the frequency of occurrence of problem behavior. In contrast, there were no such improvements reported by the waitlist group over the same period of time and before attending the program (2003, Page 8)

In summary, the services offered by early parenting centres - or mother and baby units - such as the Queen Elizabeth Centre can be critical in equipping parents with the lifelong requisite skills of parenting and in providing early intervention around the factors that are known to otherwise contribute to child abuse.

Improving the capacity of such services to meet burgeoning demand must be given significant government priority in reducing preventing and making interventions to prevent child abuse or neglect.

ABORIGINAL MANAGED HEALTH AND SOCIAL SERVICES

Aboriginal Managed Health Services are provided in a number of ways including:

- Koori Maternity Service
- The Victorian Aboriginal Health Service in Fitzroy which employees on full time MCH nurse
- Aboriginal Community Controlled Health Organisation (ACCHO) in 10 sites across Victoria
- Mainstream MCH nursing services (http://www.health.vic.gov.au/maternitycare/progs.htm#koori last accessed 3/05/11)

The role of these services is to provide women and families of Aboriginal or Torres Strait Islander descent access to timely and professional midwifery and maternal and child health care and services. Critical to the effectiveness of such services is that they are culturally appropriate and delivered in a manner that facilitates maximum engagement and utilisation by Aboriginal or Torres Strait Islander women and their families.

The services provided by ACCHOs are delivered by a combination of qualified and registered midwives or MCH nurses and or aboriginal health workers. The services often contain a very practical element of support and assistance to mothers of Aboriginal or Torres Strait Islander descent. They provide a professional component of care together with practical support measures,

such as providing transport to assist mothers and parents are able to attend appointments and utilise required support services. Such a combination of support is crucial to ensuring mothers and families of Aboriginal or Torres Strait Islander descent have access to - and moreover utilise - professional support and assistance in all aspects of parenting and care of their young infants and children.

It is also important to note that Victorian Aboriginal children can experience greater challenges from within their families compared to non aboriginal families, and that they live in homes where there is more likely to be risk factors of child abuse or neglect such as:

- Sole parent families
- High levels of parental unemployment
- High proportion of expenditure on housing
- Greater levels of poverty
- Greater levels of family stress as result of mental illness, serious physical illness, alcohol and drug related problems

Additionally the Department of Education and Early Childhood Development Victoria (2009) report titled *The State of Victoria's Children 2009. Aboriginal children and young people in Victoria* identifies that currently Aboriginal children remain overrepresented in child investigations and placements and under represented in usage of universal and secondary support services.

Policy and reform in respect of prevention and early intervention of child neglect and abuse must ensure that this unfortunate reality is reversed. Measures that improve the capacity of Aboriginal health managed services to meet the needs of their clients are crucial, and will be explored later in this submission.

2.1.3 *Specialist adult focused services in the field of drug and alcohol treatment, domestic violence, mental health, disability, homelessness, financial counseling, problem gambling, correctional services, refugee resettlement and migrant services.*

MENTAL HEALTH SERVICES

Nurse lead, mental health services have the potential to play an important role in the prevention or early intervention of childhood abuse. Fundamentally, this role is to provide professional and timely mental health care to mothers or parents, that in turn enables them to enjoy optimal health and able to parent effectively. Similarly mental health services provide expert care and referral for mothers and families thereby mitigating or preventing escalation of risk factors known to contribute to child neglect or abuse, including depression and mental ill health.

Mental Health Mother and Baby inpatient programs offer specialised assessment and management of women with psychiatric illness in the post natal period. These services are currently located at Monash medical Centre, the Mercy Hospital in the public system and at Mitcham private Hospital and St John of God Hospital in Burwood.

These specialised services have a critical function to improve maternal health and thereby improve the capacity of mothers and families to parent effectively and safely.

Additionally nurses working within adult, child and adolescent mental health services have a unique capacity to screen for and identify children either experiencing or at risk of abuse or neglect. They are therefore well positioned to implement referral to appropriate health professionals, community support services or to Child Protection Services if necessary.

There is significant scope to improve the capacity and functioning of these services to prevent or make early intervention around child neglect or abuse. These measures will be explored in detail later in this submission.

2.2 How might the capacity of such services and the capabilities of organisations providing these services be enhanced to fulfill their role in the prevention, early identification and intervention of child neglect and abuse?

There are a number of measures that are relevant to, and have general application across all of services explored so far in this submission that can enhance or improve the capacity of these services to provide prevent, identify, make early intervention of child neglect of abuse. These are:

IMPROVING THE KNOWLEDGE AND SKILLS OF ALL NURSES TO RECOGNISE AND EFFECTIVELY RESPONDING TO INSTANCES OF CHILD NEGLECT OR ABUSE

In their article tilted *Barriers that inhibit nurses reporting suspected cases of child abuse and neglect*, Plitz and Watchtel identify that *nurses with education and experience with child abuse and neglect have greater skills in recognising and reporting child abuse* (2009, page 97).

Despite this there is no standardised content in the curriculum of undergraduate nursing courses or requirement for Universities to include such content to ensure their courses are accredited by the Nursing and Midwifery Board of Australia (NMBA). Literature suggests that as consequence of inadequate or standardised undergraduate educational content in the area of child neglect or abuse that nurses from different disciplines can have different perceptions of their role in responding to or reporting child abuse and varying levels of knowledge in this area. For example, nurses working in emergency departments may not have the benefit of education and knowledge in respect of child abuse and neglect despite them regularly providing care to children that may show signs of abuse or neglect. This in turn can present as a barrier to such nurses making the necessary early interventions, such as referral to support services, or (Plitz and Wachtel, 2009; Parry, Maio-Taddeo, Arnold and Naydo, 2009) or notification to the Child FIRST service, that may otherwise be critical to identifying and preventing the escalation of child neglect or abuse.

The recent transition to national registration presents an ideal opportunity to correct this shortfall and inconsistency and ensure that educational course content regarding child protection and the prevention of child neglect and abuse is standardised across Australia, and moreover required in undergraduate nursing courses for these to be accredited by the Nursing and Midwifery Board of Australia.

Recommendation 2

ANF (Vic Branch) recommends that:

- **Specific course content in respect of matters relating to Child Protection be developed and standardised and included in the curriculum of all undergraduate nursing courses or direct entry mental health or midwifery courses**
- **Inclusion of standardised Child Protection course content be required for course accreditation by the Australian Nursing and Midwifery Accreditation Council (ANMAC)**

In contrast, MCH nurses employed in Victoria are required to hold specialist qualifications and be registered as nurses and midwives. MCH nurses must have successfully completed an accredited maternal and child health post graduate program of study such as the Post Graduate Diploma of Nursing Science in Child, Family and Community from La Trobe University. Such courses are usually delivered over one year and include specific content in respect of identification, prevention and early intervention of child neglect and abuse and include comprehensive content on working with families at risk. For example, specific modules within the subject tilted *Early Parenting: Working with At risk Families (*as contained in the Post Graduate Diploma of Nursing Science in Child, Family and Community from La Trobe University) include*:*

- Family centered practice
- Case Co-ordination and Inter Agency Collaboration
- Home visiting programs (eg PASDS)
- Parenting skills programs
- Working with parents with intellectual disability
- Working with parents with mental illness
- Working with parents experiencing domestic violence
- Working with parents with alcohol or drug issues
- Introduction to the family protection system including the Victorian Child protection system, protecting children from harm, reporting child abuse, the Victorian risk framework and the role of the MCH nurse in risk assessment

Additionally the course provides opportunities for students to gain experience working with families identified at risk, in settings such as early parenting and day stay centres, the enhanced home visiting service, and specialised parenting and assessment programs. Students are also provided opportunity to gain an insight into the Victorian Children's Court (Lael Ridgeway, Course Co-ordinator, Child Family and Community Nursing, Division of Nursing and Midwifery, La Trobe University 5/05/11; http://www.latrobe.edu.au/coursefinder/local/2011/Postgraduate-Diploma-of-Nursing-Science-in-Child%2C-Family-and-Community.6645.html last accessed 5/05/11).

At the same time MCH nurses within Victoria and particularly those working in the enhanced MCH nursing service, are provided regular professional development opportunities by the Department of Education and Childhood Development in regard to identification, prevention and early intervention around child neglect and abuse.

The extensive educational preparation of MCH nurse within Victoria contrasts with other states who may not require nurses or midwives providing MCH nursing services to undertake post graduate maternal and child health study, or to complete post graduate maternal and child health courses that have the same rigor as now provided in Victoria.

Critically, the educational preparation of Victorian MCH nurses provides a very sound platform for them to make effective interventions around child neglect and abuse. This contrasts with the educational prerequisites of MCH nurses in other states in Australia, who as identified in the study undertaken by the Australian Centre For Child Protection are likely to have undertaken undergraduate or post graduate nursing studies that do not contain any specific unit or content in respect of Child Protection (Parry, Maio-Taddeo, Arnold, Nayda, 2009).

Recommendation 3

ANF (Vic Branch) recommends that education and professional development opportunities continue to be provided to all maternal and child health (MCH) nurses regarding child protection in Victoria, thereby assisting them to prevent, identify and make effective early intervention around child neglect or abuse.

REFUGEE SETTLEMENT AND MIGRANT SERVICES

It is also important to recongnise that refugee settlement and new migrants can carry the added stresses of isolation, loss of family support networks, limited language skills, fear of the future as well as all the other factors that can contribute to the potential for child abuse and/or neglect. There needs to be education provided to all health practitioners in relation to these specific issues to ensure they are able to better assist the individual family groups.

IMPROVED COLLABORATION AND COMMUNICATION BETWEEN HEALTH SERVICES, HEALTH PROFESSIONALS AND THE CHILD PROTECTION SYSTEM

There is an identified need to improve collaboration amongst health serves, health professional and the Child protection System who may be involved in the care of children or families at risk.

The Victorian Department of Education and Early Childhood Development (DEECD) have established a Continuity of Care Reference Group to improve the continuity of care for mothers and families transitioning from maternity to community care. This group has developed a draft *Framework for communication between Victorian maternity and newborn services, the MCH Service, and other service providers 2010* which in addition to highlighting the crucial importance of the early years of a young child's life in terms of their human development, and of early identification and intervention, also aims to:

- Ensure that maternity and newborn services, MCH services and other services develop strong communication and partnerships
- The individual roles of health services, health practitioners and other services - including within the child protection system - is clear and moreover understood by health professionals or those working within the Child Protection System or involved in the care of young children at risk
- Improve the exchange of information between health services and health professionals ensuring this is maximised within the limitations of legislation and requisite parental consent
- Introduce standardised tools of assessment and communication between health services and professionals

ANF (Vic Branch) welcomes the initiatives canvassed in the relevant DEECD Advisory Group's draft *Framework for communication between Victorian maternity and newborn services, the MCH Service, and other service providers 2010* which of particular relevance to the *Protecting Victoria's Vulnerable Children Inquiry* include:

- A standardised risk assessment or screening tool be developed and used by all maternity, newborn and MCH services (including those providing care to Aboriginal and Torres Strait Islander women and families) that help to identify families at risk and trigger the need to link such families with the universal MCH service in the antenatal period, or to more intensive support and intervention services such as provided by early parenting services. The importance of early intervention cannot be overstated and such a tool would allow at risk families to have access to support prior to birth of their child and also enable the universal MCH services, the enhanced service or early parenting services to begin care planning and intervention
- A standardised consent form be developed that allows maternity and newborn services to share information about a mother, baby or family with the MCH service, the general practitioner or other services such as early parenting services, mental health services or drug and alcohol services
- A standardised template for discharge summary be developed for use by maternity and newborn services and that this be provided automatically the women's maternal and child health service and her general practitioner
- A standardised handover tool from midwifery or post natal care to the universal MCH service that provides more in depth information than is currently provided and which includes information

relating to post birth recovery, breastfeeding, health of the baby, health and well being of the mother, the families home environment including any recommended supports

- A standardised information package be developed, communicated and regularly updated for health professionals that explain the respective roles and programs within each health service. Ensuring that all health practitioners including a mother or family's GP are aware of the vast and varying roles of all health services - and the radiant benefit that such services could bring to families at risk - is critical to ensuring that health services work in concert with each other and mothers and families receive support and care as required

- A standardised guide be developed for the use of registered nurses and medical practitioners that provides guidance and information on matters relating to the Child Protection System and how they can interface with it effectively to the benefit of at risk families

- Communication and interface between Child protection/Child FIRST and health services such as midwifery, MCH, early parenting centres and health professionals providing care to vulnerable families be significantly improved, including the identified need for child protection to update and inform the above-mentioned health services of interventions that they may have implemented for families at risk

- Critically, that the improvements in collaboration outlined above be applied to the health professionals and related services involved in the care of Aboriginal or Torres Strait Islander mothers and families. This is required to resolve existing inadequacies whereby a maternity service may provide a universal MCH nursing service discharge information relating to a mother and baby's care in hospital, despite that mother actually intending to receive care via the Koori Maternity Service, an ACCHO or the Aboriginal health service. The importance of clear communication and of early intervention and care planning cannot be overstated. It is crucial that the post natal care of Aboriginal and Torres Strait Islander mothers be determined early in pregnancy, and that collaboration commence prior to birth with the service that will be provided care for the mother and child post birth

- The Australian Government has invested significant resources and funding into the development of the health national infrastructure for e-health records. All Australians will be able to make the decision to sign up for a personally controlled e-health record (PCEHR) from July 2012

  The PCEHR will bring key elements of the patient's health information together into a unified record that will be accessible only by the individual patient and authorised health care providers. The PCEHR shared health summary will contain health information such as immunisation status, past history and current medication list. The event summary will allow any participating health organisation, afterhours GP or Nurse Practitioner to create record of a health care event which will be posted the individuals health record

  The integration of shared health information across health professionals will reduce duplication of services and allow co-ordination of health care and improved communication and health care delivery. Furthermore, the implementation of a shared electronic health record will provide a life

to death comprehensive medical profile of the patient which will facilitate all health professionals to initiate health interventions without delays in access to health information

This important health reform initiative will provide a complete e-health record for Victoria's vulnerable children which will facilitate communication across all health organisations and health professionals and improve health outcomes

- The capacity of mental health services or professional to interface with all others services and health professional's involved in the care of at risk children and families be significantly enhanced. Currently mental health professionals or services may not always proactively engage the vast array of health and support services that may assist families at risk, and that may be of critical importance as a consequence of the ill health of the adult client under their care

  On this point the ANF (Vic Branch) supports the *Families where a Parent has a Mental Illness* (FaPMI) strategy which aims to strengthen the capacity of mental health services to identify and meet the needs of vulnerable families, by referring them to appropriate universal, secondary or tertiary services, community supports or to engage Child Protection Services if required

  Recommendation 4

  ANF (Vic Branch) recommends that government provide funding to enable full implementation of the measures and strategies to improve collaboration amongst health professionals, health and support services who provide care to vulnerable children as outlined in the ANF (Vic Branch) Submission to the *Protecting Victoria's Vulnerable Children Inquiry*, and as detailed in the Continuity of Care Reference Group document titled *A Framework for communication between Victorian maternity and newborn services, the MCH service, and other service providers.*

PROVIDING A SKILLED NURSING, MIDWIFERY AND MCH WORKFORCE

It is view of ANF (Vic Branch) that the provision of an appropriately skilled and qualified nursing and midwifery workforce in sufficient numbers to match the care needs of a growing population is the cornerstone to enhancing the ability of health services to prevent and make early interventions around child abuse or neglect.

Contemporary research shows the educational preparation of nurses is a significant determinant in effective prevention and management of child neglect or abuse. (Plitz and Wachtel, 2009) It is critical therefore that reform ensures appropriately educated and qualified nurses, midwives and MCH nurses are deployed across the care settings discussed in this submission, in sufficient numbers to match the increasing care demands of vulnerable or at risk children and families.

Rigorous workforce planning must occur between health services and government and give regard to key factors that affect the demand for health services providing care and support to families at risk, and additionally consider factors affecting the supply of the nursing, midwifery and MCH workforce.

Principle among factors affecting demand for health services providing care and support to children and families at risk is the exponentially increasing number of birth notifications in Victoria, and overall growth in the Victorian population.

As detailed below birth notifications have increased in Victoria from 63,622 in 2004-2005 to 73,827. (DEECD, 2004-2005; DEECD, 2009-2010).

- 63,622 (Maternal & Child Health Services Annual Report (M&CHS) 2004-2005, Department of Education and Early Childhood Development, Victoria [DEECD])
- 66,526 (M&CHS Annual Report 2005-2006, DEECD)
- 70,158 (M&CHS Annual Report 2006-2007, DEECD)
- 71,277 (M&CHS Annual Report 2007-2008, DEECD)
- 71,799 (M&CHS Annual Report 2008-2009, DEECD)
- 73,827 (M&CHS Annual Report 2009-2010, DEECD)

The increase in birth rate has obvious implications on health services providing care and support to families at risk and moreover the nursing, midwifery and MCH workforce responsible for providing such care. Workforce planning must therefore ensure that the nursing, midwifery and MCH workforce increases commensurate with existing and projected increases in birth notifications, and ensure this workforce is deployed in sufficient numbers to provide timely and quality nursing and midwifery care and support.

Measures to enhance the recruitment and retention of nurses in sufficient numbers to meet existing and projected demand will be explored in detail in this submission under term of reference 3.2, together with that factors that impact upon supply of the nursing, midwifery and MCH nursing workforce.

EXPANDING HEALTH SERVICES TO MEET EXISTING AND PROJECTED DEMAND

It is imperative that existing health services providing care and support to vulnerable children or families at risk also ensure that their services expand and adapt to the increased demand for care that logically arises from the significant increase in birth notifications, and from Victorian population growth.

This is naturally heavily dependant upon the expansion of the existing nursing, midwifery and MCH nursing workforce, and should include comprehensive assessment of the effects that increasing birth notifications and the Victorian population have on existing and projected service provision. Crucially, this assessment should also include the adequacy of health and support services provided in rural areas, and the need to expanded services in areas of high population growth.

ANF (Vic Branch) welcomes that some services engaged in the care of vulnerable families conduct regular research and evaluation of the efficacy of their services and that such information is publicly available. Such research provides invaluable information that enables these services to measure the

outcomes of their interventions and to plan and adapt to meet the increasing and changing care demands of their clients.

This research could form part of any review of the need to expand the size or number of existing health services. In the interim ANF (Vic Branch) submit that the following measures are required to better enable health services to meet existing demands for their service.

MCH Nursing Service

The interventions of MCH nurses to identify and make early interventions that circumvent child abuse or neglect depend upon them developing trusting professional relationships with the mothers and families using their service. Such relationships require time to develop and can be obstructed when MCH nurses suffer unreasonable workloads and intensification of work, and restricted or unduly pressured in respect of the time they can spend with each child and family.

At the same time inadequate MCH nurse staffing can prevent MCH nurses from providing more flexible and responsive services, that may better engage vulnerable families or those least likely to utilise MCH nursing services due to the way MCH appointments are currently structured, or the limited hours of operation of MCH services.

The allocation of MCH nursing clients is commonly determined by workload management tools which in turn are incorporated into industrial agreements. These tools vary amongst MCH nursing services, and differ in the number (from 120 to 135 per one MCH equivalent full time) of birth notifications upon which MCH nurse workloads are benchmarked. The ANF (Vic branch) is not infrequently advised of unreasonable workloads and intensification of work where benchmarks are set above 120 birth notifications.

Recommendation 5

ANF (Vic Branch) recommends that MCH nurses are deployed in sufficient number at each MCH centre to match demand, thereby ensuring safe workloads and enabling MCH nurses to provide timely and quality care and early interventions to children and families at risk.

Enhanced MCH Service

As previously outlined the enhanced MCH nursing service is critical to providing professional care and support to families identified as at risk or in need of a more intensive service.

Metropolitan regions are funded for 15 hours of direct or indirect service delivery per family, and rural regions are funded for 17 hours per family. This is in addition to the services offered by the universal system and includes hours spent providing direct client care as well as time required undertaking ancillary tasks related to this care.

Funding of this service is restricted to children aged between 0 and 12 months of age, and allocated according to socioeconomic disadvantage. This in turn is calculated using the Accessibility/Remoteness Index of Australia and the number of maximum tax benefit recipients with a child aged 0 – 6 years (Department of Education and Early Childhood Development, 2011).

This creates a virtual capping of the number of families and children that are funded to receive enhanced MCH nursing care - and as consequence – unmet need of families identified at risk but who fall beyond this arbitrary cap. These families instead return to the universal MCH service, placing pressure on it to meet the needs of clients receiving universal care.

ANF (Vic Branch) contends that the existing funding arrangements for the enhanced nursing service do not provide sufficient funding to match demand for this more intensive service. Additionally we believe that the above-mentioned funding formula does not accurately capture individual pockets of need within communities, and that their level of disadvantage can instead be skewed by the presence of families of high socioeconomic status.

Additionally, it is common that the enhanced service may continue to bring benefit to families with children aged over 1 year, and therefore essential that the funding for the enhanced service continue beyond this age.

These limitations must be removed for the enhanced MNCH nursing service to meet the demands of all families' identified as requiring more intensive MCH nursing care and support.

Recommendation 6

ANF (Vic Branch) recommends that:

- **Funding for the enhanced MCH nursing service be increased through review of the existing funding formula to ensure all families and children identified at risk - or in need of more intensive MCH service –have access to timely and quality care from the enhanced MCH service**
- **Funding for the enhanced service not be confined to children aged under one year**

MCH Line

The MCH Line is an important element in the prevention of child abuse and neglect. Whilst operating reports into this service are not publically available, ANF (Vic Branch) understands that waiting times to access the expert advice of qualified MCH nurses within this service can vary significantly. Reduction in these waiting times is necessary to ensure that the MCH Line service promotes maximum engagement form those in need.

It is therefore imperative that funding to the service increase in proportion to demand that logically arises as a consequence of the increase in birth notifications.

Recommendation 7

ANF (Vic Branch) recommends that funding of the MCH Line service be increased to ensure sufficient numbers of appropriately qualified MCH nurses are available to provide timely and expert advice to families in need.

Early Parenting Services

Despite the critical function these early parenting services provide to prevent and circumvent child abuse and abuse – and the demonstrable success that they bring - access to these invaluable services can be improved. ANF (Vic Branch) understands that waiting lists to access the residential care or day stay services provided by each of the 3 publically funded early parenting centres, currently extends between 6 weeks to 3 months.

In the context of research indicating clear differences in the outcomes for mothers and families receiving care from such services and those waiting for such care, (Hayes and Matthews 2003), it is imperative that these centres be provided additional funding that enables them to expand their existing services to match and meet demand. The benefits of early intervention and the necessity to provide timely support and care support to families and children at risk cannot be over emphasised. It is therefore imperative that these invaluable services be better resourced to improve timely access to their services, and reduce existing delays that may otherwise militate against early intervention.

ANF (Vic Branch) also note that each of the three publically funded early parenting centers offering residential care, day stay and intensive parenting skills programs are currently located in metropolitan Melbourne. We submit that families at risk form rural areas are disadvantaged by the lack of such services in rural areas and that consideration must be given to increasing the number of such specialist early parenting centers to ensure they are located strategically throughout rural Victoria and metropolitan Melbourne, including urban growth areas.

Recommendation 8

ANF (Vic Branch) recommends that additional funding be provided to early parenting centres to enhance their ability to provide timely support and intervention, and to better meet increasing demand of families at children at risk in metropolitan Melbourne and throughout rural Victoria.

Mental Health Mother and Baby Units

Despite the critical function these specialist parenting services provide to prevent and circumvent child abuse and abuse – and the potentially lifesaving and often transformative benefits they can bring for mothers with mental ill health - access to them is unacceptably limited and in need of significant improvement.

Similar to the scenario outlined above in respect of early parenting services, ANF (Vic Branch) is advised of unacceptably long waiting list times to access the specialist mental health mother and baby units, and additionally note that these specialist services are confined to metropolitan Melbourne.

It is vital that these services be better resourced to provide timely access to their services, and that delays that may otherwise militate against early intervention be minimised. It is also essential that the number of number of specialist mental health mother and baby units be expanded to ensure they are located strategically throughout rural Victoria and metropolitan Melbourne, including urban growth areas.

Recommendation 9

ANF (Vic Branch) recommends that additional funding be provided to mental health mother and baby units to: enhance their ability to provide timely support and intervention; to better meet increasing demand of families experiencing mental ill health; to prevent and provide early intervention of child abuse; and to improve access throughout metropolitan Melbourne and rural Victoria.

Aboriginal Health Services

ANF (Vic Branch) concur with our colleagues from the Victorian Aboriginal Community Controlled Health Organisation (VACCHO) that additional and ongoing funding must be guaranteed to the wide variety of health services providing professional care and support to children and families of Aboriginal or Torres Strait Islander descent. (Nicole Huxley, CEO VACCHO, personal contact 8/05/11).

In addition to the strategies outlined in this submission to facilitate better collaboration between mainstream midwifery and MCH nursing services and specific aboriginal health services ultimately providing care to children and families of Aboriginal and Torres Strait Islander descent, it is critical that each and every family receiving care have access to a qualified and registered maternal and child health nurse.

Recommendation 10

ANF (Vic Branch) recommends that:

- **Qualified maternal child health nurses - who are preferably of Aboriginal or Torres Strait Islander descent – be employed at every Aboriginal Community Controlled Health Organisation (ACCHO)**

- **Government introduce recruitment and retention measures to increase the number of MCH nurses of Aboriginal or Torres Strait Islander descent through:**

- Providing enhanced scholarships to nurses or midwives of Aboriginal or Torres Strait Islander descent wishing to undertake MCH programs of study

- Providing MCH nurses and midwives within such services competitive salaries and employment entitlements

- MCH nurses be provided accredited education and professional development in Aboriginal and Torres Strait Islander cultural awareness to ensure they provide culturally competent MCH nursing care and thereby increase engagement of MCH nursing services by mothers and families of Aboriginal and Torres Strait Islander descent

SCHOOL NURSING PROGRAMS (PSNP/SCNP)

PSNP

Whilst the PSNP provides valuable health screening children attending prep year in government and Catholic schools, this capacity of this service to identify and make early interventions around child abuse and neglect could be strengthened through further government investment.

Funding to this service currently enables the program to offer health screening, triage and referral to appropriate support or child protection services.

Under the PSNP, nurses work across regions and can be responsible for between 20 to 30 primary schools or between 1000 to 1200 students. The workloads associated with completing such assessments are not insignificant and leave limited opportunity for face to face contact with students and families identified at risk – let alone case management or more intensive follow up.

It is important to build on the services already provided by the PSNP, and ensure it is better resourced to enable nurses greater opportunity for direct contact with vulnerable children and families. Nurses within the PSNP often have established relationships in place with students they have identified at risk, have a good knowledge of community support services and can liaise with school teaching and support staff.

Recommendation 11

ANF (Vic Branch) recommends that additional Primary School Nursing Program (PSNP) nurses be employed within Victorian Primary Schools to: reduce existing PSNP workloads; and enable nurses within the PSNP greater opportunity for direct contact and intervention with children and families at risk.

SSNP

Despite the critical function provided by the SSNP this program is not universally provided, and does not extend into every secondary school in Victoria. The effect of limiting school nurses to schools identified as 'vulnerable' has the direct effect of denying all other schools- and students - the manifest benefits of the SSNP.

In its report titled *Review of the Secondary School Nursing Program Final Report (2009)*, KPMG recommended in its executive summary.

> *that additional resources be allocated to ensure there is a state funded nurse in each secondary school throughout Victoria (page 25).*

Unfortunately however this recommendation is yet to be implemented.

Recommendation 12

ANF (Vic Branch) recommends that a registered nurse be allocated and employed in every Victorian secondary school as recommended in the *Review of the Secondary School Nursing Program- Final report (2009)* undertaken by KPMG.

3. ***The quality, structure, role and functioning of: family services; statutory child protection services, including reporting, assessment, investigation procedures and responses; and out-of-home care, including permanency planning and transitions; and what improvements may be made to better protect the best interests of children and support better outcomes for children and families.***

3.2 Providing a quality service to vulnerable children and families is dependent on having a skilled workforce. What are the strengths and weaknesses of current workforce arrangements eg working conditions, training and career paths? How might any weaknesses be addressed?

MCH WORKFORCE

The maternal and child health nursing workforce is the key plank or platform for the majority of nursing services critical to the prevention and early intervention of child abuse and neglect, including the universal MCH service, the enhanced MCH nursing service, the MCH line and early parenting services.

Given this, any investment in the core maternal and child health nursing workforce will have enduring and far reaching benefits across all health care services involved in providing care and early intervention of child abuse or neglect.

It is therefore critical to identify the strengths within the current MCH workforce and areas in which it can be further enhanced and able to meet demand for MCH nursing services into the future. These will be explored in conjunction with the characteristics of the workforce detailed below:

- Qualifications. MCH nurses within Victoria are required to be qualified and registered as nurses, midwives, and to have undertaken accredited post graduate studies in MCH nursing such as the Postgraduate Diploma of Nursing Science in Child, Family and Community (La Trobe University Bundoora) or the Post Graduate Diploma in Child and Family Health Nursing (RMIT University, Bunndoora). MCH nurses may also elect to undertake further study at Masters Level.

  The comprehensive educational preparation of MCH nurses is the cornerstone to their ability to provide care and support to young mothers, families and children, and is the most significant strength in the capacity of the MCH workforce to respond to, and make early interventions that prevent or circumvent child abuse and neglect.

- Age. The MCH workforce is ageing. As of June 2010 approximately 960 MCH nurses were employed across Victoria. 33% of these were aged 56 years and over and 14% were aged 60 years and over. (Municipal Association of Victoria, 2011)

  At the same time the Australian Institute of Health and Welfare statistics confirm this trend with the average of MCH nurses being 46.2 years. (Australian Institute of Health and Welfare, 2010)

  The ageing of the MCH workforce presents challenges for workforce planning. It is imperative that estimates be made of the number of MCH nurses that can be reasonable expected to retire from the profession in the next 5 to 10 years, and moreover measures be introduced to replenish the MCH workforce in sufficient numbers to match predicted demand for MCH nursing services.

  Principle among measures to attract prospective MCH nurses to the profession are scholarships to assist nurses and midwives to undertake the requisite MCH post graduate or masters level study. These scholarships are generally $3,500 and assist prospective nurses and midwives to meet the costs of post graduate nursing studies which generally total around $12,000 to $14,000. These scholarships are currently provided by:

  - MAV under their Workforce Initiative. ANF (Vic Branch) is advised that 15 post graduate scholarships were available in 2011 (Municipal Association of Victoria, 2011)
  - Local government
  - Commonwealth government

These scholarships are a significant strength of the current MCH workforce and have been instrumental in ensuring sufficient supply of MCH nurses (Municipal Association of Victoria, 2011).

At the same time, ANF (Vic Branch) considers there is considerable scope to further enhance these scholarships through increasing their quantum and also the total number available to prospective MCH nurses.

- Gender. Similar to nursing and midwifery, the MCH workforce is predominantly female.

- Salaries and working conditions. Wages and working conditions are negotiated between individual councils that employ MCH nurses and ANF (Vic Branch) as their industrial representative. There are currently vast differences between the substantive salary provided to MCH nurses and local Councils. Addressing these differences and ensuring that MCH nurses enjoy parity in salary and employment entitlements represents a significant area in which the workforce can be enhanced and thus better equipped to provide primary preventative care and early intervention around child abuse and neglect.

  Additionally there is a strong need to improve the workloads of MCH nurses through ensuring MCH nurses are recruited and retained in sufficient numbers to meet MCH service demand.

  MCH nurses are predominantly employed Monday to Friday during office hours and are not regularly required to perform shift work commonly required of nurses and midwives in the acute setting. This is seen as a desirable aspect of their employment conditions

- Employment status. MCH nurses may be employed in fulltime and part time capacity

- Job satisfaction. There are high levels of job satisfaction within MCH nurses. This can be attributed to a range of factors including the ongoing opportunity for professional development and high professional status afforded to them by the requisite educational preparation of MCH nurses. MCH nurse job satisfaction is also attributed to the professional enjoyment gained through working with the community and the opportunity to implement primary and preventative care

- Turnover. MCH nurse turnover is relatively low, with attractions mainly arising from the ageing of the MCH nurse workforce. (Municipal Association of Victoria, 2011)

Recommendation 13

ANF (Vic Branch) recommends that government, the Department of Education and Early Childhood Development (DEECD) and Municipal Association Victoria (MAV) expand upon initiatives that enhance the retention and recruitment of Victorian MCH nurses through:

- **Continuing to require that Victorian MCH nurses be registered with the Australian Health Practitioner Regulation Agency (AHPRA) as nurses and midwives and have successfully completed post graduate or masters level MCH programs of study that contain comprehensive child protection content**

- Increasing the quantum and total number of scholarships for MCH programs of study
- Providing competitive salaries and attractive employment entitlements to MCH nurses
- Providing ongoing opportunities for professional development to MCH nurses

3.4 What are the strengths and weaknesses of our current statutory child protection services in relation to responding to and assessing suspected child maltreatment?

3.4.3 What has been the impact of the Victorian system of mandatory reporting on the statutory child protection services? Have there been any unintended consequences from the introduction of the Victorian approach to mandatory reporting and, if so, how might these unintended consequences be effectively addressed?

The Children, Youth and Families Act 2005 requires that nurses and midwives must report to Child Protection Services when in the course of their professional duty they form the belief on reasonable grounds that a child is in need of protection…. [because}:

> *….the child has suffered, or is likely to suffer, significant harm as result of physical injury and the child's parents have not protected, or are unlikely to protect, the child from harm of that type*
>
> *the child has suffered, or is likely to suffer, significant harm as a result of sexual abuse and the child's parents have not protected, or are unlikely to protect, the child from harm of that type*
>
> *the child has suffered, or is likely to suffer, emotional or psychological harm of such a kind that the child's emotional or intellectual development is, or is likely to be, significantly damaged and the child's parents have not protected, or are unlikely to protect, the child from harm of that type….*(Children, Youth and Families Act 2005) http://www.legislation.vic.gov.au/Domino/Web_Notes/LDMS/LTObject_Store/LTObjSt5.nsf/DDE300B846EED9C7CA257616000A3571/99717ED8BF56F511CA25780800819AD9/$FILE/05-96a030bookmarked.pdf last accessed 5/05/11

ANF (Vic Branch) supports the intent and principles of the Children, Youth and Families Act 2005 in respect of mandatory notifications, however at the same time signpost that such obligations can pose ethical and practical questions for nurses and midwives (Johnstone, 1999). These include:

- The perceived threat to the nurse/midwife and client professional relationship. Such a threat can weaken or sever the integrity of the professional relationship between the nurse/midwife and client and have the unintended consequence of clients withdrawing from the care of nurses and midwives, and therefore from the very services and support

that are so crucial to the prevention and early intervention of child abuse and neglect. The sensitivity with which such issues must be managed underscores the vital importance of ensuring that MCH nurses commonly charged with making such notifications - and providing care and support to children and families at risk – continue to be well qualified and experienced in managing these complex interactions

- The perceived breach of client confidentiality

- An assessment of the benefits of making a mandatory notification to Child protection Services versus the benefits and harm that could arise as a consequence of making this report. ANF (Vic Branch) is aware of the regrettable circumstance whereby nurses and midwives who have assessed that a child is at sufficient risk to trigger their obligation to make mandatory notification to Child Protection Services, feel nonetheless that such a report would achieve more harm than good for the child or family risk. This assessment commonly arises from a lack of faith in the capacity of Child Protection Services to intervene in a timely manner and provide quality support and assistance

  This scenario underscores the critical need for Child Protection Services to be resourced and supported to provide timely intervention from staff with appropriate educational underpinning to do so. This additional support and resourcing must also extend to the Child FIRST program

  Whilst the ANF (Vic Branch) fully supports the obligations for nurses and midwives to make mandatory notifications under the Act we believe it is critical that measures be implemented to minimise the unintended consequences of the Act outlined above. We are of the view that such measures should focus on providing all nurses and midwives ongoing professional education on all matters relating to Child Protection, boosting the undergraduate preparation of nurses as detailed under term of reference 2.2, and through ensuring the Child Protection Service provides timely and quality interventions from staff who are appropriately qualified and educated to do so

Recommendation 14

ANF (Vic Branch) recommends that:

- **Resourcing of Child Protection Services be significantly increased to enable it to provide quality and timely support and intervention**

- **Government consider employing experienced and appropriately qualified MCH nurses within Child Protection Services to provide quality intervention and support to families with complex issues and at significant risk of harm**

CONCLUSION

It is clear from the territory canvassed in this report that there is significant imperative and opportunity to reduce and prevent the incidence of child abuse and neglect.

Improving the capacity of existing primary secondary and tertiary health services to meet existing and projected demand, and to provide timely and quality early intervention is the linchpin to preventing and reducing child abuse or neglect.

Nurses, midwives and MCH nurses have unparalleled ability to prevent and make early interventions in the critical formative years of a child's life and beyond, and should feature significantly in reforms to improve the effectiveness of measures to prevent and reduce child abuse and neglect.

ANF (Vic Branch) is privileged to submit this paper to the *Protecting Victoria's Vulnerable Children Inquiry.*

REFERENCE LIST

Australian Institute of Health and Welfare 2010. Nursing and Midwifery Labour Force 2008. Bulletin No. 81. Cat. No. Aus 130. Canberra: AIHW. Additional Material. Table 3. Available at http://www.aihw.gov.au/piblications/inex.cfm/title/12017

Baldwin, A. (2001) *Nurses must take a Stand Against Violence,* Kai Tiaki Nursing New Zealand

Blakester, A. (2006) *Practical Child Abuse and Neglect Prevention a Community Responsibility and Professional Partnership,* NCPC Newsletter Vol. 14 No. 2: 2 – 10

Caldwell, R.A. (1992) *The Costs of Child Abuse Prevention: Michigan's Experience.* Michigan: Michigan Children's Trust Fund and Michigan State University

Children, Youth and Families Act 2005
http://www.legislation.vic.gov.au/Domino/Web_Notes/LDMS/LTObject_Store/LTObjSt5.nsf/DDE300B846EED9C7CA257616000A3571/99717ED8BF56F511CA25780800819AD9/$FILE/05-96a030bookmarked.pdf last accessed 5/05/11

Department of Communities, Queensland. (2011) www.childsafety.qld.gov.au/child-abuse/factors.htm last accessed 13/04/11

Department of Education and Early Childhood Development Victoria (2011). *Maternal and Child Health Service Guidelines 2011*
http://www.eduweb.vic.gov.au/edulibrary/public/earlychildhood/mch/mchsguidelines.pdf last accessed 10/05/11)

Department of Education and Early Childhood Development Victoria. (2009) *Maternal and Child Health Service: Practice Guidelines 2009*

Department of Education and Early Childhood Development Victoria. (2003) *The Enhanced Maternal and Child Health Service Guidelines, 2003 – 2004*

Department of Education and Early Childhood Development Victoria. (2009) *The State of Victoria's Children 2009. Aboriginal children and Young People in Victoria* http://www.eduweb.vic.gov.au/edulibrary/public/govrel/Policy/children/sovc-2009.pdf last accessed 3/05/11

Department of Education and Early Childhood Development Victoria. (2010) *Framework for communication between Victorian maternity and newborn services, the MCH Service, and other service providers 2010* (Unpublished)

Department of Education and Early Childhood Development Victoria. Maternal and Child Health Services Annual Report 2004-2005; 2005-2006; 2006-2007; 2007-2008; 2008-2009; 2009-2010 http://www.education.vic.gov.au/ecsmanagement/matchildhealth/annualdata/archive.htm last accessed 3/05/11

Department of Human Services Victoria. (2001) *Safe from Harm The Role of Professionals in Protecting Children and Young People*

Education and Training Committee, Parliament of Victoria. (2010) *Final Report Inquiry into the Potential for developing Opportunities for Schools to Become a Focus for Promoting Healthy community Living*

Hayes, L. and Matthews, J. (2003) *Report to the Queen Elizabeth Centre on the Evaluation of the Queen Elizabeth Day Stay Program for Mothers with Infants and Toddlers.* Victorian Parenting Centre. http://www.qec.org.au/assets/pdf/QEC-DayStayEval-Report1.pdf last accessed 3/05/11

http://www.health.vic.gov.au/maternitycare/progs.htm#koori last accessed 3/05/11. Victorian Government Health Information, Department of Human Services Website

http://www.latrobe.edu.au/coursefinder/local/2011/Postgraduate-Diploma-of-Nursing-Science-in-Child%2C-Family-and-Community.6645.html last accessed 5/05/11 La Trobe University Bundoora Website

http://www.qec.org.au/what-we-do.php?id=26 last accessed 3, May 2011. Queen Elizabeth Centre, Learning Parentin. Queen Elizabeth Centre, Learning Parenting Together Website Together Website

Huxley, N. Chief Executive Officer VACCHO, personal contact 8/05/11

Johnstone, M-J. (1999) *Reporting Child Abuse: Ethical Issues for the Nursing Profession and Nurse Regulating Authorities A Report to the Nurses Board of Victoria*, RMIT University

Kearney, M.H., York R. and Deatrick, J.A. (2000) *Effects of Home Visits to Vulnerable Young Families.* Journal of Nursing Scholarship; 32, 4: 369 – 376

KPMG. (2009) *Department of Education and Early Childhood Development Review of the Secondary School Nursing Program Final Report* - Executive Summary

Lawn, J.E., Tinker, A., Munjanja S.P. and Cousens, S. (2006) *Where is Maternal and Child Health Now?,* The Lancet Vol. 368: 147 – 1477

Municipal Association of Victoria. (2011) Workforce Initiative

Parry, Y., Maio-Taddeo, C., Arnold, L. and Nayda, R. (2009) Professionals Protecting Children, *Child Protection and Nursing and Midwifery Education in Australia*, Australian Centre for Child Protection, University of South Australia

Plitz, A. and Wachtel, T. (2009) *Barriers that Inhibit Nurses Reporting Suspected Cases of Child abuse and Neglect,* Australian Journal of Advanced Nursing Vol. 26, No. 3: 93 – 100

Ridgeway, L. Course Co-ordinator, Child Family and Community Nursing, Division of Nursing and Midwifery, La Trobe University Personal Contact 5/05/11

Royal Australian Nursing Federation, Infant Welfare Special Interest Group. (1980) *Our Viewpoint on Child Abuse*

The Maternal and Child Health Line Annual Report July 2000 to June 2001. (Unpublished)

The Victorian Association of Maternal and Child Health Nurses, ANF (Vic Branch). (2010) *Competency Standards for the Maternal and Child Health Nurse in Victoria*

Tomison, A. and Poole, L. (2000) Preventing Child Abuse and Neglect: Findings from an Australian Audit of Prevention Programs. *Melbourne, Australia: Australian Institute of Family Studies*

Treyvaud, K., Rogers, S., Matthews J. and Seymour, L. (2006) *Evaluation of the Queen Elizabeth Centre's 5-day Residential Program,* Parenting Research Centre. http://www.qec.org.au/assets/pdf/QEC-residential-program-final-report.pdf last accessed 3/05/11