



Submission S029
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 Family and Community Development Committee

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Ms Maree Edwards MP
 Chair, Family and Community Development Committee

c/- The Executive Officer
 Family and Community Development Committee
 Parliament House, Spring Street
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Inquiry into Perinatal Services

Dear Ms Edwards

Caroline Chisholm Society (CCS) welcomes the Inquiry into Perinatal Services of the Family and Community Development Committee and provides our submission here.

Victoria can and should be the best place in the world to have and raise your baby. Caroline Chisholm Society believes that:

- the inquiry must be clear about the definition of perinatal services to effectively reform it in response to tragedies in the community and this requires mapping of health and social services as well as analysis of data,
- however you define perinatal services, there is a clear need for better linkages between health and community services in part in order to address the social determinants of health,
- of all the social services (including housing) needed during the perinatal period the one in most dire need of investment and coordination is perinatal mental health, and
- the disparity between rural and regional areas compared with metropolitan Melbourne needs redress.

Victoria needs a perinatal service system that retains its distinctive cross-sectoral nature but is better coordinated.

Caroline Chisholm Society is in a unique position to reflect on the experiences of mothers and children. For over 45 years Caroline Chisholm Society has supported mothers and families in north and west Melbourne, the urban fringe and Goulburn Valley to offer a safe and nurturing environment for their children. At our Mother's Day and Children's Week parties, we gather the views of a wide range of mothers to inform submissions of this kind. We seek the views of volunteers engaged across the communities we work in. We also draw on the expertise of home visiting case workers who are working directly with expectant and new mothers and their families to prevent homelessness and engagement with child protection, workers offering one-off appointments to give new and pre-loved baby and maternity goods and workers who help with navigation of the service system.

We hope all members of the Family and Community Development Committee will read and consider our views about how to make Victoria the best place in the world to have and raise your baby.

Yours faithfully,



Helen Cooney
 Chief Executive Officer
 13 July 2017

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Pregnancy and family support service

Submission to the
**Victorian Parliamentary
Inquiry into Perinatal Services
2017**

Family and Community Development Committee
58th Parliament of Victoria



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Executive Summary

For over 45 years, the Caroline Chisholm Society (CCS) has supported mothers, babies, toddlers and families during the perinatal period. CCS has aimed to be available for them from the time they learn of their pregnancy until their youngest child is school age. The team has helped well over 1000 families per year in the last 5 years and it is estimated that up to 25,000 families have been supported since doors opened. In the 2016–17 financial year, CCS provided home visiting case work support to approximately 250 families in their homes and offered over 1000 appointments in our offices. At these, the most prevalent issues faced by expectant and new families were poverty, risk of homelessness, mental health concerns, social isolation and family violence. Approximately 50% of those visited for family support were born in a country other than Australia, with the majority of them being from Asia (24%) and Africa (11%).

Research confirms that governments are investing too late for the most benefits to be reaped. [See Section 1: Defining, mapping and understanding perinatal services] From the experience of CCS, lack of service integration has meant that mothers, babies and toddlers are falling through the cracks between primary health and community services. Women come to CCS for social and emotional wellbeing support. They are at commonly at risk of entering the child protection system. [See Section 2: Integrated practice between health and social services] CCS provides community based social services, to complement and support primary health services address the social determinants for health. This includes support for known social issues such as family violence, homelessness, and life controlling addictions. [See Section 3: The social determinants of health] In particular, support for perinatal mental health requires a coordinated health and community service response and significant investment for women, infants, children and other family members during and after pregnancy. [See Section 4: Perinatal mental health]

From CCS experience, the service access disparity between metropolitan rural and regional areas results in greater numbers of mothers, babies and toddlers needing their immediate needs met through a listening ear and material aid such as new and

pre-loved baby and maternity goods. When CCS offers that listening ear, it hears the realities on the ground and can see that rural and regional mothers and their babies deserve a significant proportion of any new funding. CCS has directly dealt with the social and emotional wellbeing impacts of the tragic infant deaths in Bacchus Marsh and the heartbreaking cuts to the National Perinatal Depression Initiative. [See Section 5: The rural/regional–metro divide].

In addition, to meet the needs of future generations, Victoria needs to build the capacity of staff (both in health and community services) to respond to pregnancy and early parenting with compassion and service excellence through training and other professional development and attracting young people to careers in perinatal services through ensuring people are attracted to relevant courses and enabling clear paths. [See Section 6: Victoria’s capacity to respond]

“Victoria can and should be the best place in the world to have and raise your baby...”

Victoria can and should be the best place in the world to have and raise your baby – a State where infants are able to reach their potential because all family members especially mothers are supported to raise them in a safe and nurturing environment. CCS has a vision for a Victoria where families are stable and well connected to their communities, where support is delivered by primary or universal health and community services, where secondary level services (homelessness and family violence supports) are just touch points helping to prevent and treat escalation because of an outstanding perinatal mental health system is ensuring good linkages. This is a Victoria where tertiary level services are a safety net and not a norm, where children at most risk are in the most therapeutic environments, not the least, where those in need of early intervention are helped quickly and effectively. To achieve this, Victoria needs a strong expert and growing universal service support system with integrated planning and care. [See Section 7: A Vision for Perinatal Services in Victoria]

“Caroline Chisholm Society believes that:

- the inquiry must be clear about the definition of perinatal services to effectively reform it in response to tragedies in the community and this requires mapping of health and social services as well as analysis of data,
- however you define perinatal services, there is a clear need for better linkages between health and community services in part in order to address the social determinants of health,
- of all the social services (including housing) needed during the perinatal period the one in most dire need of investment and coordination is perinatal mental health, and
- the disparity between rural and regional areas compared with metropolitan Melbourne needs redress.

Victoria needs a perinatal service system that retains its distinctive cross-sectoral nature but is better coordinated.”

Recommendations:

1.

Define perinatal services through mapping of health and social services and analysis of data.

To do this Victoria needs to:

- 1.1. Define Perinatal Services as those services meeting all needs of families including social and emotional wellbeing from the time a family learn of their pregnancy until their youngest child is 3 years of age.
- 1.2. Map the services and issues for families with complex presentations during the perinatal period including looking to health and child protection data.
- 1.3. Respond to the research and acknowledge the rights of infants during and after pregnancy by funding services focussed on the first 1000 days of life.

2.

Integrate practice between health and social services for expectant and new families.

To do this Victoria needs to:

- 2.1. Coordinate better across the silos of health, community health and social services:
 - 2.1.1. Streamline consultation (in health services) and assessment (in community services) to improve outcomes through access and integration improvements at minimal cost. For example ask questions once and share data.
 - 2.1.2. Reduce duplication of the number of professionals engaging with families long term and undertake comprehensive initial assessments, including risk assessments.
 - 2.1.3. Review health information management and privacy legislation to enable collaborative practice, continuity of care and longer-term engagement with families needing supports.
 - 2.1.4. Enable strong networks and links between social service professionals employed in hospitals and the community sector. Likewise links between health professionals employed in the community sector and the health sector.
- 2.2. Engage consistently with families through caseload models of perinatal support state-wide:
 - 2.2.1. Engage with families earlier and maintain longer term relationships from pregnancy through to a child turning at least 3 years of age – strengthening the partnership approach with families and increasing the opportunity to motivate change.
 - 2.2.2. Broaden the use of existing “caseload” models of care such as the midwife case load model and the CCS model of working with families and establish trusted long-term relationships to navigate health and community service systems. Use existing programs and integrated models of practice applying standard protocols. By mapping existing “best integrated practice” models regional service gaps will be readily identified.

- 2.3. Embed true cross-sectoral and intergovernmental collaboration and partnership including through a culture of leadership and learning:
 - 2.3.1. Share examples of best practice perinatal service delivery in community partnerships and develop standards of practice – where local government and community sector partnerships have successfully delivered long term and sustainable outcomes.
- 2.4. Allow learning from success and failure and make better use of quality systems and risk management frameworks:
 - 2.4.1 Provide a means to share and learn from our successes and our misses. Facilitate the growth of trusted learning hubs with State government central to that leadership and facilitation. Agencies must be accountable and there must be consequences for failure to meet minimum standards. Learning organisations however must be “safe” to share what didn’t work.

3.

Address the social determinants of health with good social services.

To do this Victoria needs to:

- 3.1. Carefully consider social services and their reform when looking at perinatal services:
 - 3.1.1. Including targeting social housing and homelessness support funds towards families during the perinatal period.
 - 3.1.2. Get child and family services reform right and include processes for review and amendment in the context of health.
 - 3.1.3. Ensure perinatal inquiry considers the child and family services reform, not just changes to the health and community health context.

4.**Invest immediately in perinatal services and once the critical shortage is addressed, reform and further increase funds for perinatal mental health services to meet the needs of expectant and new mothers and their babies.**

To do this Victoria needs to:

4.1. Invest immediately in perinatal services:

- 4.1.1. Including work by specialist agencies across the health and community sectors to ensure that mothers have support with the goal of preventing further family risk and complexity. This specialist work should be done on a regional basis and undertaken collaboratively across sectors to significantly strengthen and support families.
- 4.1.2. Increase access to parenting group programs.
- 4.1.3. Better protocols and referral pathways for mental health treatment and support. (e.g. By using a caseload professional to reduce the need for women to repeat their stories; For referrals and information sharing and awareness raising between relevant mental health and community service professional to meet reasonable medical concerns for the infant and the mother. This is especially important in the case of a maternal pre-existing mental health diagnoses.)
- 4.1.4. Advocate through peak bodies and leading perinatal mental health experts, to re-establish perinatal mental health funding in a national and State Government partnership.
- 4.1.5. Work with Medicare Local networks for community based programs of mental health supports and psychologist consultations to receive Medicare rebates.
- 4.1.6. Improve access to therapeutic programs on a more widely accessible basis. They provide a means of strengthening family relationships and health and wellbeing as an early intervention service, preventing the emergence of complex issues and behaviours later in life.
- 4.1.7. Fund local area, evidence based programs that enable access to address health, mental health and other complex family issues through trusted relationships with professionals.
- 4.1.8. Implement policies aligned with the WAIMH Statement on the Rights of the Infant.

4.2. Reform and further increase funds for perinatal mental health to ensure these immediate responses are working.

5. Redress the disparity between metropolitan areas and the regions.

- 5.1. Ensure the inquiry understands the needs of rural and regional Victoria's diverse needs.
- 5.2. Establish Regional Secondary Level Service in Goulburn Valley. The demand in the region is high with a high level of family complexity and regional disadvantage most notably long-term unemployment and poverty.
- 5.3. Deliver evidence based therapeutic programs in regional centres. Such programs should be initially rolled out across the State in all major centres; namely Warrnambool, Horsham, Mildura, Wodonga, Shepparton, Bendigo, Geelong, Ballarat and Gippsland (Latrobe Valley). Early intervention programs of this kind through the strong trusted networks will reduce reliance on higher secondary or tertiary care requirements in those centres, enable prompt community response if service escalation is required and ensure that families can be readily supported where they live.
- 5.4. Invest in new or enhanced regional services with expertise in cross cultural service delivery.
- 5.5. Invest in regional hubs of health and community services:
 - 5.5.1. These would be like the Craigieburn and Melton "super clinics" so families can locally access not just primary services or emergency/tertiary services in hospitals but a secondary level of service as well.
 - 5.5.2. Several regional centres have vibrant health and community services. Such regions can be targeted to establish "wrap around" services and supports that it is anticipated will in turn attract health and community professionals seeking to establish and grow new services and models of support.

6. Build Victoria's capacity to respond to perinatal issues, especially perinatal mental health.

- 6.1. Invest in future workforce
 - 6.1.1. Train more community and health sector staff as accredited providers of evidence-based parenting group-work programs. There is existing expertise to leverage and readily expand upon to achieve effective program reach to immediately alleviate the impact of the cut to the NPDI.
- 6.2. Create a clearly delineated perinatal service oversight that shares knowledge of our different roles across sectors in the provision of "whole of person and whole of family" support during that first 1000 days. Victoria must create opportunities and forums for cross sector awareness and networks. Victoria must share current and emerging research in perinatal health and perinatal service. Victoria must govern perinatal services with cross-sectoral methods.
- 6.3. Implement a Parenting Communications Information Plan to promote excellent existing parenting information, identify gaps in parenting advice, and promote existing quality resources including online, parent group and mentoring style programs.

Section 1: Defining, mapping and understanding perinatal services

Victoria has some of the best perinatal services in the world and Caroline Chisholm Society (CCS) is proud to be an important part of that perinatal system. CCS is a specialist agency offering perinatal services and leveraging support from other sources during the perinatal period. [See Appendix 1: Caroline Chisholm Society] This submission focuses on the importance of community in supporting families during pregnancy and the early years. It offers examples and evidence of “best practice” in areas considered priorities for service development.

Defining perinatal

For the purposes of this submission, CCS defines the perinatal period from the time a woman is aware of her pregnancy until the child is three years of age. Some define perinatal as to 6-weeks due to the health vulnerabilities of the mother and baby. Others, including CCS, provides services for families with children up to school age due to a desire to deliver on the promises made during the first three years. For this submission, the time a woman is aware of her pregnancy to 3 years is applied because for families who are or are at risk of becoming vulnerable during the perinatal period, there are serious service and support gaps requiring the attention of the Parliamentary inquiry.

In preparing this submission, CCS attempted to map the services available to families, including families considered at risk or vulnerable, during the perinatal period. In doing so, it became apparent that the perinatal support system may have excellent services but it is fractured there are few examples of clear pathways between services.

The attached graphic (Figure 1: Illustrating the need to define and map perinatal services) seeks to illustrate the challenge CCS faced in providing advice to the committee. It is apparent that families have few supports after their child is 6 weeks old, that there is a disjuncture between health and community services in the period after 6 weeks resulting in few alternatives than Child Protection, and there is no real way to meet the increasing demand for varying levels of mental health support.

The illustration provided here is not a complete picture and mapping by the inquiry would allow Victoria to have a better grasp of service gaps better and doing so requires the first step, to define the perinatal period.

Figure 1: Illustrating the need to define and map perinatal services

Perinatal phase	A selection of the community services entry points available			A selection of the health services entry points available		
Before 26wks	Universal	Secondary • Wellbeing (CCS)	Tertiary • Cradle to Kinder • Child Protection	Tertiary • Obstetric care	Secondary • Obstetric care • Allied health services	Universal • General Practitioners • Midwives
26wks to birth	Universal	Secondary • Wellbeing (CCS) • Mental Health (PANDA)	Tertiary • Cradle to Kinder • Child Protection	Tertiary	Secondary • Midwife case model	Universal • Antenatal Classes • Midwives
Birth to 6wks	Universal	Secondary • Wellbeing (CCS) • Mental Health (PANDA) • Breastfeeding (ABA)	Tertiary • Cradle to Kinder • Child Protection	Tertiary • Psychiatric (Mother Baby Units)	Secondary • Midwife case model • Enhanced Maternal and Child Health • Early Parenting (Tweddle, O'Connell and QEC)	Universal • Midwives • Maternal and Child Health
6wks to 2yrs	Universal • Child Care (Limited) • Playgroups (Limited)	Secondary • Wellbeing (CCS) • Mental Health (PANDA)	Tertiary • Child Protection	Tertiary • Paediatric specialists	Secondary • Early Parenting (Tweddle, O'Connell and QEC)	Universal • 24hr MCH Line
3yrs	Universal • Child Care • Early Start Kinder (Limited) • Playgroups	Secondary • Wellbeing (CCS) • Education (Early Start Kinder) • Mental Health (PANDA)	Tertiary • Child Protection	Tertiary	Secondary	Universal • 24hr MCH Line
4yrs and over	Universal • Kinder	Secondary • Wellbeing (CCS) • Mental Health (PANDA) • Breastfeeding (ABA)	Tertiary • Child Protection	Tertiary	Secondary	Universal

Notes:

- Listing only represents a selection of services dedicated to perinatal period (as opposed to general, e.g. GPs and nurse on call)
- Services may 'stay' engaged, but entry point timeline is represented here.

Research on early investment and the rights of infants during and after pregnancy

It is well evidenced that a high-risk period in a young child's life is from infancy to two years of age (Wu et al 2004). Despite this, it is noted that there is a drop-in service and support for families once a child reaches about 6 weeks of age. It is also noted that universal services pick up family support levels around three years of age when a child is able to access education and three-year-old kindergarten services.

The World Association for Infant Mental Health has recently updated and released a statement on the rights of infants. It notes that it is very common that infants to be considered "too small or young to really understand or remember". A baby's perspective and needs can therefore be overlooked by health professionals and parents alike (WAIMH 2016). WAIMH has also developed a list of policy areas that if adopted would go a long way to meet an infant's rights. [See Appendix 2: World Association for Infant Mental Health Recommendations]

In specifying the unique needs and rights of infants it is hoped there will be greater drive to establish improved evidence based infant and early years services and policy at both local community and state level. The critical importance of the first 1000 days for optimal brain development has been well known for many years (Perry et al 1995, Heckman, 2000). Likewise, the cost benefit of investment in the early years and perinatal period is also well known. [See Appendix 3: Mismatch between investment and opportunity]

Why is it that 20 years since the emergence of clear evidence supporting the case to change investment strategies has there been little move to routinely apply principles of early intervention? With this Inquiry, there is a great opportunity to make the change.

A critical driver of the CCS approach to its perinatal service delivery is the application and understanding of the social determinants of health. There is significant evidence globally that health inequality and the incidence of poor health outcomes are affected by how people are born and how they live, work, grow and age, which are shaped by money, power and resources (WHO 2010). Supporting families to house, feed and educate their children well, will have longer term societal and health benefits. This is true throughout life but critical in the perinatal period.

Why is it that 20 years since the emergence of clear evidence supporting the case to change investment strategies has there been little move to routinely apply principles of early intervention? With this Inquiry, there is a great opportunity to make the change.

Research findings are very clear on the importance of "getting in" early with families, especially antenatal. Evidence is well established and expanding on the importance to individual long-term wellbeing of sound attachment and a healthy parent-child relationship. (Bowlby 2005, Ainsworth and Bell 1970). A number of health and community services including CCS can and are providing these evidence and attachment based programs. A range of evidence based programs such as Circle of Security (Hoffman et al 2006), "Tummies to Toddlers", "Bumps to Babes" (Queen Elizabeth Centre) and Tuning into Toddlers (Havighurst et al 2012) are delivered in Melbourne and some Victorian regional centres. These programs while not universally accessible are great examples of supporting families during this critical and formative stage of learning and development.

It is also noted that there are excellent examples of collaborative practice between community and health services and such practices need to be showcased and formally assessed for potential to be rolled out to provide greater access across the State. An excellent example is the midwifery caseload program where qualified specialist professional midwives support women through pregnancy and birth as well as postnatally, coordinating care and support needs across the range of services. The key to success and improved health and wellbeing outcomes for parents and children is the establishment of longer term trusted relationships between professional and mother. Maternal and child health nursing services are also a treasured community resource, not only providing postnatal health supports for mothers and infants but also providing group programs and links to other community programs and supports for families. CCS prides itself on our collaborative practice in the community sector. [See Appendix 4: Collaborative Practice at Caroline Chisholm Society]

CCS advocates that, while a child protection and out of home care safety net is needed, families where possible need to be supported to establish and maintain healthy relationships and stay together. Where children are taken into care, especially when very young, not only is the health and wellbeing of the child impacted upon as shown in attachment based research but so too is that of the mother. Prevention through supporting healthy relationships and enhanced parenting skills not only leads to more resilient healthy adults but minimises cost of associated mental health and child protection services (Perry).

To ensure families are strong and healthy and together Victoria needs to address a number of priorities areas and strengthen the way perinatal and other professionals work together across the service system as well as how professionals respond to the diversity of families and family needs in the Victorian community. Given the Victorian population growth and increased birth rates, Victoria needs to not only to grow services state-wide, but also must find efficiencies and improved practice through collaboration, service integration and for vulnerable families, increase our expertise in supporting diverse and often complex health and psycho-social needs.

SITUATION: What and Where are Perinatal Services?

There is currently no shared understanding of what constitutes the perinatal period and what services are available to support families at this important time. Is the perinatal period from awareness of a pregnancy until birth? Until 6 weeks? Until 2 or 3 years of age? Many agencies working families during this time would probably not even consider themselves as a perinatal service.

In terms of families at risk, CCS understands that over the past 5 years there has been an increase in the number of babies and toddlers at significant risk that are known to the perinatal service system including those services incorporated in to the child protection system.

✔ SOLUTION: Define and Map the Perinatal Sector

It is urged that, as a very preliminary step a service mapping exercise be undertaken. Figure 1 above is a start but a full comprehensive picture of perinatal services and their reach/accessibility across the Victoria is needed. This will enable services to be reviewed, duplications or gaps to be identified and point to key sector reform priorities. A clear definition of the perinatal period is also needed.

It is further recommended that the Parliamentary Committee consider how relevant services need to develop to address needs of "at risk" families during the perinatal period. It is recommended the Committee ask for, and be given without hesitation, the raw figures and the proportionate increase over 5 years of:

- Children involved with substantiated reports to Child Protection
- Children being placed in out of home care
- Critical incidents being reported to DHHS, and
- Referrals to ChildFIRST.

These data should be provided in the categories of "unborn", "under 1 year" and "under 4 years". Data also needs to be provided showing numbers regionally, especially metropolitan and rural.

Recommendation 1:

Define perinatal services through mapping of health and social services and analysis of data.

To do this Victoria needs to:

- 1.1. Define Perinatal Services as those services meeting all needs of families including social and emotional wellbeing from the time a family learn of their pregnancy until their youngest child is 3 years of age.
- 1.2. Map the services and issues for families with complex presentations during the perinatal period including looking to health and child protection data.
- 1.3. Respond to the research and acknowledge the rights of infants during and after pregnancy by funding services focussed on the first 1000 days of life.

Section 2: Integrated practice between health and social services

SITUATION: There is patchy service integration – some service gaps, some over servicing and duplication – and mothers and babies are falling through the system cracks

While there are some strong established bridges or referral pathways between health and community sectors and links to universal early years health and education services, integration of practice and case management approaches to family health and support are not the norm. Established formal referral pathways exist with most of the major maternity hospitals - Southern Health (Monash and Casey), Royal Women's Hospital, Mercy Hospital for Women and Western Health (Sunshine). Relationships include neonatal units, early parenting and paediatric services. In addition, referral pathways from and to ChildFIRST platforms and general family services are well established, although more work needs to be done. One inhibitor of improved service integration is the ability to share relevant personal information between services. Despite one of the intentions of these programs being to enable families to navigate the services system easily and safely, it is still common to see families needing to work with multiple professionals and repeatedly telling their medical and family histories. A recent family case involving CCS had a staggering 30+ professionals involved. Reason enough for a family not seek help and support.

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SOLUTION: Better linkages between services across the silos of health, community health and social services

Enhancing service integration logically will not necessarily increase costs. The link between midwifery and maternal and child health is clean and this kind of transfer can occur between sectors if the permission is given to do so. Funding changes are necessary where service demand increases. Improved outcomes and improved service access can come from streamlined consultation and family assessment processes, minimising numbers of professionals engaging with families and undertaking comprehensive initial assessments, including risk assessments, that can be shared. A review of health information management and Privacy legislation is needed to enable continuity of care and longer term engagement with families needing supports. Changes to NSW information sharing requirements have recently been made – Chapter 16A allows information to be exchanged between prescribed bodies despite other laws that prohibit or restrict the disclosure of personal information, such as the *Privacy and Personal Information Protection Act 1998*, the *Health Records and Information Privacy Act 2002* and the *Commonwealth Privacy Act 1988* – and a review of these changes and possible adaptation to meet Victorian service requirements is urged.

Following the Family Violence information sharing legislation, the next logical step in Victoria for legislative reform is children. It is time to consider a Victorian version of NSW's "Chapter 16A" of their *Children and Young Persons Care and Protection Act* which allows information to be exchanged between prescribed bodies despite other laws that prohibit or restrict the disclosure of personal information. Children currently have limited agency. They need a voice. While Victoria must not go back to times when expressing concern about a young child was as simple as making a phone call, Victoria does need

to consider whether current practice really protects long term health and wellbeing. It's time for the pendulum to return some ways.

Victoria must enable strong networks and links between social service professionals employed in hospitals and the community sector. Likewise, health professionals employed in the community sector must consult and engage routinely with the health sector.

It is timely for the next budget be a landmark budget that demonstrates Victoria is world class for the raising and protection of children.

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Following the Family Violence information sharing legislation, the next logical step in Victoria for legislative reform is children. It is time to consider a Victorian version of NSWs "Chapter 16A" of their *Children and Young Persons Care and Protection Act* which allows information to be exchanged between prescribed bodies despite other laws that prohibit or restrict the disclosure of personal information. Children currently have limited agency. They need a voice. While Victoria must not go back to times when expressing concern about a young child was as simple as making a phone call, Victoria does need to consider whether current practice really protects long term health and wellbeing. It's time for the pendulum to return some ways.

SITUATION: Build trusted long-term relationships to encourage accessing evidence-based programs

It takes a village to raise a child; this truism requires an integrated approach to maternal and family support during the perinatal period. Over the last ten years there are many examples of pilot programs that have had very successful outcomes for families and young children. These health and community sector pilots are usually formally evaluated and shown to have excellent outcomes for family health and wellbeing. Unfortunately, many such programs either only continue as a locally funded service in small limited catchments or are discontinued due to lack of funding or strong networks and referral pathways that can support delivery. Success factors are commonly:

1. The service is based in local community where it is readily accessible
2. Different services, both health and community services may be co-located and actively share information, as enabled proximity and well-established relationships as well as through sharing information in accordance with any privacy requirements
3. Built on establishing long term relationships with both the parent, usually the mother, and the child
4. Built on extensive and trusted local area professional networks.

The midwifery caseload model has been very successful where it has been implemented. But few areas of the State currently benefit from this approach. Other programs that are designed around an integrated partnership. Communities for Children and Best Start programs where strong interagency and local government links are established. Bumps to Babes and Beyond successfully trialed with aboriginal families. The application of the attachment based Circle of Security therapeutic program. Not all of these successful programs have continued nor are they readily accessible to all families who would benefit from them. The outcomes from these pilots provide essential learnings for any systems reform undertaken.

✔ SOLUTION: Offer caseload models of perinatal support state-wide

More consistent practice is required. Engaging at an earlier stage with families from a universal platform strengthens the partnership approach with families and increases the opportunity to motivate change. To work more effectively with a broader range of agencies both clinical interventions and psycho social supports are needed. Together across the Victoria such models must apply. CCS is one agency already delivering partnered services to families for long term support. It is well positioned to coordinate services to young families at all levels of care, with well-established networks and relationships across the health and community sectors in the regions it currently works. Similarly midwife case managers can operate immediately on this basis. It is recommended that Victoria use existing programs and integrated models of practice applying standard protocols and codes of practice. By mapping existing “best integrated practice” models regional service gaps will be readily identified.

SITUATION: Inconsistent service delivery and the need to work together with all levels of government

Emphasis has been placed on the need for stronger links and partnerships between health and community sectors. The critical role of all levels of Government is also a major factor in whether service systems are the highest quality they can be. Local government is a major service provider to young families delivering maternal and child health services, child care – programs that clearly need strong links to community services and the health system. Overarching policy and quality accreditation frameworks, the domain of all three tiers of Government and particularly state government is fundamental to community trust that individual will access the highest standards of care and support. There is State-wide variation of approaches by local government to both service delivery of early years services as well as how strong links to relevant community and health services are.

The last five years have seen the establishment in Victoria of Quality frameworks for all funded community and family service agencies. A very welcome initiative. It is not as yet transparent however whether policy makers are using the wealth of data collected from audit processes. This is true internally for individual agencies as well as at a statewide level. Are we sharing and learning from, not just the good news, but from mistakes that we identify? Accreditation processes are well known to be time consuming and costly. The return from this important investment must be continuous improvement, must be ongoing policy review and development. it must not become an annual “tick the box exercise”.

✔ SOLUTION: Embed true cross-sectoral and intergovernmental collaboration and partnership including through a culture of leadership and learning

It is recommended that regions where local government and community sector partnerships have successfully delivered long term and sustainable outcomes be identified and standards of practice be shared. It is understood, from Best Start learning that a level of ongoing funding is required to facilitate and sustain the partnerships. This investment in the long term reduces costs through shared service models, reducing duplicated service delivery and unnecessary competition for resources. it also enables collaborative practice. Agencies especially small specialist agencies can grow that expertise and work with community partners with other specialist services. Brimbank’s community partnerships for example have successfully delivered services for over ten years and the hallmark of the success has been active involvement of all levels of government together with health and community service agencies.

✔ SOLUTION: Allow learning from success and failure and make better use of quality systems and risk management frameworks

The State Government needs to lead and facilitate learning hubs. These are a means to share and learn from our successes and our misses, but to establish such fora requires trust. Funded agencies must be accountable, and there must be consequences for failure to meet minimum standards. However, learning organisations must be “safe” to share what didn’t work without risk of over regulation as a result. Information sharing sessions from quality accreditation systems have been conducted and outstanding practice has been shared. Victoria needs to go a step further. This cannot happen in isolation and further development and engagement of relevant health and community services in policy does and must continue to complement learning opportunities.

Recommendation 2:

Integrate practice between health and social services for expectant and new families.

To do this Victoria needs to:

- 2.1. Coordinate better across the silos of health, community health and social services:
 - 2.1.1. Streamline consultation (in health services) and assessment (in community services) to improve outcomes through access and integration improvements at minimal cost. For example ask questions once and share data.
 - 2.1.2. Reduce duplication of the number of professionals engaging with families long term and undertake comprehensive initial assessments, including risk assessments.
 - 2.1.3. Review health information management and privacy legislation to enable collaborative practice, continuity of care and longer-term engagement with families needing supports.
 - 2.1.4. Enable strong networks and links between social service professionals employed in hospitals and the community sector. Likewise links between health professionals employed in the community sector and the health sector.
- 2.2. Engage consistently with families through caseload models of perinatal support state-wide:
 - 2.2.1. Engage with families earlier and maintain longer term relationships from pregnancy through to a child turning at least 3 years of age – strengthening the partnership approach with families and increasing the opportunity to motivate change.
 - 2.2.2. Broaden the use of existing “caseload” models of care such as the midwife case load model and the CCS model of working with families and establish trusted long-term relationships to navigate health and community service systems. Use existing programs and integrated models of practice applying standard protocols. By mapping existing “best integrated practice” models regional service gaps will be readily identified.
- 2.3. Embed true cross-sectoral and intergovernmental collaboration and partnership including through a culture of leadership and learning.
 - 2.3.1. Share examples of best practice perinatal service delivery in community partnerships and develop standards of practice – where local government and community sector partnerships have successfully delivered long term and sustainable outcomes.
- 2.4. Allow learning from success and failure and make better use of quality systems and risk management frameworks:
 - 2.4.1. Provide a means to share and learn from our successes and our misses. Facilitate the growth of trusted learning hubs with State government central to that leadership and facilitation. Agencies must be accountable and there must be consequences for failure to meet minimum standards. Learning organisations however must be “safe” to share what didn’t work.

Section 3: The social determinants of health

SITUATION: Working with Families with Complex Needs

CCS supports women and families who are commonly living outside their local community and service systems. This may be through lack of knowledge of what perinatal services are available or because of a lack of trust in the system. At the extreme of this are women who actively conceal pregnancy for fear of losing a child through domestic violence or through child protection (Murphy Tighe and Lalor 2016, Marsh 2016). The range of risk factors women and families present with is significant. While it is beyond the scope of this review to address them all in detail, they include:

1. Homelessness and poverty both short and long term – currently being reformed by the Victorian Government.
2. Family violence – Also under reform by the Victorian Government.
(NB: CCS, McAuley Community Services for Women and VincentCare are partners to deliver the new “Children and Mothers in Mind” program – See Appendix 4: Collaborative Practice at Caroline Chisholm Society; Children and Mothers In Mind)
3. Cultural and linguistic diversity, such as coming from emerging communities including recent migrants and refugees – An area notionally a commonwealth responsibility but increasingly an issue for such areas as family violence and child protection.
4. Aboriginal families – for whom principles of self-determination are critical in guiding services that reinforce Aboriginal culture and encourage best health and community support practices.
5. Substance abuse – Women and their partners managing drug and alcohol issues and the increased risk of harm to children in their care involving child protection.
6. Families where other health factors impact upon health and parenting capacity such as long term chronic conditions.
7. Families where children and infants have special needs such as chronic illness or a disability.

8. Families where fathers are ill-equipped and missing the opportunity for change presented at the time of becoming a parent.
9. Pre-existing maternal mental health issues impacting on maternal and child health perinatally.

The breadth of these factors that link to the social determinants of health is significant. Each of these areas requires specialist expertise that may be clinical or medical or expertise in addressing welfare, work and psych-social issues. The key and most pressing area to address now is family mental health to ensure long term benefit to the individual, the family and the broader community. Mental health issues commonly co-present with other risk factors listed above. Specialist help in addressing issues face by families will necessarily need partnerships to mental health supports.

✔ SOLUTION: Careful consideration of social services and their reform when looking at perinatal services

Many of these risk factors are being addressed by specialist agencies across the health and community sectors. This has been further supported by the recent comprehensive family violence package that is now being rolled out. There is urgent work underway that will help be a ‘glue’ or will ‘underpin’ perinatal services helping to prevent family risk and complexity. This specialist work, on a regional basis and undertaken collaboratively across sectors will significantly strengthen and support families.

The most fundamental and basic needs of people – especially in the perinatal period – need to be met in order to allow parents to offer a baby or toddler esteem, love and security. The current investment in housing and homelessness support by the Victorian Government will go some way to supporting especially vulnerable families to meet the needs of their infants, but there must be targeted support for both young and older mothers as they raise their children while at risk of homelessness or while homeless.

✔ SOLUTION: Target social housing and homelessness support funds to families during the perinatal period

SITUATION: The Complexity and Opportunity of Multi-Tiered Reform

The Victorian Government has several tranches of community services reform underway and there is potential for significant change to the way that vulnerable expectant and new families are serviced by Victorian Government funded programs during the perinatal period.

Family Violence Royal Commission

The first segment of reform that CCS highlights is in the response to the Family Violence Royal Commission. This includes the creation of support and safety hubs. ChildFIRST is to be included in these hubs. In Victoria, if a community member is concerned about the wellbeing of a child but is not concerned enough to warrant a report to child protection, that family can be referred to ChildFIRST. This is an intake system that family services providers (such as Caroline Chisholm Society) assist in governing and making decisions about how it operates. Increasingly, the referrals are coming from Child Protection instead of the community. The recently released 'concept' for these support and safety hubs proposes to take account of the best interests of children. However, there is a risk that the system will be either more or less orientated around family violence than is needed and services will be either less or more likely to be working with certain types of families. For example, an unintended consequence may be that more complex families are receiving more support, which is good, but at the cost of early intervention with parenting support for others.

Roadmap to Reform

The second segment of reform is the Roadmap to Reform. The Roadmap is an attempt to move the children and family services system from a crisis response to one focussed on prevention and early intervention. The work was intended to focus on 1) universal services such as health, maternal and child health, early childhood education and care, schools and 2) secondary services such as ours that work with vulnerable families and 3) improving outcomes for children and young people in out of home care. In practice that trio has become 1) Intensive Support in the Early Years, 2) Support and Safety Hubs plus Family Services Redesign and 3) reform of out of home care.

Family Services redesign

The project to redesign Family Services, which funds CCS home-visiting casework and is approximately 84% of CCS service provision, is intended to work on parenting skills. It tends to be focussed on working to prevent engagement with child protection. The redesign is currently considering how family services might work across a spectrum meaning the service would:

- Work with families when their child is in out of home care (e.g. to support re-unification of families, decisions by families to relinquish their custody, and/or offer therapeutic responses to support the mental health impacts for mothers).
- Work with families who have additional need for specific activities, such as advice, single session work and group work.
- Be measured differently, including through 'outcomes' as defined by the department with the potential for it be used as the contractual measure for services (e.g. instead of hours or cases, services might be measured by their capacity to change a family's situation by a measure that is not yet known).

This redesign is notionally to work on the 'back end' or 'service provision' and to take account of the changes to the 'front end' or 'assessment' caused by moving from ChildFIRST to support and safety hubs.

Intensive Support in the Early Years

As part of the Budget, the Victorian Government announced \$33.88 million over the next two years to:

- establish a new intensive in-home early childhood support service for vulnerable families based on the right home, Cradle to Kinder and Aboriginal Cradle to Kinder programs.
- work with Aboriginal communities to co-design and develop a tailored maternal child health service for Aboriginal families to encourage greater participation and improve outcomes by delivering more culturally responsive and high-quality services.
- expand the Healthy Mothers, Healthy Babies program to support more vulnerable women during pregnancy.
- These reform proposals include opposing messages – the value of the specialist services that exist and making them state-wide services, and the other of the need for reform and broad banding of funding streams.

Reform readiness

Services across the state working with vulnerable perinatal families across the state are working to be reform ready. There is the potential for substantial reform to impact the capacity of Victorian services to meet the needs of the mother or child that presents at their door because of fracturing of the system that is designed to be a safety net for children. While CCS takes the proposal at face value and looks forward to co-design being real and responsive to what isn't working in pilot sites, there is a risk that incidents involving children under 3 years of age will increase if services can't respond immediately.

✔ **SOLUTION: Get child and family services reform right and include processes for review and amendment in the context of health**

✔ **SOLUTION: Ensure perinatal inquiry considers the child and family services reform, not just changes to the health and community health context**

Recommendation 3:

Address the social determinants of health with good social services.

To do this Victoria needs to:

- 3.1. Carefully consider social services and their reform when looking at perinatal services:
 - 3.1.1. Including targeting social housing and homelessness support funds towards families during the perinatal period.
 - 3.1.2. Get child and family services reform right and include processes for review and amendment in the context of health.
 - 3.1.3. Ensure perinatal inquiry considers the child and family services reform, not just changes to the health and community health context.

Section 4: Perinatal mental health

Worldwide, women who have just given birth are at risk of experiencing a mental disorder, primarily depression. In developing countries, the rate is 15.6% during pregnancy and 19.8% after child birth. As noted by the World Health Organisation, "In severe cases mothers' suffering might be so severe that they may even commit suicide. In addition, the affected mothers cannot function properly. As a result, the children's growth and development may be negatively affected as well. Maternal mental disorders are treatable. Effective interventions can be delivered even by well-trained non-specialist health providers." (WHO, 2017) While there are also concerns for fathers, and extended family and community have a role in raising children, women by far carry the greatest portion of the early parenting load and must be supported if in need of a response to mental health issues.

There is no question that there is a need to invest immediately in perinatal services and once the critical shortage is addressed, reform and further increase funds for perinatal mental health services to meet the needs of expectant and new mothers and their babies.

There is no question that there is a need to invest immediately in perinatal services and once the critical shortage is addressed, reform and further increase funds for perinatal mental health services to meet the needs of expectant and new mothers and their babies. In the experience of CCS, families without suitable support for their mental health are at greater risk of engagement with tertiary services such as the emergency departments of hospitals, family violence services and child protection.

SITUATION: Loss of Perinatal Funding

The National Perinatal Depression Initiative (NPDI) aimed to improve prevention and early detection of antenatal and postnatal depression and provide better support and treatment for expectant and new mothers experiencing depression. This initiative benefited women who are at risk of or experiencing depression during pregnancy or in the first year following childbirth.

In 2015, the funding was cut and the loss is significant. For example, Victorian early parenting centres (EPC), such as Tweddle Child and Family Health Service in Footscray, have been funded through the program to provide psychological supports for women admitted to its programs and assessed through postnatal depression screening tools as suffering from post-natal depression (PND) and clinical anxiety relating to the birth. This secondary service level supported mother baby units in their treatment and support of acutely ill women. The secondary service reduced the long-term costs of mother baby unit bed days by providing a community based pathway to care and support. In addition to supporting maternal mental health EPCs through the NPDI funded psychologist teams, were able to provide mental health assessments of infants and fathers.

Maternal and child health nurses were also trained and supported through NPDI funding to provide a universal PND screening via application of the Edinburgh Postnatal Depression Scale. (EPDS). Community based professionals were also funded across the state to coordinate support for women identified as suffering perinatal mental health issues. Regionally these professionals had significant issues because of the large areas that they were responsible for but the service in rural Victoria was embraced. It was achieving positive outcomes helping to address factors in small communities that exacerbated PND. Social isolation, financial pressures and community stigma most notably. Without the NPDI funding it is feared that rates of perinatal depression screening will fall and ill women and children will not receive the early intervention treatment and support that they need. Trusted psychologists and counselling support will be less accessible.

The use of scales like EPDS and the Kessler Psychological Distress Scale (K10) may also assist with managing risk, holding services to account for quality of assessments, measuring client outcomes, and measuring service system wide outcomes, but doing so requires investment in research, applying the research, choosing the measures, and training the staff (and volunteers) to respond to the results.

One mother was seeking support from CCS during her pregnancy, and upon the birth of her child, her mental health deteriorated. Within two weeks of the birth of her baby, this mother was placed in a secure psychiatric unit. Due to the risks presented by other patients, the baby was not able to stay with the mother which resulted in her mental health worsening and the baby missing out on critical times to bond.

There are heartbreaking examples of the impact of this cut CCS can describe. One mother was seeking support from CCS during her pregnancy, and upon the birth of her child, her mental health deteriorated. Within two weeks of the birth of her baby, this mother was placed in a secure psychiatric unit. Due to the risks presented by other patients, the baby was not able to stay with the mother which resulted in her mental health worsening and the baby missing out on critical times to bond.

 **SOLUTION: Invest immediately in perinatal services**

It is noted that the Andrews Government has increased the mental health budget in 2016-17 seeking to in part compensate for the savage cuts federally. This is applauded. To ensure robust metropolitan and regional services and to retain specialist regional professionals additional funding is required. The Federal Minister for Health has recently declared mental health supports as a priority for his portfolio. Peak bodies, such as Beyond Blue, PANDA (Perinatal Anxiety & Depression Australia), Australian Psychology Society and professional leaders must once again seek to re-establish funding for these important services in partnership with State Government. Perinatal services must also work with Medicare Local networks for community based programs of mental health supports and psychologist consultations to receive Medicare rebates.

SITUATION: Evidence based therapeutic services group programs

Attachment theory is now widely accepted through research and a key factor in the health and wellbeing of mothers and infants. A number of local and overseas teams have developed therapeutic models of practice that strengthen maternal and child bonds from infancy as the basis for developing healthy and well adults. Group programs based on the accredited United States program Circle of Security are widely delivered across Australia with many early years professionals trained and accredited in its delivery. Similarly, an Australian based therapeutic program Tuning into Toddlers is designed to achieve positive health outcomes for very young children and their families. Bringing up Great Kids – The early years is another that focusses on mindfulness techniques. The programs provide a play group type environment that enables trained group leaders to work collectively and with individual mother-baby dyads on positive parenting and parenting skill development using positive reinforcement of mother-child interaction to develop the family bond. Secondly program leaders often identify other family issues through the development of a trusted relationship with a family. The programs are not readily or universally accessible and as community based programs are not state-wide. Broad access to group programs are also urged as an effective support for women diagnosed with post-natal depression.

✔ SOLUTION: Increase access to parenting group programs

Therapeutic programs must be more widely accessible. They provide a means of strengthening family relationships and wellbeing as an early intervention service, preventing the emergence of complex issues and behaviours later in life. Cost offsets will be achieved through long term benefits of optimal health and development pathways for the infant, healthy family relationships and reduced reliance and cost of tertiary community and health services.

SITUATION: Supporting women with complex needs and pre-existing mental health needs

Women need ready access to perinatal mental health supports from when they become aware of their pregnancy through to at least 6 weeks post-partum. Such services are accessible where a family is connected in to primary health care supports via referral from a general practitioner. Perinatal mental health issues can go unrecognised where a woman is more isolated from the service system, the more common client of CCS and other family service agencies.

Additionally, CCS commonly supports women who have pre-existing mental health issues such as bipolar disorder or schizophrenia. Such illnesses are difficult to manage prenatally because of the nature of the medication regimes. It is important for medical practitioners and perinatal specialists to work together to manage what is currently a challenging balancing act between health and wellbeing of the mother and the unborn child.

✔ SOLUTION: Protocols and referral pathways for mental health treatment and support

Establish clear protocols for referrals and information sharing and awareness raising between relevant professional to meet reasonable medical concerns for the infant and the mother. Referral pathways for vulnerable families to receive mental health support are also difficult. The need for a referral is understood but streamlining pathways via a caseload model would reduce the need for women to repeat their stories. Fund local area, evidence based programs that enable trusted access to address health, mental health and other complex family issues through trusted relationships with professionals. Access to group programs, counselling services and where indicated clinical intervention.

The new Perinatal Mental Health Guidelines currently under development Guideline serve to provide health professionals with the latest evidence to guide best practice in assessment and management of perinatal mental health across the range of primary, maternity, postnatal and mental health settings. In the implementation of these it is recommended that a broad range of health and community service professionals be trained in the use and interpretation of data from a range of mental health screening and parenting assessment tools.

Recommendation 4:

Invest immediately in perinatal services and once the critical shortage is addressed, reform and further increase funds for perinatal mental health services to meet the needs of expectant and new mothers and their babies.

To do this Victoria needs to:

4.1. Invest immediately in perinatal services:

- 4.1.1. Including work by specialist agencies across the health and community sectors to ensure that mothers have support with the goal of preventing further family risk and complexity. This specialist work should be done on a regional basis and undertaken collaboratively across sectors to significantly strengthen and support families.
- 4.1.2. Increase access to parenting group programs.
- 4.1.3. Better protocols and referral pathways for mental health treatment and support. (e.g. By using a caseload professional to reduce the need for women to repeat their stories; For referrals and information sharing and awareness raising between relevant mental health and community service professional to meet reasonable medical concerns for the infant and the mother. This is especially important in the case of a maternal pre-existing mental health diagnoses.)
- 4.1.4. Advocate through peak bodies and leading perinatal mental health experts, to re-establish perinatal mental health funding in a national and State Government partnership.
- 4.1.5. Work with Medicare Local networks for community based programs of mental health supports and psychologist consultations to receive Medicare rebates.
- 4.1.6. Improve access to therapeutic programs on a more widely accessible basis. They provide a means of strengthening family relationships and health and wellbeing as an early intervention service, preventing the emergence of complex issues and behaviours later in life.
- 4.1.7. Fund local area, evidence based programs that enable access to address health, mental health and other complex family issues through trusted relationships with professionals.
- 4.1.8. Implement policies aligned with the WAIMH Statement on the Rights of the Infant.

4.2. Reform and further increase funds for perinatal mental health to ensure these immediate responses are working.

Section 5: The rural/regional–metro divide

The poorer health and lower life expectancy of people living in rural or remote Australia are often attributed to the under-supply of health services in those areas, but this is only one contributing factor. Far more important is the distribution of health risk factors and how they interact with the nature of rural and remote places. (Barclay, 2014) Poorer outcomes during the perinatal period are no different. From the experience of Caroline Chisholm Society in Shepparton, there are complex social and economic reasons, but the fact remains that the disparity between rural and regional outcomes and those in metropolitan is so large must be resolved.

From the experience of Caroline Chisholm Society in Shepparton, there are complex social and economic reasons, but the fact remains that the disparity between rural and regional outcomes and those in metropolitan is so large must be resolved.

SITUATION: Lack of service and support in rural and regional areas

From a CCS perspective, there are three major matters of note when considering perinatal needs in the regions:

- New government policy directions for a decentralised Victoria. The move of some government service head offices, their staff and families to large regional centres combined with planned infrastructure improvements notably regional rail and roads
- Recent widely publicised problems with perinatal and maternity services in small regional centres
- The enormous population growth both current and forecast in Melbourne's growth corridors and especially in Melbourne's west.

These issues raise further questions for perinatal service delivery:

- If regional centres are to grow how can health and community services grow to address the inevitable regional increase in demand for services?
- How should Victoria address the needs of culturally diverse communities including communities with English as a second language, in both regional and metropolitan areas?
- How should Victoria attract perinatal health and community professionals and their families to work outside Melbourne?
- Most acute services, specifically mother baby units, neo natal care, are located in Melbourne – should this continue or is there an opportunity to provide such services regionally?

✓ SOLUTION: Ensure the inquiry understands the needs of rural and regional Victoria's diverse needs

SITUATION: Perinatal mental health services in the regions

In section 4, the impact of the cut to the National Perinatal Depression Initiative is identified as a key issue for the inquiry. Cuts of that kind have disproportionately impacted rural and regional communities. In Shepparton, there are now no services for perinatal anxiety and depression and other perinatal mental health issues. For many years, the community has sought a secondary level mother-baby unit. There are many suitable facilitating agencies in the community who have expertise who can work together to ensure that such a unit would be effective. Such a unit would be well placed to work with Family Care, The Bridge Youth Service and Rumbalara Aboriginal Co-operative and other local services including Caroline Chisholm Society to meet the perinatal mental health needs of central Victoria.

✔ SOLUTION: Establish regional secondary level service in Goulburn Valley

As a provider of perinatal services in the Goulburn Valley, CCS supports the establishment of a secondary level mother baby unit in Shepparton. The demand in the region is high with a high-level of family complexity and regional disadvantage most notably long-term unemployment and poverty. CCS does not advocate the establishment of an acute mother baby unit rather the establishment of a facility more akin to an early parenting centre linked to existing services such as the Shepparton Hospital (Goulburn Valley Health) and supported by a range of quality community-based perinatal services working in partnership.

✔ SOLUTION: Deliver therapeutic programs state-wide

Delivery of evidence based therapeutic programs is highly successful in regional centres. This is in part due to the very strong regional professional networks that, while they have some gaps, are stable with extremely long-term professional trusted relationships in place. Workforce mobility is higher in Melbourne and the ability to sustain long term relationship is lessened as a result. It is strongly recommended that such programs be

initially rolled out across the State in all major centres; namely Warrnambool, Horsham, Mildura, Wodonga, Shepparton, Bendigo, Geelong, Ballarat and Gippsland (Latrobe Valley). Early intervention programs of this kind through the strong trusted networks will reduce reliance on higher secondary or tertiary care requirements in those centres, enable prompt community response if service escalation is required and ensure that families can be readily supported where they live.

✔ SOLUTION: Establish Regional Services Expert in Cross Cultural Service Delivery

Basic Interpreter Services, as a minimum need to be established in Victoria's key regional centres. Further culturally respectful services are also needed. Where large new communities have settled in regional centres, cross cultural training is now a necessity, especially in the sensitive areas of pregnancy and maternal health. It is essential for health and community sector professional understand and work with diverse family practices and social mores relating to birth and parenting.

✔ SOLUTION: Invest in regional hubs of health and community services

There is a migration of young families to regional centres already underway in part driven by housing affordability and in part by lifestyle choices. With the establishment of new transport infrastructure and the shift of agencies and major companies to our large regional centres, families will continue to be attracted by employment and housing but only where they know they will be able to access the best quality care and education services. It is recommended that Government partnerships establish more "hub" style services like the Craigieburn and Melton "super clinics" so families can locally access not just primary or emergency/tertiary services in hospitals but a secondary level of service as well. A number of regional centres have vibrant health and community services. Such regions can be targeted to establish "wrap around" services and supports that it is anticipated will in turn attract health and community professionals seeking to establish and grow new services and models of support.

Recommendation 5:

Redress the disparity between metropolitan areas and the regions.

To do this Victoria needs to:

- 5.1. Ensure the inquiry understands the needs of rural and regional Victoria's diverse needs.
- 5.2. Establish Regional Secondary Level Service in Goulburn Valley. The demand in the region is high with a high level of family complexity and regional disadvantage most notably long-term unemployment and poverty.
- 5.3. Deliver evidence based therapeutic programs in regional centres. Such programs should be initially rolled out across the State in all major centres; namely Warrnambool, Horsham, Mildura, Wodonga, Shepparton, Bendigo, Geelong, Ballarat and Gippsland (Latrobe Valley). Early intervention programs of this kind through the strong trusted networks will reduce reliance on higher secondary or tertiary care requirements in those centres, enable prompt community response if service escalation is required and ensure that families can be readily supported where they live.
- 5.4. Invest in new or enhanced regional services with expertise in cross cultural service delivery.
- 5.5. Invest in regional hubs of health and community services:
 - 5.5.1. These would be like the Craigieburn and Melton "super clinics" so families can locally access not just primary services or emergency/tertiary services in hospitals but a secondary level of service as well.
 - 5.5.2. Several regional centres have vibrant health and community services. Such regions can be targeted to establish "wrap around" services and supports that it is anticipated will in turn attract health and community professionals seeking to establish and grow new services and models of support.

Section 6: Victoria's capacity to respond

Victoria's services working with families in the perinatal period, be they mainstream or specialised to this cohort, need the skills, knowledge and capacity to respond to the strengths and needs of expectant and new mothers, their babies and families. At the same time, services should also be working towards a vision for families that are empowered and independent.

SITUATION: Professional Development and Sector Growth

From the experience of Caroline Chisholm Society, mothers and families presenting at our appointments seek multiple levels of intervention and usually require some level of mental health support in addition to our social and emotional wellbeing support – secondary services (such as PANDA groups and psychology services) but also psychiatric and tertiary services. The loss of highly skilled workers following the cut to the National Perinatal Depression Initiative was devastating for families. It is apparent that all those interacting with expectant and new mothers and families require competency in perinatal mental health.

From the experience of Caroline Chisholm Society, mothers and families presenting at our appointments seek multiple levels of intervention and usually require some level of mental health support...

...Victoria must develop capacity of the perinatal professional workforce.

Victoria must develop capacity of the perinatal professional workforce. Regionally it is not always possible to attract specialists. Some perinatal professions need to grow either as a result of an aging workforce or simply not attracting enough young people to learn and study specialist fields. For example, maternal and child health nurse workforce is aging and measures need to be taken to support this valued service into the future. Much work has already been done in Victoria to promote nursing and its specialist disciplines as a career. This still has not gained enough traction with maternal and child health. How should policy makers attract students and new graduates to a range of perinatal professions and to rural and regional Victoria?

Policy makers must also address how to keep professionals abreast of emerging research and new evidence based programs as well as how we learn to deliver evidence based therapeutic programs of care. The health sector, especially nursing, has a well-defined professional development approach as part of industrial awards as well as part of AHPRA requirements. This is not so well developed for a number of community based professionals.

✔ SOLUTION: Invest in future workforce

It is necessary to ensure that community and health sector staff are trained, proficient and accredited to deliver programs such as Circle of Security, Tuning into Toddlers and Bringing Up Great Kids – the early years. Such an investment would develop our perinatal workforce and make working in the field attractive. Current expertise, albeit in an aging workforce, can be leveraged and thus the workforce can readily expand.

✔ **SOLUTION: Cross sector awareness and learning**

CCS offers a specific service for expectant and new mothers to help them navigate the service system. It is apparent from our work in that program that staff in services are lacking awareness and respect for the highly developed skills and expertise that are brought to perinatal services by the various professions. Perinatal services are currently, in a way, nebulous. For example, a worker from Caroline Chisholm Society and a clinician from the health sector are both delivering perinatal services, but in the absence of a definition this may be disputed. While some health services describe the perinatal period as post-partum (up to 6-weeks post birth), the social determinants of health needs suggest a shared responsibility for a longer period. CCS believes there is a need to more clearly delineate perinatal services and share knowledge of our different roles in the provision of “whole of person and whole of family” support during that first 1000 days. Victoria must create opportunities and forums for cross sector awareness and networks. Victoria must share current and emerging research in perinatal health and perinatal service.

SITUATION: Parenting preparation and ongoing skills development

Victoria needs families that are strong and resilient and need less professional support. To achieve that, perinatal services need to support parents to be confident, effective and loving. Parenting skills development from the antenatal period is critical to setting up families to meet the needs of their infants. Across the State there are excellent community-based antenatal classes. However, it is common for parents not to think beyond the birth and not imagine how they might parent until they are already doing it. Many parents take guidance from how they were parented to know how to raise their children. Sadly, this can play to issues of intergenerational disadvantage.

In the context of recent epigenetics, it is hard to find a higher priority for early intervention to prevent social determinants of health than strong mother-infant interactions for development. The research at cellular and physiological levels tells of the environmental factors turning genes on and off. To some extent, disadvantage is hereditary and this research shows that you can break that genetic cycle if you change the environment in which babies grow.

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Others learn their parenting skills from online chats late at night and through internet searches. An important example of parenting decisions and how

information is accessed has been the increasing concerns about vaccinations. Not all information accessed is based in evidence. Can Victoria guard against decisions being made based upon poor science? Evidently not. But we do need though to find ways to build faith in information that is accessible and promote information sources that are based on evidence.

There is also growing acknowledgement that there is a great opportunity for change presented at the time of becoming a parent, especially for fathers who are ill-equipped for parenting. Parenting is an immediate career and the most important that we do in our lives. By our actions and our confidence in our parenting we can and do significantly impact on our children's and our own health.

✔ SOLUTION: A Parenting Communications Information Plan

Victoria should continue to support and promote existing quality resources including online, parent group and mentoring style programs. The Raising Children Network, a Commonwealth Government parenting website, and the Green Book (My Health Learning and Development Record) provided by Maternal and Child Health nurses offer excellent examples of what good information for after the birth of a child can look like. Early parenting centres have comprehensive websites with tips and advice for the early days and months. Online and telephone nursing and medical advice is available via the State Government and a number of departmental websites have useful maternal and child health and parenting advice. Navigation is not always easy nor is even knowing the information is there. Public information programs are needed to increase access to and usability of sites. Notices in general practice at community health centres and simpler easy to read material will help. CCS proposes a communications plan for the perinatal period to promote excellent existing materials and to identify any significant gaps in parenting advice. In addition, it is recommended that the materials include signposts to more intensive supports where they may need to be offered.

Recommendation 6:

Build Victoria's capacity to respond to perinatal issues, especially perinatal mental health.

To do this Victoria needs to:

- 6.1. Invest in future workforce
 - 6.1.1. Train more community and health sector staff as accredited providers of evidence-based parenting group-work programs. There is existing expertise to leverage and readily expand upon to achieve effective program reach to immediately alleviate the impact of the cut to the NPDI.
- 6.2. Create a clearly delineated perinatal service oversight that shares knowledge of our different roles across sectors in the provision of "whole of person and whole of family" support during that first 1000 days. Victoria must create opportunities and forums for cross sector awareness and networks. Victoria must share current and emerging research in perinatal health and perinatal service. Victoria must govern perinatal services with cross-sectoral methods.
- 6.3. Implement a Parenting Communications Information Plan to promote excellent existing parenting information, identify gaps in parenting advice, and promote existing quality resources including online, parent group and mentoring style programs

Section 7: A Vision for Perinatal Services in Victoria

Caroline Chisholm Society urges the Family and Community Development Committee of the 58th Parliament of Victoria to look to a future where families are achieving their potential because all family members, including infants and young children, are nurtured. A future where families are stable and well connected to their communities and neighbourhoods, where support is delivered by primary or universal health and community services. Where secondary level services such as homelessness and family violence are touchstone systems that to a large degree are prevented or treated because of outstanding perinatal mental health services. A future where tertiary level services are a safety net and not a norm. A future where children at most risk are in the most therapeutic environments, not the least. And where those in need of early intervention are quickly helped. To achieve this, Victoria needs a strong expert and growing universal service support system with integrated planning and care. Victoria needs a perinatal service system that retains its distinctive cross-sectoral nature but is better coordinated.

Caroline Chisholm Society has a vision for perinatal services in Victoria – Victoria can and will be the best place in the world to have and raise a baby. But only if the opportunity presented by this Parliamentary Inquiry into Perinatal Services is holistic in its approach and proposes investment and reforms consistent with this submission; and only if the Victorian Government makes 2018 a landmark budget for children, and only if the Opposition also commit to serious investment and support for early parenting.

Caroline Chisholm Society looks forward to the next Victorian budget and the next election being focussed squarely on the most vulnerable people in our society – our babies and toddlers.

Appendix 1: Caroline Chisholm Society

The Caroline Chisholm Society (CCS) is unique as a specialist perinatal service in the community service sector. It is a leading integrated family services (IFS) provider in Victoria, particularly in Melbourne's west and western urban fringe and in Goulburn Valley. CCS offers support from the moment a woman learns of her pregnancy to the time her youngest child goes to school. In addition to the Department of Health and Human Services (DHHS) funded Integrated Family Service, CCS is also funded to offer homelessness support and has received some Department of Education funding to run supported playgroups. More recently it, in partnership with specialist family violence services, has been funded to provide perinatal support to this very vulnerable group of women, infants and young children.

The agency's priority is early intervention for vulnerable families. It seeks to minimise out of home care and support for children and operates a service system that is premised upon both the application of the social determinants of health and the application of evidence based practice. In particular, CCS delivers programs based upon the critical importance of the mother/infant relationship and its importance in the achievement of long term health and wellbeing – attachment based models of practice.

CCS is funded to provide services for the catchments of Brimbank and Melton and Western Melbourne which includes the local government areas of Wyndham, Hobsons Bay, Moonee Valley, Maribyrnong, and Melbourne. It also provides specialist support for parents in the perinatal period from Goulburn Valley, based in Shepparton.

CCS's mission is to deliver a range of pregnancy and family support services that respond to the needs of families and support them to achieve and maintain a safe and nurturing environment for themselves and their children. CCS does this by offering support to women (and children) who are:

- linked to clinical supports for their pregnancy and are in need of additional supports to ensure family safety and wellbeing

- not already linked to health or social services and need pregnancy and early parenting support
- vulnerable and present with one or more risk factors that impact on the best interest of the child(ren) and the parent.

The CCS team provides:

- stable trusted and continuous relationships with clients
- assistance and support to navigate the health and community service systems as needs and priorities change over to time
- one-off appointments for counselling and support to empower families
- ongoing case management work to support good parenting while at risk of or facing homelessness, family violence and mental health issues
- group work and volunteer support and mentoring
- day to day maternal and child welfare – goods needed to care for an infant and the mother and other young children

Demand for CCS is much higher than currently funded service targets. The service strives to meet the demand by all initial client consults including a risk assessment as well as advice, leveraging other agency capacity, working in partnership to increase reach, donations and through the tireless work of volunteers.

CCS sees over 1000 clients per year (1226 in 14–15). This varies depending on funds and complexity of client needs. CCS supported families through over 900 one-off appointments in FY14–15 and worked with over 257 casework clients. The CCS experts are supported by a large and dedicated volunteer team who are hidden gems.

Appendix 2: World Association for Infant Mental Health Recommendations

To ensure optimal health and development of an individual we seek the development and implementation of policies that:

1. support adequate parental leave so that parents can provide optimal care for their infants during the crucial early years of life.
2. minimise changes in caregiver during the early years of development.
3. promote the provision of informational support to parents regarding the health and developmental needs of their infants and young children.
4. recognise the importance of facilitating emotional support for mothers, fathers, and caregivers, as an important component of fostering the optimal development and well-being of the infant.
5. promote access to evaluation and treatment of risks to development by trained professionals who are culturally sensitive and knowledgeable about early development and emotional health.
6. provide infants with life-limiting conditions access to palliative services.
7. ensure the provision of adequate circumstances, including time for mothers, fathers, caregivers to get to know their infants and become skilled in providing for their infant's care and comfort, throughout the support of their family and community.
8. The right for parental leave, and its duration, should be valorised by the society, in a way that fits its contextual reality.
9. ensure the provision of access to relevant early educational and psychological opportunities and programs that promote good-enough relationship experiences and thus, enhance cognitive and socio-emotional development.
10. ensure the provision of prompt access to effective mental health treatment for mothers, fathers, and caregivers that alleviates infants' suffering and insure optimal development for the child.
11. allocate resources for training and supervision for caregivers in babies' institutions, foster care professionals and foster parents, as well as resources for assessing and treating foster care infant's emotional and developmental status.

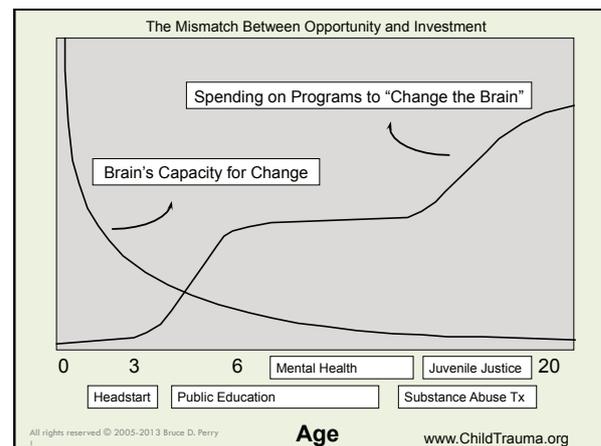
Appendix 3: Mismatch between investment and opportunity

Dr Bruce Perry – a leading expert in neurology and brain development and the long-term impact of child abuse and neglect – argues that the rapidly organising and developing brain is easier to change, influence, modify, teach and heal.

In the early years, the dynamism of brain development is a perfect opportunity to have significant and positive impacts on the health and wellbeing of an individual.

The policy imperative is therefore a need for programs and policies that promote safe, predictable, nurturing and enriched intrauterine and early childhood experiences. In turn, it is reasonable to conclude that it is much more likely that such early intervention programs will enable optimal brain organisation and functioning – more so than programs that seek to influence and change the brain later in life. Programs at all age levels are needed but the early years of life provide a powerful and cost-effective opportunity to help children become healthy, creative, productive and socially able.

Figure 2: Capacity for change versus spending on programs



Appendix 4: Collaborative Practice at Caroline Chisholm Society

1. Children and Mothers In Mind – 2017–2018

Funded by the Victorian State Government as one of 26 family violence early intervention pilots across the state, *Children and Mothers in Mind: a two generations approach demonstration program* provides therapeutic interventions to support young women and children under the age of four, who are victim survivors of family violence and are no longer living with the perpetrator of the abuse.

CMiM recognizes that women who have experienced family violence often lose confidence in their ability to parent effectively, particularly if their parenting is or has been undermined or criticized by an abusive partner, leading to isolation and unhealthy coping mechanisms.

The program will be delivered over 22 weeks in three distinct phases, with thorough pre- and post- assessment components and refresher sessions monthly after the completion of the program. The phases are 1) Addressing the trauma, 2) Re-establishing the Mother/Child Attachment and 3) Empowerment and Sustainability. Underpinning the group work is individualised therapeutic responses including a case model of engagement.

The core component of the program has its origins in two Canadian evidence-informed programs – Mothers in Mind and Connections – developed and successfully delivered by the Child Development Institute and Mothercraft/Breaking the Cycle respectively. The underlying case work component throughout the engagement period, in addition to the therapeutic work distinguishes this program from a mere counselling or a case work model of intervention.

Children and Mother's in Mind will specifically:

- support mothers and young children early to overcome the impact of trauma due to family violence and improve developmental outcomes for children;
- increase parenting competency using a combination of psycho-educational and behavioural approaches;
- support improvement of mother-child bond in order to repair and rebuild the mother-child relationship;
- create an opportunity to decrease mother and child isolation for those families who feel out of place in traditional parenting support programs;
- provide strategies to support the mother with her parenting of her very young child, and ultimately ensure the health, safety and wellbeing of the child.

Incorporating practice elements originating from Canada, this evidence-informed program will be available at five trial sites across Victoria and be jointly delivered by Children's Protection Society, Anglicare Victoria, Caroline Chisholm Society, Barwon Centre Against Sexual Assault/Minerva, Merri Outreach Support Services, McAuley Community Support for Women, Vincent Care and Quantum Support Services.

2. Shepparton Collaboration for pregnant and new mothers – 2016

The “Shepparton Collaboration for Expectant and New Mothers” was a special project funded by the Helen Macpherson Smith Trust. The project was to select and implement one or two achievable co-ordination projects for expectant mothers or who have children under school age.

Goulburn Valley Pregnancy and Family Support Service – Caroline Chisholm Society – was funded to work with volunteers, families and colleague agencies in Shepparton, including Rumbalara, CatholicCare Sandhurst and Save the Children, to identify what its future focus was to be for support for mothers and their families, including children and their fathers.

Mapping: The project mapped services for mums at 20 agencies, offering over 60 services, and identified over 40 service gaps. Little duplication was identified, but lack of coordination was raised – not for a lack of will or facilitation, but rather lack of capacity to respond. Logical skills matches were found through three key networks: Best Start, Communities For Children, and Child And Family Services Alliance. Being ‘grassroots’, Caroline Chisholm Society was also able to connect through Lighthouse and others.

Deciding: Five mothers, 15 volunteers and 20 agencies decided together what Caroline Chisholm Society’s role is in our community. With 4 named collaborators, 3 partners in decision making and 13 participating agencies, our agency listed 8 projects suited to offering in our community. One such project was “Mother’s in Mind”, which has since been funded as a demonstration project by the Victorian Government.

Implementing: Collaboratively, the people of Shepparton decided that the project would be to give out Baby Boxes (a Finnish model of Bassinet). This is called, “The Baby Box Project”. In providing the boxes, the community sought a safe, simple and supportive way to engage with local families.

The community loved its simplicity; it’s a box that’s recyclable and can become a toy box. The community loved its safety; it’s a great way to

encourage safe sleeping practices. The community loved its model of support; it’s a way to engage with families to prevent social isolation, family violence, the impacts of homelessness and engagement with child protection.

The results of the project were:

- A Shepparton specific parenting survey, seeking to understand the knowledge and confidence of new mums. And if there was a question of confidence, to open up a discussion.
- 33% of respondents expressed a less confidence than knowledge.
- Questions 2, 1 and 6 had the most number of mums (9%) with the greatest difference (averaging 1 point) between their knowledge and confidence. Q2 asked about ‘Coping with having a baby’. Q1 asked about ‘Looking after baby’. Q6 asked about ‘Knowing where to go in the community’.
- Caroline Chisholm Society will continue to collect this information to see if it changes over time or as a result of being in touch with us. All of those who collected a box said they are willing to provide feedback at a later date.
- 36% of those receiving a baby box sought additional support. Of those, the requests were for support with: Financial support; Mental Health / Social Isolation (incl. migration) / Flat Affect; Disability / Chronic illness; Family Violence; Accessing services when required; Parenting skills.
- 36 Baby Boxes were given out, and those 36 families had safe sleeping messages reinforced, a simple way to put their hand up for help and a supportive environment to receive advice. 47% were the first baby for mum. 30% of the families identify as Aboriginal. 25% identified their culture as something other than Australian, with the answers being Malaysian, Macedonian, Muslim, Iraqi, and Indian.

Baby Boxes continue to be available for all new babies born in Shepparton and surrounds, free of charge.

3. Engaging Wyndham Families

Engaging Wyndham Families (EWF) is funded by the release of funding in the 2016 Victorian Budget that was designed to help services meet demand in Integrated Family Services.

The Department of Health and Human Services (DHHS) of Victoria provided the extra funding state wide to the Child First and Integrated Family Services Alliances to trial a different way to meet vulnerable families' needs. This was in part a response to the recent recommendations from a Victorian Auditor-General Office (VAGO) report in to early intervention services. The report made many recommendations which has led to a 12-month review of DHHS funded program delivery to vulnerable families.

In this funded project, DHHS wanted to focus on:

- Responding to demand - some areas in Victoria experience faster population growth then growth in infrastructure (buildings, roads, transport etc.) & community services that help vulnerable families and communities to be strong, healthy and safe. The City of Wyndham is a growth area.
- Early intervention for identified priority groups that experience a range of social, health or well-being issues. The priority groups are: Aboriginal and / or Torres Strait Island families (First Nation People); families from other countries (CALD); families who experience a disability (learning/ intellectual, physical or acquired) or other complex issues. The project staff will be out in the community where vulnerable families go e.g. playgroups; Maternal Child health, Kinders, schools etc. to try and provide help to families earlier.
- Outcome measured interventions this means that the workers/project ask families/ professionals and other community members if what we say we will do has made a difference. This may be asked with permission at the start of us working with a family or professional; at the middle of the work/project; at the end of the work/ project or 3 months after the work/project

The Western Melbourne Child and Family Services Alliance decided to focus on the City of Wyndham, the Early Years and Schools sectors as it met the above criteria based on data analysis.

The following Agencies are partners in the Western Melbourne Child and Family Services Alliance and are a part of the Engaging Wyndham Families Project: Caroline Chisholm Society, CatholicCare, VACCA, ICP Health, and Anglicare – Child First.

The EWF agencies workers aim to deliver a shared model of care that meets the needs of children, parents, carers and family members currently living in Wyndham. They endeavour to provide support in a timely and efficient manner, provide an outreach service, undertake secondary consultation, undertake group work or community education sessions, and provide information or resources.

4. Empowering kindergartens with knowledge of vulnerability – 2016–2017

Funded through the “City of Melton – The Club Caroline Springs Supplementary Grants”, the project “Empowering kindergartens with knowledge of vulnerability” is designed to help the community in the City of Melton implement the BestStart Vulnerability Framework Tool Kit that was developed in Shepparton.

What is the “Vulnerability Framework”?

- Kindergarten teachers and Maternal and Child Health nurses in the Shepparton Enhanced Best Start site were supported to write a “Vulnerability Framework”. In Shepparton, it is now being prepared with carers and educators in childcare centres.
- The framework is a two-sided piece of paper which is a quick reference guide for practitioners when presented with a family in need.
- Having been trained in its use, the practitioner then uses it to help them decide what to do next (e.g. report to child protection versus refer to community services versus help within the program).
- Later, the practitioner collects de-identified data, which is used to plan services (universal, secondary and tertiary) in a way that is highly responsive to the needs of the neighbourhood as identified by universal services.

Caroline Chisholm Society is working with community kindergartens in Melton so that the teachers:

- receive training to achieve a shared understanding of vulnerability
- have a double-sided sheet that helping them to classify a situation into one of five categories of vulnerability and indicative reasons (i.e. high level of vulnerability, moderate level, or developmentally on track).

- have relationships with other services so that they can help those families:
 - who are ‘high’ with a report (e.g. to Child Protection/Police),
 - who are ‘moderate’ get help more easily (e.g. via ChildFIRST from integrated family services like Caroline Chisholm Society home-visiting case workers / Parenting or supported playgroups / early childhood intervention etc. etc.),
 - who are ‘developmentally on track’ have support from the universal service.

This work is designed to are seeking to ensure that all kindergarten teachers in Melton LGA are trained and use the vulnerability guide

The toolkit has been developed ‘by practitioners, with practitioners, for practitioners’ in Shepparton to facilitate a shared/common understanding of child and family vulnerability by Maternal and Child Health Nurses and Kindergarten teachers. It is now, five years on, not only helping them identify families but also helping them plan services such as supported playgroups.

Together with the Melton City Council, CCS identified that the tool is suited to our community. One of the great challenges for CCS is balancing the demand for high volume early intervention services (such as parenting groups) in the face of increasing demand from complex families (who Caroline Chisholm Society helps with home-visiting integrated casework). Caroline Chisholm Society has always done both, but the balance is shifting in the wrong direction. Caroline Chisholm Society believes this project will assist kinder teachers with options for help and will assist our team in getting referrals earlier to prevent issues with, for example, child protection. This will help families to achieve safe and nurturing environments for their children.

5. ECMS Outreach Family Support Program, Brimbank Melton – 2016–2017

Thanks to an outreach family support pilot program led by ECMS and funded by the Victorian Government through the Department of Education and Training, Caroline Chisholm Society seconded two senior staff into early childhood services to support inclusion in early start kindergarten and to support the effective use of pre-purchased kindergarten places funded by the Victorian Government.

The intention and purpose of the pilot was to:

1. Assist kindergarten services within the catchment area to fill pre-purchased places and sustain attendance.
2. Support kindergarten services and key referral agencies to engage families experiencing vulnerability and disadvantage to enrol children who will be eligible for three and four-year-old kindergarten for 2017 and beyond.
3. Support families who are experiencing vulnerability and disadvantage to access pre-purchased places. Priority cohorts include:
 4. Aboriginal and Torres Strait Islander children
 5. children known to Child Protection, including those in out-of-home-care
 6. children eligible for Early Start Kindergarten and extension grant
 7. children eligible for Kindergarten Fee Subsidy.

Additionally, participation support focused on supporting services to engage families to increase access to three and four-year-old kindergarten programs in 2017.

Caroline Chisholm Society worked collaboratively to ensure that the staff doing such a role were:

1. experienced enough to support highly qualified teachers with secondary consultations,
2. knowledgeable to help with effective linkage to secondary (integrated, innovative and intensive family services) and tertiary (Family Violence, Out of Home Care, Child Protection) community service systems, and
3. knowledgeable about parenting, family violence and financial counselling.

The results of the project are clear: ECMS was able to support 98 children to access early learning services in 2017. These are children who more than likely would have otherwise missed out due to structural and financial barriers.

Appendix 5: References

1. Ainsworth, M. D. S., & Bell, S. M. "Attachment, exploration, and separation: Illustrated by the behavior of one-year-olds in a strange situation" – *Child Development*, Volume 41, 1970 49–67
2. Barclay, Lesley: "Unravelling why geography is Australia's biggest silent killer" (March 13, 2014 6.44am AEDT) <https://theconversation.com/unravelling-why-geography-is-australias-biggest-silent-killer-23238> (Accessed on 8 July 2017)
3. Bowlby, J.: "A Secure Base- Clinical Applications of Attachment Theory" – Routledge London 2005
4. Havighurst, Sophie S., Wilson, Katherine R., Harley, Ann E., Kehoe, Christiane, Efron, Daryl, Prior, Margot R.: "Tuning into Kids": Reducing Young Children's Behavior Problems Using an Emotion Coaching Parenting Program" – *Journal of Child Psychiatry & Human Development* April 2013, Volume 44, Issue 2, pp 247–264
5. Heckman, J.J.: "Policies to foster human capital" - *Journal of Research in Economics*, 2000 Volume 54, 3–56, <http://www.idealibrary.com>
6. Hoffman, Kent T., Marvin, Robert S., Cooper, Glen, Powell, Bert: "Changing toddlers' and preschoolers' attachment classifications: The circle of security intervention". – *Journal of Consulting and Clinical Psychology*, Vol 74(6), Dec 2006, 1017–026.
7. Marsh, Wendy: "Babies Removed at Birth: Narratives of Mothers and Midwives" – Thesis accepted for admission to PhD. University of Surrey, 2016
8. Murphy Tighe, Sylvia and Lalor, Joan: "Concealed pregnancy and newborn abandonment: a contemporary 21st century issue Parts 1 and 2" *TPM*, June 2016, vol.19, issue 6 and *TPM*, July/August 2016, vol.19, issue 7
9. Perry, B.D.: Maltreatment and the developing child: How early childhood experience shapes child and culture. The Inaugural Margaret McCain lecture (abstracted); McCain Lecture Series, The Centre for Children and Families in the Justice System, London, ON, 2005
10. Perry, Bruce D., Pollard, Ronnie., Blaicley, Toi L., Baker, William L., and Vigilante, Domenico: "Childhood Trauma, the Neurobiology of Adaptation, and "Use-dependent" Development of the Brain: How "States" Become "Traits" " – *Infant Mental Health Journal*, Vol. 16, No. 4, 1995
11. WHO: "Maternal mental health" 2017 http://www.who.int/mental_health/maternal-child/maternal_mental_health/en/ (Accessed on 8 July 2017)
12. World Association for Infant Mental Health: "Position Paper on the Rights of Infants" Edinburgh, 14–18 June, 2014 (amended March 2016)
13. World Health Organisation: "A Conceptual Framework for the Social Determinations of Health", 2010
14. Wu Samuel S., MaChang-Xing, Carter Randy L., Ariet Mario, Feaver Edward A., Resnick Michael B., Rorh Jeffrey: "Risk factors for infant maltreatment: a population-based study" – *Child Abuse & Neglect* Volume 28, Issue 12, 2004, Pages 1253–1264