Protecting Victoria's Vulnerable Children Inquiry

Submission from
Mercy Hospital for Women
Heidelberg

28th April 2011

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MHW SUBMISSION TO VICTORIAN VULNERABLE CHILDREN INQUIRY

Introduction

Mercy Hospital for Women (MHW) was established as a public hospital in East Melbourne 40 years ago by the Sisters of Mercy, in partnership with the Victorian government. From 1971 to the present, MHW's history of commitment to serving the needs of mothers and vulnerable children has continued to grow and develop. This commitment has included the furthering of women's and children's health in Culturally & Linguistically Diverse (CALD) and Aboriginal communities. MHW is one of the four Melbourne hospitals to participate in the Aboriginal Hospital Liaison Officer (AHLO) program since its inception, and one of the first hospitals in Melbourne to establish a Department of Multicultural Services

The relocation of MHW in 2005, from East Melbourne to a very different community in Heidelberg, gave rise to a review of the hospital's services to effectively meet the needs of our clients, including those women and children considered to be the most socially vulnerable. While retaining its tertiary, state-wide medical services, MHW became the women's health service for Melbourne's north-east region.

Mercy Health's values, and the relocation of MHW, pointed both to the opportunity and the need for the establishment and maintenance of effective partnerships and working relationships with key local health and welfare agencies, as essential activities to further the support of young vulnerable mothers and children. The timing of MHW's relocation coincided with the introduction of the new Child Protection legislation and integrated support services for vulnerable children under Child FIRST.

While there has been little previous evidence of effective collaboration between health services and welfare agencies in Victoria (CPS/MHW 2008), research from other contexts points to how such a 'continuum of care'—starting from pregnancy—is essential to provide for optimum support of vulnerable children and, thus, helping to break the cycle of inter-generational disadvantage.

MHW Partnerships and collaborations: Experience informing understandings

Mercy Hospital for Women has been involved in a number of partnerships and collaborations with local and State agencies. These efforts have enhanced MHW's understanding of the complexities involved in effectively conceptualising and putting into operation efforts to support vulnerable children. Among these partnerships are:

- Transitions Clinic - partnership with the Victorian Aboriginal Health Service (VAHS) - established in 2000. Since that time it has provided specialist obstetric care by a small, multidisciplinary team to 3 categories of women, i.e. very young women, Aboriginal women and chemically-dependent women. Excellent continuity-of-care and streamlined access to a large institution are believed to be especially important, in order for these women and their babies to receive regular antenatal care, and careful discharge planning. Excellent obstetric outcomes have been achieved.

- New Directions – a program funded by the Office of Aboriginal & Torres Strait Islander Health (OATSIH) under the Federal "Closing the Gap " initiative with the aim of improving the health of Aboriginal women and their children up to the age of 8 years. The focus of the program is to identify gaps in the provision of maternity and child health services for Aboriginal Women and to support and enhance existing services to make them safe and culturally acceptable for these women.
- Memorandum of Understanding with O'Connell Family Centre -This agreement came about to facilitate referral and, where appropriate, prioritise timely admission of 'MHW families' for Early Parenting support**.** However, families of Aboriginal and diverse cultural backgrounds have rarely accessed the Early Parenting Centres (EPC) - unless directed to do so by Child Protection- and EPCs have acknowledged the need to make their services more culturally appropriate.
- Protocol with Berry Street Victoria - Through this arrangement, a 'safe space' is provided at MHW (After Hours) for Family Violence support workers to meet with women who experience family violence and their children. A regular weekly 'outposting' of a Berry Street Family Violence support worker to MHW is planned to commence by June 2011. This will provide easier access to specialist support for women attending the Mercy who have experienced family violence, will provide secondary consultation to individual MHW staff members, and will enhance education of clinical staff members regarding the leading cause of death & disability among Victorian women aged 15-44 (Dept of Women's Affairs, 2010)
- Northern Centre Against Sexual Assault (NCASA) collaborates with MHW to offer counselling services to women at MHW where this is preferred, instead of clients always needing to attend NCASA, based at Repatriation campus
- MHW is an 'Industry Partner' in the Australian Research Council Linkage Project *From colonisation to conciliation* (c2c), and hence has been involved in the conceptualisation and putting into operation of the first ever nation-wide survey of Aboriginal and Torres Strait Islander recipients of support services. The findings of this project include specific recommendations from Aboriginal community members and social work practitioners and academics for culturally appropriate social work education in Australia.
- I'm an Aboriginal Dad (IAAD), a program partnership between MHW and Children's Protection Society (CPS), with support of VAHS, which aims to support the capacity of Aboriginal fathers to grow with their children (DEECD, 2010)
- Partnership with RMIT University School of Social Work - Work has begun on this project to systematically 'map' health and welfare services that support young vulnerable women living in the LGAs of Banyule, Darebin, and Whittlesea & Nillumbik. Through this mapping exercise, gaps in required services can be identified. In addition, the project also examines the various referral pathways (both formal and informal) used by service recipients and providers. Initial funding/support has been provided by RMIT and, upon identification of sufficient funding, the aim is to present the mapping in a way that is easily updated and easily accessible to clients and professionals in local health and welfare agencies.
- Mentoring Mums- established in partnership with Children's Protection Society in 2007 and with support of the Potter Foundation- to provide ongoing

support to vulnerable women and babies living in the local area, by volunteers who are matched, trained, supervised and supported by a social worker-coordinator employed by CPS. The program has been evaluated by researchers from the Alfred Felton Research Program, Dept of Social Work, University of Melbourne and found to be very successful

- Adopt-an-Auntie- proposed program of volunteer support for Aboriginal women and babies by female Elders- support has been received from Children's Protection Society (CPS), all three Early Parenting Centres (O'Connell, Tweddle & Queen Elizabeth) and Volunteers of Banyule. Many Aboriginal women attending MHW lack appropriate support from within their informal networks of family & friends. A strong level of support is provided during pregnancy especially by the Aboriginal Women's & Family Support Unit (AWFSU) & Transitions Clinic staff, the challenge however is to sustain support in the postnatal period during a child's early years
- MHW social workers working with obstetric patients meet regularly with Specialist Infant Protective Workers (Child Protection) on an informal basis, to discuss issues of mutual relevance
- Multidisciplinary staff members liaise closely with mercy@home midwives and, as appropriate, with Maternal Child Health nurses.

Building on these collaborations, MHW has developed a greater understanding and appreciation of the provision of services related to vulnerable children in Victoria, and especially for children living locally. These understandings continue to develop and inform efforts to enhance the effectiveness of those services. Delineated within the framework of the 'Protecting Victoria's Vulnerable Children Inquiry', they include:

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

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

- A broad holistic model of identifying the multiplicity of factors that can adversely impact vulnerable children is vital. Examples of such factors encountered by MHW, and where we perceive gaps and deficiencies in services include:
    - a lack of access to suitable, affordable housing is inextricably linked with poverty for vulnerable pregnant women, particularly for those who rely solely on Centrelink payments. Aboriginal women are over-represented in this group. There are currently no pregnancy-related payments before the birth of the baby in the first pregnancy. The maximum payment of Youth Allowance for women < 25 years living away from home is **currently** $388.70 per fortnight. This provides no opportunity for a young woman whose housing is unstable to improve her situation prior to baby's birth.
    - MHW prepared a submission to the 2008 Federal Green paper on homelessness. Unfortunately, the Green paper did not address the needs of pregnant women. The situation has worsened since 2008.
    - A local housing agency recently advised that the wait for 'Early' public housing is now around five years, and for the most urgent

'Recurring homelessness' (Segment 1) the wait can be around three years.
    - Only around 10% of applicants for Transitional housing are successful at any stage.
    - It is of course crucial to avoid any perception of pregnancy as an 'easy' solution to homelessness. Access to housing would need to be tied to an appropriate model, which would require participation in comprehensive, culturally appropriate Parent Education, engagement with Maternal &Child Health etc. This would also need to be tied in with eventual, supported participation in vocational training to increase employment and income and to reduce ongoing (inter-generational) poverty/sole reliance on Centrelink payments.

It has been demonstrated that carefully-targeted and adequately-resourced investment in a child's early years to yield sound economic dividends in terms of increased participation in education and employment, lower rates of involvement with police and Courts, and less inter-generational disadvantage (Shonkoff 2000)

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

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

- Community midwifery and 'Healthy mother, healthy baby' midwife programs are highly valued by clients and health professionals, however availability is inconsistent and 'silo' approach remains. In the MHW local area, community midwife services exist in the LGAs of Banyule, Darebin & Whittlesea, but not Nillumbik, and the 'Healthy mother, healthy baby' program is available only to residents of Whittlesea and Hume. Services evaluated as effective should be expanded to be available to women in all LGAs, and require adequate resources for recruitment and retention of community midwives

- mercy@home (Domiciliary) midwives offer a postnatal visit to all public patients at MHW.A safe home visit check list is conducted prior to discharge, for staff safety. If a risk factor, eg recent domestic violence, is identified, women are offered a post-discharge consultation back at MHW, instead of receiving a home visit. It is not always possible for these most vulnerable women and their babies to attend, hence placing them at further disadvantage and isolation.

- Unfortunately, a recurring theme encountered by MHW is inadequate and inconsistently located Early Intervention services and other supports for families whose babies have ongoing needs

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

- Women with significant post- natal depression or other psychiatric diagnoses, and their babies, needing admission to Mother-Baby Units (MBU), often face lengthy delay - Austin MBU (which covers one-third of Victoria) has only 6 beds
- No public rehabilitation facility in Victoria can accommodate a mother who may need rehabilitation (eg following a difficult delivery or complex medical situation) and also her baby
- Withdrawal of funding for hospital based breastfeeding support has resulted in significant changes to service provision, with full day stay programs being replaced with short consultations. Families experiencing breastfeeding difficulties that also have additional complex needs are further disadvantaged, as there is now limited scope to adequately assess maternal and infant well being and provide the appropriate additional parenting support.
- Ongoing support for children whose parents have a learning difficulty or intellectual disability is inadequate. Eligibility requirements are restrictive, and even for parents who meet them, the level of available support is low
- Women without Medicare entitlement- usually recently-arrived migrants - are ineligible for a funded post-discharge Domiciliary midwife visit, unless able to pay for the service themselves. On the basis of identified need, mercy@home midwives offer a postnatal visit without charge.
- Within CALD communities in Victoria, little is known about Vulnerable Children issues and supports, including universal supports. There are individual case examples where cultural misunderstandings have led to children being placed into out-of-home care. However, with better education of both health professionals and CALD communities (e.g. parents) some of these may be prevented. For migrants to Australia (regardless of whether they are refugees, international students or skilled migrants) timely, accurate and easily understood information is the key, including dispelling the myths about the child protection system. Coming from different (or sometimes non-existent) systems, dealing with settlement issues, possible torture & trauma issues – all impacts on how children are treated. It is easy to say that children born/living in this situation are at higher risk, but more support is required for new migrants. Settlement and other migrant support services must be involved.

3. The quality, structure, role and functioning of: family services; statutory child protection services, including reporting, assessment, investigation procedures and responses…..

a. Family Services

3.3 What are the strengths and weaknesses of current services designed to assist families who are at risk of becoming involved in the statutory child protection system (for example ChildFIRST)?

- Child FIRST agencies in MHW's local area appear overwhelmed and or under-resourced and very often have their waiting-list 'closed'. Families identified as vulnerable during the antenatal period frequently agree to Child FIRST referral, but then decline to actually engage with services during the postnatal period. As engagement even with 'universal' services eg with

M&CH nurses is voluntary, these children can easily 'fall between' the gaps. Vulnerable families may be the least likely to engage with and *maintain* involvement with universal services, and this is exacerbated by the frequent moves associated with unstable housing. Child FIRST resources have not been increased in line with greater responsibilities; this is needed both to meet current demand, and also to more actively 'outreach' to families identified both as vulnerable and reluctant to accept support services.

b. Statutory child protection services, including reporting, assessment, investigation procedures and responses…..

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

- Child Protection services remain fragmented: when a report is made to and concerns found to be substantiated, families are frequently required to engage with multiple caseworkers at various stages of investigation; this can be confusing and frustrating for both clients and health professionals
- Case workers are assigned to parents, i.e. adults are seen as primary clients, rather than explicit focus as advocate for the child
- Adversarial nature of the Court system results in some children being returned to dangerous family situations
- Kinship placements require much greater support for the family members involved
- Reports to the local DHS Child Protection region regarding children under 2 years old have almost tripled since 2005

3.1 Over recent years Victoria has been developing an increasingly integrated service delivery approach to the support of vulnerable children and families. From a systems perspective what are the strengths and weaknesses of this approach? How should any identified weaknesses be addressed?

- Attempts to develop an increasingly integrated service delivery approach should be encouraged and supported. MHW's experiences include examples of ways by which such attempts can compromised and/or limited in their intent. These include:
  - Women without Medicare entitlement are also ineligible for a post-discharge Domiciliary midwife visit, unless able to pay for the service
  - Women with significant post- natal depression or other psychiatric diagnoses, and their babies, needing admission to Mother-Baby Units, often face lengthy delays. These are exacerbated by the fact that there are only six such dedicated beds at Austin MBU, which covers one-third of Victoria.
  - No public rehabilitation facility in the state that can accommodate a mother (eg who may need rehab following a difficult delivery or complex medical situation) and also her baby

- The State government funding model for post-discharge Breast-feeding support has recently been cut, thereby disadvantaging women who wish to breast-feed but experience difficulty in doing so
- There is inadequate ongoing support for children whose parents have a learning difficulty or intellectual disability

What we would like to see

- A case management approach whereby pregnant women identified as vulnerable could have services purchased on their behalf, based on their perceived need (as identified by client, and health/welfare professionals- rather than eligibility for currently available services) and with some client obligation around enhancing parenting capacity, secure attachment for child, support to meet developmental milestones etc. (Similar to Family Coaching Victoria model, but not only for children at immediate risk of removal from home)
- Better coordinated and more consistent provision of services…while recognising that needs vary in different locations according to levels of population disadvantage, current service provision often appears to be ad hoc

- Resourcing to allow for domiciliary outreach for vulnerable families by 2 workers together eg midwife and social worker

- Funding of services to care both for health/welfare professionals and the client families

- Greater resources/support for the role of fathers, especially those who are primary or sole carers of children

- Long-term support for children and adolescents who have previously experienced family violence and/or sexual assault, to help address the ongoing impact, and later implications for them as parents, and for their children

- Resourcing to enable hospital social workers to engage with families at lower levels of vulnerability than is presently possible

- A 'public health' model based on early identification of vulnerability, and support *before* families come to the attention of Child Protection, thereby reducing the currently inter-generational nature of vulnerability

- Closer links between government, services and universities are needed- for research and for best education of graduate health and welfare professionals, including:
  -Long-term, qualitative research involving follow-up of vulnerable babies and children. This is currently lacking, and would be extremely important to inform best practice and policy development

- reasons why vulnerable women 'fail to attend' appointments for themselves and their children

- More research is needed in the area of vulnerable children in CALD communities, which in turn will inform development of appropriate strategies and programs. Cultural sensitivity and competence is vitally important in both the development of strategies and the services provided. Settlement and other migrant support services must be involved. Service providers (across relevant sectors) and policy makers need to be aware of issues faced by migrants, their needs and challenges in raising children in a new country. (Lewig et al 2009) Socio-economic disadvantage and a lack of understanding of the Victorian system has a lot to do with this and these issues should be dealt with together. Issues of social exclusion, discrimination, racism (perceived or actual) are still relevant.

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