Victorian Association of
Maternal & Child Health Nurses
ANF (Vic Branch)

Protecting Victoria's Vulnerable Children Inquiry

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On behalf of the Victorian Association of Maternal & Child Health Nurses, thank you for the opportunity to provide a submission to 'Protecting Victoria's Vulnerable Children Inquiry'. Please see our comments below in relation to the Terms of Reference.

To inquire into and develop recommendations to reduce the incidence and negative impact of child neglect and abuse in Victoria, with specific reference to:

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

1.1 Given the different forms which child abuse and neglect may take, and the very broad range of risk factors involved (for example, parental substance misuse, domestic violence, socio-economic stress, inadequate housing, availability of pornography, parental history of child maltreatment, poor parent-child attachment, social isolation etc):

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

The early years are a critical time of development and adverse experiences such as poverty, physical or emotional abuse, chronic neglect, and family violence are particularly damaging, and can have lasting effects on the development of an infant's brain. The origin of many of the health and wellbeing problems that affect adults such as obesity, diabetes and heart disease, mental health problems, criminality, family violence, poor literacy, unemployment and welfare dependency have their origins in early childhood. If detected and managed early many of these conditions and common problems are preventable or reduced in impact. Given these facts the focus for supporting families should be geared toward supporting families in their early parenting experiences.

The inclusion of Maternal and Child Health (MCH) New Parent Education Programs, especially those which target the first time parents, throughout the state provide parents not only with the latest evidence based parenting knowledge but the opportunity to gain peer support and prevent social isolation. Topics include paediatric first aid and resuscitation, sleep/settling, what to expect in the early weeks post delivery, relationship changes, feeding, developmental progress, safety and more, these provide parents with proactive preventative parenting strategies.

Factors that influence positive outcomes are - access to child and adult focused services (MCH, mental health, early intervention, disability, drug and alcohol, family support), positive parenting experiences and anticipatory guidance, sense of belonging to home, family, community and a strong cultural identity, pro social peer group, high quality kindergarten, school opportunities, accessible and affordable child care, inclusive community neighbourhoods, and a service system that has an understanding of neglect and abuse. ***The services need the capacity to respond to family concerns and the capacity to work in collaboration with other service providers to identify and coordinate support services rather than each service operating in isolation. All families need access to universal and responsive services****.*

The MCH Service actively encourages all Victorian families and their children access to and engagement with the MCH Service. The MCH service take into account the

families' strengths and vulnerabilities to provide timely contact and on-going primary health care in order to improve their health, development and well being. By providing a comprehensive and focused approach to managing the physical, emotional or social factors affecting families in contemporary communities assists in promoting healthy outcomes for children and their families. The focus is on the prevention, promotion, early detection and intervention of health and wellbeing concerns of children and their families. Early detection includes identifying risk and protective factors at the individual, family and community level. Interventions to improve outcomes for children and families are implemented and families may require referrals to other allied health and intervention services. Protocols and referral practices that are streamlined, easy to navigate and mutually recognised, are essential between services that are focused on better outcomes for families. Timeliness in referral and response from services such as ChildFIRST are essential in protecting children and families in vulnerable situations.
Families also need access to anonymous phone support to discuss areas of family concern with a health professional in a timely manner 24 hours a day, seven days a week. The MCH Line is ideally placed to deliver this service given the strong links it has with the Universal MCH Service. The MCH Line is able to refer to appropriate service and link the families back into their maternal and child health service to re-establish community connections.

1.1.2 What strategies should be given priority in relation to immediate, medium and longer term priorities?

- *Immediate consideration should be given to provide the capacity for services to collaborate and attend case conferences to coordinate service provision.*
- *The adoption of common validated assessment tools which have meaning across the service sectors will encourage common language and response to families in crisis.*
- *Increase funding and capacity of targeted programs, like the Enhanced MCH Service, to support children & families with identified risk factors. EMCH Services are not stigmatised because they are part of the Universal MCH Service and vulnerable families are more likely to engage with these services.*
- *In the longer term the work should focus on a responsive service system that enables practitioners to have flexibility in their care of individual families.*
- *The design of an integrated IT system enabling e-referrals and where the basic information about clients populates across the system and allows different levels of access for professional areas as determined by the family. This would reduce the need for the family to re-tell the story and provide the same information many times over.*
- *Long term should include the employment of maternal and child health nurses to work in the high risk infant program within the child protection system. This would help ensure the health and developmental needs of the infant are at the forefront of decisions affecting the long term care of infants.*

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

- *Prevention and early access for families to a well qualified and responsive workforce. Previous studies out of the US indicate a clear cost benefit to supporting families early and preventing long term financial and emotional burden.*
- *Housing – adequate and appropriate housing for families to develop a sense of community and access to resources such as Kindergartens & Community Health services. There have been instances where a family becomes ineligible for public housing because of rent owing to public housing system. Children are*

then at further risk from unstable accommodation arrangements moving frequently and missing out on health & education services.

1.1.4 Do the current strategies need to be modified to accommodate the needs of Victoria's Aboriginal communities, diverse cultural groups, and children and families at risk in urban and regional contexts?

There is a need to protect and promote the cultural and spiritual identity and development of an aboriginal child. Understanding Aboriginal values and how they relate to Aboriginal child rearing practices is critical. Understanding the past, beliefs and practices that are thousands of years old and understanding their obligations to the land and a sense of belonging to each other is crucial to their every-day living. Aboriginal children require knowledge and information of their culture and how it relates to their own community and tribal group. Complex circumstances need to be closely considered, for example - placing a child in out of home care to ensure their safety may impact negatively on their stability by disconnecting with their families and local community. Opportunities to promote family experiences by connections with friends, clubs, schools and cultural events are indeed important.

1.1.5 Some in the sector have argued for the introduction of a 'Public Health Model' in relation to child protection. What might be the benefits of introducing such a model in Victoria? What are the main characteristics of such a model?

A Public Health Model provides a theoretical framework that spans the service continuum and describes preventative interventions as primary, secondary or tertiary interventions *(Tomison & Poole, 2000). Primary/Universal Interventions are offered to everyone and provide support and education before problems arise i.e. MCH Services; Secondary interventions are targeted at families in need and provide additional support or help to alleviate identified problems and prevent escalation i.e. Enhanced MCH Services & Early Parenting Centres; Tertiary interventions are comprised of statutory care and protection services and provide services where abuse and neglect has already occurred to help keep children safe and well i.e. Child Protection, Family Services, out-of-home care.*

A well-balanced system has primary interventions as the largest component of the service system, with secondary and tertiary services progressively smaller components of the service system. For example, research into the cost-effectiveness of early intervention programs has shown that $1 spent early in life, can save $17 by the time a child reaches mid-life (Blakester, 2006). But most importantly, investment in primary prevention programs has the greatest likelihood of preventing progression along the service continuum and sparing children and families from the harmful consequences of abuse and neglect.*

References:

Blakester, A. (2006). Practical child abuse and neglect prevention: A community responsibility and professional partnership. Child Abuse Prevention Newsletter (National Child Protection Clearinghouse)*, 14(2).*

Tomison, A., & Poole, L. (2000). Preventing child abuse and neglect: Findings from an australian audit of prevention programs*. Melbourne, Australia: Australian Institute of Family Studies.*

**The Victorian Association of Maternal and Child Health Nurses would agree that investing in Universal Services with a primary preventative focus would offer the most benefits in increasing the likelihood for children to reach their potential and to be the most cost effective. The Victorian MCH Service is already well developed and established in the community with a highly skilled workforce that is highly valued by*

the community. The MCH Service is well positioned to work collaboratively with other services rather than fragmenting the services further by introducing another service specifically for vulnerable families.

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

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

2.1.1 Universal and primary children's services such as general medical practitioners, antenatal services, maternal and child health services, local playgroups, early childhood education and care services, primary schools, secondary schools, and telephone and internet based services for children and young people seeking information and support.
Maternal and Child Health Nurses have a role in identifying the risk factors and working with families to identify their strengths that are protective for children. Through family centered practice which engages families in a partnership, the nurses work to support parenting skills and improve developmental outcomes.
As well as being mandated, MCH Nurses have undertaken extensive professional development and training in recognising and understanding child abuse and neglect.

The MCH service is a universal and universally accepted service and 98% families of families engage with the service, all families need support as they transition into their new role of parenting. At present this service seeks to meet service targets where the objective is to address many of the at risk concerns. However MCH is a relationship based service and the reality is that it takes time to connect and develop a relationship especially with chaotic families and the service needs more flexibility to respond and support all families. The relationship with the family allows for a thorough assessment of the family and the ability for the professional to engage with and work with a strengths-based approach. Collaboration between services will eventually lead to a more coordinated delivery of support. Professionals need the capacity to attend case conferences where services can work with the family to identify key goals which will enhance their family functioning and parenting skills.

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.
Some families may require additional support for a period of time before being reconnected with their community located services. EMCH can provide this bridge then withdraw once the more immediate needs are addressed. The benefit of this service is the very close links with the two other aspects of the MCH services - the Universal Service and the MCH Line, thus a family is not stigmatised by their referral and acceptance in the EMCH service.

Services offered through the Department of Justice should be considered in the services effecting children, clients of services such as community corrections are often caring for children while under supervision. These services are aware of individual family situations and often refer for counselling and other services.

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.
For families that are at higher risk the interventions need to begin when they are first identified in the antenatal period and services then need to work closely with community services to coordinate a safe transition plan. This needs to be negotiated with the family and service providers with clear expectations of the outcomes and roles of each service in case conferences. Services again need the capacity to attend case conferences and collaborate with other service providers.

2.2 How might the capacity of such services and the capability of organisations providing those services be enhanced to fulfil this role?

2.3 What strategies should be given priority in relation to immediate, medium and longer term priorities?
As identified in the reports of the Department of Human Services (DHS, 2006) and DHS (2007), some families under-utilise the Victorian Maternal and Child Health Service and may disengage early as demonstrated by the declining participation after the first year of a child's life. Vulnerable families were identified as the families more likely to under-utilise the service (DHS, 2006) and this is consistent with the findings of Stevens (2006) and Stevens, Seid, Mistry and Halfon (2006). The concern is that the children of those families that have disengaged early will not benefit from the opportunity to identify early developmental delay/disability or significant risk factors and therefore fail to receive the subsequent intervention that could improve developmental and other social outcomes (Oberklaid et al., 2002).

The lack of flexibility in consultations offered by appointment has been identified as a barrier for some families. Carbone et al., (2004) found that factors such as inflexible appointment systems as well as inaccessible locations, lack of public transport, limited hours of operation, lack of attention to multiculturalism, and insensitive or judgmental attitudes and behaviours of staff or of other parents, created barriers in accessing Maternal and Child Health Services. Whereas, outreach home visiting may offer a strategy for improving access and participation as recommended by Carbone et al. (2004).

The focus is increasingly on providing flexible and accessible services that engage vulnerable families and a recognition that vulnerable families are under-utilizing the Victorian Maternal and Child Health Service. Despite the framework for the provision of the Maternal and Child Health Service suggesting that consultations could be offered in a variety of settings such as maternal and child health centres; child care centres; kindergartens; Indigenous cooperatives; family support agencies or in the family's home, key age and stage consultations are usually conducted at a centre by appointment.

Rogers and Moore (2003) found that there was a need to refocus services for young children and their families toward prevention, early identification and intervention. They discuss that this may be achieved through service flexibility because a "one size fits all" approach does not recognise differing needs and that service delivery models that reflect local parent and child needs, community needs and are based on research evidence need to be developed.

Delivering the service in the home was found to offer advantages in that parents did not have to arrange transport which was one of the barriers in accessing services. Nurse-delivered home visiting programs have been found to provide positive

outcomes for families particularly when the nurse was well educated and programs were focussed on building a trusting relationship. The most effective home visiting programs included nurses with advanced education. The longstanding and rigorous twenty year longitudinal research by Olds, Robinson et al.(2004) found the benefits for mothers and children were significantly greater in the families visited by nurses with a degree in nursing and experience in community or maternal and child health nursing compared to home visitors without formal qualifications.
It would appear that outreach home visiting could be an effective strategy particularly if it were delivered by well educated nurses. Maternal and child health nurses are well positioned to provide this strategy as they are required to have achieved qualifications in general nursing (Division 1 Registered Nurse), midwifery and post graduate studies to gain registration as a maternal and child health nurse in Victoria. Expansion of the Universal MCH Service to have the capacity to provide more flexibility in service delivery should be given priority.

References:

Carbone, S., Fraser, A., Ramburuth, R., & Nelms, L. (2004). Breaking cycles, building futures. Promoting inclusion of vulnerable families in antenatal and universal early childhood services: A report on the first three stages of the project. Melbourne: Department of Human Services.

Department of Human Services.(DHS) (2006). Evaluation of Victorian Maternal and Child Health Service.

Department of Human Services.(DHS) (2007). Maternal and Child Health Services Annual Report 2006-2007. Department of Human Services, Victoria.

Oberklaid, F., Wake, M., Harris, C., Hesketh, K., & Wright, M. (2002). Child health surveillance and screening: A critical review of the evidence Journal.

Olds, D., Robinson, J., Pettitt, L., Luckey, D., Holmberg, J., Ng, R., et al. (2004). Effects of home visits by paraprofessionals and by nurses: Age 4 follow-up results of a randomized trial. Pediatrics, 114, 1560-1568.

Rogers, R., & Moore, T. (2003). The Early Years Project: Refocusing community based services for young children and their families: A Literature Review Journal.

Stevens, G. (2006). Gradients in the health status and developmental risks of young children: the combined influences of multiple social risk factors. Maternal and Child Health Journal, 10(2), 187-189.

Stevens, G., Seid, M., Mistry, R., & Halfon, N. (2006). Disparities in primary care for vulnerable children: the influence of multiple risk factors. Health Services Administration, 41(2), 507-531.

2.4 What are the most cost-effective strategies to enhance early identification of, and intervention targeted at, children and families at risk?
It would be financially sensible for adequate resources to be guaranteed for the MCH services, the systems are already in place; ensuring an ongoing, appropriately qualified workforce (through recognition of qualifications and suitable remuneration) to enable MCH nurses to continue to work with families.
Appropriate work conditions would attract nurses and midwives to further study to

work in the area and families would benefit from being supported by health professionals with a very strong educational basis in family care.

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

3.1 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?

The support of this triple aspect (Universal, EMCH and MCH Line) of interlinked care has a positive effect on reducing demand on other health services. MCH Nurses are viewed in a non judgemental way by the community and with the focus on health and well being (as opposed to sickness) and the MCH Service is seen as a service for all. The establishment of ongoing relationships between the MCH nurse, MCH Services and the family assist in the early detection of situations that can assist in collaborative practices with other services. Community based knowledge of MCH services ensure the MCH nurse is very well placed to address families' concerns, and make appropriate referrals, in a timely manner. There is a need to strengthen the relationships between MCH Services and other services for children.

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

A weakness of the current workforce is that there is a constant turnover of staff (workers and management positions) in Child Protection Services - this issue needs to be addressed. Therefore, staff recruitment and retention strategies for Child Protection Services and ChildFIRST are in urgent need so that there is continuity for the family with the same worker. This would improve engagement and confidence in the service to assist them to understand the families' needs better. As well as improve communication and links with MCH Services who feel like they are left 'holding the baby' until a worker is found or allocated to the family. MCH Nurses find it hard to work out whom to pass on vital information to when there are constant changes of workers and shortages of workers. In our experience, the best outcomes are achieved for children and families when MCH Nurses have been able to communicate effectively and work with Child Protection or Family Services to support families together.

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)?

3.3.1 How might the identified weaknesses be best addressed? Are there places where some of these services work more effectively than elsewhere? What appear to be the conditions associated with this and how might these conditions be replicated elsewhere in the State?

3.3.2 Is the overall structure of such services appropriate for the role they are designed to perform? If not, why and what changes should be considered?

Perhaps some uniformity across the State would have been good for the way ChildFIRST operates as this can be different depending on the Region. ChildFIRST and the referral process is still very fractured as various services have tendered and they are all operating differently.

3.3.3 Do the current services accommodate the needs of vulnerable children and families from diverse ethic and cultural backgrounds?

3.3.4 Are there particular services that best meet the needs of vulnerable Aboriginal children and families?
The Victorian Aboriginal Health Service (VAHS) has a MCH Nurse employed as part of their services – they provide a very good service for families. The only weakness of this service is the lack of an official process for notification and communication between Universal MCH services & VAHS as families move in and out of both services it is difficult to follow them up. Municipalities across the State have a process for transferring and keeping track of families that move residence.

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?

3.4.1 How might the identified weaknesses be best addressed? If there are places where some statutory child protection services work more effectively than elsewhere, what appear to be the conditions associated with this and how might these conditions be replicated elsewhere in the State?
Not enough resources and experienced workers. There are insufficient child protection workers suitably qualified and family support services to meet the current demand. This is a fundamental flaw of the system that significantly undermines the system's ability to protect Victoria's vulnerable children. This inadequacy is reported by some nurses as a deterrent to making mandatory notifications due to their perception that even when reported, the child protection system is inadequately resourced to implement measures that will bring enduring benefits beneficial for children and parents.

3.4.2 Is the overall structure of statutory child protection services appropriate for the role they are designed to perform? If not, what changes should be considered?

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

c. Out-of-home care, including permanency planning and transitions

3.5 What are the strengths and weaknesses of the range of our current out-of-home care services (including respite foster care, foster care of varying durations, kinship care, permanent care and residential care), as well as the supports offered to children and young people leaving care?

3.5.1 How might any identified weaknesses be best addressed? If there are places where these services work more effectively than elsewhere, what appear to be the conditions associated with these successes and how might these conditions be replicated elsewhere in the State?

3.5.2 Is the overall structure of out-of-home care services appropriate for the role they are designed to perform? If not, what changes should be considered?

3.5.3 What more might need to be done to meet the needs and improve the outcomes of children in out-of-home care and those leaving care regarding:
- Their education, health and mental health needs;

o The needs of children from culturally and linguistically diverse backgrounds; and
o Arrangements for developmentally appropriate contact between a child in out-of-home care and members of his or her family?

3.5.4 How can the views of children and young people best inform decisions about their care? How can the views of those caring for children best inform decisions affecting the wellbeing of children in their care?

3.5.5 How can placement instability be reduced and the likelihood of successful reunification of children with their families, where this is an appropriate goal, be maximised?

3.5.6 How might children who cannot return home and who are eligible for permanent care, achieve this in a way that is timely? What are the post-placement supports required to enhance the success of permanent care placements?

- *For some families the reality is that the child may never be able to be cared for by the natural family this is often apparent early and if this seems the likely outcome then it is in the child's best interest to be placed with long term care. It is well documented that attachment to primary carer enhances long term health and wellbeing including mental health.*
- *Decision needs to made early in the best interests of the child. It is frustrating for MCH Nurses who continually identify issues and concerns for a child when a parent is clearly inadequate and unable to parent safely and has had several children removed previously and yet it takes a long time before a decision is made to remove the child – sometimes years and it seems that the child remains in the unsuitable environment until the child is displaying a developmental delay instead of preventing the delay whilst knowing from the research that the family clearly have risk factors that lead to adverse outcomes.*
- *Support and information for carers regarding health care and resources for the children in their care. A great resource is "Calmer classrooms: A guide to working with traumatised children" (2007) Published by the Child Safety Commissioner, Melbourne, Victoria.*

3.5.7 What are the strengths and weakness of the current Victorian adoption legislative framework and practice for children who cannot return to the family home? Should Victorian legislation and practice reflect that in other jurisdictions?

4. The interaction of departments and agencies, the courts and service providers and how they can better work together to support at-risk families and children.

4.1 Given the very broad range of professions, services and sectors which need to collaborate to achieve the best outcomes for vulnerable children:

4.1.1 Are current protocols and arrangements for inter-organisational collaboration in relation to at-risk children and families adequate, and how is the implementation of such protocols and arrangements best evaluated?
No - the protocols for inter-organisation collaboration are not adequate. There should be reciprocal sharing of information with MCH Services.

4.1.2 What needs to be done to improve the quality of collaboration at the levels of policy development and implementation, local and regional service planning and delivery, and direct service to individual children and families?

ChildFIRST and Child Protection need to share information with MCH Services so that all services are aware of the families' issues and the appropriate support required can be provided and not duplicated.

4.1.3 Are there specific models of inter-professional, inter-organisational and/or inter-sectoral collaboration which have been shown to be effective or promising, and which may be worthy of replication? This may relate to two organisations (for example, child abuse issues in which both police and statutory child protection services need to collaborate in an investigation) or to a much broader service network.

4.1.4 How might professional education prepare service providers to work together more effectively across professional and organisational boundaries?

4.1.5 How might the current funding approach to support vulnerable children and families, which is often based on very specific service types and activities, be adapted so that resources are more effectively allocated and service delivery more integrated?

5. The appropriate roles and responsibilities of government and non-government organisations in relation to Victoria's child protection policy and systems.

No Comment

5.1 Given Victoria's distinctive history in relation to the role of not-for-profit community service agencies in caring for children and families in need, and the recent emergence of some for-profit organisations in the sector:

5.1.1 What is the most appropriate role for government and for non-government organisations (both for-profit and not-for-profit) in relation to child protection?

5.1.2 What roles currently performed by statutory organisations, if any, might be more effectively and efficiently performed by non-government organisations, and vice versa?

5.1.3 What is the potential for non-government service providers to deal with some situations currently being notified to the statutory child protection service, and would it be appropriate (as is the case in Tasmania) for referrals to a service such as ChildFIRST to fulfill the legal responsibilities of mandated notifiers?

5.1.4 Is it necessary to strengthen the capability of organisations in the nongovernment sector to better equip them to work with vulnerable children and families and if so, how?

5.1.5 What is the responsibility of the State to ensure that all organisations in the community which are engaged with children fulfill their duty of care to protect children from sexual abuse and other forms of maltreatment and how might that responsibility be exercised?

5.1.6 What are the strengths and weaknesses of current Commonwealth and State roles and arrangements in protecting vulnerable children and young people, for example through income support, family relationship centres, local early childhood initiatives such as "Communities for Children" etc? What should be done to enhance existing roles or address any weaknesses?

6. Possible changes to the processes of the courts referencing the recent work of and options put forward by the Victorian Law Reform Commission.

No Comment

6.1 In light of recent child protection legislative changes, trends in other jurisdictions, and in particular the options put forward by the Victorian Law Reform Commission[1]:

6.1.1 What changes should be considered to enhance the likelihood that legal processes work in the best interests of vulnerable children and in a timely way?

6.1.2 Are specific legislative changes necessary? For example, in relation to a Protection Application by Safe Custody (where children are brought into care and immediate orders from the Children's Court are sought in relation to a child's placement), should the current 24 hour time limit be extended and if so, what should be the maximum time limit?

7. Measures to enhance the government's ability to: plan for future demand for family services, statutory child protection services and out-of-home care; and ensure a workforce that delivers services of a high quality to children and families.

No Comment

7.1 Given the resources required to provide appropriate services and care for children and young people referred to statutory child protection services and in out-of-home care, what is the likely future demand for services and what needs to be put in place to help sustain services and systems and plan for and meet future demand pressures?

7.1.1 Is there sufficient research into child protection matters to support government's ability to plan for future child protection needs? If not, how might government encourage and support sufficient research in this area?

7.1.2 How might those providing home-based care and residential care for children be most effectively recruited and supported?

7.1.3 What workforce development and retention strategies are required to meet the needs of the child and family welfare sector in the future?

There is a high job satisfaction for Maternal and Child Health Nurses as well as a high retention rate in many of the municipalities in Victoria - salaries, working conditions, status and professional development opportunities contribute to this outcome. Enterprise Bargain Agreements in Local Government contain various positive conditions of employment for Maternal and Child Health Nurses – these have been fought for long and hard over a number of years with the support of the ANF (Vic Branch). Some of the conditions include mentoring programs for new graduates, allocated professional development days, regular clinical supervision, salary structures for career development and qualification allowances for further studies. These conditions and salaries are the envy of other States.

Further tertiary education equips the Maternal and Child Health Nurse to work in the community offering a universal non-judgmental public health service. Perhaps some of the strategies used for MCH Nurses could be replicated for the child and welfare workforce development.

8. The oversight and transparency of the child protection, care and support system and whether changes are necessary in oversight, transparency, and/or regulation to achieve an increase in public confidence and improved outcomes for children.

No Comment

8.1 There is currently a range of oversight processes involved in the child protection and care system (for example, Ministerial/Departmental inquiries into child deaths and serious injuries, internal organisational complaints procedures, and the statutory roles of the Ombudsman, the Victorian Auditor General, the Child Safety Commissioner and the Coroner).

8.1.1 Are these processes appropriate or sufficient?

8.1.2 What exists in other jurisdictions which may be worth considering?

8.1.3 What changes, if any, are required to improve oversight and transparency of the child protection, care and support system? How would those changes contribute to improved outcomes for children?

8.1.4 Are there strategies which might increase public understanding of, confidence in, and support for child welfare services?