workers will also have strong knowledge of family violence issues and child protection services. Similarly, Maternal & Child Health Services are able to work very closely within the Family Youth and Children's Services unit, especially with Integrated Family Services and Child FIRST. Such integration means that all workers have excellent training in a broad range of areas. This strength and breadth of knowledge is one of the benefits of an integrated service.

19. Because of the complexity and number of issues with which many victims and perpetrators of family violence present to Gippsland Lakes Community Health, it is unlikely any one service can respond to, meet and address all the needs of these clients. In my experience, a multidisciplinary response that draws upon local services provides the best assistance and support to these clients, much more so than providing a siloed response by specialist services.

20. Our vision has been to create an integrated service, because through our experience, we know that this model is what works in rural areas. In rural regions, services are forced to integrate because of the lack of funding. Implementing a successful integrated model has been challenging, requiring a lot of testing and refining in parternship with staff.

21. In my experience, there is very good integration in the East Gippsland community across the services and various bodies operating within the family violence space. There are very strong relationships with police, Child Protection, the local Aboriginal Community Controlled Organisation and the courts, as well as social suppo r services in the area.

22. Gippsland Lakes Community Health has a Men's Behaviour Change Program which successfully runs two 16 week programs per year. We know that this program is successful based on the regular attendance of participants for the whole 16 week period, reports from partners of improved behaviour and positive feedback from Corrections and Child Protection in respect of behavioural changes in clients referred through their programs. However, other than the Men's Behaviour Change Program, we do not have any programs specifically designed for men.

Difficulties faced by rural communities

23. I think that the current system of providing specialist se r ices fails to adequately cater for rural and remote communities. Remote and rural communities are constantly disadvantaged because access to specialist services in these areas is

always limited. We should instead be flexible and responsive to the needs of the individual or family within their local environment. Services need to be developed in partnership with the local community and service sector.

24. Through my work at Gippsland Lakes Community Health, I have observed over a number of years that there is a tendency for governments to respond to significant social issues and problems through the development of new programs, tests and pilots. These new initiatives often do not take into account the existing service delivery system. As a result, there has been a proliferation of services that claim exclusivity to client groups or problems, which often leads to duplication in the services provided.

25. This "silo-ing" effect is problematic in rural areas, resulting in already limited resources being further stretched to accommodate such duplication and increased reporting. Rural agencies were directed that the recent RAMP funding had to be implemented strictly according to the guidelines. In my opinion, these guidelines have not been developed with rural communities in mind, and as a result, the funding is inefficiently used in the rural context. However, there was no flexibility or scope to use the RAMP funding to instead build on and utilise existing services and structures, which would have been of greater benefit to the rural community.

26. In my experience, the court system in rural areas is not conducive to hearing matters of family violence. Often magistrates are not well versed in the latest thinking regarding family violence, so it is a lottery as to the magistrate hearing a matter and the decision handed down. The courts are also practically ill-equipped to hear family violence matters. For example, there are no designated rooms or areas to ensure the victim does not have to confront the perpetrator. I have witnessed situations where the victim is forced to come into contact with the perpetrator in the carpark of the court. This is far from ideal and can affect the safety of the victim and any children involved.

27. Another example of the lack of flexibility of the current system is the Men's Behaviour Change program. The way this program is run is too constricted and does not take into account that some men might need to travel significant distances to attend the program in circumstances where there is limited public transport. Further, there are not enough workers to provide this service. The only training provider is located in Melbourne and limited provision is made to help people to attend the training.

What practical changes might improve integration and coordination? What barriers to integration and coordination exist?

28. Integrated approaches in rural areas need to be explored in partnership with local agencies. Integration should be prioritised and developed rather than implementing new programs and creating a reliance on a single response through specialist services. The provision of specialised services that do not incorporate responses into more mainstream services is a significant barrier to integration in rural communities.

29. A key factor to successful integration in rural areas is flexibility and responsiveness. There needs to be flexibility built into the system and into the funding received so that the unique challenges in each area can be explored and addressed.

30. Confidentiality and ease of access are important to rural clients experiencing family violence issues while living in a small community. As we are a local community health service, victims can more easily seek support without identifiably seeking assistance from a family violence service. This increases safety for victims. It also allows for greater integration with universal programs increasing their knowledge and understanding which in turn improves the safety and wellbeing of people affected by family violence. Models such as this should be explored for other rural and remote communities where the local health service would be seen as non-threatening and trusted.

Programs for Children

The 0-2 Program

31. The early years of a child's life are critical for improving the child's developmental trajectory and subsequent life changes. Patterns established during these early years have lifelong consequences, impacting learning outcomes, and adolescent and adult health.

32. We established the '0-2 Program' in 2004, having identified that a large number of the children being reported to Child Protection were under three years old and experiencing family violence. Following an initial six month research and development phase, we implemented the pilot project with a view to reducing and preventing notification and re-notifications to Child Protection. We used funding from the Maternal and Child Health Enhanced Home Visiting Service for the pilot

program to support mothers most at risk. I consider that the success of the 0-2 Program, which was established by re-focusing existing funding, is a prime example of how we need to assess the systems already in place and build on those systems, rather than implementing new systems.

33. The aim of the 0-2 Program is to provide an evidence based comprehensive early intervention program that supports high risk families with children aged 0-2 years. These high risk families are often the ones who do not access mainstream services and are the most challenging to work with and keep engaged.

34. Research shows that the existence of the following factors indicates potential risk to the baby:

34.1. where the mother is aged under 20 years;

34.2. evidence of a chaotic lifestyle, for example, frequently moving house or changes in partner;

34.3. social isolation;

34.4. substance abuse;

34.5. prematurity, low birth weight and/or signs of a failure to thrive;

34.6. inappropriate accommodation and/or homelessness;

34.7. Koori (reflective of the large Indigenous population in the East Gippsland area); and/or

34.8. previous or current mental health and/or emotional issues (reflective of the high incidence of mental health problems identified in the initial six months after giving birth).

35. Mothers presenting with these factors form the target group that the 0-2 Program aims to support.

36. There are three key components to the model for the 0-2 Program:

36.1. the Antenatal Screening Tool;

36.2. the Young Pregnant & Parenting Group; and

36.3. the Intensive Home Visiting Program.

37. Depending on the mother's circumstances, we may then have a lot to do with the mother during her pregnancy. For example, depending on the issues involved, the nurse may refer the mother to other services within Gippsland Lakes Community Health, such as the Drug and Alcohol unit.

38. We have sufficient funding to provide the 0-2 Program for two years, however there are many families who need support beyond two years. We do not have the resources to support these families for longer through the 0-2 Program, but if families need continued support, we refer those families to Integrated Family Services. However, only those with very severe needs will be referred to Integrated Family Services, as their resources are also very limited.

39. The 0- 2 Program is able to engage with the Aboriginal community due to the trust that community has with two of the Maternal & Child Health nurses in the 0-2 Program. Those nurses have been part of the program for 12 years and so have built a strong foundation of trust with the Aboriginal community. In my experience, the key to successfully engaging with the Aboriginal community is to develop and maintain strong relationships.

40. The 0-2 Program is based within the universal platform of Maternal and Child Health nursing and is focused on early intervention for those families identified at risk. This means it can work with families across a range of levels of risk including those with a lower threshold of risk than Integrated Family Services, Child FIRST and Child Protection would normally engage. In my opinion, if we are to prevent the long term social, emotional and economic impact of trauma on children. We need targeted programs such as the 0-2 Program which work across the spectrum of risk but especially aim to get in at an early stage when the risk is not so high.

The Antenatal Screening Tool

41. During the pilot program, we considered that mothers and families at risk generally present with similar indicators. To assess these mothers at an early stage, we incorporated into the 0-2 Program an antenatal screening tool. This simple tool uses evidence based indicators of risk to the baby to identify women who should be referred to the program. The tool is applied in the antenatal period by local General Practitioners, the maternity unit of the local hospital and/or the intake worker at Gippsland Lakes Community Health. The screening tool seeks verbal consent from

the mother for referral to the program and is then faxed directly to the Maternal and Child Health Service at Gippsland Lakes Community Health.

42. We developed the screening tool to be simple and efficient to complete and provide back to us. We knew that this was the key to getting doctors and hospitals on board with using the screening tool. The tool would not be effective if it was burdensome on doctors and the hospital to complete. We also found that it was necessary to make the screening tool as simple as possible so that mothers would be able to easily understand it and feel that they could provide informed consent. In this regard, we found that the language initially used in the screening tool was too complex, and that this deterred mothers from accepting the program.

Young Pregnant & Parenting Group

43. Approximately 10% of babies born in the Gippsland Lakes area are to young mothers. The Young Pregnant & Parenting Group is a support group that specifically targets women under the age of 21 who are pregnant or have given birth in the previous 12 months. The group is facilitated by two family support workers and new members are actively supported during the initial engagement process. From its inception, this group continued to grow and evolve as we learnt how it could best operate. We found that a flexible approach was essential to best meet the changing needs and dynamics of group participants.

44. The Young Pregnant & Parenting Group has evolved over the time it has been operating and especially as a result of feedback from participants. It now operates on a model where the participants identify their needs and the group activities are structured to meet these. Also each participant is assisted to develop their own personalised plan and then supported by the facilitators to achieve their goals. Over the period of time participants are part of the group it is designed so they develop the skills to move on and lead the group independently.

45. The Young Pregnant & Parenting Group is now well established in Bairnsdale and Lakes Entrance and continues to operate successfully within the overall framework of the 0-2 Program. We struggle to fund the Youth Parent & Pregnancy Group but continue to source resources for it, because it is considered to be a very valuable support group.

Intensive Home Visiting Program

46. The Intensive Home Visiting Program is a targeted outreach home visiting program provided by Maternal and Child Health nurses. We found that Maternal and Child Health nurses are key to the program because there is no stigma attached to their involvement with a family, so they are best placed to intervene early and provide support.

47. The Intensive Home Visiting Program incorporates a comprehensive assessment of the family's needs and a systematic, multidisciplinary approach to providing the required services. The services and visits provided by the Maternal and Child Health nurses are family orientated. This ensures that the family is involved at all points of the program, from engagement to case closure. The family centred approach also engages fathers in the program but the success of this has been mixed. The engagement of fathers is seen as very important so currently we are looking at how we can improve this and have planned a program that we intend to trial this year. The trial will seek to engage fathers in a specific program designed around their needs and involving male practitioners from a range of services at Gippsland Lakes Community Health. It will be conducted during the evenings.

48. We quickly found that many of the families we visited at home were experiencing various mental health issues. As a result, we incorporated access to counselling. Subsequent evaluation also identified that we needed to increase the hours of operation to not only meet increasing referral patterns but also to enable us to retain the 0-2 Program model.

49. The initial model adopted for the Intensive Home Visiting program has been maintained with changes only occurring through the addition of assessment tools and pathways for clients with specific needs.

FAB Tuesdays

50. In addition to the 0-2 Program, we run a program called FAB (Families and Babies) Tuesdays. This program was developed in response to the well-recognised need to address issues of perinatal anxiety and depression. We sought to provide women with a group that offered them the support they, their infants and families needed to thrive. We named the group 'Families and Babies' to focus the group on their families, and not on the mental health aspect of the group.

51. The group targeted mothers experiencing symptoms of mild to moderate depression and anxiety. We also sought to engage those with previous mental health issues or current circumstances such that might cause them to be more vulnerable to psychological distress in the perinatal period.

52. In developing this program, we wanted to avoid reinventing the wheel. We did not follow a particular model in setting up the program, but instead borrowed different aspects from similar programs already in existence, for example the Hunter New England Local Health Post Natal Depression Group and the Reconnexion's Communicating Connecting and Caring Postnatal Depression Group. We acknowledged that, from the mothers' perspective, it was vital to keep an open mind and let the group be driven by what the families most needed. No firm agenda is set for the sessions, instead just a broad guide is provided.

53. We explored the option of providing child care so that mothers could attend the program without their children. We were initially concerned that having children present would be a distraction. However, we were unable to offer childcare to mothers due to lack of funding. We suggested to mothers that they arrange their own child care to attend the program, but we acknowledge that this is a definite flaw in the plan as we know that the very reason some of the women are at risk is because of the lack of practical support they have. As the program developed however, it became clear that having children present at the program did not hinder the meetings, and in some cases, aided development.

54. A theme which came out strongly from of some our initial discussions with the mothers was the sometimes competitive nature of New Parents groups. For us, it was very important that women felt supported from within the group, and not just by the staff.

55. As part of evaluating the program, we used the Edinburgh Postnatal Depression Scale to assess the mothers' existing symptoms. However, we did not limit ourselves to assisting only mothers who displayed these symptoms, but also engaged those at risk of developing symptoms of postnatal depression. We considered women with psychosocial risk factors such as past mental health issues, real life stressors (difficult pregnancies, traumatic births, family violence) or simple lack of practical supports.

56. Using the Edinburgh Postnatal Depression Scale, the average score for women commencing the FAB Tuesday program in October 2014 was 12.5. At completion of the FAB Tuesday program, the average score was 10. This decrease in scores was achieved despite two participants experiencing extremely stressful life events. For our first group in 2015, the average score for women on commencing was 15.5 and on completing was 10.

Ailsa Carr

Dated: 8 July 2015