WITNESS STATEMENT OF BERNADETTE ANNE HARRISON

I, Bernadette Anne Harrison, Maternal and Child Health Coordinator, City of Greater Dandenong, of 225 Lonsdale Street Dandenong, in the State of Victoria, say as follows:

1. I make this statement on the basis of my own knowledge, save where otherwise stated. Where I make statements based on information provided by others, I believe such information to be true.

Maternal and Child Health Service – Universal and Enhanced Services

2. The Maternal and Child Health Service is a universal primary care service for Victorian families with children from birth to school age. The service is run by Maternal and Child Health Nurses (**MCHNs**) who are registered nurses with extra qualifications in midwifery and maternal and child health. These nurses have the knowledge and experience to deal with child and family health issues and problems.

3. The service is provided in partnership with the Municipal Association of Victoria, local government and the Department of Education and Training. It aims to promote healthy outcomes for children and their families. The service provides a comprehensive and focused approach for the promotion, prevention, early detection, and intervention of the physical, emotional or social factors affecting young children and their families in contemporary communities.

4. The Universal Maternal and Child Health Service supports families in the areas of parenting, health and development, promotion of health, wellbeing and safety, social supports, referrals and linking with local communities. MCHNs offer information, guidance and support on issues including:

   - breastfeeding;
   - child health and development;
   - infant and child nutrition;
   - maternal health (including emotional health);

- parenting skills;
- home safety for children;
- immunisation;
- relationships (including your relationship with your baby); and
- local support services.

5. Most Maternal and Child Health Centres run some additional sessions, such as baby-settling seminars, new parent groups, breastfeeding assessment and enhanced MCHN services for particular needs.

6. The Universal Service also offers ten free Key Ages and Stages consultations to correspond with certain times in a baby's development. At each of these consultations, parents are given the opportunity to discuss their concerns, parenting experiences, how to optimise their child's health, growth and development and their own health and wellbeing.

7. The Enhanced Maternal and Child Health Service responds assertively in an outreach model to the needs of children and families at risk of poor outcomes, in particular where there are multiple risk factors. The Enhanced Service is provided in addition to the suite of services offered through the Universal Service. It provides a more intensive level of support, including short term case management in some circumstances. Support may be provided in a variety of settings, such as the family's home, the Maternal and Child Health Centre or another location within the community.

8. The primary focus of the Enhanced Service is families with one or more of the following risk factors:

   - drug and alcohol issues;
   - mental health issues;
   - family violence issues;
   - families known to Child Protection;
   - homelessness;

- unsupported parent(s) under 24 years of age;
- low-income, socially isolated, single-parent families;
- significant parent–baby bonding and attachment issues;
- parent with an intellectual disability;
- children with a physical or intellectual disability; and
- infants at increased medical risk due to prematurity, low birth weight, drug dependency and failure to thrive.

9. Families receiving the Enhanced Service are eligible for an average of 15 hours of service per family in metropolitan regions and an average of 17 hours in rural regions.

10. The Enhanced Service is provided predominantly by MCHNs. However, a multidisciplinary approach is encouraged within the Enhanced Service and it may be of benefit to employ professionals from other backgrounds such as Aboriginal health workers, early childhood workers, family support workers, alcohol and drugs workers, social workers and psychologists.

Current role

11. I am the Maternal and Child Health Coordinator for the City of Greater Dandenong. I have held this position since November 2012. In this position I am responsible for managing the Maternal and Child Health Program for the City of Greater Dandenong.

Background and qualifications

12. I am a registered nurse and registered midwife. I have a Graduate Diploma in Community, Family and Child Health and a Masters of Education – Leadership, Policy and Change.

13. I have worked in Universal and Enhanced Maternal and Child Health Service for 18 years including at Kingston, Port Phillip, Stonnington and Frankston councils.

14. My experience as a MCHN has included working with culturally diverse communities and the most vulnerable 'At Risk' families with drug and alcohol, family violence, mental health and trauma and torture issues. Due to the nature of these family issues, frequent attendance in the Children's Court over 11 years, ensured families

received optimal support and guidance. I also developed a court protocol to support MCHNs and presented at several conferences on the importance of supporting vulnerable families. As a lecturer in Maternal and Child Health, my focus was educating nurses to support families 'At Risk'. During this time, I worked in the Enhanced Maternal and Child Health service in both Frankston and City of Greater Dandenong. Since 2012, I have been at Maternal and Child Health Co-ordinator for the City of Greater Dandenong.

History of Maternal and Child Health Nurses

15. The first Maternal and Child Health Service were provided in Richmond by voluntary welfare associations in 1917. The statewide Maternal and Child Health Service was founded as the Infant Welfare Service in 1926, following a Royal Commission into the welfare of women and children in Victoria in 1925. At that time, the emphasis was on addressing high infant mortality and morbidity rates that resulted from infectious diseases and poor nutrition. Local governments have since been central to the delivery of the Maternal and Child Health Service.

16. The service has evolved to respond to new understandings and approaches relevant to maternal and child health. Since 1992, the parent-held Child Health Record has provided parents with information and a history of their child's health from consultation visits to service providers such as general practitioners and MCHNs.

17. Also of significance was the introduction in 1994 of a framework that articulated the goals of the Universal Service, specified uniform program components, introduced consistent standards for service delivery and addressed inequalities in resource distribution.

18. The development of the Maternal and Child Health Service has acknowledged a worldwide trend that recognises the value of enhancing parenting confidence and home visiting services. By the late 1990s, home visiting services and other new models of service delivery were operating in a small number of municipalities.

19. Research conducted in the 1990s/2000s also shifted the focus of the Maternal and Child Health Service to the welfare of the mother and infant mental health. Research showed that well supported mothers often raised thriving infants. Maternal health and wellbeing consequently became a priority.

20. Focus also turned to infant mental health due to the impact that issues at home could have on a baby's development. In particular, this could be seen through withdrawal patterns of babies and children. If the mother was not physically, psychologically and emotionally in touch and connected with the child through attachment and bonding, this would impact the child's development including reflexes and the child's neurological and emotional state.

21. The introduction of the Enhanced Service in 2000/01 enabled local government to build more intensive service responses for families requiring support in addition to that available through the Universal Service. Some Enhanced Services introduced multidisciplinary staffing models, with MCHNs working alongside family support workers, Indigenous workers, ethnic support workers and early childhood workers. Multidisciplinary centres are discussed in further detail later in this statement.

Working with fathers

22. In the last 10 years, Maternal and Child Health Service has experienced an increased focus on working with fathers. The mother/child relationship is obviously the pinnacle but I am of the view that fathers are just as important. As such I think that Maternal and Child Health should instead be called Family and Child Health to represent the holistic nature of the service.

23. In my experience as a MCHN, I have found that I often uncover issues, including family violence, when I start asking questions about the father. We cannot segregate fathers and exclude them from the picture. We need to be more inclusive and aware that each consultation with the family and every service or support that we provide, should include and/or consider the father and his needs whether he is present or not.

24. Even in a family violence context, it is my view that children have the opportunity to benefit from both parents whether their relationship is intact or not. Children have a right to know who their father is and to have a relationship with him providing it is in the best interest of the child and not detrimental to the health and wellbeing of the child. We need to inform fathers that although they have a history of family violence, we want them to be involved in the family where appropriate, with the right supports in place.

25. Fathers should have an equal opportunity to support their family in the community and we need to build programs for an open and educative process for fathers. This responsibility doesn't just sit with Maternal and Child Health Services because, in a

lot of ways, fathers are excluded from many services. As a result of timing and funding constraints, it is often considered easier to work with just mothers and children rather than developing programs and means to engage the whole family. It is important that fathers are no longer considered 'too hard'.

26. We need to consider how we can help and support men to understand that family violence is not acceptable in our community. It is important for children to know that this type of role modelling is not normal and not to be replicated. In this context, education is paramount. Consideration of gender equity, cultural context, resources of the families and community and the timing is integral to the implementation of education. We therefore need to consider who is responsible for such education – is it, for example, the families, community, primary prevention, Men's Behavioural Change Programs? Or is it a partnership inclusive of policy makers and wider society. It is also important to consider when education begins and to acknowledge that it is not acceptable to wait until males or females are of high school age before educating them that family violence is not acceptable. A preventative and proactive approach embedded into the universal platform will ensure that families are informed, supported and aware of positive change in this circumstance.

Antenatal programs and support

27. I am a strong advocate for Maternal and Child Health Services starting at the antenatal stage. I think that the antenatal and early infancy periods are the most important time to support and begin the trusting and professional relationship with families. In my experience working with vulnerable families in a cycle of poverty, violence and/or abuse, positive changes can best be achieved if we work on the strengths base of families. For example, encouraging young mothers to go back to school, discussing options of enrolling their children in childcare, offering positive experiences and social and emotional opportunities for change, as opposed to children remaining in potentially unhealthy environments.

28. During my time as a MCHN working at Frankston Council between 2005 to 2010 I saw great changes from such initiatives, as Frankston is an area with a high level of generational poverty. These changes were a result of small steps such as children attending childcare and being taught to count to 10 for the first time at the age of three, young mothers enrolling in TAFE courses, children learning how to kick footballs instead of watching television, families eating healthier food and children no longer being exposed to cigarettes. As MCHNs, we can help families to think

differently and engage with services and supports that they otherwise would not have considered or been aware of the benefits. It is very rewarding when I see changes and know that I have made a small difference to a family, and that it is long lasting.

29. Successful examples of Maternal and Child Health Services starting at the antenatal stage are the Right@home research program and 'Bridging the Gap', which are discussed in further detail below.

The right@home program

30. The right@home program is an Australian multi-state sustained nurse homevisiting randomised controlled trial designed to promote family wellbeing and child development. The program is a research collaboration between the Australian Research Alliance for Children and Youth, the Centre for Community Child Health and the Centre for Health Equity Training Research and Evaluation.

31. The trial is based on the Maternal Early Childhood Sustained home-visiting program and incorporates additional modules based on the best evidence that are focused on helping parents care for, and respond to, their children, and create a supportive home learning environment. The Victorian component of right@home was launched on 30 April 2013. Final results, analysis and public reporting are expected to occur in 2016.

32. The cornerstone of right@home is the training and support provided to nurses and a social worker to enable them to establish professional, warm and effective relationships with parents, and in turn, promote children's development in the home. The program aims to determine how the Universal Service might be improved to better meet the needs of all families:

    32.1. Families in the intervention group will be offered the program from the antenatal period (around 26 – 28 weeks gestation) to when the child turns two years old. Those families receive up to 25 visits in the period of antenatal to two years old, with roughly one visit a month on average.

    32.2. Families in the control group continue to receive usual care.

33. When the child turns two years old, the study evaluates the impact of the sustained nurse home-visiting program on:

- Parent care;

- Parent attunement and responsivity; and
- Supportive home environment.

34. In-home visits from nurses and social workers evaluate markers such as the mother/child interaction, building capacity in the family unit, development of the child and social and psychological matters. This is an example of the capacity for professionals to work together in a multi-discipline, preventative model and it is vital in building trust and rapport.

35. Families in the program begin to realise that workers will be involved in their lives for a long period of time. This is very important because so often vulnerable families are moved from one service to another and therefore have contact with a wide range of workers. I previously worked with a mother who was 16 years old and had seen 23 different workers. It is impossible for families to build trust and rapport and to obtain an understanding of the system and services in those circumstances as there is no continuity of care

36. right@home allows families to have a stable relationship, stay engaged, positive role modelling opportunities and build trust with their workers. The problem that we now face is that once right@home families are discharged back into Universal Services, those families revert back to having contact with a wide range of workers. We are therefore currently working to establish a process for re-introducing families back into Universal Services.

37. In general, the impact and changes that right@home is having on families is incredible. I think the program is fantastic and can see the right@home model actually superseding Enhanced Services.

The 'Bridging the Gap' program

38. 'Bridging the Gap' is a partnership program that brings together health service clinicians and managers, policy makers and researchers to create sustainable improvements in the quality of maternity and early childhood health care. The aim is to improve health and health care outcomes for families of refugee background.

39. Quality improvement projects are being implemented in four maternity hospitals (Western Health and Monash Health) and two local government maternal and child

health services (Cities of Wyndham and Greater Dandenong) with evaluation of process and outcomes occurring concurrently.

40. Together the Bridging the Gap partnership is developing projects that will lead to:

- earlier and better identification of families of refugee background;
- opportunities for clinicians and front-line staff to build their understanding of the refugee experience through training and professional development;
- improved linkages and referral systems between health, settlement and social service providers;
- greater continuity of care for families of refugee background;
- alternative ways of providing clinical care and health education that engages bicultural workers and interpreters;
- community engagement in service planning; and
- more seamless, integrated care across maternity and early childhood health services.

41. I think it is crucial that Maternal and Child Health Services build capacity in the antenatal and early childhood period. Maternal and Child Health Services, the community and the antenatal and postnatal wards of hospitals should all be connected. Bridging the Gap has been instrumental in making those connections.

Factors most relevant/common to family violence

42. In my experience, the main factors relevant to family violence include a history of childhood trauma, poor role models and past parenting, drug and alcohol addiction and mental health issues.

43. Generally, it is the father who is the perpetrator of family violence, although dependent on the circumstance this can vary.

44. Family violence is inter-generational and many fathers who we work with, particularly in disadvantaged areas, were born into a generation of poverty and therefore did not know anything different and were not aware or ready for accessing resources.

Children pick up and learn from their parents then bring those behaviours and attitudes into their own adolescent and adult relationships.

The importance of asking questions to identify family violence issues

45. MCHNs are usually not aware of family violence issues until the mother discloses. We observe women, their children and the physical environment for signs of unsafe family life related to family violence. In some circumstances, we may observe indicators such as the mother becoming emotional when talking about her relationship with the father or saying something that you then try to unpack only to have her shut down. Other signs include physical injury, emotional state, body language and developmental stages in babies. Whether mothers are free to meet on their own with us will also be noted.

46. When meeting with mothers, we work from various documents including the following:

    46.1 Maternal and Child Health Services: Practice Guidelines 2009;

    46.2 Maternal and Child Health Services Guidelines; and

    46.3 Family Violence Risk Assessment and Risk Management Framework and Practice Guides 1 – 3.

    Copies of the above documents are attached to this statement and marked **'BH 1'** to **'BH 3'**.

47. The above documents suggest that MCHNs can start asking questions and discussing family violence issues from four weeks into the program. Specific questions to ask the mother are set out in the Week 4 Key Age and Stage Maternal Child Health Consultation document (page 27 of attachment **'BH 1'**).

48. These four questions about family safety, set out below, are to be asked in a conversational style in order to be non-threatening or accusatory:

    48.1 Are you in any way worries about the safety of yourself or your children?

    48.2 Are you afraid of someone in your family?

    48.3 Has anyone in your household every pushed, hit, kicked, punched or otherwise hurt you?

48.4 Would you like help with this now?

49. These questions can also be asked at any visit if professional judgment warrants it

50. I am of the view that we should be encouraged to ask questions more than once. If we ask at every visit, the mother will consider whether she's ready to tell and disclose family violence issues. In my experience and that of my colleagues, it's not usually the first or second visit but consequent visits, once we have built trust and rapport, that a mother will open up and disclose. I see it as part of our role to ask the right questions and to continually do so.

51. We are concerned however, that while it is vital that we ask these questions, often there are not adequate resources to respond if we do and the mother discloses family violence issues. The service sector needs to be further informed and educated about our role and where we fit in terms of family violence detection, prevention and response.

52. MCHNs are trained in family violence, using the Common Risk Assessment Framework (**CRAF**) but our role and responsibility is to set up the pathway to the appropriate services, it's not to start the intervention. We can support families going through family violence issues and it is important that we have the background and partnerships with other services but our role is not interventionist.

53. Further, while it is very positive that Maternal and Child Health Nurses are now trained to identify family violence issues, we need the support, time, and flexibility to actually utilise this training. Time constraints, for example, are a disincentive for nurses to ask difficult questions and may result in nurses avoiding or choosing not to ask such questions.

54. Time constraints are also particularly prevalent for MCHNs in circumstances where all geographical areas have the same targets in terms of number of appointments. Funding for the Universal Service mandates that MCHNs schedule an appointment every half an hour. These targets are also challenging when we are trained in risk assessment and required to ask questions, including around family violence, the responses to which would inevitably need us to spend a lot more time with a client.

55. If MCHNs therefore seek to provide the same service in Greater Dandenong as in our neighbouring councils, we would require double the time for appointments due to the increased need for interpreters and higher representation of vulnerable and at

risk clients in the Greater Dandenong area. Funding for the Universal Service also does not account for disadvantaged and high risk areas. We are granted the same dollar per head amount in Greater Dandenong as our counterparts in affluent areas.

56. I am of the view that Maternal and Child Health Services urgently requires a new funding scheme, similar to the 'Gonski' school funding scheme, which takes into account the issues such as socio-economic status and cultural diversity to ensure that the services provided, reflect the level of need and risk in different geographical areas.

Multi-disciplinary centres and immediate response teams for family violence issues

57. If a MCHN identifies a family violence issue, we need services to link in, and to do so - as part of an immediate response. I think that the ideal response would involve a complete and connected multi-disciplinary team.

58. Currently, there is no unified response processes or teams following the identification of a family violence issue. For example, a mother recently attended an appointment at a Springvale Maternal and Child Health Centre with her two children, for a Key Age and Stage appointment for the 18 month old child. She was extremely distressed and trying to find sharp items in an attempt to hurt herself because she wanted to die. This mother had waited two days for a half hour appointment with Maternal and Child Health. Her husband, who is the father of her children, has gambling issues and was in debt. As a result, strangers had turned up at the family home when the husband was not home and sought to recover his debts. They ransacked the house and held a gun to the heads of the mother and three year old child. Neighbours called the police but that information did not lead to an immediate response to support that mother.

59. When the mother attended her appointment, and disclosed the situation in very broken English the MCHN sent an email to the Leadership Team requesting support and assistance. To that end:

    59.1. The Enhanced Services Team Leader responded and attended the Centre but it was determined that a further response was required.

    59.2. We called a Crisis Assessment and Treatment Team (**CATT**) but were informed that the CATT could not attend and we would have to take the mother to hospital ourselves.

59.3. We contacted Child Protection but were informed that they were also not able to assist.

59.4. We again contacted CATT and stated that we needed an immediate response, only to be informed that we should call an ambulance.

59.5. Neither the police nor ambulance workers were able to transfer the children with the mother to hospital. Child Protection Services would not take the children.

60. As is clear from above, the whole response was a complete mess. These fragmented responses often result in MCHNs being considered 'holding bays' until Child Protection and/or CATT is available. While we are able to temporarily respond to 'At Risk' families, it is often not understood or appreciated that we are mandated to continue to attend an appointment every half an hour.

61. If an immediate response team was available, we would have the flexibility to re-evaluate our workload and, if required, be released to work with that response team to address some of the family violence issues. Alternatively, it may be that other workers would attend to transfer the mother and children to a central hub to work through issues in a safe environment where all relevant services are available. This would enable a more planned and tailored approach.

62. An immediate response team could receive a complete hand-over from MCHNs or enable us to become part of that consultative liaison team moving forward, depending on the circumstances. This would ensure that the appropriate people were involved at the appropriate times and empower them to consult and collaborate to build partnerships with other services.

63. Ultimately, multi-disciplinary teams in which all workers have a common understanding and responsibility to move through the system with families could be used to facilitate a sharing of information and identification of needs, which leads to better outcomes for those families.

Community Outreach Programs

64. Maternal and Child Health Services cannot support families alone. It is therefore important to work within a community services framework to engage other services including, for example, childcare, playgroups, kindergartens, family and youth services.

65. In my experience, once a family has accessed the Enhanced Service and their goals have been achieved, or partially achieved, they are often then linked back into the Universal Service despite a reluctance to return. In these circumstances, I believe that Community Outreach Programs should supersede the Enhanced Service. Community Outreach Programs could offer a range of services dependent on the needs of the community and are staffed by experienced MCHNs, nurses specialising in refugee health, social workers, early parenting educators, Indigenous health workers and youth workers. The programs could include routine infant health and developmental screening and health promotion and aim to enhance family functioning, parenting and life skills of vulnerable families. Together this team would develop collaborative partnerships and link with local services when needed.

66. We need to offer a multi-discipline approach for families which should stay on the Universal Services platform, where most families access services. I have proposed a new Community Outreach model for Universal Services which encompasses a broader scope including responding to issues such as family violence and Aboriginal health.

New Model for Maternal and Child Health inclusive of Enhance Maternal and Child Health (EMCH)

67. Below is my vision for the new model of Maternal and Child Health inclusive of EMCH.

68. I am of the view that a Maternal and Child Health Outreach Service (**Outreach Service**) is needed with specific access to many service providers (including interpreters), to ensure a far more flexible and responsive service to meet the immediate needs of families. The Outreach Service needs to be across EMCH and Universal Services as many families can transition between both services over several years. The Outreach Service should assist not only the families from the culturally and linguistically diverse (**CALD**) and refugee background but also the most socially disadvantaged families in our community.

69. We should explore the concept of a Maternal and Child Health Community Outreach Team, which could incorporate the antenatal period, more vulnerable families, and the Universal Service team. This team's role could be similar to that of a Health Visitor and it could become a multidisciplinary 'cluster' team incorporating both the Universal and EMCH teams with team members specialising, but not limited to their role.

70. This team could have a Maternal and Child Health Team Leader to manage services such as:

- A Core Universal Maternal and Child Health Team offering centre consultations and home visits.
- A Community Outreach Team (previously known as EMCH) inclusive of MCHNs, Early Parenting Support Officers (**EPSOs**), social worker and/or psychologist, refugee health/AMES nurse. The team would accept referrals and liaise with the multitude of services to engage CALD families dependent on assessment. There could be one team per cluster or one or two per municipality, dependent on need.
- A Central Parent Education Team to organise education sessions across the municipality. Both MCHNs and EPSO's would engage in the antenatal period offering education sessions in the hospitals and community.
- The need for skilled bicultural workers with early years competencies.
- An Indigenous MCHN.
- Breastfeeding or lactation service.

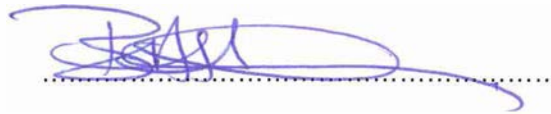
71. Each team would have affiliations with local services, agencies and referral pathways, as well as the broader network, to develop partnerships and programs into preschools, childcare, playgroups, libraries and local primary schools. These partnerships must identify the learning outcomes for children with Maternal and Child Health and develop a better understanding of the 'Better Outcomes Model', regardless of whether they are in a dedicated Maternal and Child Health Centre or other venue.

72. Each team could also plan for a more flexible, responsive approach by offering additional home visits, parenting education groupwork or individual home visits for sleep settling or breastfeeding issues. This is important because a father returning to work often impacts on the lack of transport for the family, causing difficulties for the family to attend Maternal and Child Health Centres until the father is available.

73. If families are facing other psycho-social issues and the Maternal and Child Health Framework is focused on only the child's development, those issues may be missed. Further consideration should be given to including psychosocial assessment to

ensure a more holistic overview of the family's needs, particularly in CALD communities.

74. In my experience, EMCH has limitations due to criteria for entry into the program and the need for skilled practitioners. The flexibility with this proposed multidisciplinary approach would allow for rotation through the 'cluster', allowing the MCHNs to utilise their skills and work across both Universal Services and more vulnerable families. Dependent on the demographics and needs of each municipality, each team may look different but all will focus on addressing the individual and local community needs. We should consider establishing one 'cluster' team in the municipality or redefining the whole team in its entirety. This would be dependent on each council and its needs.



Bernadette Anne Harrison

Dated: 12 August 2015