Maternal and Child Health Program
resource guide
September 2006
1. Introduction

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 provided in partnership with the Municipal Association of Victoria, local government and the Department of Human Services and 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.

About the resource guide

The *Maternal and Child Health Program resource guide* is published annually for Maternal and Child Health Service providers. It outlines service delivery and monitoring requirements in accordance with *Future directions for the Victorian Maternal and Child Health Service* (Department of Human Services, 2004), which was jointly prepared by the Department of Human Services and the Municipal Association of Victoria and is an outcome of the Maternal and Child Health Service Improvement Project. The document is available on the Department of Human Services website at www.dhs.vic.gov.au/earlychildhood.

Quality guidelines for service delivery are also outlined in the *Maternal and Child Health Service Program Standards* (Health and Community Services, 1995), and the *Standards of Professional Practice for Maternal and Child Health Nurses* (Maternal and Child Health Nurses Special Interest Group, 1993).

The *Maternal and Child Health Program resource guide* supports the Department of Human Services approach to quality assurance and improvement across funded programs. The guide is an adjunct to the Department of Human Services *Office for Children Policy and Funding Plan 2006–2009*. It complements service agreements that exist between the Department of Human Services regional offices, local governments and other agencies in the delivery of the Maternal and Child Health Service.
2. Policy context

A Fairer Victoria (Victorian State Government, 2005) outlines the State Government’s commitment to improve access to vital services, reduce barriers to opportunity, and strengthen assistance for disadvantaged groups, people with disability and people with mental illnesses – thereby strengthening our community as a whole. Giving children the best start in life is a key government strategy within A Fairer Victoria and acknowledges that the first four years are critical to the long-term health, development and future life chances of children.

The Department of Human Services is currently developing a more comprehensive and coordinated approach to the provision of early childhood services via the ‘Statewide plan for children’ within the Office for Children. The plan will identify priorities to improve future outcomes for children and families.

The Growing Victoria Together policy (Victorian State Government, 2001) outlines the State Government’s commitment to building cohesive communities and delivering high quality, accessible health and community services, with particular reference to services that support mothers and children from pregnancy to eight years of age. The Growing Victoria Together policy adopts a social model of health, which clearly identifies that for further gains to be made in the health and wellbeing of the Victorian population, social determinants of health must be better addressed within service activities; this includes the service activities of Maternal Child Health Services.

The Joining the dots report (Premier’s Children’s Advisory Committee, 2004) (the PCAC report) acknowledges and supports Future directions for the Victorian Maternal and Child Health Service and recommends that the ‘Victorian Government make a strong commitment to maintaining the universal nature of the Maternal and Child Health Service’. The government, in Putting children first (Victorian State Government, 2004), responded to the PCAC report by identifying the universal nature of the Maternal and Child Health Service as ‘one of its great assets’.

The Children first policy (Victorian State Government, 2002) highlights the need to link universal and secondary early childhood services to improve the early identification of children at risk and to improve outcomes for children and their families. This policy includes new ways to build, strengthen and connect services, including maternal and child health, maternity, early intervention, kindergarten, child care and family support services.

The 2003–04 State Budget committed an additional $16 million over four years to strengthen the Maternal and Child Health Service as well as an additional $1 million over four years for professional development for staff delivering the Maternal and Child Health Service. As a result of this investment, a range of initiatives are now underway. These initiatives include the:

- implementation of professional development opportunities based on the outcomes of the Maternal and Child Health professional development needs analysis
- Municipal Association of Victoria’s recruitment and retention project
- scholarships for maternal and child health nurses
- evaluation of the Victorian Maternal and Child Health Service
- review of the Maternal and Child Health Service program standards
- development of municipal early years plans by all local governments
- Continuity of care, a communication protocol for Victorian public maternity services and the Maternal and Child Health Service 2004 (Department of Human Services, 2004)
and
• reflective practice and mentoring resource.

A Fairer Victoria…next steps (Victorian State Government, 2006) will provide a further $25 million over the next four years to assist councils in Melbourne’s outer suburbs to increase services for children and their families. Provision will be made for six new children’s centres, funding for nine Best Start projects and nine multipurpose facilities. The funding will boost services such as parent support groups, in home parenting services, responses to postnatal depression and specialist child health teams. Maternal and child health services should work in partnerships with these groups.

The role of local government in the planning, development and coordination of community services and infrastructure is vested in the Local Government Act 1989. Local government provides and funds a range of primary care services and has an important role in local public health planning, advocacy, community development and delivery of children’s and other services.

In October 2002, the Department of Human Services and the Municipal Association of Victoria co-signed a partnership protocol. This protocol recognises the complementary roles of State Government and local governments in the planning, funding and delivery of community services and the shared commitment to achieve better health and wellbeing outcomes for children, families and communities across Victoria. A revised memorandum of understanding is currently being developed and will further articulate the partnership between the Municipal Association of Victoria on behalf of local government and the Department of Human Services in relation to the Maternal and Child Health Service.

The Maternal and Child Health Service Improvement Project, undertaken by the Department of Human Services and the Municipal Association of Victoria, produced the document Future directions for the Victorian Maternal and Child Health Service. This document guides changes to the Maternal and Child Health Service that, along with other services, will contribute to the improvement of the health and wellbeing of children and their families in Victoria. The Maternal and Child Health Service Improvement Implementation Advisory Group has been established to oversee the successful implementation of this new approach.

The PCAC report, Joining the dots (2004), confirmed the important role of local government, not only in providing maternal and child health services but in the planning, development and delivery of early years services. The Government, in its response to PCAC, emphasised even further the role of local government in improving the health, learning, development, wellbeing and safety of Victorian children.

Local governments in all 79 municipalities have either completed their municipal early years plan (MEYP) or have a draft MEYP awaiting ratification. The MEYPs have highlighted that the development and coordination of local services for children and their families is an integral component of the municipal planning process.

Legislation
Maternal and child health services will be required to work in conjunction with the following two newly created Acts of Parliament:

Child Wellbeing and Safety Act 2005
The purpose of the Act is:
• to provide common principles for those child and family services provided to vulnerable children and families under the Children, Youth and Families Act 2005 and other primary and universal services provided to children and
families under other legislation, such as child care and maternal and child
health services

- to provide for the establishment of bodies to oversee the child and family
  service system and to coordinate government policy in this area, including
  the Victorian Children’s Council, the Children’s Service Coordination Board
  and the Child Safety Commissioner. For further information, see

*Children, Youth and Families Act 2005*

Key aspects of this Act include:

- common principles to guide practice and decision making
- pathways to connect vulnerable children and families to the prevention and
  early intervention services they may need
- more flexible Child Protection responses from reports
- a new focus on cumulative harm
- maintaining vulnerable Aboriginal children within their communities
- promoting stability in care arrangements and beyond
- a capacity to intervene in cases where children aged over 10 but under 15
  years are engaging in sexually abusive behaviours
- powers and orders of the Children’s Court
- a framework for registration and quality assurance of community services
  and carers
- clearly authorised information sharing to promote children’s safety,
  wellbeing and development.

Further implications of these Acts upon maternal and child health services are
included in Appendix 5: Child abuse and neglect and Appendix 7: Birth
notifications.
3. Vision, mission, goals and principles

The vision, mission, goals and principles for the future directions for the Victorian Maternal and Child Health Service outlined in Future directions for the Victorian Maternal and Child Health Service (2004) are as follows.

Vision

All Victorian children and their families will have the opportunity to optimise their health, development and wellbeing during the period of a child’s life from birth to school age.

Mission

This vision for the Maternal and Child Health Service is supported by the mission:

> to engage with all families in Victoria with children from birth to school age, to take into account their strengths and vulnerabilities, and to provide timely contact and ongoing primary health care in order to improve their health, development and wellbeing.

Goals

The framework for the provision of the Maternal and Child Health Service is guided by an overarching goal:

> to promote healthy outcomes for children and their families, providing a comprehensive and focused approach to managing the physical, emotional or social factors affecting families in contemporary communities.

To support this goal, two further objectives have been developed. These are:

**Enhance family capacity** to support young children and address physical, emotional, social and wellbeing issues affecting young children.

**Enhance community capacity** to support young children and their families to address physical, emotional, social and wellbeing issues affecting young children.

Principles

The guiding principles for the Maternal and Child Health Service are:

**Consultation and participation**
Consultation with, and participation by, families is integral to the service. Services will be informed by, and seek to meet, the needs of young children and their families.

**Access and availability**
All families with young children should be able to readily access the information, services and resources that are appropriate for, and useful to, them.
Primacy of prevention
Prevention of harm or damage is preferable to repairing it later. Early detection of risk factors is required, and intervention, where appropriate.

Capacity building
Promotion of resilience and capacity is preferable to allowing problems to undermine health or autonomy.

Equity
All children should be able to grow up actively learning, healthy, sociable and safe – irrespective of their family circumstances and background.

Family-centred
The identification and management of child and family needs requires a family-centred approach that focuses on strengths.

Diversity
The diversity of Victorian families should be recognised and valued.

Inclusion
Inclusive practices are essential for all children to get the best start, irrespective of their family circumstances, differing abilities and background.

Partnership
Quality services are achieved through integrated service delivery and partnerships with other early childhood and specialist services, and with families.

Quality
All families with young children must be confident of the quality of information, services and resources provided to them.

Evidence and knowledge
Policies, programs and practice are based on the best evidence and knowledge available.

Evolution of services
Programs and services will continue to evolve to meet needs in a changing environment.

Continuously improving and adding value to services
Sustained and improved services for families and children promote better outcomes for children and their families.

Critical success factors
The Maternal and Child Health Service is underpinned by six critical success factors: (Future directions for the Victorian Maternal and Child Health Service, Department of Human Services, 2004)

1. Universal access and participation for all children from birth to school age and their families
A schedule of consultations at key ‘ages and stages’ and other activities that provide information, advice and support relevant to individual child development and family circumstances. There is a focus on approaches to include families who
are not engaged by the service and those who have the greatest burden of morbidity and risk.

2. **A focus on the prevention, promotion, early detection and intervention of health and wellbeing concerns of children**

   Early detection includes identifying risk and protective factors at the individual, family and community level. Interventions to improve outcomes for children and families are informed by evidence from relevant contemporary studies and may require referral to other services.

3. **Provision of services for children and families, recognising a diversity of need**

   All families with young children can benefit from information, advice and support. The type of support undertaken should consider the needs of individual families and recognise cultural diversity. The service also assertively identifies and responds to children at risk of poor outcomes, and contributes to an interdisciplinary and integrated service response across program boundaries.

4. **Partnerships with families, communities, service providers, and state and local governments**

   A partnership approach is reflected in the service’s family-centred orientation and partnerships between service providers. The strong partnership between State Government and local governments will continue to realise benefits for children, families and communities.

5. **Local planning, flexibility and collaboration**

   Local governments, in consultation with the department, have the flexibility to design Maternal and Child Health Service models in response to identified individual, family and local community needs. These models will be required to support service integration, include defined mechanisms for collaboration among services and build on new understandings about the importance of place-based approaches to supporting families within their community.

6. **Support to provide a quality service**

   Service quality will be improved and guided by the department’s Service Quality Framework and local government ‘best value’ processes.
4. Maternal and Child Health Service activities

All families with young children can benefit from information, advice and support relevant to their circumstances and their child’s individual development. The Maternal and Child Health Service is a universal service available for all families with children from birth to school age through a schedule of consultations at key ages and stages and other activities including groups for parents. Additional support is also available through the Enhanced Maternal and Child Health Service, which is available to respond to children and families at risk of poor outcomes. The service is provided 52 weeks of the year, and supported by the 24-hour Maternal and Child Health Line.

The Maternal and Child Health Service provides a schedule of contact and activities for all families, with an emphasis on prevention, promotion, early detection and intervention for health and wellbeing. In addition, the Maternal and Child Health Service provides a universal platform that can:

- help to identify children and families who require further assessment, intervention, referral and/or support
- bring families together, foster social networks, support playgroups and strengthen local community connections
- deliver other service and supports, such as family support services, immunisation programs and volunteer programs.

The Maternal and Child Health Service is part of the broader service system, which builds on the identification of individual, family and community needs at a local level. This approach requires an integrated response to families that crosses program boundaries. Maternal and Child Health Service providers have the flexibility to design innovative service models that support service integration and collaboration while maintaining the universal nature of the service. Strategies that promote service integration include co-locating services, establishing interdisciplinary teams, sharing protocols, and using common assessment frameworks and referral tools as well as joint service delivery. A local service network may include maternal and child health services, maternity services, general practitioners, kindergarten and child care services, Indigenous organisations, early childhood intervention services, parenting and family services, school nursing services, child protection services, and specialist services such as those addressing disability, drug and alcohol abuse, mental illness and family violence issues.

Service providers are encouraged to articulate their priorities and strategies for the Maternal and Child Health Service within their annual (strategic) plan, taking account of the needs of families and communities at a local level. Linkages with other initiatives and networks, including Best Start, Family Support Innovation Projects, Neighbourhood Renewal and Primary Care Partnerships, may further enhance the capacity of services to support families.

The type of support and activities undertaken during consultations with children and their families is guided by evidence-based approaches, concerns elicited by parents, observation, physical examination of the child, and information from other sources.

Service approaches may include, but are not limited to, one-on-one consultations, ‘drop in’ services, group consultations, extended service hours, outreach services including consultations in the home and service delivery in other settings such as child care centres, shopping complexes and Aboriginal cooperatives.
Local knowledge and data will identify specific groups who are under-represented users of the service or who have the greatest burden of morbidity and risk. The inclusion of Indigenous families, families from culturally and linguistically diverse backgrounds, families with a child or parent with a disability, families with substance abuse issues, disadvantaged families and children in out-of-home care may provide gains in child health and wellbeing. Innovative local approaches should be developed to promote the service to these families and to actively engage them. Service providers should also consider that there may be pockets of greater need in certain locations within the municipality and should recognise and address this diversity.

Staffing of Maternal and Child Health Service
Primarily, the Maternal and Child Health Service is staffed by maternal and child health nurses who are required to be registered with the Victorian Nursing Board as a Registered Nurse in Division 1, with Midwifery and Maternal and Child Health qualifications. With the inception of the Enhanced Maternal and Child Health Service in 1999–2000, local services have also benefited from the complementary skills of workers from other professional backgrounds. A multidisciplinary approach is encouraged and, in addition to maternal and child health nurses, may include Indigenous workers, ethnic workers, early childhood workers, family support workers, psychologists, social workers and drug and alcohol and mental health workers.

Research involving Department of Human Services/Maternal and Child Health clients
Maternal and child health nurses should ensure, prior to allowing an external researcher access to maternal child health services staff, clients and client information, that approval for the research has been obtained through the Office for Children Research Coordinating Committee. All research requests should be referred to Ronelle Hutchinson (email: Ronelle.Hutchinson@dhs.vic.gov.au).

Maternal Child Health Service collaboration with local initiatives
Partnerships with other service providers play a central role in maximising the support available to children and their families. As a result, maternal and child health services are expected to assertively reach out and work collaboratively with local initiatives such as Primary Care Partnerships, Kids-Go for your life, Neighbourhood Renewal, Best Start and Growing Communities, Thriving Children to name a few. A brief description of these initiatives follow:

Primary Care Partnerships (Primary Care Partnerships Strategic Directions, Department of Human Services 2000) are voluntary alliances formed with neighbouring services. While some maternal and child health services have developed these partnerships, all are required to build upon these partnerships. An independent evaluation of the Primary Care Partnerships strategy found measurable benefits to both consumers and services (Australian Institute for Primary Care, July 2002). For further information see: www.health.vic.gov.au/pcps/

Kids–Go for your life projects are being developed through the municipal early years planning framework in a number of local government areas to develop sustainable approaches to child nutrition. For further information see: www.goforyourlife.vic.gov.au

Neighbourhood Renewal targets the most disadvantaged communities by bringing together residents, government, business, service providers and the local community in the development and implementation of a community action plan. For further information see: www.neighbourhoodrenewal.vic.gov.au

Best Start projects are expected to improve access to child and family support, health services and early education; parents’ capacity, confidence and enjoyment of
family life; and child and family friendliness of communities. Phase 3 (2005–09) will include a total of 23 Best Start projects, including mainstream and Aboriginal projects. For further information see: www.dhs.vic.gov.au/beststart/outcomes.htm

Growing Communities, Thriving Children will target nine local governments that are based in the rural-metropolitan interface. It will involve the creation of new children’s centres, child health teams, responses to postnatal depression and parent support groups.

Aspects of Maternal and Child Health Service activities are outlined below.

Universal Maternal and Child Health Service

Ten key ages and stages consultations

The Maternal and Child Health Service provides ten key ages and stages consultations from birth to 3.5 years including an initial home visit and consultations at two, four and eight weeks, four months, eight months, 12 months, 18 months, two years and 3.5 years of age for all children and their families.

Key ages and stages consultations may be one-on-one, or with a group of children with parents present. Prior to conducting a group consultation, maternal and child health nurses should ensure they are competent to manage nurse-led questions and client responses on sensitive topics such as domestic violence and postnatal depression. The consultations may be offered in a variety of settings including a maternal and child health centre; a community service or location, for example a child care centre, kindergarten, Indigenous cooperative or family support agency; or in the family’s home.

Models that promote ease of access for families to the Maternal and Child Health Service may be required to engage families who under-utilise the service and who have an increased incidence of risk and morbidity. Ways to do this may include out of hours consultation sessions, conducting consultations at child care centres or at Indigenous cooperatives.

Key ages and stages consultation activities, outlined in Appendix 1, will remain unchanged during 2006–07.*

Redevelopment of universal key ages and stages service activities commenced in March 2006 and is being guided by the identification of priorities for gain for children and families in relation to child health, development, learning and wellbeing. The Program Resource Guide working party, a sub group of the Maternal and Child Health Service Improvement Advisory Group, will examine the emerging early years policy and research, the need for evidence-based practice within the Maternal and Child Health Service and alignment with Future directions for the Victorian Maternal and Child Health Service. The group will consult with local Maternal and Child Health Service managers, the coordinators’ group, the Maternal and Child Health Special Interest Group, maternal and child health practitioners, and the universities delivering the postgraduate training program for maternal and child health nurses. Regular progress updates will be circulated. A pilot study will be implemented to trial the recommended service activity changes. The outcome of this process will be articulated in the Maternal and Child Health Program resource guide for 2007–08.

* Note Aboriginal and Torres Strait Islander children and health checks by GPs
In June 2005, the Commonwealth Government provided a new Medicare-funded Annual Indigenous health check for all children birth–14 years. This yearly health check, performed nationally and mostly by GPs, is in addition to, and will complement, the ten maternal and child health checks. For further information see www.racgp.org.au

This document is managed by the Department of Education and Early Childhood Development, Victoria (as of 27 August 2007)
Flexible service capacity

There are a number of categories of flexible service capacity activities. An example of flexible funding can be found in Appendix 2.

**Group sessions** include parent groups inclusive of, but not limited to, first time parents. Group sessions are a required activity within this component. Other group sessions may be tailored for teenage parents, particular cultural communities, working parents or fathers, as appropriate. Parent groups should provide health education, build parenting capacity, offer parenting support and foster community connections.

Groups may also be conducted to address particular issues, such as postnatal depression, infant settling or breastfeeding. (These groups are separate from the key ages and stages consultation activities that are undertaken with a number of children and their parents.)

Maternal and child health plans will provide details on the duration, focus and size of parent groups based on local family and community needs.

**Other community strengthening activities** to engage and build community capacity may include, for example, organising volunteer programs to support socially isolated parents; contributing to parenting programs conducted by neighbourhood houses or community health services; or arranging for groups of parents, such as those from a particular cultural group, to meet independently from the Maternal and Child Health Service.

**Health promotion programs** may be delivered within the flexible model of delivery by maternal and child health services. Mounting evidence of the effectiveness of health promotion programs has led to the development of *Integrated Health Promotion: a practice guide for service providers* (Department of Human Services, 2003). This guide and resource kit (available at http://www.dhs.vic.gov.au/phkb), illustrates how to measure health promotion impacts and how to plan for effective health promotion evaluation. The resource kit is a guide for maternal and child health services to work with neighbouring agencies using a Primary Care Partnership. Use of this approach will contribute to the delivery of high quality integrated health promotion programs by maternal and child health services.

**Additional consultations** for children and families who require support in addition to the ten key ages and stages consultations are counted as flexible funding. Assertive outreach may be required to engage families who under-utilise the service and have an increased incidence of risk and morbidity. There is clear evidence of an inverse relationship between the level of family need and the use of health services. Vulnerable families are the least likely to access maternal and child health services. Engagement with vulnerable families is under-represented in the Maternal and Child Health Service and remains one of the major challenges for all maternal and child health services in 2006–07.

**Telephone consultations** to provide advice and support for families regarding the health and wellbeing of the child or family are also considered an aspect of flexible funding. (This does not include administrative phone calls such as appointments and general enquiries.)
Enhanced Maternal and Child Health Service

There have been indications in recent years of an increase in the level of risk for many children due to the complexity of issues for families (see Appendix 3). A new understanding of the way in which risk factors often cluster together for some families means service approaches need to draw on a range of expertise.

The Enhanced Maternal and Child Health Service assertively responds to the needs of children and families at risk of poor outcomes, in particular where there are multiple risk factors. This service is provided in addition to the suite of services offered through the universal Maternal and Child Health 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 other location within the community.

The primary focus of the Enhanced Maternal and Child Health 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
- infants at increased medical risk due to prematurity, low birth weight, drug dependency and failure to thrive
- Indigenous families who are not linked into, or who require additional support to access, the universal Maternal and Child Health Service are included in the target group. Maternal and child health services will be encouraged to develop specific action plans to demonstrate strategies to increase the participation of Aboriginal families in both the universal and enhanced services.

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

Regular clinical supervision and critical incident debriefing is a key aspect of the Enhanced Maternal and Child Health Service to support staff delivering this service. Furthermore, in accordance with *Continuity of care, A communication protocol for Victorian public maternity services and the Maternal Child Health Service*, (Department of Human Services, 2004) and the *Child, Youth and Family Act 2005*, Enhanced Maternal Child Health Service nurses should be actively involved in cross-service and cross-sector case conferencing when a child is vulnerable or involved with Child Protection.

Maternal and Child Health Line

The Maternal and Child Health Line provides 24-hour telephone advice. It provides appropriate information, advice, support, counselling and referral to families with children from birth to school age. The service is instrumental in linking families to
the universal Maternal and Child Health Service and to other community, health and support services.

**Referrals from the Maternal and Child Health Line to the universal Maternal and Child Health Service:** When families experiencing particular difficulties contact the Maternal and Child Health Line, they will be offered a referral to the universal Maternal and Child Health Service. Referrals occur with the caller’s consent (approximately 2 per cent of consultations).

**Referral process:** Referrals will be followed up to the Maternal and Child Health Service as soon as possible during business hours. Referral details will only be discussed directly with a maternal and child health nurse. When a nurse is not available, a telephone message will be left for the nurse to return the call and collect the details. If the maternal and child health centre is not open or the nurse is unable to be contacted and an immediate referral is required, the maternal and child health coordinator will be contacted. Following a referral, there is an expectation that the family will be contacted by the universal Maternal and Child Health Service. Referrals will remain open until contact with the service has been made.

**Contact with the Maternal and Child Health Line:** Following a referral, the Maternal and Child Health Line welcomes feedback from the maternal and child health service regarding the outcomes. Contact can be made during business hours on (03) 9843 5448.
5. Performance measures and targets

The *Maternal and Child Health Program resource guide* is an adjunct to the Department of Human Services *Office for Children Policy and Funding Plan 2006–2009*, and complements service agreements between the department and local government in the delivery of the Maternal and Child Health Service.

Municipal targets for the universal Maternal and Child Health Service and its flexible service capacity activities are negotiated between the Department of Human Services regional offices and individual local governments. These targets are articulated in service agreements (also see Table 3).

Individual municipal targets for the Enhanced Maternal and Child Health Service are aligned with the service’s equity funding formula.

To meet current targets, participation rates in key ages and stages consultations must increase by 30,000 children statewide from July 2004 until June 2007. The focus will be on improved participation rates at 18 months, two years and 3.5 years. This is, however, not at the expense of maintaining participation rates from birth to 12 months of age. Regions and individual municipalities will negotiate how best to increase participation rates at key age and stage consultations.

From 1 July 2005, key age and stage consultations will be collected for all children using two different categories: each family will either be recorded as non-Aboriginal and Torres Strait Islander, or Aboriginal and Torres Strait Islander.

**Performance measures and data collection**


### Table 1: Annual reporting and data collection

#### Universal Maternal and Child Health Service

<table>
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<tr>
<th>Performance measures</th>
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<th>Reporting due date</th>
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<td>Yearly July</td>
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<table>
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<tr>
<th>Data collection</th>
<th>Reporting Frequency</th>
<th>Reporting Due Date</th>
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<td>Maternal and Child Health March data collection</td>
<td>Yearly April</td>
<td>13 April</td>
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<tr>
<td>Maternal and Child Health Annual data collection</td>
<td>Yearly July</td>
<td>15 August</td>
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#### Enhanced Maternal and Child Health Service

<table>
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<th>Performance measures</th>
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<tr>
<td>Number of clients receiving a service</td>
<td>Quarterly</td>
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<tr>
<th>Data collection</th>
<th>Reporting frequency</th>
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<tbody>
<tr>
<td>IRIS (Integrated Reports and Information System)</td>
<td>Quarterly</td>
<td>By the 15th day of the following month</td>
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Notes: Annual data collected at the end of each financial year should be emailed to the nominated program and policy adviser within the Office for Children maternal and child health team.
**Table 2: March data collection**

**Collection Period: 1 July 2006 to 31 March 2007**

| Municipality: Centre, Municipal use only |

<table>
<thead>
<tr>
<th>Analysis of Enrolments</th>
<th>1</th>
<th>2</th>
<th>3</th>
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<th>5</th>
<th>6</th>
<th>Total</th>
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<tr>
<td>1. No of infants enrolled from birth notifications received in previous financial year (2005–06) (Column 8.2 Birth Notice and Enrolment Record*)</td>
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<td>2. Total No. of infant record cards</td>
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* This applies to those children born before 31 June 2005 and enrolled from 1 July 2006

**Notes:**

- March data collection. The municipal total is collated to include all centres and is then forwarded to the Department of Human Services Regional Maternal and Child Health Program and Service Advisers, by 13 April 2007 (contact details are listed in Appendix 12).

To ensure that calculation of the Maternal and Child Health Funding Formula 2007–08 is based on the most current data available, the following data is requested by 13 April 2007:

- The number of infants enrolled from birth notifications received in the previous financial year. That is, those infants who were born in the previous financial year (2005–06) and enrolled in the current financial year (2006–2007). This information is found in column 8.2 of the Birth Notice and Enrolment Record (refer Appendix 11).

- The total number of record cards in each year from 0–6 years at 31 March 2007. This will require a count of both active and non-active records. Based on the nine-month data provided, projections will be made for 12 months to calculate 2007–08 funding allocations.

The maternal and child health stationary requirements for each municipality are no longer being collected as most services have implemented an electronic data collection system. It is proposed that all 2006–07 annual data collection stationary be obtained from the maternal and child health warehouse distribution centre. WFDS Pty Ltd (03) 9793 8111 or email: trath@wfds.com.au
<table>
<thead>
<tr>
<th>Service component</th>
<th>Performance measure</th>
<th>Statewide target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children enrolled 0–1 years</td>
<td>Number of children enrolled 0–1 years</td>
<td></td>
</tr>
<tr>
<td>Children 0–1 month enrolled from birth notification</td>
<td>Percentage of children 0–1 month enrolled in the Maternal and Child Health Service from birth notifications</td>
<td>98% of infants 0–1 month</td>
</tr>
<tr>
<td>Key ages and stages consultations</td>
<td>Number to complete child health assessments:</td>
<td>Percentage of child health assessments completed:</td>
</tr>
<tr>
<td></td>
<td>Home visit</td>
<td>2004–05</td>
</tr>
<tr>
<td></td>
<td>2 weeks</td>
<td>98%</td>
</tr>
<tr>
<td></td>
<td>3–4 weeks</td>
<td>98%</td>
</tr>
<tr>
<td></td>
<td>8 weeks</td>
<td>95%</td>
</tr>
<tr>
<td></td>
<td>4 months</td>
<td>90%</td>
</tr>
<tr>
<td></td>
<td>8 months</td>
<td>80%</td>
</tr>
<tr>
<td></td>
<td>12 months</td>
<td>74%*</td>
</tr>
<tr>
<td></td>
<td>18 months</td>
<td>65%*</td>
</tr>
<tr>
<td></td>
<td>2 years</td>
<td>59%*</td>
</tr>
<tr>
<td></td>
<td>3.5 years</td>
<td></td>
</tr>
<tr>
<td>Flexible capacity</td>
<td>Hours undertaking group sessions</td>
<td>Hours of service determined by funding and contained within service agreements. Activities and targets to be negotiated between Department of Human Services regions and individual municipalities.</td>
</tr>
<tr>
<td>Other community strengthening activities</td>
<td>Hours of community strengthening activities</td>
<td></td>
</tr>
<tr>
<td>Additional consultations</td>
<td>Hours of additional support activities</td>
<td></td>
</tr>
<tr>
<td>Telephone consultations</td>
<td>Hours conducting telephone consultations</td>
<td></td>
</tr>
<tr>
<td>Enhanced Maternal and Child Health Service</td>
<td>Number of clients receiving a service per annum</td>
<td>5,883 families in 2006–07</td>
</tr>
<tr>
<td></td>
<td>Number of hours of service</td>
<td>Individual municipal targets are in line with the Enhanced Maternal and Child Health Service equity funding formula</td>
</tr>
</tbody>
</table>

*Targets to be negotiated between Department of Human Services regions and individual municipalities based on previous year’s performance and to meet statewide targets.
Service hours

Service hours include the time devoted to activities defined in the program
descriptions and include activities such as travelling to visit a client, planning for
sessions and record keeping. Service hours do not include general administrative
activities, meetings unrelated to individual children or families or professional
development activities.

Service hours includes both direct and indirect service delivery.

Direct service delivery
The time devoted to direct contact with clients. This typically relates to direct
consultation with clients either in person or on the telephone (excluding
administrative phone calls for example, appointments and general enquiries), as
well as group activities.

Indirect service delivery
The time devoted to indirect activities required to support direct services to clients.
Indirect activities may include facilitated referral; case conferences; consultation
notes; travel; planning for group sessions, and any other work-related activities
undertaken outside, but related to, direct work with clients.

Travel
The time spent travelling between clients or service activities. Travel time includes
travelling from the main work base (for example, maternal and child health centre)
to a client’s home, or to a community site such as a child care centre or Indigenous
cooperative, to consult with numerous clients. Travel time also includes the time
spent travelling from one home visit or community site to another home visit or
community site. Return travel time is recorded after consultation with the last client
when the worker returns to their main work base (ibid.).

The performance measure ‘service hours’ will be collected for the flexible service
capacity undertaken by the universal Maternal and Child Health Service. Providers
must report an aggregate for the hours of the flexible capacity annually.
6. Recording of activities

Data collection is an integral aspect of the Maternal and Child Health Service and should be consistent across the State. Accurate data collection provides:

- measures of performance that reflect the role of the Maternal and Child Health Service
- a basis for calculating State Government funding for the Maternal and Child Health Service within each municipality
- service information related to the Enhanced Maternal and Child Health Service
- an important source of information to a wide range of key stakeholders
- data for comparative studies with other program areas to inform future development and planning of services and cross-program linkages.

Daily activity sheet

The following information will assist in the completion of the daily activity sheet (see Appendix 13). The daily activity sheet can be used by service providers to collect annual data including service hours. Many service providers will have other pre-existing data collection systems in place for data and reporting.

Key ages and stages consultations

- Each assessment is entered on the daily activity sheet once only. Consultations are also recorded in the child’s centre-held history and Child health record.

- **Key ages and stages consultations columns**
  
  There are now two key ages and stages columns. ‘Key ages and stages consultations – non-Aboriginal and Torres Strait Islander’ and ‘Key ages and stages consultations – Aboriginal and Torres Strait Islander’. This will provide information regarding participation in key ages and stages by these two groups in the annual report. **Only one activity** is recorded for each session in either the non-Aboriginal and Torres Strait islander or Aboriginal and Torres Strait Islander column.

  - The first home visit to the family following the birth of the child is the only home consultation recorded in the key ages and stages ‘Home consultation’ column.

  - **Other key ages and stages consultations** (whether undertaken at a maternal and child health centre, in the client’s home, or at another venue such as an Indigenous cooperative) **are recorded** in either the ‘Key ages and stages consultation – non-Aboriginal and Torres Strait Islander’ or the ‘Key ages and stages consultation – Aboriginal and Torres Strait Islander’ column **only once at the completion of the assessment**.

  - **If a return visit is required to complete a key age and stage consultation, the visit is recorded when the assessment has been completed.** The first consultation may be recorded as flexible service capacity consultation.

  - The 3.5 year old assessment should be carried out on children aged between three years and six months to four years. Assessments made after age four are **not** recorded as a 3.5 year old key age and stage consultation. These consultations may, however, be recorded as flexible service capacity consultation.
Flexible service capacity

Flexible service capacity relates to all activities undertaken by the universal Maternal and Child Health Service that are not identified as key ages and stages consultations. The type of consultation is classified into one of the following activities:

- groups*
- community-strengthening activities
- additional consultations
- telephone consultations (does not include administrative phone calls for example, appointments and general enquiries).

These are recorded on the Maternal and child health centre daily activity sheet in two parts:

- in the ‘Flexible capacity consultations’ column only once at the completion of the assessment
- in the ‘Flexible capacity service hours’ column against the relevant time category. For example, a telephone consultation that takes seven minutes, including completion of consultation notes, is recorded in the column ‘1–15 minutes’. Service hours are totalled as the maximum value of the time category, that is, 15 minutes.

Both parts should be recorded for each flexible service capacity activity. Service hours incorporate both direct and indirect service delivery.

*Groups are no longer counted as a series of sessions (previously one group was counted as eight sessions). Each individual group session is now counted, whether single or multiple sessions are conducted for the same group of parents. Service hours to complete each individual group session should be recorded on the Maternal and child health centre – daily activity sheet in the ‘Flexible capacity service hours’ column.

Enhanced Maternal and Child Health Service

The universal maternal and child health annual data collection for 2006–07 no longer includes a performance measure to record the number of families participating in the Enhanced Maternal and Child Health Service.

The Enhanced Maternal and Child Health Service data is collected and collated separately to identify the number of families who receive this service. Since 1 January 2005, the Department of Human Services has requested that all Enhanced Maternal and Child Health Service data be submitted electronically. The data collection requirements for the Enhanced Maternal and Child Health Service remain unchanged from previous years. Enhanced Maternal and Child Health Service data should be forwarded electronically to the Department of Human Services (iris.data@dhs.vic.gov.au) quarterly by 15 October, 15 January, 15 April and 15 July. To support this requirement, the Department of Human Services makes available free of charge for all municipalities across Victoria the Integrated Reports and Information System (IRIS), including training and automatic upgrading of software. Please contact the IRIS help desk, telephone number 9616 6919 to organise training and installation of the software if required.

There has been a change to the counting of families receiving this service – the number of case closures will no longer be recorded.
The new counting rules are:

1. Count in the first quarter of the financial year:
   - ongoing cases at the beginning of the quarter and
   - new cases opened during the quarter.
2. Count for the remaining three quarters of the financial year:
   - new cases opened during the quarter.

**Example**

Ongoing cases at the beginning of the financial year = 5
New cases opened during the first quarter = 1
New cases opened during the second quarter = 2
New cases opened during the third quarter = 0
New cases opened during the fourth quarter = 1
Number of clients receiving a service = 9 (5 + 1 + 2 + 0 + 1)

No longer should cases be closed as part of data collection. The length and intensity of contact by the Enhanced Maternal and Child Health Service with a family is a matter for professional judgement based on the complexity of family needs and efficient and effective service provision for families.

Service hours will also be collected for the Enhanced Maternal and Child Service.

**Note:**
Funding arrangements require that key ages and stages consultations delivered by the Enhanced Maternal and Child Health Service are reported in the universal Maternal and Child Health annual data report on 30 June each year.

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**Birth notification and enrolment record sheet**

For changes to birth notifications as a result of the *Child Wellbeing and Safety Act 2005*, refer to Appendix 7.

**Recording a birth notification**

Refer to the Birth notification and enrolment record, Appendix 11.

- Complete columns 1, 3, 4 and 5 only. Do not make an entry in column 7 until the baby has been enrolled at the centre. For a multiple birth, make a separate entry for each child born. A separate birth notification should have been issued for each child.
- When the baby is enrolled, complete columns 2, 6, 7 and 8. Once this is complete, the totals of columns 6, 7 and 8 should be equal.
- If a baby is not enrolled at the centre, an entry is made in column 9.

**Recording other enrolments**

- Complete columns 1, 2, 3, 5, 6, 7 and 8.
- An entry is made in column 10 for first-time mothers with infants 0–1 enrolled for the **first time in Victoria**. On transfer, this should not be recorded again.
- For a child who is transferring in from another centre, the enrolment is not recorded until the child’s history has been received from the previous maternal and child health centre.
Additional annual data

Counselling

To record a ‘C’ in these sections, the level of information of guidance is specific to an identified health concern. This should not to be confused with the range of information expected to be provided as part of the maternal and child health schedule of activities at key ages and stages of development. Not all consultations by the maternal and child health nurse therefore are counted as counselling consultations.

Referral

A referral is only recorded when communication is made to the referral agency with the consent of the parent. This may take the form of a written letter, a phone call to the referral agency or a recording made in the parent-held Child health record by the maternal and child health nurse. The exception is in the case of mandatory reporting when parental consent is not required.

A referral implies that counselling and referral occurs during a consultation. It is possible to provide counselling and referral at a consultation for more than one identified child, maternal or family health issue.

Breastfeeding status

As outlined by the Australian Government Department of Health and Ageing, the World Health Organization (WHO) and other health authorities, it is important to provide a consistent definition of breastfeeding to enable accurate comparison of data.

Fully breastfeeding
The fully breastfed rate is the combined rate of exclusively breastfed and predominantly breastfed. An exclusively breastfed infant receives only breast-milk with no other liquids or solids except vitamins, mineral supplements or medicines. A predominantly breastfed infant receives breast-milk and water, water-based drinks, fruit juice or oral rehydration salts but no breast milk substitutes or solids.

(Commonwealth Department of Health and Aged Care, 2001)

Partially or complementary breastfeeding
The infant receives breast milk and solids or semi-solid foods or non-human milk. It allows the infant to receive any food or liquid including non-human milk as well as breast milk (ibid.).

Aboriginal and Torres Strait Islander status

All governments throughout Australia have agreed to cooperate in sharing information that will improve the health of Aboriginal and Torres Strait Islander people. The Department of Human Services requires maternal and child health nurses to provide information on the Indigenous status of every child attending the Maternal and Child Health Service.

This information is used to:

- identify the main health problems for Victorian Aboriginal and Torres Strait Islander children and their families
• provide appropriate intervention to improve the health, development and wellbeing of Aboriginal and Torres Strait Islander children and their families
• record the total number of identified Aboriginal and Torres Strait Islander children aged 0–6 years
• record the number of Aboriginal and Torres Strait children who have attended each of the ten key age and stage consultations
• record the number of Aboriginal and Torres Strait children aged 0–6 years who have attended the service at least once during the current financial year.

The official definition of an Aboriginal or Torres Strait Islander is a person of Aboriginal or Torres Strait Islander descent, who identifies as being Aboriginal or Torres Strait Islander and who is accepted as such by the community with which the person associates.

**In using this definition, it is important to remember that determining Aboriginality will depend upon the parent or guardian identifying their child as an Aboriginal or Torres Strait Islander.**

Maternal and child health nurses cannot be certain whether any child is Aboriginal or Torres Strait Islander without asking the parent or guardian of every child born in Australia the question: ‘Is your child of Aboriginal or Torres Strait Islander origin?’ If the parent or guardian replies ‘yes’ to this question, they should be asked further questions to help to correctly record the details of the child’s Indigenous status, as required by the Department of Human Services standards and agreed national standards.

Maternal and child health nurses need to record Aboriginal status and Torres Strait Islander status separately. The answers to the question ‘Is your child of Aboriginal or Torres Strait Islander origin?’ should be clearly recorded on the centre-held Child health record as ‘Yes’ or ‘No’. For example:

- NO – not Aboriginal or Torres Strait Islander origin
- YES – Aboriginal
- YES – Torres Strait Islander
- YES – Aboriginal and Torres Strait Islander.

Maternal and child health nurses need only ask and record the child’s Aboriginal or Torres Strait Islander status once. They can then continue to refer to this record for future daily analysis data collection at each key ages and stage visit.

The key age and stages consultations data collection will record one entry in either the ‘Key ages and stages consultations – non Aboriginal and Torres Strait Islander’ column or the ‘Key ages and stages consultations – Aboriginal and Torres Strait Islander’ column.
7. Maternal and Child Health Service funding formula

Funding for the universal Maternal and Child Health Service is based on the total number of children aged 0–6 years enrolled (both active and non-active). This data is collected by service providers on 31 March each year. Data for 0–1 years is proportionally increased to give a projected full year figure.

Funding for the universal service is jointly provided by the Department of Human Services and local government.

Universal Maternal and Child Health Service

**Funding for key ages and stages consultations** is based on the total number of children eligible to receive services at the specified key ages and stages consultations.

**Funding for the flexible service capacity** is based on three hours of service for 40 per cent of children 0–1 year of age and three hours of service for 40 per cent of the average number of children of each age in the 0–6 year age group. This component of the universal maternal and child health funding can be used to provide any of the flexible service capacity activities outlined in Appendix 2. Individual maternal and child health services are thereby able to tailor their services to the identified needs and priorities of local children, families and communities.

The Department of Human Services applies an **additional weightings formula** to the universal Maternal and Child Health Service funding which uses the Accessibility/Remoteness Index of Australia (ARIA) and the number of maximum Family Tax Benefit (FTB) recipients with a child aged 0–6 years. The addition of the weightings reflects the increased cost of service delivery in rural settings and the additional resources required in areas of socioeconomic disadvantage and high need.

Enhanced Maternal and Child Health Service

The Enhanced Maternal and Child Health Service is fully funded by the Department of Human Services. Funding is calculated on a total of 15 hours of direct or indirect service delivery per family in metropolitan regions and 17 hours per family in rural regions in recognition that delivery of services in rural areas takes longer. This funding is weighted according to socioeconomic disadvantage and rurality.

Maternal and Child Health Line

Maternal and Child Health Line is fully funded by the Department of Human Services to provide 24-hour telephone advice and support to families with young children.
Interpreting services

The Department of Human Services allocates additional funding to language services for department programs and funded organisations. Commencing 1 October 2006, ONCALL will provide services for Department of Human Services Language Services Credit Line. Bookings can be taken up to 30 days in advance by calling ONCALL 9867 3788. Maternal and child health services will be provided with a new PIN, which can be found on the Funded Agency Channel www.fac.dhs.vic.gov.au or by telephoning ONCALL. Old PINs will not be effective after 1 October 2006. Guidelines to access the new service can be found at www.dhs.vic.au/multicultural.

Other resources that can be accessed www.dhs.vic.gov.au/multicultural are:

- the Department of Human Services Language and services policy
- a multimedia training resource, Making the connection: language services in the human services sector
- Interpreter Symbol and Card
- Health Translations Directory
- Find Your Language

The Australian Government, through the Department of Immigration and Multicultural and Indigenous Affairs, provides a national toll free 24-hour Telephone Interpreting Service (TIS) on 131 450.
8. Other resources

The Maternal and Child Health Service is supported by a number of additional resources that are available for parents and service providers. The following is offered as a guide to some key resources. It is not intended to be a complete list of available resources. Service providers are encouraged to access information from other credible sources as appropriate.

**Office for Children resources**

The following resources are available free of charge to all maternal and child health services in Victoria. An order form is available from the Department of Human Services website and some resources may be downloaded. Website: [www.office-for-children.vic.gov.au](http://www.office-for-children.vic.gov.au)

**Child health fact sheets for parents**
Asthma, attention deficit hyperactivity disorder, autism, breastfeeding, breastfeeding facts for fathers, care of your child in hot weather, croup and bronchiolitis, care of your child’s teeth, eczema, fever, gastroenteritis, middle ear infection, vomiting
Translated into: Arabic, Aramaic, Bosnian, Cambodian, Chinese, Croatian, Greek, Macedonian, Serbian, Spanish, Somali, Tagalog, Turkish and Vietnamese.

**Additional information available for parents**
*Fact sheet about the Distraction test for hearing screening July 2005*, *Immunisation*, *Communication language and play series birth to five years*, *Maternal and Child Health Service information sheet*, Frequently asked questions about the Maternal and Child Health Service, Maternal and Child Health Service centre directory

**Child health fact sheets for professionals**
Attention deficit hyperactivity disorder, autism, communication disorders, conduct disorders and associated challenging behaviours in children, congenital infection of the newborn, fragile X syndrome, how services can assess and diagnose autism in preschool age children, low birth weight babies, parental grief and adjustment to a child with a disability, and understanding normal variation in childhood gait and posture

**Child health record**
The *Child health record* is a parent-held record, provided to every child at birth, that gives parents, health workers and caregivers information about the health and development of children from birth through to the teenage years.

**Brochures**
*The importance of early childhood*
*Is your child 3–4 years old?*

**Wall charts**
*Your child’s health and development – birth to six years*
*Child and health development – birth to 18 years*
*Kids talk: 75 ways to encourage children* (available in nine languages)
Child health and nutrition fact sheets
Food in the first year of life, Healthy eating for young toddlers, Healthy eating for older toddlers, Healthy eating for preschoolers, Healthy eating for kindergarten, Try it you’ll like it – vegetables and fruit for children, Why no sweet drinks for children?

Bulk orders available through the Warehouse Fulfilment Distribution Solutions, phone 1300 798 698, fax 9793 0211 email trath@wfds.com.au or pdf file located on www.health.vic.gov.au/nutrition

Resources from other organisations
Kidsafe fact sheets: Birth–9 months, 9–18 months, 1 ½–3½ years, 3½ –5 years, 5–7 years, Farm safety, Home safety, The family car, Cars on hot days, Choosing a helmet, Christmas Wheels, Christmas toys, Fire and burns, Poisoning, Scalds, Water safety, Nursery equipment, Pedestrian injuries
Translated into: Arabic, Chinese, Turkish and Vietnamese
A broad range of information is also available on the website at www.kidsafe.org.au

Information for service providers
Office for Children website: Data collection and reports

          Annual Report 2005–06 Form
          MCH Neighbourhood Renewal Data Collection
          MCH Services Workforce Planning as at June 2006
          Regional Contacts for MCH
          Birth Notification Form July 2006
          Daily Tally Sheet July 2006
          Daily Activity Sheet July 2006
          Parent Groups Form July 2006

2004–05  Maternal and Child Health Statewide Data Report
          Barwon–South Western Rural
          Eastern Metropolitan
          Gippsland Rural
          Grampians Rural
          Hume Rural
          Loddon Mallee Rural
          North and West Metropolitan
          Southern Metropolitan

Office for Children website: Maternal and Child Health
Maternal Child Health Conferences: program and slides dating from November 2005
Future Directions for the Victorian Maternal Child Health Service
Maternal and Child Health Program resource guide
Maternal and Child Health Service Improvement Plan tool 2006–07
Summary of 2005–06 Improvement Plans
Maternal and Child Health workforce assessment report
Maternal and Child health workforce strategy 2004
Maternal and Child Health Service Improvement Project newsletters professional
Development Needs Analysis for the Maternal and Child Health Services
Information Maternal Child Health New Parent Kit (includes folder, growth chart with developmental messages, 2 week Communication language and play information, wall poster Encourage kids to talk)
Websites of interest

Dental health resource folder Oral health information for maternal and child health nurses
www.dhsv.org.au

Kindergarten – Best start for learning: www.beststart.vic.gov.au

Royal Children’s Hospital
www.rch.org.au/ecconnections
Evidence-based practice resources
www.rch.org.au/kidsinfo
www.rch.org.au.cch/research

Behaviour
Child adolescent smoking
Eating behaviour
Injury
Language and literacy
Overweight and obesity
Passive smoking effects on children
Sleep and settling
Smoking effects during pregnancy

Royal Women’s Hospital (RWH)
www.rwh.org.au

The Children’s Hospital at Westmead
www.chw.edu.au

Australian Breastfeeding Association
www.breastfeeding.asn.au

Kidsafe Australia
www.kidsafe.com.au

Parenting Research Centre
www.parentingrc.org.au
Formally Victorian Parenting Centre

Child and Youth Health - Government of South Australia
www.cyh.com

TGA – Therapeutic Goods Administration
www.tga.health.gov.au

St. Vincent’s Hospital Melbourne – Department of Dermatology
www.dermatology.svhm.org.au/
New Zealand Dermatological Society Incorporated – DermNet NZ  www.dermnetnz.org
Orthoptic Association of Australia Inc  www.orthoptics.org.au
Panic, Anxiety and Depression Assistance (PADA)  www.pada.org.au
Beyond blue: The National Depression Initiative  www.beyondblue.org.au
Domestic Violence and Incest Resource Centre  www.dvirc.org.au
Municipal Association of Victoria (MAV)  www.asn.au
National Association for Prevention of Child Abuse and Neglect  www.napcan.org.au
Health translations  www.healthtranslations.vic.gov.au
Raising Children Network (National Parenting Information)  www.raisingchildren.net.au
Appendices

Appendix 1 Key ages and stages consultation activities

Key ages and stages consultation activities will remain unchanged during 2005–06, except for the cessation of the Modified Ewing Hearing Screening. This key age and stage activity component ceased on 30 June 2005.

The Department of Human Services is considering the redevelopment of service activities in 2006–07. This process will be guided by the identification of priorities for gain for children and families in relation to child health, development, learning and wellbeing. Any changes will be further articulated in the Maternal and Child Health Program resource guide for 2007–08.

Activities codes

<table>
<thead>
<tr>
<th>Surveillance</th>
<th>Intervention</th>
</tr>
</thead>
<tbody>
<tr>
<td>O – Observation</td>
<td>I – Information, advice, health promotion</td>
</tr>
<tr>
<td>E – Examination</td>
<td>M – Management, treatment or referral</td>
</tr>
<tr>
<td>D – Discussion</td>
<td></td>
</tr>
<tr>
<td>A – Assessment</td>
<td></td>
</tr>
<tr>
<td>P – Plan, evaluate, update and record individual care plan</td>
<td></td>
</tr>
<tr>
<td>R – Child health record entry</td>
<td></td>
</tr>
</tbody>
</table>

Appendix 1 – Table 1: Key ages and stages consultation activities

<table>
<thead>
<tr>
<th>Consultation by type or age</th>
<th>Goal 1: Reduce preventable premature mortality</th>
<th>Goal 2: Reduce the impact of disability</th>
<th>Goal 3: Reduce incidence of vaccine preventable disease</th>
<th>Goal 4: Reduce incidence of adult diseases which originate in childhood</th>
<th>Goal 5: Enhance family functioning</th>
</tr>
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This document is managed by the Department of Education and Early Childhood Development, Victoria (as of 27 August 2007)
<table>
<thead>
<tr>
<th>Consultation by type or age</th>
<th>Goal 1: Reduce preventable premature mortality</th>
<th>Goal 2: Reduce the impact of disability</th>
<th>Goal 3: Reduce incidence of vaccine preventable disease</th>
<th>Goal 4: Reduce incidence of adult diseases which originate in childhood</th>
<th>Goal 5: Enhance family functioning</th>
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<tr>
<td>Maternal health status – OEDAPIM</td>
<td>Genetic history – ODAP</td>
<td>Infant health status, physical, developmental – ODAPIMR</td>
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<td>'At risk' hearing screening – OEDAPIMR</td>
<td></td>
<td>Infant feeding – OEDAPIMR</td>
<td>Parent smoking habits – DAPIM</td>
<td>Maternal health, physical and emotional – ODAPIM</td>
</tr>
<tr>
<td>2 weeks</td>
<td>Maternal health status – ODAPIM</td>
<td>Infant health status, physical developmental – OEDAPIMR</td>
<td>Infant primary immunisation – DAPI</td>
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<tr>
<td>Infant health status, physical developmental – OEDAPIMR</td>
<td>'At risk' hearing screening – OEDAPIMR</td>
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<td>Infant feeding – OEDAPIMR</td>
<td>Parent smoking habits – DAPIM</td>
<td>Maternal health, physical and emotional – ODAPIM</td>
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<td>Injury prevention – DAPI</td>
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<td></td>
<td>Infant feeding – OEDAPIMR</td>
<td>Parent smoking habits – DAPIM</td>
<td>Maternal health, physical and emotional – ODAPIM</td>
</tr>
<tr>
<td>Local family services – I</td>
<td>Infant development, crying, sleep – DAPI</td>
<td></td>
<td></td>
<td></td>
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<td>Infant development, crying, sleep – DAPI</td>
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<tr>
<td>Consultation by type or age</td>
<td>Goal 1: Reduce preventable premature mortality</td>
<td>Goal 2: Reduce the impact of disability</td>
<td>Goal 3: Reduce incidence of vaccine preventable disease</td>
<td>Goal 4: Reduce incidence of adult diseases which originate in childhood</td>
<td>Goal 5: Enhance family functioning</td>
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<td>Maternal health status – ODAPIMR</td>
<td>Administer third dose where required – IMR</td>
<td></td>
<td>Parent/child/sibling interaction – ODAPIM</td>
<td>Local family services – I</td>
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<td>Infant health status physical, developmental – ODAPIMR</td>
<td>Infancy health status physical, developmental – OEDAPIMR</td>
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<td></td>
<td>Family planning/child spacing – DIM</td>
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<td>Maternal health status – OPAPIM</td>
<td>Infancy health status physical, developmental – OEDAPIMR</td>
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<td></td>
</tr>
<tr>
<td>8 weeks</td>
<td>Infant health status physical, developmental – OEDAPIMR</td>
<td>Infant primary immunisation – DAPI</td>
<td>Infant feeding – DAPIMR</td>
<td>Maternal health, physical and emotional – ODAPIM</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Maternal health status – OPAPIM</td>
<td>Infancy health status physical, developmental – OEDAPIMR</td>
<td>Infant feeding – DAPIMR</td>
<td>Infant development, expectations – DAPIMR</td>
<td></td>
</tr>
<tr>
<td>Consultation by type or age</td>
<td>Goal 1: Reduce preventable premature mortality</td>
<td>Goal 2: Reduce the impact of disability</td>
<td>Goal 3: Reduce incidence of vaccine preventable disease</td>
<td>Goal 4: Reduce incidence of adult diseases which originate in childhood</td>
<td>Goal 5: Enhance family functioning</td>
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</tr>
<tr>
<td>4 months</td>
<td>Infant primary immunisation – DAPI</td>
<td>Infant feeding – DAP (introduction to solids)</td>
<td></td>
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<td></td>
</tr>
<tr>
<td></td>
<td>Maternal health status – ODAPIM</td>
<td>Infant health status physical, developmental – OEDAPIMR</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Injury prevention – DAPI</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>12 months</td>
<td>Injury prevention – DAPI</td>
<td>Infant primary immunisation – DAPI</td>
<td></td>
<td></td>
<td>Child development, behaviour – DAPI</td>
</tr>
<tr>
<td></td>
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<td></td>
</tr>
<tr>
<td>18 months</td>
<td>Child health status physical, developmental –</td>
<td>Child health status physical, developmental –</td>
<td>Infant primary immunisation (booster)</td>
<td>Toddler diet – DAPI</td>
<td>Child development, behaviour – DAPI</td>
</tr>
<tr>
<td></td>
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</table>

This document is managed by the Department of Education and Early Childhood Development, Victoria (as of 27 August 2007)
<table>
<thead>
<tr>
<th>Consultation by type or age</th>
<th>Goal 1: Reduce preventable premature mortality</th>
<th>Goal 2: Reduce the impact of disability</th>
<th>Goal 3: Reduce incidence of vaccine preventable disease</th>
<th>Goal 4: Reduce incidence of adult diseases which originate in childhood</th>
<th>Goal 5: Enhance family functioning</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Injury prevention – DAPI</td>
<td></td>
<td></td>
<td></td>
<td>Maternal/family health, wellbeing – ODAPIM</td>
</tr>
<tr>
<td>2 years</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Child development, toilet training, behaviour – DAPI</td>
</tr>
<tr>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td></td>
<td>Injury prevention – DAPI</td>
<td>MIST screening – OEDAPIMR</td>
<td></td>
<td></td>
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<tr>
<td>3.5 years</td>
<td></td>
<td></td>
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<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Maternal/family health, wellbeing – ODAPIM</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
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</table>

**References**


Department of Health, Government of Western Australia 2006, *Child health services, birth to school entry universal contact schedule early detection and prevention*, Policy CH001, Government of Western Australia, Western Australia

Health and Community Services 1992, *Child health surveillance*, Victoria


Jolly, D 1992, *Health goals and targets for Australian children and youth*, Child, Adolescent and Family Health Service, South Australia

National Health and Medical Research Council 2002, *Child health screening and surveillance: A critical review of the evidence*, Report prepared by the Centre for Community Child Health, Royal Children’s Hospital, Melbourne
Appendix 2 Example of a flexible service capacity plan

Example only

Appendix 2 – Table 1: Components of universal Maternal and Child Health Service funded by Department of Human Services and local government

<table>
<thead>
<tr>
<th>Key ages and stages funding</th>
<th>Flexible funding pool</th>
<th>Combined funding pool</th>
</tr>
</thead>
<tbody>
<tr>
<td>$60,000</td>
<td>$20,000</td>
<td>$80,000</td>
</tr>
</tbody>
</table>

In this municipality total funds for flexible service capacity are $20,000.

One hour = one unit. Unit cost 2006–07 is $64.88 (includes 2.6% indexation)

Appendix 2 – Table 2: Unit costings by activity type

<table>
<thead>
<tr>
<th>Type of activity</th>
<th>Average duration</th>
<th>Number of units</th>
<th>Number of activities to be delivered this year</th>
<th>Total yearly hours</th>
<th>Unit cost</th>
<th>Total cost = total hours \times unit cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Groups</td>
<td>2 hours</td>
<td>2</td>
<td>50</td>
<td>100</td>
<td>$64.88</td>
<td>$6,488</td>
</tr>
<tr>
<td>Community-strengthening</td>
<td>1 hour</td>
<td>1</td>
<td>20</td>
<td>20</td>
<td>$64.88</td>
<td>$1,297.60</td>
</tr>
<tr>
<td>Additional support</td>
<td>30 minutes</td>
<td>0.5</td>
<td>350</td>
<td>175</td>
<td>$64.88</td>
<td>$11,354</td>
</tr>
<tr>
<td>Telephone consultation</td>
<td>7 minutes*</td>
<td>0.11</td>
<td>300</td>
<td>33</td>
<td>$64.88</td>
<td>$2,141.04</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td></td>
<td></td>
<td>328</td>
<td></td>
<td>$21,280.64</td>
</tr>
</tbody>
</table>

*Anticipated average telephone consultation duration
Appendix 3 Risk factors in early childhood associated with adverse outcomes

Appendix 3 – Table 1: Risk factors in early childhood associated with adverse outcomes

<table>
<thead>
<tr>
<th>Child characteristics</th>
<th>Parents and their parenting style</th>
<th>Family factors and life events</th>
<th>Community factors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low birth weight</td>
<td>Single parent</td>
<td>Family instability, conflict or violence</td>
<td>Socioeconomic disadvantage</td>
</tr>
<tr>
<td>Birth injury</td>
<td>Young maternal age</td>
<td>Marital disharmony</td>
<td>Housing conditions</td>
</tr>
<tr>
<td>Disability</td>
<td>Depression or other mental illness</td>
<td>Divorce</td>
<td></td>
</tr>
<tr>
<td>Low intelligence</td>
<td>Drug and alcohol abuse</td>
<td>Disorganised</td>
<td></td>
</tr>
<tr>
<td>Chronic illness</td>
<td>Harsh or inconsistent discipline</td>
<td>Large family size/rapid successive pregnancies</td>
<td></td>
</tr>
<tr>
<td>Delayed development</td>
<td>Lack of stimulation of child</td>
<td>Absence of father</td>
<td></td>
</tr>
<tr>
<td>Difficult temperament</td>
<td>Lack of warmth and affection</td>
<td>Very low level of parental education</td>
<td></td>
</tr>
<tr>
<td>Poor attachment</td>
<td>Rejection of child</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Poor social skills</td>
<td>Abuse or neglect</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Disruptive behaviour</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Impulsivity</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Reference
Appendix 4 Definitions

Child health definitions

**Accident**
Any unexpected or unplanned event that may result in death or injury. Accidents frequently are the result of both physical and mental factors that can result in unsafe operating systems at work, home or other sites (Mosby 1990, p. 8).

**Active/non-active infant record cards**
Child centre-held histories are active if the child has attended the Maternal and Child Health Service at least once during the current financial year. They are non-active if the child has not attended during the current financial year.

A third category for child centre-held histories relates to children who have enrolled in the Maternal and Child Health Service but have since died, moved interstate or moved overseas. Centre-held histories in the third category are not counted in either the March or June data collection reports.

A child in the third category can become active again if they return to Victoria from interstate or overseas. They do not need to be re-enrolled at the centre they were previously attending. If the child transfers to another centre within Victoria, the centre-held history is transferred to that centre when the parent signs a request for transfer of records.

**Auditory**
The state at which an individual experiences, or is at risk of experiencing, a change in the amount, pattern or interpretation of incoming auditory stimuli (Carpenito 1995, p. 353).

**Communication**
The state in which an individual experiences, or could experience, a decreased ability or inability to speak but can understand others.

**Community strengthening activity**
Any activity that requires a sustained effort to increase connectedness, active engagement and partnership among members of the community, community groups and organisations.

**Congenital anomaly**
Any abnormality present at birth, particularly a structural one, which may be inherited genetically, acquired during gestation, or inflicted during parturition (Mosby 1994, p. 379).

**Counselling**
The International Council of Nurses, World Health Organization, Royal College of Nurses, Australian Nursing Federation, and the National Health and Medical Research Council, acknowledge that nurses have a counselling role as a part of the therapeutic care of their clients.

Counselling enables a client to explore their concerns and options and take an active part of the planning of strategies/interventions.
The main objectives of nurses as counsellors are to:

- create an atmosphere in which others feel accepted, understood and valued, so that they are helped to explore their thoughts, feelings and behaviours
- help others reach clearer understanding
- help others find their own strengths to cope more effectively with their lives by making appropriate decisions
- help others evaluate the consequences of their actions and to plan and engage in further actions if necessary (Health and Community Services 1993, p. 21)

A second definition is: ‘The act of providing advice and guidance to a patient or the patient’s family. It is a therapeutic technique that helps the patient recognise and manage stress and that facilitates interpersonal relationships between the patient and the family, significant others, or the health care team’ (Mosby 1994, p. 404).

*Definitions of nursing diagnoses have been extracted from the Handbook of nursing diagnosis (6th Ed.) by Lynda J Carpenito, Mosby’s Medical, Nursing and Allied Health Dictionary and other sources. These definitions ensure international consistency of diagnostic criteria and enable accurate comparison of data. Permission to use the definitions in this publication has been granted by J. B. Lippincott Company and the Mosby-Year Book inc.

**Dental and oral conditions**

Dental – of or pertaining to a tooth or teeth (Mosby 1994, p. 453).

Oral – of or pertaining to mouth (Mosby 1994, p. 1113).

**Development**

The state in which an individual has, or is at risk for, an impaired ability to perform tasks of his or her age group (Carpenito 1995, p. 152) (adapted).

**Developmental dysplasia of hips (DDH)**

Developmental dysplasia of the hip denotes abnormal development of the hip joint. This may involve the acetabulum, the femoral head or both. The term congenital is inappropriate because the condition is not always present at birth or apparent in early infancy. Many are first felt at about four months of age (Aronsson et al. 1994, 94[2], pp. 201–08).

**Growth**

The state in which an individual has, or is at risk of, experiencing altered physical growth (Carpenito 1995) (adapted).

**Illness**

An abnormal process in which aspects of the social, physical, emotional or intellectual condition and function of a person are diminished or impaired, compared with that person’s previous condition (Mosby 1990, p. 604).

**Nutrition**

*More than body requirements*

The state in which an individual experiences, or is at risk of experiencing, weight gain related to an intake in excess of metabolic requirements (Carpenito 1995, p. 255).

*Less than body requirements*

The state in which an individual experiences, or is at risk of experiencing, reduced weight related to inadequate intake or metabolism of nutrients for metabolic needs (Carpenito 1995, p. 244) (adapted).
**Potentially disabling condition**
Perceived or identified chronic health condition requiring referral to a medical practitioner. Examples include asthma, diabetes and eczema.

**Protective notification**
Maternal and child health nurses are mandated to report where they suspect the presence of either physical or sexual abuse. *(Children and Young Person’s Act 1989 [Vic], Children and Young Person’s (Further Amendment) Act 1993 [Vic])* These Acts are to be superseded in March 2007 with the introduction of the *Children, Youth and Families Act 2005*.

**Referral**
Referral is only recorded when communication is made to the referral agency with the consent of the parent. This may take the form of a written letter, a phone call to the referral agency or the use of the *Child health record* by the maternal and child health nurse. It is important not to confuse this with linkage to a community agency where a person may be given the option of contacting the agency, but the formal referral procedure is not used; for example, it may be suggested that a breastfeeding mother contacts the Australian Breastfeeding Association for extra support or information for a breastfeeding issue.

A referral implies that counselling has also occurred at the time of the consultation.

**Visual**
The stage at which an individual experiences, or is at risk of experiencing, a change in the amount, pattern or interpretation of incoming visual stimuli (Carpenito 1995, p. 353).

**Definitions of maternal health issues**

**Emotional**
Where a woman reports emotional difficulties in the first weeks and months after having a baby. This can encompass mothers reporting feelings of not coping, experiencing distress and unhappiness or depression. Such feelings may be associated with extreme exhaustion, life stresses such as moving house, family illness, difficulties with the baby or older children, financial concerns, relationship difficulties, being isolated or other individual issues for the woman (Small 1995).

**Physical**
An abnormal process, in which aspects of the physical condition and function of a person are diminished or impaired, compared with that person’s previous condition. (Mosby 1990, p 604).

**Definitions of family wellbeing**

**Domestic violence**
Domestic family violence occurs between people who are known to each other by way of familial or other domestic relationships, past or present. It includes abuse of parents, siblings and other relatives, but predominantly involves violence against sexual partners and the abuse of children. Women and children are overwhelmingly its victims and where violence between adults and the sexual abuse of children are concerned, men are primarily the perpetrators.
Violence may be defined as the use of force, implied or actual, to achieve control over another person. Domestic violence involves a range of violent behaviours, some of which have attracted criminal sanction and others which are not recognised as criminal behaviour but are nonetheless damaging to the victim. These behaviours include assault; sexual abuse of women and of children of both sexes; and economic, social, psychological and spiritual abuse (Professional Education Taskforce on Family Violence 1992).

**Family planning**
The use of a range of methods of fertility regulation to help individuals or couples to attain certain objectives: bring about wanted births; produce a change in the number of children born; regulate the intervals between pregnancies; and control the time at which a birth occurs in relation to the age of the parents. It may include an array of activities ranging from birth planning and the management of infertility to sex education, marital counselling and genetic counselling.

Family planning ‘enables people to make informed choices in the area of sexual and reproductive health’ (World Health Organization).

**Social interaction impaired**
The state in which an individual or family experiences, or is at risk of experiencing, negative, insufficient or unsatisfactory responses from interaction (Carpenito 1995, p. 367).
Appendix 5 Child abuse and neglect

Child abuse and neglect is any act, or failure to act, by a parent that endangers a child’s physical or emotional health or development. It may be a single incident, or pattern of parenting which, over time, accumulates to cause harm to a child’s development or wellbeing. Child abuse is classified into four categories:

1. Physical abuse
2. Emotional abuse
3. Sexual abuse
4. Neglect

The incidence of parental drug and alcohol use, psychiatric illness and family violence is high amongst substantiated cases of child abuse. In situations such as these, harm can occur as a consequence of parents failing to adequately care for and protect their children, as much as from direct and intentional abuse. It is the significance of the harm for the child, which results from parental actions or inaction, which should be the focus for health and welfare professionals.

The immediate and long-term effects of abuse and neglect can be disastrous for the individual child, their family and the community. Early intervention can have a dramatic effect on lessening the harm and promoting recovery of the child and the family.

Maternal and child health nurses need to be able to recognise when children may have been harmed or are at risk of harm. Physical and behavioural indicators of each abuse type are listed at the end of this document. Use of the indicators assists professionals who work with children to identify potential areas of concern. Indicators are starting points only and further consultation with supervisors and colleagues can assist in clarifying the extent of the concerns and the most appropriate action.

Legal context of abuse and harm

The law regarding children in need of protection in Victoria is presently contained in the *Children and Young Persons Act 1989*. This legislation enables professionals and others in the community to notify Child Protection if they believe children are in need of protection.

This legislation will be superseded in early 2007 with the introduction of the new *Children, Youth and Families Act 2005*. The new legislation contains a number of features including common principles to guide practice, better pathways to early intervention services, more flexible responses and a focus on cumulative harm.

The new legislation enables two possible responses.
1. An early intervention or protective response.

1. Early intervention response – significant concerns for a child’s wellbeing

Child First Teams (Commencing in early 2007)

With the introduction of the new legislation early 2007, a key strategy to promote children’s best interests is the creation of pathways to ensure that prevention and early intervention services are provided to vulnerable children and families.

Where a person has a significant concern for the wellbeing of a child (where there is concern for a child’s wellbeing or welfare, but the child is not considered to be in need of
Registered community-based child and family services will be able to consult with a specific range of services and professionals about assessment and outreach to the child and family. Information collection and disclosure is legally authorised for these purposes. This provides a strengthened prevention and early intervention capacity within the system to connect vulnerable children and families to the services that they may need.

When a person has a significant concern for the wellbeing of a child before his or her birth (an unborn child) a referral can be made to a Child First Team or Child Protection about an unborn which will enable the provision of assistance to the unborn child’s mother.

Strong collaborative relationships and processes will be developed to enable Child First Teams and Child Protection intake workers to work with community agencies and professionals to ensure better responses to children and families to achieve better outcomes.

It is important that a maternal and child health nurse takes action whenever she or he has concerns regarding the welfare of a child. It is important to document the observations and actions on the child’s record. That action includes a number of options, depending upon the nature of the concerns.

Maternal and child health nurses often have the opportunity to counsel parents regarding issues that affect the welfare of their child, and to refer to support services, such as Child First Teams, family support, family violence, drug and alcohol, mental health, problem gambling or income support services.


Where a person believes on reasonable grounds that a child is in need of protection, a notification may be made to Child Protection. (The term ‘notification’ will change to ‘report’ in the Children’s Youth and Families Act 2005.)

The legal definition of a child in need of protection as defined in the present Children’s and Young Persons Act 1989 is outlined below. This definition will remain the same in the new legislation.

For the purpose of this Act, a child is in need of protection if any of the following grounds exist:

a. The child has been abandoned by his or her parent and after reasonable inquiries:
   i. the parents cannot be found; and
   ii. no other suitable person can be found who is willing and able to care for the child;

b. The child’s parents are dead or incapacitated and there is no other suitable person willing or able to care for the child;

c. The child has suffered, or is likely to suffer, significant harm as a result of physical injury and the child’s parents have not protected, or are unlikely to protect, the child from harm of that type;
d The child has suffered, or is likely to suffer, significant harm as a result of sexual abuse and the child’s parents have not protected, or are unlikely to protect, the child from harm of that type;

e The child has suffered, or is likely to suffer, emotional or psychological harm of such a kind that the child’s emotional and intellectual development is, or is likely to be, significantly damaged and the child’s parents have not protected, or are unlikely to protect, the child from harm of that type;

f The child’s physical development or health has been, or is likely to be, significantly harmed and the child’s parents have not provided, arranged or allowed the provision of, or are unlikely to provide, arrange or allow the provision of, basic care or effective medical, surgical or other remedial care.

(Children’s and Young Persons Act 1989)

In Victoria, a child or young person is a person under the age of 17 years.

It is the dual focus on harm to the child, and the inability or unwillingness of the parent to protect, which legally defines a child who is in need of protection. Reporters only need to form a reasonable belief a child is in need of protection. It is the responsibility of Child Protection to assess the significance of the harm and the parent’s capacity and willingness to protect their child.

**Reporting children at significant risk of harm to Child Protection**

Any person may make a notification (report) to Child Protection if they believe on reasonable grounds that child is in need of protection.

Some professional groups that work frequently with children are required by law to notify Child Protection whenever they form the belief on reasonable grounds that a child is in need of protection due to harm from physical or sexual abuse. This requirement is known as ‘mandatory reporting’.

The following groups are mandated:
- doctors (including psychiatrists)
- nurses (including maternal and child health nurses)
- primary and secondary school teachers
- school principals
- police officers.

‘Reasonable grounds’ for forming the belief that a child is in need of protection may exist where, for example:
- a disclosure is made to the professional by the child that she or he has been physically or sexually abused
- someone else, such as a relative, friend or acquaintance of the child, tells the professional that the child has been abused
- the professional’s observations of the child’s behaviour or knowledge of children generally leads him or her to believe that the child has been abused
- the professional observes signs or indicators of abuse.

The decision to report a child in need of protection to Child Protection can be difficult. Maternal and child health nurses may fear they have insufficient grounds for their concerns or that parents may be angry or discontinue their contact with the centre.
These are legitimate concerns, however it is important to work from the principle that children, particularly infants, are highly vulnerable and unable to protect themselves. Abuse and neglect of infants has the potential for life threatening injury, serious impairment of brain development, attachment and the development of trust and healthy relationships in later life.

Where their parents are unable or unwilling to do so, a responsible adult must ensure that steps are taken which will ensure a child’s safety and development are protected.

It is important not to assume that another person has made a notification where more than one person is aware of the cause for concern. Even where you are aware that a notification (report) has been made to Child Protection before, it is important you notify on each occasion you become aware of any further grounds to believe a child is in need of protection.

A useful guide for making the decision about whether to report to Child Protection is outlined below.

**Appendix 5 – Table 1: Steps to deciding when to notify (report) Child Protection**

<table>
<thead>
<tr>
<th>Step</th>
<th>Description</th>
<th>Action</th>
</tr>
</thead>
</table>
| **Step 1** **Concern** | You are concerned about a child because you have:  
  - received a disclosure from a child  
  - observed warning signs (refer to [Indicators of possible child abuse and neglect](#))  
  - (after new legislation in early 2007) been made aware of a child who is as yet unborn about which you have concerns | Make sure you record your observations |
<p>| | The concerns are of serious physical injury or sexual abuse | Go to Step 5 |
| | Otherwise | Go to Step 2 |</p>
<table>
<thead>
<tr>
<th>Step</th>
<th>Description</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Step 2</strong> Gathering information</td>
<td>Consider doing the following: &lt;li&gt;Record your observations&lt;/li&gt; &lt;li&gt;Consult notes or records at the centre&lt;/li&gt; &lt;li&gt;Speak with the child if appropriate&lt;/li&gt; &lt;li&gt;Speak with the parents if appropriate&lt;/li&gt; &lt;li&gt;Follow local protocols regarding support referral and reporting of child abuse&lt;/li&gt; &lt;li&gt;Consult with colleagues, supervisor or centre coordinator&lt;/li&gt;</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>After early 2007</strong>, where established: consult with Child First Teams regarding possible options for assistance and support.</td>
<td></td>
</tr>
<tr>
<td>Are you wondering if your concerns need to be reported to Child Protection?</td>
<td>No</td>
<td>Continue to monitor and support child</td>
</tr>
<tr>
<td></td>
<td>Yes</td>
<td>Go to Step 3</td>
</tr>
<tr>
<td><strong>Step 3</strong> Forming a belief</td>
<td>Ask yourself: &lt;br&gt;‘Am I <strong>more likely</strong> to believe that the child is in need of protection (‘at risk of significant harm’) or <strong>less likely</strong> to believe that the child is in need of protection?’</td>
<td></td>
</tr>
<tr>
<td></td>
<td>If you are <strong>more likely</strong> to believe there is a need for protection</td>
<td>Go to Step 4</td>
</tr>
<tr>
<td></td>
<td>If you are <strong>less likely</strong> to believe there is a need for protection</td>
<td>Continue to monitor and support child as in Step 2</td>
</tr>
<tr>
<td><strong>Step 4</strong> Referring to other services</td>
<td>Ask yourself: ‘Would a specific service or professional assist the parents with care of this child?’</td>
<td></td>
</tr>
</tbody>
</table>
### Step Table

<table>
<thead>
<tr>
<th>Step</th>
<th>Description</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>Discuss with child’s parents and assist with a referral to a service if they are agreeable</td>
<td>Continue to monitor and support the child as in Step 2</td>
</tr>
<tr>
<td>No, or can’t find out</td>
<td>You are in doubt about the child’s safety and the parent’s willingness or ability to protect the child</td>
<td>Go to Step 5</td>
</tr>
</tbody>
</table>

### Step 5 Notifying Child Protection

Contact your local regional Child Protection Intake Unit. Department of Human Services. If your call is after hours, phone: 13 12 78

- Allow a minimum of 30 minutes to discuss your concern.
- Have your notes at hand with your observations and child and family details.
- Consider the level of immediate risks to the child.

### Protection for reporters of children at risk to Child Protection

Currently Section 64 of the Children and Young Persons Act provides the following protection for reporters (this protection will also be provided by the Children, Youth and Families Act from early 2007):

- a notification does not constitute unprofessional conduct or a breach of professional ethics on the part of the person by whom it is made
- if made in good faith, a notification does not make the person by whom it is made subject to any liability in respect of it
- does not contravene section 141 of the *Health Services Act 1988* or section 120A of the *Mental Health Act 1986*
- requires that the name of the person who made the report or any information likely to lead to the identification of the referrer, remain confidential.

Section 67 provides similar protections for a person who provides information in confidence to a protective intervener during the course of an investigation.

### Protection for referrers of cases to Child First Teams (after commencement of CYFA in early 2007)

Section 40 of the *Children, Youth and Families Act 2005* provides the following protection for those who refer to Child First:

- a referral does not constitute unprofessional conduct or a breach of professional ethics on the part of the person who made it
- does not make the person by whom it is made subject to any liability in respect of it
- does not contravene section 141 of the *Health Services Act 1988* or section 120A of the *Mental Health Act 1986*. 

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Section 41 requires that the name of the person who made the report or any information likely to lead to the identification of the referrer, remain confidential. Section 37 provides similar protections for a person who provides information in confidence to a Child First Team when consulted.

Possible indicators of abuse and neglect

Physical abuse
Physical abuse refers to a situation in which a child suffers or is likely to suffer significant harm from an injury inflicted by a child’s parent or caregiver. The injury may be inflicted intentionally or may be the inadvertent consequence of physical punishment or physically aggressive treatment of the child.

Physical injury and significant harm to a child may also result from neglect by a parent or caregiver. The failure of a parent or caregiver to adequately ensure the safety of a child may expose the child to extremely dangerous or life threatening situations that result in physical injury and significant harm to the child.

Physical indicators
Physical injuries include bruising, welts, burns, cuts, fractures, suffocation, poisoning, internal injuries and assault with weapons. Actions by a parent or caregiver which may result in physical injury or harm include hitting, biting, shaking, punching, burning, twisting of limbs, administration of poisonous substances and drowning.

A child may be in need of protection where the type or extent of harm is undefined, but total circumstances lead to this belief. For instance:
- threats of violence directed toward the child
- the child being left unsupervised, either at home, on the street or in a car
- the child being left with older children or persons who could not reasonably be expected to provide adequate care and protection
- inadequate attention to the safety of the home, such as children being left in rooms containing an unguarded fire or dangerous medicines left where children may have access to them.

The nature of the abuse and the significance of the harm from physical abuse are determined by a protective assessment, which will often include a medical examination.

Behavioural indicators
- Wearing inappropriate clothing in an attempt to cover injuries
- Apprehension when other children cry or shout
- Behavioural extremes, for example, aggression or withdrawal
- Fear of adults
- Afraid to go home or to school
- Reports injury by parent or gives inappropriate explanation of injury
- Excessive compliance
- Extreme wariness
- Attaching too readily to strangers.

Sexual abuse
Sexual abuse occurs when an adult or older child uses their power or authority over the child or takes advantage of the child’s trust, respect or compliance to involve the child in sexual activity, and the child’s parent or caregiver has not protected the child. Physical force is sometimes involved. Child sexual abuse does not only refer to sexual
intercourse. Child sexual abuse involves a wide range of sexual activity. It includes fondling of the child’s genitals, masturbation, oral sex, vaginal or anal penetration by a penis, finger or other object, or exposure of the child to pornography.

**Physical indicators**
Sexual abuse is not usually identified through physical indicators, although the presence of sexually transmitted diseases, vaginal or anal bleeding or discharge may be detected during medical examination and can indicate sexual abuse.

**Behavioural indicators**
A child may disclose sexual abuse to a trusted person. Such disclosures should always be taken seriously. Other behavioural indicators include:
- sexual knowledge and behaviour beyond what is expected for their age
- developmentally unusual level of interest in own or other’s genitals, taking into consideration their age and circumstances
- constant complaints of headaches and/or abdominal pains without organic cause
- sudden change in behaviour or temperament
- regression in toilet training, for example, soiling, wetting
- refusal to go home
- frequent or prolonged unexplained or inadequately explained absence from school
- inability to sit comfortably
- self-harming behaviour, such as cutting, scratching with implements, burning.

**Emotional abuse**
Emotional abuse is persistent behaviour by a parent or caregiver that impairs the emotional development of the child. This may involve threats or rejection, such as repeated humiliation, name calling, demeaning the child’s achievements, coldness or open hostility. It may also involve extremely inconsistent responses to the child’s developmentally appropriate behaviour, such as alternating between hostility and affection; or alternately punishing and praising the same behaviour.

Emotional abuse is most prevalent as a corollary of other forms of abuse or neglect. There are few physical indicators of such abuse.

**Behavioural indicators**
- Behavioural extremes that cannot be explained by other circumstances
- Extremely low self-esteem
- Compliance, passivity, withdrawal, tearfulness
- Aggressive or demanding behaviour
- Depression
- Persistent high anxiety
- Poor social and interpersonal skills
- Very delayed development, for example speech
- Persistent habit disorder, for example, sucking, biting, rocking
- Self-harming behaviour
- Unexplained change of performance at school.

**Neglect**
Neglect refers to a situation in which a child’s parent or caregiver fails to provide the child with the basic necessities of life, such as food, clothing, shelter, medical attention
or supervision, to the extent that the child’s health and development is, or is likely to be, significantly harmed. An abandoned child is also a neglected child.

**Physical indicators**
- Constant hunger
- Non organic failure to thrive
- Malnutrition
- Inappropriate dress for the weather conditions
- Unattended physical problems or medical needs
- Health or dietary practice that endangers health or development, for example fad diets.

**Behavioural signs**
- Stealing food
- Frequent fatigue, listlessness, or falling asleep during sessions
- Aggressive or inappropriate behaviour.

**Specific indicators of concern for infants**

Infants are highly vulnerable and cannot protect themselves. Their rapid body growth and brain development in the first two years makes them extremely susceptible to the effects of neglect and malnutrition. Their soft skull, lack of muscle development and unprotected body make them extremely vulnerable to head and other serious injuries from shaking or direct blows to the body.

Where professionals who work with infants and young children identify the following indicators (particularly where several indicators are present), consultation with supervisors/colleagues should occur. Consideration should be given to a notification to Child Protection if there is a reasonable belief that the child is in need of protection.

**Note:** From early 2007, consultation should be sought with the local Child First Team where the observed indicators suggest concern for the child’s development and wellbeing. Where the indicators suggest the child may be at significant risk of harm and in need of protection, a report should be made to Child Protection.

Indicators include:
- evidence of physical injury inconsistent with the child’s age and stage of development
- child is listless and immobile
- child is emaciated and pale
- child is below expected birth weight
- child displays inconsistent weight gain
- child is born drug dependant
- child may sleep for longer periods than would be normally expected
- child appears depressed and unresponsive to social involvement
- child cries excessively or not at all
- child displays self stimulatory behaviours, for example, rocking, head banging
- child does not seek comfort from the parent
- child has poor muscle tone and motor control
- child exhibits significant delays in gross and fine motor development and coordination
- parent is consistently impatient or unresponsive to infant cues
- parent does not respond to assistance from the maternal and child health nurse
• parent misunderstands or fails to respond to the child’s cues
• parent has past/current substance abuse issues
• parent had poor antenatal care
• parent was aged under 20 at birth of child
• parent is highly transient/homeless
• parent is engaged in a violent relationship
• parent has a mental illness.
Appendix 6 Calculating participation rates in the Maternal and Child Health Service

Appendix 6 – Table 1: Participation of clients from birth notifications

For birth notifications received in 2006–07
(Figures taken from the Maternal and child health birth notification and enrolment record columns for data collection)

| Column 7.1 – number enrolled from birth notifications, plus column 9.1 – number enrolled in other centres within municipality; plus column 9.2 – number enrolled in other centres outside municipality, as a percentage of column 4 – total number of birth notifications received. Minus column 9.4 – total number of stillbirths; minus column 9.3 – total number of deaths within one month, minus column 9.5 – total number of other. |

Appendix 6 – Table 2: Percentage of clients attending

For each year of the child’s age:
Active record cards (those children who attend a centre at least once in the 2006–07 financial year) as a percentage of total record cards (all registered clients whether currently attending or not)

Appendix 6 – Table 3: Participation rates – key ages and stages

| A – Home visit | Number of home visits as a percentage of total infant record cards of children aged 0–1 year old |
| B – 2 weeks | Number of 2-week visits as a percentage of total infant record cards of children aged 0–1 year old |
| C – 4 weeks | Number of 4-week visits as a percentage of total infant record cards of children aged 0–1 year old |
| D – 8 weeks | Number of 8-week visits as a percentage of total infant record cards of children aged 0–1 year old |
| E – 4 months | Number of 4-month visits as a percentage of total infant record cards of children aged 0–1 year old |
| F – 8 months | Number of 8-month visits as a percentage of total infant record cards of children aged 0–1 year and 1–2 years divided by 2 |
| G – 12 months | Number of 12-month visits as a percentage of total infant record cards of children aged 0–1 year and 1–2 years divided by 2 |
| H – 18 months | Number of 18-month visits as a percentage of total infant record cards of children aged 1–2 years and 2–3 years divided by 2 |
| I – 2 years | Number of 2-year visits as a percentage of total infant record cards of children aged 2–3 years |
| J – 3½ years | Number of 3½-year visits as a percentage of total infant record cards of children aged 3–4 years and 4–5 years divided by 2 |
**Appendix 6 – Table 4: Child health referral rate**

For all of the referral categories: Total referrals for a referral type as a percentage of total active record clients (clients who have attended at least once in the 2006–07 operating year).

**Appendix 6 – Table 5: Breastfeeding rate (fully or partially)**

<table>
<thead>
<tr>
<th>Category</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>A – On discharge</td>
<td>Number of mothers breastfeeding at discharge as a percentage of total registered clients aged 1–2 years</td>
</tr>
<tr>
<td>B – At 2 weeks</td>
<td>Number of mothers breastfeeding at 2 weeks as a percentage of total registered clients aged 1–2 years</td>
</tr>
<tr>
<td>C – At 3 months</td>
<td>Number of mothers breastfeeding at 3 months as a percentage of total registered clients aged 1–2 years</td>
</tr>
<tr>
<td>D – At 6 months</td>
<td>Number of mothers breastfeeding at 6 months as a percentage of total registered client aged 1–2 years</td>
</tr>
</tbody>
</table>

**Appendix 6 – Table 6: Immunisation rates**

This information is obtained from the Australian Childhood Immunisation Register and will not be collected as part of the *Maternal and Child Health Annual Data Report*. 
Appendix 7 Birth notification from the Child, Wellbeing and Safety Act 2005

Part 7 Birth Notification

42. Application of Part
1. This part applies in the case of every birth in Victoria, whether the child is born alive or dead, except for the delivery of a non-viable foetus.
2. This part applies in addition to the requirements of the Births, Deaths and Marriages Registration Act 1966

43. Early Notification of births
1. If a child is born in Victoria, notice of the birth of the child (‘the birth notice’) must be given by the responsible person to the
   a) the Chief Executive Officer of the council of the municipal district in which the mother of the child usually resides; or
   b) if the municipal district is not known to the person giving notice, the Chief Executive Officer of the council of the municipal district in which the birth occurs; or
   c) if the mother of the child usually resides outside Victoria, the Secretary.
2. The notice must be in the prescribed form
3. In this section ‘responsible person’ has the same meaning as it has in section 12 of the Births, Deaths and Marriages Registration Act 1996

44. How must the notice be given?
1. The birth notice must be given
   a) personally; or
   b) by post; or
   c) by facsimile; or
   d) by electronic communication
2. The birth notice must be given within
   a) 48 hours after the birth to which the notice relates; or
   b) If a longer period is prescribed in respect of a particular municipal district, that longer period

45. What must be done once a notice is received?
On receipt of the birth notice the Chief Executive Officer of a council must, as soon as is practicable, send a copy of the notice—
1) If in the municipal district of the council there is a Maternal Child Health Centre under the control of and subsidised by the council, to the nurse whose duty it is to visit or communicate with the house to which the notice relates; or
2) In any case, to the secretary

46. Offence to fail to give notice
1. Any person who fails to give notice of a birth in accordance with this Part is guilty of an offence and is liable to a penalty of not more than 1 penalty unit
2. It is a defence to a prosecution for an offence under subsection (1) if the person
   a) Satisfies the court that he or she had reasonable grounds to believe that notice had been duly given by another person; or
   b) Had other reasonable grounds for not giving the notice

‘Maternal Child Health Centre’ means a centre where health advice is given to the parents and other caregivers of children under six years of age.
Appendix 8 Information Privacy Act 2000 and Health Records Act 2001

Information Privacy Act 2000

The Act regulates the collection and handling of personal information in Victoria. The Information Privacy Act covers all Victorian public sector agencies including local government.

Objectives of the Information Privacy Act are:

- to balance public interest in the free flow of information with respect to privacy and protection of personal information
- to promote responsible and transparent handling of personal information
- to promote public awareness of these practices.

The Health Records Act 2001

As from 1 July 2002, the Health Records Act regulates the collection and handling of health information in Victoria. The Act contains provisions which:

- establish a framework to protect the privacy of a person’s health information
- provide people with an enforceable right of access to their own health information.

Any organisation that holds health information or health reports about clients or customers is subject to the Health Records Act. Clients or customers include Victorian Government departments, local government, schools, kindergartens and child care centres, and Maternal and Child Health Service centres.

The Freedom of Information Act 1982 (Commonwealth) will continue to regulate a person’s access to their own health information where it is held by public sector agencies including local government and State Government departments.

The Information Privacy Act and the Health Records Act each contain a set of privacy principles (10 Information Privacy Principles and 11 Health Privacy Principles) which organisations must follow. The principles relate to the collection, use, disclosure, quality, security, retention and transfer of people’s personal and health information. They also apply to people’s access to health records.

It is the responsibility of each individual organisation and agency to have clearly expressed policies in line with the Information Privacy Act and the Health Records Act. A maternal and child health nurse who has to resolve an information privacy problem should do so with the assistance of their line manager(s) and in accordance with their organisation’s information privacy policy.

Neither the Information Privacy Act nor the Health Records Act prevent mandated professionals from reporting child abuse to the Department of Human Services Child Protection Service. Section 67 of the Children and Young Persons Act 1989 (Vic) states that giving of information to a protective intervenor does not constitute unprofessional conduct or breach of professional ethics, or make that person subject to any liability.

The Office of the Victorian Privacy Commissioner is an independent statutory office that provides information and guidance for Victorian Government agencies and local government in the collection and handling of personal information. The office is also responsible for ensuring organisations comply with the Information Privacy Act. Further
information regarding the Information Privacy Act 2000 and the 10 Information Privacy Principles can be found at www.privacy.vic.gov.au

The Health Services Commissioner is responsible for the implementation of the Health Records Act including educating organisations that collect and handle health information, as well as educating Victorians regarding their rights under the Health Records Act. Further information regarding the Health Records Act 2001 and the 11 Health Privacy Principles can be found at www.health.vic.gov.au
Appendix 9 Disposal of maternal and child health records

The Local Government Records: General Disposal Schedule was revised by the Public Record Office of Victoria in June 1998. This revision brings disposal schedules into line with other confidential public documents and provides for a person to pursue relevant information within seven years after attaining the age of 18 years. Records are confidential and care should be taken to avoid unauthorised access.

Further information is available from the Public Record Office of Victoria at:

- telephone 9348 5600 or 1800 657 452
- email: ask.prov@dvc.vic.gov.au

The local government records departments in each municipality can also offer information.

The schedule does not refer specifically to all the documents currently used by the Maternal and Child Health Service. Examples pertaining to the Maternal and Child Health Service are included below.

### Appendix 9 – Table 1: Public Records Office Victoria: PROS 98/01, Authority, Local Government Records General Records Authority, version 2002 incorporating variations 1 and 2, Part four, General records authority

<table>
<thead>
<tr>
<th>Function description</th>
<th>Disposal action</th>
<th>Examples of records</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>The following is a list of common examples. It is not an exhaustive list</td>
</tr>
<tr>
<td>12.5.0 Immunisation</td>
<td>Destroy one year after administrative use is concluded</td>
<td>Campaign diaries, Vaccine order and inventory book, Parent consent records</td>
</tr>
<tr>
<td>12.5.2 The process of administering an immunisation program</td>
<td>Destroy one year after administrative use is concluded</td>
<td>Infant record cards, Caller cards, Expectant mother cards, Analysis of daily activities sheets</td>
</tr>
<tr>
<td>12.6.0 Maternal and child health</td>
<td>Destroy 25 years after last contact</td>
<td>Birth notification forms, Birth notification and enrolment sheets</td>
</tr>
<tr>
<td>12.6.1 Client case management</td>
<td>Destroy one year after date of notification (Note: centres may choose to destroy six years after date of birth.)</td>
<td></td>
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</tbody>
</table>
## Appendix 10  Parent groups – attendance record July 2006

<table>
<thead>
<tr>
<th>Parent/carer name</th>
<th>Contact details</th>
<th>Child's name</th>
<th>Name/purpose of group</th>
<th>Date group commenced</th>
<th>No. of sessions offered</th>
<th>No. of sessions attended</th>
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<tbody>
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# Appendix 11

## MATERNAL AND CHILD HEALTH - BIRTH NOTIFICATION AND ENROLMENT RECORD July 2006

<table>
<thead>
<tr>
<th>Name of Centre:</th>
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<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
<td>8</td>
<td>9</td>
<td>10</td>
<td></td>
</tr>
<tr>
<td>Mother</td>
<td>Baby</td>
<td>Surname</td>
<td>First Name</td>
<td>Date birth notification (BN) received</td>
<td>Date of birth</td>
<td>Date of enrolment</td>
<td>Current financial year</td>
<td>Past financial year</td>
<td>Four previous financial years</td>
<td>BN received this financial year</td>
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<td>7.1</td>
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</tbody>
</table>

**Mother**
- Surname
- First Name

**Baby**

**Address**

*Carry forward figures → TOTALS*
<table>
<thead>
<tr>
<th>REGION</th>
<th>MCH CONTACT</th>
<th>ADDRESS</th>
<th>CONTACT NUMBERS</th>
</tr>
</thead>
</table>
| North West Metropolitan | Anne Thompson        | Northern Region 145 Smith Street Collingwood 3066 (PO Box 1332) Fitzroy Vic 3065 | Tel: 9412 5412  
|                     |                      |                                                                          | Fax: 9412 5476  |
| Southern Metropolitan | Karen McFarland      | Southern Region 122 Thomas Street (PO Box 692) Dandenong Vic 3175       | Tel: 9213 2185  
|                     |                      |                                                                          | Fax: 9213 2143  |
| Eastern Metropolitan | Ana Tsaganos         | Eastern Region 883 Whitehorse Road (Locked Bag 2015) Box Hill Vic 3128 | Tel: 9843 6178  
|                     |                      |                                                                          | Fax: 9843 6118  |
| Loddon Mallee       | Dianne Wilson        | Loddon Mallee Region 37 Rowan Street (PO Box 513) Bendigo Vic 3552      | Tel: 5430 2373  
|                     |                      |                                                                          | Fax: 5430 2467  |
| Grampians           | Sharelle Knight      | Grampians Region Cnr Main and Doveton St PO Box 712 Ballarat Vic 3350    | Tel: 5333 6938  
|                     |                      |                                                                          | Fax: 5333 6831  |
| Gippsland           | Bronwyn Saffron      | Gippsland Region 70 Smith Street (PO Box 244) Warragul Vic 3820         | Tel: 5177 2565  
|                     |                      |                                                                          | Fax: 5623 5160  |
| Hume                | Jill Guerra          | Hume Region 163 Welsford Street Shepparton 3632 (PO Box 1060) Shepparton Vic 3630 | Tel: 5832 1590  
|                     |                      |                                                                          | Fax: 5831 1851  |
| Barwon South Western | Vicki Henderson      | Barwon-South Western Region Cnr Fenwick & Lt Malop Sts (PO Box 760) Geelong Vic 3220 | Tel: 5226 4997  
|                     |                      |                                                                          | Fax: 5226 4751  |
|----------------------|-------------------------------------------------|-------------------------------------------|--------------------------------|-------------------------------|----------------------------------|
|                      | 2 Weeks                                         | 4 Weeks, 8 Weeks, 4 Months, 8 Months, 12 Months, 18 Months, 2 Years | 4 Weeks, 8 Weeks, 4 Months, 8 Months, 12 Months, 18 Months, 2 Years | 1-15 Minutes, 16-30 Minutes, 31-45 Minutes, 46-60 Minutes, 61-90 Minutes, 91-120 Minutes, 121-180 Minutes | C = Counselling, R = Referral |

<table>
<thead>
<tr>
<th>Date:</th>
<th>Name of Centre:</th>
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<table>
<thead>
<tr>
<th>Family Name/Activity</th>
<th>4. Key Ages and Stages Consultations - Aboriginal and Torres Strait Islander</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>2 Weeks, 4 Weeks, 8 Weeks, 4 Months, 8 Months, 12 Months, 18 Months, 2 Years</td>
</tr>
</tbody>
</table>

Total Number of Hours

Total Hours

eg. 9 consults x 10 mins = 90 mins or 1.5 hrs

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</thead>
<tbody>
<tr>
<td>4. Key Ages and Stages Consultations - Non Aboriginal and Torres Strait Islander</td>
<td>Key Ages and Stages Consultations - Aboriginal and Torres Strait Islander</td>
<td>Flexible Consultations</td>
<td>MIST Attributed</td>
<td>Opportunity Immunisation</td>
<td>C = Counselling</td>
<td>R = Referral</td>
<td>C</td>
<td>C</td>
<td>C</td>
<td>C</td>
</tr>
<tr>
<td>2 Weeks</td>
<td>4 Weeks</td>
<td>8 Weeks</td>
<td>4 Months</td>
<td>8 Months</td>
<td>12 Months</td>
<td>18 Months</td>
<td>2 Years</td>
<td>3 Years</td>
<td>4 Years</td>
<td>5 Years</td>
</tr>
</tbody>
</table>

Date

Total
References


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Legislation

Children and Young Persons’ Act 1989 (Vic)

Children and Young Person’s (Further Amendment) Act 1993 (Vic)

Children, Youth and Families Act 2005 (Vic) (effective March 2007)

Child, Wellbeing and Safety Act 2005 (Vic)

Health Records Act 2001 (Vic)

Information Privacy Act 2000 (Vic)