

TRANSCRIPT

FAMILY AND COMMUNITY DEVELOPMENT COMMITTEE

Inquiry into perinatal services

Bendigo — 24 October 2017

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Witness

Ms Helen Lees, maternal and child health clinical coordinator, City of Greater Bendigo.

The DEPUTY CHAIR — I welcome to this public hearing Ms Helen Lees, maternal and child health clinical coordinator from the City of Greater Bendigo. Thank you for attending here today. All evidence at this hearing taken by the committee is protected by parliamentary privilege as provided by the Constitution Act 1975, and is subject to the provisions of the Parliamentary Committees Act 2003 and other relevant legislation. Any comments you make outside this hearing will not be afforded such privilege, and it is a contempt of Parliament to provide false evidence. These proceedings will be recorded and you will be sent a proof copy of the transcript. I invite you to make a 15-minute statement and, as you have seen, it will be followed by questions from the committee.

Ms LEES — Thank you for this opportunity. I am a registered nurse and registered midwife, with a postgraduate diploma in paediatrics and a masters in child, family and community, resulting in qualification as a maternal and child health nurse. I have been working in nursing for 34 years, and in the last 17 years I have been working in maternal and child health in Bendigo.

Evidence tells us that from conception through pregnancy and then the first 1000 days of life are the most important for growth and development when the building blocks for life are laid down in the brain. Parents, as their child's first teachers, are primarily responsible for this period of time. Therefore it is important to support them as they provide for and stimulate their children's development. UNICEF in 2008 talked about the challenge of ending child abuse being the challenge of breaking the link between adults' problems and children's pain. The three largest characteristics of children entering state care back in 2005 were parental substance abuse, 69 per cent, domestic violence, 65 per cent and parental mental health problems, 63 per cent. I think these are still the main issues we face today, and therefore it is important to have an impact on these for the sake of the children.

We receive between 1400 and 1500 birth notices per year in the City of Greater Bendigo. Our new enrolments are higher than our birthrate, though. We had 1642 enrolments in the 2016–17 year across the six years that we service, and of those, 528 were first-time mothers. The MCH universal and enhanced team here is 16.4 EFT, made up of 26 staff, with three full-time and the rest part-time. Our enhanced MCH team has a target set by the Department of Education and Training to service 156 children in this coming financial year, and the number of children in the 0 to 6 age range in the MCH service is around 9000. Out-of-home care placements with child protection are around 80 at any given time in the City of Greater Bendigo, and there are often children from the smaller surrounding municipalities placed in care here. We have two hospitals — one public and one private. We also have a fairly high teenage pregnancy rate. In the 2016–17 year we had 38 of 109 identified as complex pregnancy care clients, and so far this year we have had 11 out of 26 of those complex pregnancy care clients being identified as teenage pregnancies with complications.

We are becoming a much more multicultural community as opposed to the past, and we have family violence refuge housing in Bendigo, so therefore we often have families relocating to Bendigo. In addition to the MCH key age and stage framework, which I am sure you have already heard about, we also offer new parent groups, a young pregnant and parenting group, interpreter sessions for our Karen refugees secondary settlement families in two of our locations, and the complex pregnancy care program, which I will explain in more detail later.

In relation to access for vulnerable clients, maternal and child health funding currently is not really aligned with service direction. The maternal and child health key age and stage program, plus a small amount of flexible service capacity funding, is incongruent with the overarching focus on engaging those families with higher needs and most vulnerable children. It is still valuable, but it seems to be around the wrong way. The measuring of outcome rather than throughput, which is the current practice, is where the MCH service wants to head. The question is what to measure and what demographic data to incorporate within our workload tools to ensure we are servicing those who require the most service with an adequate allocation of time.

In the City of Greater Bendigo we have a very dedicated, passionate, educated and proactive MCH team, and we have developed strong relationships with the services we work with to provide service to families with children to school age. As a result of this we have some fantastic initiatives and communication happening in this space. Unfortunately it is reliant currently on the people, goodwill and passion, rather than on a system supported by technology. We do have systems; however, they currently do not talk to each other, which was mentioned earlier. There is opportunity for this to be developed now and into the future with the right funding and infrastructure. Communication is the key between services and the community.

With the establishment of the child development information system, CDIS — I am not sure whether you have heard about that from other speakers — it is currently being used by 62 of the 79 municipalities in maternal and child health, and hopefully all of the 79 municipalities in time. This gives a platform for linkage with the universal service for all children aged zero to school age in the state. If the systems at the hospital could speak to this system — automatically loading birth and hospital discharge information — I think that is the way of the future for improving communication. I am on the reference group for this program, and there is a lot of potential for this to develop. However, it will require further funding to be enabled.

The advantages in having a statewide system have been very evident to me in relation to the most vulnerable children in our community. Previously, when we used systems that were just in our municipality, you may have a baby on the system multiple times, particularly children of transient families or who have been in and out of out-of-home care in different locations with different carers. Being able to establish what has happened for this child is important to provide the most appropriate care. The plan is for each child to have one history on CDIS that moves with the child for the duration of birth to school entry. With 62 municipalities on CDIS, there has been the ability to have children's histories following them, giving them a fuller picture, and the merging of the multiple entries and creating one, more comprehensive history. For example, if I hear from child protection that a child from Mount Alexander shire has gone into out-of-home care in Bendigo, as I am the key contact for the out-of-home care agreement for the City of Greater Bendigo, I am able to find the history on CDIS and transfer the history into our area on the spot, enabling continued care and follow-up for whatever is required for that child and the ability to see what has already occurred and what needs to happen. This is best practice.

One of our current issues is that we still have two of our surrounding municipalities not on this system — Loddon and Campaspe — which means it takes more time and effort to obtain the child's history and know what is happening with the family. Having a uniform platform is fantastic; it is how to connect the other things into this platform and service model. MCH is in a unique position, where we cut across the medical model and the social community model of care, developing relationships with families, where they are at, building on their strengths and working with them while providing public health promotion messages in an individualised way. We are a true primary health service. The transition from hospital to community is important in relation to continuity of care, particularly in the era of early discharges with breastfeeding not fully established and domiciliary providing one to two visits and then handing over to the MCH service. Our relationship with services is very important. There have been great improvements in communication with child protection around our most vulnerable children. However, we require further work in this area and an established consistent practice across the sector with communication.

I am currently a representative on the high-risk infant panel at child protection for the area, which has enabled me to develop relationships with local child protection and assist in providing health information to inform practice as plans are developed for the best support for children at highest risk under 2 years of age.

Time is what is needed to engage the most vulnerable in our community. For many vulnerable families meeting Maslow's hierarchy of needs is the priority, so having a roof over their heads and food to eat. Therefore our white middle class approach with an emphasis on education is incongruent with where they are at and requires a respectful, consistent and persistent approach to have an impact for their children. It is about helping families to meet their primary needs and allowing them space to think about other things that we regard as valuable, like reading, talking and playing with their children.

Access for families to family support, as it is a voluntary service, is also an area for improvement. Some families will require support whenever they have a child in their care to enable them to provide for their child's needs. MCH has very high participation rates for our service, which is a voluntary service. We use assertive outreach to engage the most vulnerable of families, with really good success. We do have issues with some of these families not being picked up or staying engaged with family support through Child First at this time.

We currently have a young pregnant and parenting program incorporating case management and a group for women under 25 years of age with vulnerabilities and having their first baby. The program is run by Bendigo Community Health Service. The City of Greater Bendigo-enhanced MCH co-facilitate the group with the YPPP worker. That program is currently under review in regard to its funding. From our service perspective it is a necessary service for these women. Watching the change in the women within the group, in their attachment with their babies and their increased confidence is amazing, and ongoing support and availability of this specialised group for young mothers is vital.

I am involved in meeting with both of our hospitals on a three-monthly basis to discuss how we do things, improving things, keeping informed and being informed of changes. This has been a great forum at both hospitals to inform change to practice and enable better communication. There is of course still room for improvement with this and always will be. However, we have some good established processes happening.

Cradle to Kinder has only recently commenced at Bendigo. The BDAC workers spoke about Aboriginal Cradle to Kinder being funded by Njernerda, and we are establishing how we work with them currently. Prior to this coming to Bendigo we only had the universal and enhanced MCH service alongside family services working with our vulnerable families, unlike other areas in the state with Cradle to Kinder, Healthy Mothers, Healthy Babies and right@home. We are looking forward to the intensive support in early years program being established, enabling the enhanced MCH and universal MCH service to reduce the amount of high risk they currently hold and spreading the load amongst services.

In relation to the Bendigo and District Aboriginal Co-operative, the maternal and child health service has developed connections over time enabled by the current communities for children family liaison position, which is held by our enhanced MCH nurse. For the families that identify as Aboriginal or Torres Strait Islander we currently offer an outreach model of MCH service here, so they can have home visits for their key age and stage visits, attend at one of the centres or have an appointment with the outreach or enhanced MCH nurse at BDAC in one of their clinic rooms.

This has resulted in good participation rates — around the same rate as our non-Aboriginal and Torres Strait Islander children in the 2016–17 financial year. Representatives from BDAC medical and family services attend monthly at our enhanced MCH allocation meeting to improve communication in relation to joint clients. We also have that same process with representatives from Child First, the perinatal emotional health program and YPPP and Cradle to Kinder, which also attend monthly at our enhanced MCH allocation meetings — each week a different service on a rotating basis.

In relation to addressing the issues, including family violence, we have recently met with the Centre for Non-Violence to look at how we can work more together with the introduction of the fully-funded family violence consultations for MCH to use, to explore the opportunities for joint visits and to improve engagement for our clients with these services. MCH often holds risk with clients who disclose but are not ready to engage with another service.

In relation to low birth weight babies, previously babies were kept in hospital until they were 2.5 kilograms. That was considered a weight at which they could maintain their temperature and have enough energy to feed well. Now they seem to go home anywhere from 2 kilograms onwards and require close monitoring. We have an arrangement with both hospitals here to share the care of these babies until they reach 2.5 kilograms and are stable for discharge fully to our service.

At Bendigo to my knowledge we do not have a dedicated antenatal clinic for women with drug and alcohol issues like the service that operates out of the women's hospital. It would be good to see maybe satellite programs in the regions for this program, as I believe that service is very comprehensive for these women and their babies. Our referral of CPC clients from Bendigo Health indicates an increasing number of antenatal mothers with drug and alcohol issues.

Sudden unexpected infant deaths need to remain on the agenda, as do stillbirths. Last financial year we had three deaths within the first month and 14 stillbirths. There were also SUID deaths other than in the first month, which is devastating for families. The other area to improve in relation to SUID is the communication to services about this having occurred so adequate support can be provided for families in a timely manner.

Mental health remains an area to be addressed. This has been improved by the opening of the parent infant unit at Bendigo Health this year and the return of the perinatal emotional health program funding, although it is not as it used to be. However, there are still gaps for access to care in a timely way in the community. Some women are either too acute for some services or not acute enough for others, and that is a problem for our service.

In relation to our workforce, we currently have maternal and child health nurses looking for more work — we do not have a shortage here — and we have had four to five students over the last few years in maternal and child health. However, this will then be depleting the midwife pool locally. Availability of services for clients

with lack of staffing in public paediatric specialties in rural and regional areas is a concern for us — for example, audiologists.

In relation to lactation consultants, we do have maternal and child health nurses on our staff with these qualifications. However, this is not currently funded to enable increased LC services by our team. The public breastfeeding services at Bendigo Health are available free for those who deliver there for up to six weeks and at a cost for those who deliver privately. The clinic operates only as an outpatient service, so if a client is re-admitted with breastfeeding issues or is in the parent infant unit, it is difficult to access the LC clinic staff; they are very busy.

After six weeks the Australian Breastfeeding Association and private services are all that is available unless they luck an appointment with one of the MCH nurses with LC as an extra qualification in their clinic. If we are serious about improving our breastfeeding rates, which is a whole-of-community public health issue, we need to provide more services to support this, free and accessible, when clients require it. Reducing the rates of breastfeeding has been shown to increase the rates of obesity in children, which also has a flow-on effect when they become mothers as well.

There are advantages and disadvantages with being in regional and rural areas comparative to metro. The advantages for MCH are that we have two main feeder hospitals and we can work together to develop systems with good communication. For example, we have a system for receiving our birth notices in the legislated time frame of 48 hours in a secure manner. Each of these hospitals sends the birth notice through either on the day or the next day after delivery to a centralised and secure inbox via Connectingcare.

With home births, we find that the birth notices from the private midwives are often received by our service outside of the legislated time frame of 48 hours. The communication from these midwives — handover et cetera — is also not consistent and is something that needs addressing. If there have been complications and the baby has been born prematurely after the mother has been transferred to Melbourne to birth there, receiving the birth notice in the legislated time frame is less likely.

The DEPUTY CHAIR — Helen, can I just pause you there for a moment? We invited you to speak for 15 minutes; we are well over 15 minutes. Have you got a lot more that you want to say?

Ms LEES — Sorry, I have one page. I really would like to talk to you about the complex pregnancy care program.

The DEPUTY CHAIR — That is all right because our questions will probably be along those lines.

Ms LEES — I was told 15 to 20 minutes. Sorry, I will be really quick.

The DEPUTY CHAIR — That is okay.

Ms LEES — Distance for travel is actually one of the issues that does come up for us a lot, particularly with providing home visiting. For our Elmore clients, where we had 11 births last year, a home visit might take 2 hours there and back, including the consultation on top of that. The funding allocation does not really cover a lot of the travel that is required for those distances. In relation to identification of best practice, I would like to finish by discussing the model of care that has been developed in regard to high-risk clients identified antenatally at Bendigo Health and the increased engagement with MCH as a result. The complex pregnancy care model embraces the ethos of the Children, Youth and Families Act 2005 in order to promote the best interests of the child by providing a more preventative approach to vulnerable families as opposed to the crisis-driven intervention approach.

It commenced in 2007, with domiciliary services noticing changes with women and the delayed recognition and response to these high-risk families resulting in confused and unsupported families, premature births and low birth weight babies, prolonged length of stay in maternity wards, extended number and length of domiciliary visits and maternal and child health services being unprepared for such vulnerable clients. As a result of that, this improved information sharing, identification of risk and discharge planning have all involved supporting the family. So the common referral triggers are substance misuse, mental health, disability, homelessness or transient housing, lack of antenatal care, family violence, current child protection involvement with other

siblings, unborn reports or significant health issues. Combinations of these issues are apparent in all of these cases.

Having this complex pregnancy care program has enabled planning for workload, communication in relation to supports and the development of pre-birth case conferences or pre-discharge case conferences facilitating communication with all services involved, including the family — so a more prompt and approach response to families when they take their baby home. The issues for the family are identified and spoken about, rather than it taking a long time in some cases for the family to tell their story.

In 2011 MCH started being part of this process, and the process has evolved over time. Currently a complex pregnancy care plan is sent via Connectingcare to MCH two months prior to the expected delivery date if they have booked in or are known to the hospital. A pre-birth case conference or a pre-discharge case conference is attended by one of our staff. Child protection organise those if they are already involved or they have received an unborn report, and a maternity support worker organises it if child protection is not involved. Child protection will often close on the unborn report post the pre-birth case conference, with the requested response to happen in relation to child protection, depending on the level of risk.

Complex pregnant care patients are discussed at our weekly enhanced allocation meeting. When the birth notice arrives, all the relevant staff are notified and joint home visits occur between the maternal and child health nurse and the enhanced program for home visits, two-week and four-week, key age and stage visits. Our learnings from that are that at least one of mental health, family violence and substance abuse are involved in all of those cases. Improved engagement with families and MCH service has resulted in an increased KAS participation. In 2016-17 we had 98 to 100 per cent in the first eight weeks of our case consults for those families; improved communication with the hospital staff and child protection; an opportunity to connect or reconnect with the older siblings in the household, observe family dynamics and other impacts in the home setting; and improved engagement with other services involved with these families.

The DEPUTY CHAIR — Thank you. That was an extremely comprehensive statement. As such, you have answered a lot of the questions that we would have had on the way.

Ms LEES — It is a comprehensive service.

The DEPUTY CHAIR — I am going to start with some questions around workforce. Did you say there were 26 in the City of Greater Bendigo, three full-timers and the rest part-timers?

Ms LEES — Yes.

The DEPUTY CHAIR — And that is addressing the need quite well?

Ms LEES — I would say the levels of complexity in our area have grown and, as I said, Cradle to Kinder coming has assisted in that area, but we are really looking forward to that ISEY program to help take some of that highest risk end and improve the service for them. So we do the best with what we have is what I would say in response to that.

The DEPUTY CHAIR — And the reason you have so many part-time staff, is that employer choice or employee choice?

Ms LEES — A combination of both, but majority employer choice. A lot of women, when they go into maternal and child health, have had their own families and make a choice to work part-time and have a work-life balance. The City of Greater Bendigo really encourages that. It actually is a great advantage to me managing that team because it means if we have a large number of births in one week I have staff that I can ask to work additional hours in the next week to cover those home visits.

The DEPUTY CHAIR — So you have an additional budget for casual hours?

Ms LEES — Yes, we do have casual hours. So we have a relieving team as part of that 26.

The DEPUTY CHAIR — I think you mentioned that recruitment was not an issue?

Ms LEES — It has not been, no. It used to be, but it is not currently.

The DEPUTY CHAIR — How long ago did it used to be?

Ms LEES — When I was employed 17 years ago there was a massive shortage. I would say in the last 10 years we have been building. There are still 11 staff over 65 in our team, but we have a lot of younger staff members coming through as well.

The DEPUTY CHAIR — If the 11 staff retired overnight, would there be enough capacity locally?

Ms LEES — That is a very good question. I have to crunch the numbers. Two of our current students will be finishing in November and they are looking for work, and I definitely have about five other staff that would like more hours.

The DEPUTY CHAIR — Obviously they are living local now, but have people moved here to work or have they lived here?

Ms LEES — We have a combination. Some people have always lived and worked here, done their general training here and continued on. There are other staff that have started here, gone away and come back. I am one of those people. I did my general training in Bendigo. We do have some people that have moved for family reasons to Bendigo, wanting to bring their children up in a regional area, and they happen to be maternal and child health as well.

The DEPUTY CHAIR — Do you know how many maternal and child health nurses there are in central Victoria?

Ms LEES — That is a very good question. I am not 100 per cent sure of the numbers. No, sorry.

The DEPUTY CHAIR — If you had to pinpoint the main challenges, and I know you did provide a very comprehensive statement, but what are the —

Ms LEES — I think those main three things — the mental health issues that women face, the drug and alcohol issues and the domestic violence or family violence issues — would be our three biggest issues to deal with.

The DEPUTY CHAIR — And how does that impact on the worker?

Ms LEES — On the worker, I would say, particularly for our enhanced maternal and child health team, it can have a large impact depending on their relationship with the family. The impact is larger when those women want to stay with our service and do not want to engage with another service in addition to that. Part of our role is around assisting them to engage with other services, and we work very hard on that. But yes, we do hold a reasonable amount of risk in that sense.

Ms BRITNELL — I just have one question, and it is a bit of an extension of Cindy's, and that is around worker safety. Is that becoming an issue, given that you have identified those three areas — mental health, drugs and alcohol, and family violence — and if so, what does the increase look like and how do you put your risk assessment of work safety around a workplace perspective?

Ms LEES — I suppose that identification of those complex pregnancy care clients has actually assisted us in that process, and we do joint visiting for those families. In a lot of our cases with our enhanced clients they would be joint visits with one of our team, but in recent times we have done much more joint visit work with child protection and with the other services — family services et cetera. We have had an exchange program with family services at Anglicare so that they understand our service better and we understand their service better, so we have been doing quite a lot of work in that area, which I think improves our safety. But from a personal perspective in maternal and child health, we are a well health service; we are not seen as a threat. I think that our service is received very well by the community, and having worked on the ground in some very high risk areas, I have never felt unsafe. Our workers are all trained in what to do if they encounter an unsafe situation or if they just do not feel safe walking into a house — they exit gracefully and leave. They might do a visit with child protection if that was required.

Ms EDWARDS — Thank you, Helen. That was a very comprehensive presentation. You left me with nothing much to ask, but I did want to extend a little bit on the mental health issues that we have women

confronting in relation particularly to perinatal depression and anxiety. I just want to know what the challenges are for women experiencing that and also what support we have here in Bendigo and perhaps a little more broadly — I do not know if you are familiar with Mount Alexander. But what support is there for women — and men too — who might be experiencing mental health issues during that perinatal period?

Ms LEES — There are services antenatally at the hospital. The maternity support worker does a lot of work in that area and the PEHP worker — the perinatal emotional health program. The parent infant unit coming on board — we have had a number of families admitted to that unit, which has been fantastic. Those services are there. We also have the Raphael service, which I think you are hearing from?

Ms EDWARDS — Yes, they are presenting.

Ms LEES — Excellent. Psych services at the hospital have a youth team, and there is the John Bomford centre, but that is what I was saying — often clients are not acute enough to get into that service but they may be too acute for the Raphael service. There are private practitioners but not a lot of other public health options.

Ms EDWARDS — Do you feel as a maternal and child health nurse yourself that you have been trained well to identify those sorts of mental health problems?

Ms LEES — I believe it is an area that we can always have more training in, but we do receive training in that area, and statewide we get those rollouts of perinatal emotional health. And training, I think, is a massive area that is growing. It is about making the decisions or encouraging women to actually access services as well, because for a lot of women that is actually part of their barrier. Needing a mental health plan and going to a GP to then access the service I would see as being quite a large barrier for a lot of women. I have actually heard a woman at a complex pregnancy pre-birth case conference say, ‘I have not got mental health issues; I have just got depression and anxiety’, so I think recognition of what is going on for them is also a whole-of-community issue. While we talk about it in the community, I am not sure that everyone takes up the understanding.

The DEPUTY CHAIR — I just want to drill down a little bit more on the out-of-home care. Did you mention that there are 80 births from —

Ms LEES — There are 80 children in out-of-home care at any given time in our area. They will vary in age.

The DEPUTY CHAIR — And the pregnancy rate within that group? Sorry, you mean they have already had their babies?

Ms LEES — Correct.

The DEPUTY CHAIR — And they are still in out-of-home care?

Ms LEES — The children in out-of-home care will be with child protection. They have been removed from their home for whatever period of time and they come in and out of out-of-home care depending on what order they may be on. But in the City of Greater Bendigo at any given time there would be 80 children in out-of-home care.

The DEPUTY CHAIR — So obviously they are under 18 to be —

Ms LEES — The children? Yes, and I am talking about the 0 to 6 age group.

The DEPUTY CHAIR — Sorry, I was talking about the parents. I was talking about the parents who would be in out-of-home care who have had babies.

Ms LEES — No, so the parents who have been in out-of-home care and have had babies, I do not actually have specific stats on that.

The DEPUTY CHAIR — Sorry, I misinterpreted that.

Ms LEES — No, that is okay. A large number of the families that are involved with child protection also have a history of having been in out-of-home care themselves, and a lot of our complex pregnancy care clients would fit into that category.

The DEPUTY CHAIR — My final question: you mentioned that there are a number of refugees in the area who have been birthing. Are many of them new mothers or have they had their second or third child here?

Ms LEES — A mixture. Some of them were born in a refugee camp and are having their first child here.

The DEPUTY CHAIR — And are they guarded about our health system or quite open?

Ms LEES — I think they are quite overwhelmed by our health system, but they are an extremely appreciative group of people who are very grateful for anything that they receive. They engage with services very well.

The DEPUTY CHAIR — Yes, that was my question. So having child health nurses come into their homes is quite well appreciated?

Ms LEES — Yes, we have never had any problem with that.

The DEPUTY CHAIR — That is good. Okay, thank you very much for your time. It was very interesting and greatly appreciated.

Ms LEES — Thank you.

Witness withdrew.