TRANSCRIPT

FAMILY AND COMMUNITY DEVELOPMENT COMMITTEE

Inquiry into perinatal services

Melbourne — 27 November 2017

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Witnesses

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Dr Anastasia Gabriel, director of prevention and health promotion, Department of Education and Training.

The DEPUTY CHAIR — I welcome to these public hearings Ms Kim Little, assistant deputy secretary, early childhood portfolio, and Dr Anastasia Gabriel, director of prevention and health promotion, from the Department of Education and Training. 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 the hearing will not be afforded such privilege. 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 now to make a 15 to 20-minute statement, which will followed by questions from the committee.

Ms LITTLE — Thank you, Deputy Chair. I will start with a short statement before we move on to our questions and discussions, which we are very much looking forward to. As you would know, the Victorian MCH service provides a universally accessible health, wellbeing and development service for all families with children aged from birth to school age. By being a universal platform, it provides a really crucial non-stigmatising opportunity for the promotion, prevention and early identification of a range of issues. They include concerns with a child's physical or cognitive development, parental physical or mental health concerns, a risk of family violence, child safety, immunisation, breastfeeding, nutrition and family planning. It is the first community-based service that most families access post-birth and it provides more comprehensive and regular checks and support for families than other comparable programs in Australia, which is something that Victoria historically can be quite proud of.

The delivery model essentially is a partnership between the Department of Education and Training and the Municipal Association of Victoria as the representative of local government. We partner in the planning, funding and provision of the service. It is delivered in all 79 local government areas. There were 480 000 children enrolled in the MCH service in 2015–16 and it is delivered from 644 locations across the state, so it genuinely is a local service for families. The vast majority of that service delivery is done by local government either directly or through contract arrangements with a small number of other community health providers, and there is one Aboriginal community-controlled organisation that we fund to deliver. I am happy to say more about some innovations that are happening in that space on request.

The comprehensive nature of the MCH service actually has a legislative underpinning which is in the Child Wellbeing and Safety Act 2005. That requires hospitals or midwives in the case of homebirths to notify the relevant council of every new birth so that a locally-based MCH nurse can make contact with the family and provide the service to that family. In 2015–16 there were 79 000 birth notifications to MCH by largely local government across the state.

I will say something quickly about what the service offer actually is, and I can say more about a new development around an app if people are interested later. The core service offer has three components: the universal MCH service, the enhanced MCH service and the MCH line, which is a phone line. It is also supported by the principal MCH nurse adviser, which is a clinical leadership position that has been established in DET, and we are very lucky to have the principal MCH nurse with us in the audience today.

The universal MCH service is obviously free. It is universally accessible. It is not mandatory that people attend this statewide service. It engages in promotion and prevention activities, it identifies children and families who need further support and it brings families together and fosters social networks, including through first-time parents groups. It also has a flexible funding component which can be used to support activities, including those first-time parents groups, health promotions, play groups or additional targeted consultations. It can also be used to support continuity of care in working with hospitals and is used in a number of places across the state for that purpose, which I am happy to talk about more.

There are 10 key ages and stages visits, which are scheduled visits which cover a specified series of activities in each one. They happen from birth through to 3.5 years old. There is an initial home visit, and that happens within the first two weeks of life, and then there are consultations at two, four and eight weeks and at four months, eight months, 12 months, 18 months and at two years old and three and a half years old. All up, it is 6.75 hours worth of service, and that is provided universally along with those flexible opportunities. Seven of the 10 visits are in the first year of life, and that is because we recognise there can be more issues emerging, more concerns, more risks to parents and to children.

Ms COUZENS — Are they home visits?

Ms LITTLE — The very first visit is a home visit and then there is flexibility to do home visits for families, for example, if they are vulnerable, or for other reasons. But generally the first visit would be in-home and the remainder of the visits would be in clinic, but I can say something about the enhanced MCH service as well. I will say quickly before I move on to that that there is a very high participation rate, particularly early on. For that first visit, which is in the home as you would expect, it is between 99 and 100 per cent of families who are happy to have that visit. It does start to taper, particularly after about the eight-month visit, so by the time you get to the one-year visit you have got between around the early 80 per cent — between 79 per cent and 83 per cent is the data from the last five years — participation for all families across the state by the time you get to that first-year visit. There are a number of reasons why that occurs. Some of them can relate to families who might be experiencing vulnerability and need extra outreach. Some might be families who have had several children before and might feel that they do not need to go for that extra visit, although we would encourage them to do so. Some people might go late to some of their visits — I could not possibly comment on those people — and so on. We can talk a little more about that.

We also know that Aboriginal families are less likely to attend as time goes on. Their participation falls off more rapidly. I can talk about a project that we have got going at the moment with Aboriginal community-controlled organisations to help tackle precisely that issue.

There were a total of 668 736 key ages and stages visits that happened in 2015–16, so it was genuinely a mammoth effort from our state's MCH nurses. The enhanced MCH program is a more targeted program that is offered to children and their families where they are identified as being at risk of poor outcomes. This is an additional service on top of the universal key ages and stages visits. Usually what happens is the universal MCH nurse will refer into the enhanced service, but there are also referrals from other sources, including from maternity hospitals, which can refer direct when they identify issues prior to birth or around the time of birth. General practitioners can also make referrals and so can child protection.

Currently the enhanced MCH program is funded exclusively by the state. It is funded for 10 per cent families for up to 15 hours per family. I say 'currently' because I am pleased to say that in the last budget we got significant additional funding, which I will flag in a moment. It provides a more intensive level of support, including short-term interventions in some circumstances, as well as liaising with other services where that is actually required to form a team around that child and family. That would include Child First, family support, parenting and other early intervention services connecting to supported playgroups, which are expanding across the state, so that family has as much support as possible around it.

I will flag the sorts of things that often lead to a referral to enhanced MCH: infants at medical risk due to prematurity, low birth rate, drug dependency and failure to thrive; significant parent-baby bonding and attachment issues; and mental health issues. Significant family violence issues always appears within the top 10 of referral reasons. Others include families known to child protection; and low income, socially isolated or single-parent families. In fact being socially isolated is the number one cause for referral. Also included are issues such as: a parent with an intellectual disability, children with a physical or intellectual disability, drug and alcohol, homelessness and unsupported parents under 24. Often these things coexist as well — sometimes families will have more than one risk factor.

There are specific guidelines around the enhanced MCH program, which are currently being updated with the sector to ensure they reflect current best practice. In 15–16 a total of 11 356 Victorian families received this additional service.

The final part of the service offer is the maternal and child health line. That is owned and operated by the Department of Education and Training. It is staffed by maternal and child health nurses, and it is a 24-hour advice service. It links parents to the universal MCH service, it offers advice where appropriate on the phone, and you can also be referred into enhanced MCH straight from the line. It is a very well used and patronised service. Last financial year there were close to 99 000 calls to that service, which runs out of the building across the road.

I also flagged that the DET has established the position of principal MCH nurse adviser. That was established in 2015, and it is to provide high-level strategic and expert clinical practice advice to inform statewide policy and also work on and improve guidelines and support to the sector.

Very quickly, funding arrangements for enhanced MCHs: I have flagged that the state funds 100 per cent of the enhanced MCH service and 100 per cent also of the MCH line. We go halves with local government on the delivery of the universal service, and that includes flexible funding within that. I am happy to provide any figures in relation to those. I am also happy to flag that in the 2017–18 budget the Victorian government committed an extra $81.1 million to the maternal and child health service, which was a significant additional investment in the context of a program where, for example, we spend $42.7 million for the universal service and $16.1 million for the enhanced service. So this is an additional $81.1 million over four years.

The enhanced MCH program will be expanded. Instead of supporting 10 per cent of families it will support 15 per cent. Instead of offering 15 hours of service it will offer 20 hours of service. So these are really large increases in both the proportion of the population able to be covered and the amount of service they will receive. This will allow the enhanced MCH service to be offered beyond when a child turns one, which was the original design, up until those later years where there can still be issues and risks.

We will also establish an additional family violence consultation for 15 per cent of families within the universal service. What that means is if a nurse has any concern at all that there might be family violence and feels like she needs to spend more time with the family to determine what might be going on, to safety plan and so on, she would be able to conduct an additional visit with that family wherever it is safe to do so. That might be in the home, but it might be in the clinic, it might be at a local library or it might be at a child-care centre or anywhere that is appropriate in order to work further with that family and try and establish referral pathways and safety planning if that is actually what is needed.

There is tailored training for MCH nurses regarding family violence and response, engaging families in sensitive conversations around these matters and trauma-informed practice as part of that funding. There is more funding for workforce development and attraction to help support the supply of MCH nurses, which I know is an issue that you have been talking about today. We have increased the value of postgraduate scholarships for midwives to study maternal and child health. I am pleased to say that, while the scholarships have not been announced yet in terms of who is receiving them, we actually have a record number of scholarships being granted this year on the basis of that change. There are also scholarships for hard-to-staff areas, and there is supervision for new graduates and university students.

We have also expanded the MCH line to take an additional 20 000 calls per year, employing extra nurses on that line, and provided some funding to improve the connections between first-time parents groups, which are offered by MCH services — usually six sessions — and community playgroups. So families who do feel socially isolated and who do want the support of other families can receive it. All of this investment was part of the $202 million committed to deliver the Education State Early Childhood Reform Plan.

The DEPUTY CHAIR — No comments?

Dr GABRIEL — No, that is it. Everything was covered.

The DEPUTY CHAIR — Thank you. I will lead off with questioning: a couple of times you have quoted the 15–16 data. Given that we are well past the end of the following financial year, when will that data be used?

Dr GABRIEL — We are just actually finalising all the data now. That should be available in the next year. We will do the annual report for 16–17.

The DEPUTY CHAIR — When does the annual report get tabled in Parliament?

Dr GABRIEL — It does not get tabled in Parliament. It is just a report that we publicly provide on our website.

Ms LITTLE — There is often a range of work that needs to be done with the Municipal Association of Victoria, because their data system connects with ours, so we do that work in order to ensure the data is robust before it is published.

The DEPUTY CHAIR — I want to have a look at where we talked about the visiting system: your two and four and eight weeks up until three and a half years, and seven out of 10 visits are in year one. We talked about the drop-off rate. Can you tell me what that is like in rural Victoria and then also in remote Victoria?

Ms LITTLE — We certainly have data around rural and regional Victoria. There is not any pattern of difference between metro, rural and regional areas. There are slight variations, but they do not form a clear pattern. For example, it does not show that it is higher in metro, then lower in regional, then lower in rural. In fact it is variable across the state within very small bands in terms of participation. There is no clear pattern in the data. It is roughly similar basically across the state in terms of participation rates.

I do not have the data for what would be considered remote within Victoria, but that is something that we can provide on notice in terms of councils.

The DEPUTY CHAIR — I would be interested in that because we hear about social isolation and when people are living in very small communities. If you may not have a post office, accessing services sometimes can be difficult.

Ms LITTLE — Indeed. One thing that might be useful to flag is that in relation to, for example, the enhanced MCH service and indeed the funding formula for the universal service, there are rural loadings — so in effect councils that have larger terrains to cover in order to get nurses to where they need to be do get additional funding in order to support travel. We will certainly, on notice, provide you with as much information as we have that breaks down to those more remote LGAs.

The DEPUTY CHAIR — That would be good. Thank you very much. I have got a whole bunch of questions, but I will pass on to the others first. My next question is — you mentioned that there was in excess of, I think, 99 000 calls to the maternal and child health line and that you are going to be able to put additional staff on to pick up an extra 20 000 calls —

Ms LITTLE — Indeed.

The DEPUTY CHAIR — Where have those 20 000 calls been now? Have they been on hold not being able to get through?

Ms LITTLE — In some cases, yes.

The DEPUTY CHAIR — Whereabouts — or you do not know?

Dr GABRIEL — On the line. They can take six calls at a time on the line — sorry; six calls can be wait listed on the line — and then there is a message that will say that if you cannot get through, you can call a nurse on call if there is an emergency. Those sort of messages are provided on the line. So the call centre, depending on the day and the time, has a number of different nurses available to answer the calls.

Ms LITTLE — So there may well be people who phone who, after they have waited for a period, stop waiting — basically get off the line.

The DEPUTY CHAIR — What is the average wait time?

Dr GABRIEL — I would have to take that on notice. I cannot recall off the top of my head what the average wait time is, but I can find that information out for you.

Ms LITTLE — The average call time for the actual answered call, for the consultation, is about 15 minutes.

The DEPUTY CHAIR — So that is how long you spend on the phone.

Ms LITTLE — But the wait time is something we would have to get for you. I will say that these reasons were precisely the rationale behind the additional resources going into the line to make it the case that we could get to everyone who called.

Ms EDWARDS — Just on the call centre line, did you say there were six nurses?

Dr GABRIEL — No. It depends on the time of day how many nurses are on. There are peak times, which are usually in the afternoon and early evening, so there are more nurses on in the peak times.

Ms EDWARDS — Yes. That 6 o'clock cocktail hour.

Dr GABRIEL — Yes, the witching hour.

Ms EDWARDS — I know exactly what you mean. So they are trained maternal and child health nurses?

Dr GABRIEL — They are all qualified maternal and child health nurses.

Ms EDWARDS — The other question I have around that is: do they undergo cultural awareness training? And also what happens when there is a language barrier in terms of —

Dr GABRIEL — We have interpreters available that they can call on to actually work with them on the telephone line.

Ms EDWARDS — Okay. So you actually have interpreters working with the maternal and child health nurses at the centre?

Dr GABRIEL — Yes, both at the MCH line and also throughout the service in general. We have interpreters available for families.

Ms EDWARDS — For all languages?

Dr GABRIEL — Yes.

Ms EDWARDS — Do they have cultural awareness training in terms of Indigenous culture?

Dr GABRIEL — Yes, they do.

Ms LITTLE — And that is an increased focus now. With your indulgence, one of the things that was funded in not this budget but the previous budget was a project to work with Aboriginal community controlled organisations and local government in order to shape up some different ways of delivering MCH services in partnership and in some cases actually out of the premises and controlled by Aboriginal community controlled organisations. There are nine sites that have been selected for piloting of those different approaches, those different partnership approaches, starting now and two towards the end of next year. The aim is to better engage Aboriginal families in those services, given that their participation rates are lower and they have told us that they often prefer services delivered out of Aboriginal community controlled organisations because it gives them continuity of care and it gives them the cultural safety that they want and are entitled to. As part of that as well we are working with the mainstream services on better cultural safety training within the MCH service as a whole, so that is specifically around Aboriginal families.

There has also been a really significant project which Stacey has led around translating a whole series of the essential maternal and child health service material — say, around safe sleeping, for example — into 10 different community languages to make them much more accessible across the community.

Ms EDWARDS — You mentioned the scholarships. Are there any dedicated scholarships specifically for Aboriginal women to train as nurses and go on to train as maternal and child health nurses given that we know that that is probably one of the ways of addressing the gap?

Dr GABRIEL — Yes. Out of the scholarship guidelines, Aboriginal nurses who want to train as an MCH nurse have a priority. If they apply, they are a priority cohort.

Ms EDWARDS — How many of those scholarships are there; do you have the number?

Dr GABRIEL — I can say we awarded 84 scholarships this year. I do not know exactly the breakdown.

Ms EDWARDS — It would be good to know.

Dr GABRIEL — But I can find out for you, yes.

Ms EDWARDS — Thank you.

Ms COUZENS — It is not taken up as much as it should be, though.

Dr GABRIEL — I think we funded nearly all of the scholarships.

Ms COUZENS — The Aboriginal?

Dr GABRIEL — Aboriginal ones, yes.

Ms COUZENS — You funded all the Aboriginal scholarships?

Dr GABRIEL — No, no, I am sorry, we funded all the —

Ms COUZENS — They are the ones I was talking about; they are not taken up as much.

Dr GABRIEL — We will find out for you and we will provide the data.

Ms EDWARDS — I just have one question in relation to the additional $81 million that is allocated in the budget and the exciting announcement today, I have to add too, which I am happy for you elaborate on, unless you want me to read it into the Hansard transcript. We know that there is an ageing workforce amongst maternal and child health nurses.

Dr GABRIEL — Yes.

Ms EDWARDS — And we also know that retaining them in regional communities is becoming increasingly difficult. What proportion of that $81 million do you think will be going towards addressing that retention and addressing the retirements over the next five to 10 years that we know are going to happen. Do you have a breakdown?

Ms LITTLE — I might say something broad and then leave it to Stacey in terms of the dollars. We do keep a very close eye on the supply of maternal and child health nurses, along with our colleagues in local government. While at a statewide level — and I do emphasise at a statewide level — there is currently not a shortage, although there are shortages in particular areas; there is a distribution issue. We do know, exactly as you said, that with the ageing of the maternal and child health workforce — which because they are triple-qualified amongst other things, is an older workforce — there is likely to be pressure on supply in future years. That is why the workforce development and attraction initiatives have effectively been put in place.

But we are also continuing to work through what is known as the MCH Expert Reference Group, which is something that was established under this government and which includes MCH leaders from across the state and is co-chaired with the Municipal Association of Victoria. We are continuing to work with them on workforce attraction, supply and retention as well in this space and how to make the most of this very valuable resource of MCH-qualified nurses.

Ms EDWARDS — Do you have a list of what those initiatives are that you could provide the committee with?

Ms LITTLE — Around the initiatives that are being funded?

Ms EDWARDS — Yes.

Ms LITTLE — Absolutely, yes.

Ms EDWARDS — That would be great. Thank you.

Dr GABRIEL — And I can give you a bit more detail about the scholarship program. We have increased the funding from $5000 to up to $10 000 for the scholarship program.

Ms EDWARDS — Has there been an increase in the number of scholarships?

Dr GABRIEL — Yes.

Ms EDWARDS — So, what was that again?

Dr GABRIEL — We have 84 scholarships we have awarded this year.

Ms EDWARDS — Compared to what? What was it before?

Dr GABRIEL — It was in the mid-40s.

Ms EDWARDS — That has doubled.

Ms LITTLE — So it is a really significant increase.

Dr GABRIEL — Yes, it is a very significant increase. Priority is also given to graduates in rural and remote areas as well as the Aboriginal nurses and midwives.

Ms EDWARDS — Just on that, and in terms of what we have been discussing with other presenters today around the training for maternal and child health nurses and the triple degree that they are required to have, there has been some discussion around somehow streamlining that to enable more maternal and child health nurses to get out there into our communities who are qualified. Do you envisage that there is an opportunity to perhaps have, as discussed previously with one of our other presenters, a four-year nursing degree that incorporates midwifery that then only requires an additional one year? Currently it is the undergrad, the midwifery degree, then the maternal and child health degree.

Ms LITTLE — I think it is probably a matter for government to consider whether or not it would be interested in that as a policy change from the history that we have had in Victoria, which is around a triple-qualified workforce. I think anything I would say about that would probably be my personal opinion, so I think I will leave that for the government and ministers to consider.

Ms COUZENS — Thanks for your presentation today. I just wanted to go back and unpack the enhanced program.

Ms LITTLE — Sure, yes.

Ms COUZENS — So the universal service is 100 per cent funded?

Ms LITTLE — It is half-and-half with local government.

Ms COUZENS — Okay. And then the enhanced program is 100 per cent funded by government?

Ms LITTLE — One hundred per cent by the state, yes.

Ms COUZENS — And the enhanced program is for at-risk communities; is that right?

Ms LITTLE — At-risk individuals, so whether or not that be due to drugs and alcohol, family violence, premature birth, social isolation, young mothers —

Ms COUZENS — So it is not necessarily an area; it is more the individuals that it is targeted at?

Ms LITTLE — There is a formula. Once the money has been allocated, then it is down to the assessment of the referrer, which is usually the universal MCH nurse but, as I said previously, not always; sometimes there can be a referral direct from maternity services or child protection or GPs. I will let Stacy say something quickly about the way that the funding formula works at an LGA-by-LGA level, which does take into account whether particular communities are more likely to have larger groups of vulnerable families.

Dr GABRIEL — I will tell you about how we fund the service. Basically funding is allocated for the universal service based on a unit price for the 6.75 hours of delivery. On top of that we have got flexible funding for families that require more support outside the standard consultations, and that might include provision for additional consultations, first-time parent groups and community development groups. On top of that there is a weighting component for rurality and disadvantage, so a portion of the funding is weighted so that rural councils and more socially disadvantaged councils will get more funding to support those families in that municipality.

Ms LITTLE — And that weighting applies both at universal and also in the allocation of the funding formula for allocating enhanced MCH. So a suburb in Melbourne which was a high SES suburb, for example, would get less enhanced MCH funding than a relevantly sized LGA in another area that had more socio-economic disadvantage.

Ms COUZENS — So who determines that, though?

Dr GABRIEL — So it is the funding formula that we have that determines how much funding for each local government —

Ms LITTLE — It is a set formula.

Ms COUZENS — So when a council gets the money, do they then decide where those services are going to be provided?

Dre GABRIEL — They are provided across the state, so because —

Ms COUZENS — Yes, I understand that, but within a community —

Ms LITTLE — The enhanced maternal and child health nurses — and in some LGAs they are actually a different group from the universal nurses and in some cases they overlap; they roster people onto both — will determine using the criteria, which are set out in the enhanced maternal and child health nurse guidelines, which families receive the service based on those risk factors that I read out earlier.

Ms COUZENS — Okay, so do they also then decide when they are not going to service a community that is at risk?

Ms LITTLE — They would not ever not service a community. All communities would receive the enhanced maternal and child health service and all communities are funded by the state to receive enhanced maternal and child health. The clinical decision of the nurse is about which families fit those criteria, which I read out before, to determine which families would receive enhanced maternal and child health and how much, but there is no community which either through our funding formula or, to the best of our knowledge, through the LGA-delivered service would be excluded from receiving the service.

Ms COUZENS — So the council is making the decision about where those services are provided and they may be using the formula — I do not know. In one instance I am aware of they have taken a service out of a very low socio-economic area and moved it into the next suburb because the nurses believed the mothers were not coming to the service. So instead of looking at why, they have moved the service to another suburb, making it even more difficult for mums to get that service. I suppose that is the point I am getting at. How do they make that decision —

Ms LITTLE — The location — the physical location of maternal and child health outlets, if you like — is a matter for local government about where it locates them. Sometimes what happens is local government decides it is going to set up larger hubs where, for example, they can be co-located with GPs or they are going to build an integrated centre, and in some cases the state will offer partial grants to help support the establishment of those centres where you get MCH plus kindergarten plus supported playgroups. So sometimes that can lead to a reconfiguration —

Ms EDWARDS — Community health?

Ms LITTLE — Indeed, but I am not aware of the particular case you are flagging and am probably not in a position to comment on it.

Ms COUZENS — I know. I am just asking who makes those decisions and how they are made, because you have got a very vulnerable community that has no longer got a service there because it has been taken to the next suburb. So although we have got all these wonderful things here, it is not always working for the people who most need it. That is the point I am making.

Ms LITTLE — The physical location of maternal and child health services is a matter for local government.

Ms COUZENS — Right.

Ms LITTLE — One thing to flag is that in the case, particularly, of the enhanced maternal and child health service many of the visits would be home visits rather than the universal.

Ms COUZENS — Yes, I understand that. I suppose I am really interested to know what you see as being some of the ways of dealing with the mums that kill their babies or even the dads that kill their babies. What sort of things do we need to put in place in the early intervention and preventative mechanisms? Have you got any ideas or thoughts around what your department is doing in relation to those areas?

Ms LITTLE — I can certainly talk to the current policies, practices and funding which are available within the maternal and child health service and also some work we are doing with DHHS around very early intervention. In terms of what currently happens around the mental health of parents, there is a well-established approach which is actually informed by PIRI, who was speaking to you previously.

There are well-established guidelines about engaging at various points along the journey. There is a family wellbeing check which takes place very early — I think it is at two weeks — and then at four weeks and eight weeks there are check ins around mental health and emotional wellbeing. Usually they are with the mother, but in some cases with the father, particularly in a father suffering from anxiety and so on. They use the Edinburgh Postnatal Depression Scale and use the guidance which has been established through working with PIRI to do those checks and look into how parents are basically faring.

Depending upon the results of those checks, that then allows appropriate support and referral. So if you were to score reasonably high on that Edinburgh Postnatal Depression Scale, then you would usually be referred to a GP or in some cases to a psychologist, but usually to a GP. If you were to score lower but the MCH nurse was still concerned, you might be provided with some additional flexible supports or some enhanced MCH, depending upon what that looks like. So you might be provided, for example, with some extra visits to your home to check on you and see how you are going. That, in combination with the referral pathways, is designed to identify, as early as the MCH service can identify, those sorts of issues.

I will also say that we know there are some really good examples across Victoria of councils that are using some of their flexible funding to assist families where there have been risk factors identified — and we heard what some of those risk factors were, and some of those can be identified before birth — around serious mental illness. There can be work with the maternity services prior to the birth of the baby, and so there is what they call sometimes in the trade a 'warm handover' or a 'warm referral', where the MCH nurse is already well apprised.

I hasten to add in all of this that of course the vast majority of mums and dads who have mental health issues around the birth of a child are not a risk to the safety of their children. I really want to emphasise that, because of course we do not want to stigmatise people who are experiencing the sorts of really common mental health issues that can come along with birth. But by having this universal service, particularly in those first few visits, which touches almost every family in Victoria, you do have that ability to be able to keep an eye on what is going on in families across the state.

Ms COUZENS — Do you think referral to a GP is enough?

Ms LITTLE — I think it depends on what the issue is. As you would know, GPs are the pathway for getting referrals into psychiatric services.

Ms COUZENS — But there are mental health services out there as well.

Ms LITTLE — And certainly MCH nurses are able to refer to those and to psychologists in particular, and they have very good connections in many cases with those other services. But that is always something we can continue to build up.

Ms COUZENS — In the Aboriginal area you talked about expanding existing services. I know we are running out of time, but can you just quickly give me an overview of what is planned?

The DEPUTY CHAIR — Just on that, you mentioned earlier that there was one Aboriginal community-controlled organisation that you are currently delivering in.

Ms LITTLE — That is VAHS — the service known as VAHS.

The DEPUTY CHAIR — And where is that?

Dr GABRIEL — It is in Fitzroy, but they have outreach across the north.

Ms COUZENS — So state based.

Dr GABRIEL — Yes, state based.

Ms LITTLE — The money that was allocated to work with local government Aboriginal community-controlled organisations was basically an innovation pool of funding that was allocated not in this budget but in the previous budget. We have been working very closely with the Aboriginal organisations and with local government to co-design an approach, which has been extremely successful. That led to an expression of interest process, which was conducted earlier and has led to nine successful partnerships being funded to be established across the state. There were a few different delivery models.

One delivery model is in the universal MCH service, so it is in the local government service, but with very heavy involvement from the local ACCOs, the local Aboriginal community-controlled organisations, to help make that service have a more effective outreach, to be more culturally safe and to be more acceptable and of high quality for Aboriginal families. That is one model. Another model is where the local government has an MCH nurse employed by it go to the ACCO and be placed within the ACCO and work with those ACCO services. The final model, which is a genuine innovation, is to have MCH nurses actually employed by the ACCO themselves but to then have partnerships back into the local government.

So all of those models have been funded across the state, many in rural and regional areas, and we are really looking forward to seeing what comes out of them.

Ms COUZENS — Fantastic. Thank you.

The DEPUTY CHAIR — I just want to finish up with a couple of quick ones. You mentioned a priority for the scholarships being rural and remote. Is that a change in policy?

Dr GABRIEL — No, it has been like that for a few years now, but we have got more scholarships.

The DEPUTY CHAIR — But what sort of uptake did you get previously in rural and remote?

Dr GABRIEL — I will have to take that on notice as well and provide it to the committee.

The DEPUTY CHAIR — Gut feeling? Is it not very many or lots?

Dr GABRIEL — I am sorry, I cannot recall, so I will have to find out.

The DEPUTY CHAIR — You were here for part of the evidence of the previous witnesses. They were talking about screening for postnatal depression, and we have just spent some time discussing that. We seem to be giving the maternal and child health nurses more and more to do in terms of, 'You need to be able to do this. You need to look at autism. You need to look at depression. You need to look out for family violence and signs of stress that is happening at home'. What feedback are you getting from the maternal and child health nurses about that?

Ms LITTLE — Probably a point of clarification would be it is not so much that maternal and child health nurses are being asked to do more, because looking for signs of family violence, conducting assessments using, for example, the Edinburgh postnatal depression scale, engaging with families who have experienced trauma — all of those checks have been built into the key ages and stages visits for some time. So that is a well-established platform. The thing we are doing now is better supporting maternal and child health nurses in executing those responsibilities.

The DEPUTY CHAIR — How are you doing that?

Ms LITTLE — Through a few different things. One is by providing them with better training around doing that. With family violence, it is additional family violence training. The training that has been funded in the last budget as well as the rollout of the new risk assessment framework that is happening as part of the broader family violence work is funding for training for trauma-informed practice. There is now funding available that has been announced this morning around better supporting nurses in their role around looking for signs of

autism and working with families around that. There is also more money for the service delivery. As I flagged before, there is now a whole additional visit in the universal MCH service, which is 100 per cent funded by the state for 15 per cent families where there are concerns there might be family violence. So just more time with families to inquire into those issues and work with them and a significantly more enhanced MCH offer for families who are struggling or have other risks. It is a combination of better training to engage in those things you mentioned, which are part of the KAS, the key ages and stages, and more time funded to enable them to do that.

The DEPUTY CHAIR — And what do they tell you that they need, and how do they do that?

Ms LITTLE — We have an MCH expert reference group, which has been established under this government, which is quite a large group of very highly regarded maternal and child health nurses from across the state, which we co-chair with the Municipal Association of Victoria. We also have our principal —

The DEPUTY CHAIR — And the idea of that is to get to hear from the people on the ground.

Ms LITTLE — Absolutely. That is absolutely the point of that, along with our principal MCH nurse practitioner who is out there talking and running workshops and conferences with the MCH service to develop things like the —

The DEPUTY CHAIR — But that is you telling them more. I am looking at how do you get up —

Ms LITTLE — No, by all means they are telling us —

The DEPUTY CHAIR — Good.

Ms LITTLE — what they want in the new enhanced MCH guidelines — for example, the framework and so on. The MCH nurse workforce are, as we have said before, a very highly qualified workforce. They are very keen to share with us their views on the kinds of support that they want and need and have been extremely supportive of the package of reforms.

The DEPUTY CHAIR — Thanks. Our time frame is done, but Maree has one quick question.

Ms EDWARDS — I will be very quick.

Ms LITTLE — Certainly, I will be quick too.

Ms EDWARDS — It depends on your answers, I suppose.

The DEPUTY CHAIR — The question can be quick.

Ms EDWARDS — My question will be relatively quick. Can I say that we are, as a committee, very excited to hear that announcement today of $1.1 million to train our maternal and child health nurses. That was a clear recommendation from this committee —

Ms COUZENS — Very exciting.

Ms EDWARDS — and we are elated by that news. You mentioned the app.

Ms LITTLE — Yes. We promise we will answer quickly.

Ms EDWARDS — I know, it depends on your response as to how quickly —

Ms LITTLE — We are quite excited, but we will try and make it brief. Go, Stacy, go.

Dr GABRIEL — Partly we did a lot of work with the CALD and refugee community, who told us that one way of engaging with the service is to have some very credible information for them at their fingertips. So through the last budget process, $950 000 was committed to developing a smartphone MCH app, which will have very credible information. They wanted information that they could rely on about all the things that impact on them, about their child and about themselves. So the app is currently being developed and will have basically

a whole raft of information around the child's development. You could input your child's date of birth and it will —

Ms EDWARDS — Different languages?

Dr GABRIEL — It will be released shortly in our top 10 languages. Release one will be just the static information in English. Release two will be in our top 10 languages because we know that is one way of engaging with families. We heard that families would go to their websites in their home countries to try to find credible information about development of their children, so this app is certainly very helpful in engaging them in a service that is free and accessible —

Ms EDWARDS — And how will that be advertised, distributed, publicised?

Dr GABRIEL — Through the green book. You know, you get the green book when you leave hospital?

Ms EDWARDS — Yes.

Dr GABRIEL — It will have information in there about the app.

Ms LITTLE — And through the MCH service as well.

Dr GABRIEL — MCH nurses as well. So, yes, very exciting.

Ms EDWARDS — Good. Okay, thank you.

The DEPUTY CHAIR — Thank you very much to Kim and Anastasia for coming and presenting today.

Dr GABRIEL — Thank you.

Ms LITTLE — Thank you.

Witnesses withdrew.