T R A N S C R I P T

FAMILY AND COMMUNITY DEVELOPMENT COMMITTEE

Inquiry into perinatal services

Mildura — 9 November 2017

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Mr Jason Spratt, manager, family services, Mallee Family Care.

The CHAIR — I welcome to these public hearings Mr Jason Spratt, manager of family services from Mallee Family Care. 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. 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. If you would like to start with a 10 to 15 minute spiel, that would be great, and then we might ask some questions if that is okay with you.

Mr SPRATT — Yes, it sounds good.

The CHAIR — Thanks very much.

Mr SPRATT — Before I begin I would like to acknowledge the traditional owners of the land, the Latji Latji people, and their neighbouring communities, the Barkindji people. Thank you, guys, for the chance to submit. We did not put a submission to the inquiry. My presence is a response to an email from Greg in particular asking about a couple of services that we deliver, a couple of programs that we deliver in the Mallee, the Cradle to Kinder program and the Stronger Families program. I am going to talk a little bit to the Child First service and how that links into our experience with perinatal care, I suppose. Ours is a little bit away from a health model and more a community/family context.

Mallee Family Care is a community organisation that has been working in the Mallee for almost 40 years, and our services extend across the north and the south of the Mallee into New South Wales and some very small services in South Australia. We deliver children, youth and family services, disability services, foster care, mental health services, housing and settlement services in the southern Mallee, legal and financial services, learning and education services — so quite broad. In particular the stuff I am going to talk about is our family services. My plan is just to give you a fairly brief overview of what the programs are and then respond to the things in particular that you are interested in knowing.

Stronger Families and Cradle to Kinder are both services that we deliver in partnership with Mallee District Aboriginal Services. When the invites to tender went out to those, we partnered with MDAS to try and deliver, I suppose, a collaborative model. Initially with Stronger Families there was a partnership approach; there was an Aboriginal Stronger Families service and a Stronger Families service. We are very similar but have some differences. Our Cradle to Kinder is a little bit different in that we put in a submission for it and then, based on our model, brokered a position from MDAS to deliver services to Aboriginal mothers.

Stronger Families is an integrated placement prevention and family reunification service, providing intensive casework support to vulnerable families as well as specialist services, new services, therapeutic services and early years services — early parenting service. It comes with a significant amount of flexible funding packages to support families to do things a bit differently. We deliver that service across four LGAs — the Buloke, Gannawarra, Swan Hill and Mildura LGAs. It is a service that lasts for 12 months and the eligibility criteria are families who have a substantiated report with child protection who are at risk of entering foster care for the first time or returning to the care of their parents after being in foster care for up to a six-month period.

Initially it was targeted towards working with families where the child was 10 to 15 years old or nought to two. That was based on a pilot that was delivered in Victoria — the family coaching program, I think it was called at the time. It was identified that first-time contact with child protection services generally came for people at nought to two — because they have not been alive before that of course — and 10 to 15, when things start to change for families. Whilst they are the focuses, it is open to children of all ages. Since commencement of the service, which was in 2013, we have worked with 58 families, including 177 children. Of those children, 43 have been under one and only two referrals that have come through that service have been for unborns, so whilst the mother is still pregnant.

I will talk a bit to the Cradle to Kinder — just brief overviews. Cradle to Kinder is a little bit different. The idea of the service is to work with particular cohorts of mothers that had been identified as being at high risk of further contact with child protection services. It is designed to work with mums from the second trimester of pregnancy up to six weeks of age of the child as the entry point. The three target areas for mothers are mothers who are in or have been in foster care, mothers who identify as Aboriginal and mothers with a learning difficulty.

The DEPUTY CHAIR — What was the last one, sorry?

Mr SPRATT — With a learning difficulty. It is an interesting one, because it does not have to be a diagnosed disability. I think the criteria says anyone who has had problems learning anything ever, so it is pretty broad.

Ms COUZENS — That is broad.

The DEPUTY CHAIR — That is probably everyone**.**

Mr SPRATT — Yes, we reckon everyone fits there. Interestingly, though, because it is for mothers under 25, mothers over 25 can get entry to the service if they do have a diagnosed intellectual disability, so it is an interesting distinction. The service works with mothers for up to a four-year period with a real focus on health and education and connection to health and education services, and it is based on some of the research that says typically those cohorts of mothers have not had great experiences with health and education services in their own lives, so trying to get in really, really early.

Our model, when we put that to tender, was across the whole Mallee. We have one staff member based in Swan Hill, we have one staff member based in Mildura and we did have one staff member with Mallee District Aboriginal Services; that was up until the end of June this year. That changed because Aboriginal Stronger Families has now come to the region. MDAS was successful in getting that program, so the staff member that we had there has come back to us. They are no longer located there. We have had 52 families come through that service since 2014. Obviously all of those children fit within the perinatal age range.

The other part that I was going to talk to was the Mallee child and family services alliance. It is sort of where my experience with Child First becomes relevant. Our agency is funded as the facilitator of that alliance. Effectively what it is is a partnership between government and local service providers to deliver family services across the catchment. It is split up into Child First, which is the entry point. They assess referrals that come in, which tend to be where someone has identified a concern for children or the impact of something that is going on within the family that is having an impact on the children and looking at possible supports to try to divert families away from a more tertiary response or a child protection response.

The back end of that is family service providers, so Child First becomes the conduit into family services. In the last 12 months Child First in the Mallee responded to just over 1600 referrals. They are split up into what are called non-substantive referrals, so contact that lasts up to about 2 hours, through to substantive referrals. About 1000 of those were non-substantive referrals, and only about 500 were substantive referrals that required a response, and about 41 or 42 per cent of those referrals end up being referred to family service providers. So that was about 300 new families across the Mallee that received that support in the last 12 months. That is about all I was going to talk to you about. I was going to then see what you guys wanted to ask.

The CHAIR — Fantastic; suits us. Thanks for the info. I might go down to Christine first if she wants to ask a couple of questions and we will work our way back up.

Ms COUZENS — Yes, okay. You talked about the program shifting and going to the Aboriginal service provider.

Mr SPRATT — Yes, it is a new program. Ours initially was Cradle to Kinder. There is a different program which is Aboriginal Cradle to Kinder. So ours has shifted in that we felt that, because of the cohort of families that that program was targeting, being able to access an Aboriginal service as an entry point would have been beneficial for families and for mothers, as they would more likely engage. That has now changed for us and it has come back, but there is a new service that covers that.

Ms COUZENS — So are you still providing service to Aboriginal women?

Mr SPRATT — Yes. We still always provide to Aboriginal women through not just the MDAS worker but also in Swan Hill and also in Mildura. Yes.

Ms COUZENS — Does your organisation have cultural training?

Mr SPRATT — Yes, we do. We do it in a couple of different ways. Because we are a foster care provider we do have some requirements for foster carers and staff there to undergo specific cultural competence training. Our family services staff — the alliance that I talked about before, the family service providers — look at a shared approach to training for all family service providers, and we typically look at cultural competence training through that avenue. Previously we have looked at bringing people in from out of town to deliver that, and the feedback from community and our staff was that it did not have a local approach. I reckon about two years ago MDAS started to deliver that training locally, so they were able to deliver cultural competence training that had relevance to our community.

Ms COUZENS — In a general sense, in getting skilled health professionals, is it your experience that there is an issue for the community and the organisations getting skilled health workers?

Mr SPRATT — Ours is not health. Generally we would look at a diploma of community services or equivalents or a bachelor of social work or equivalents to be a minimum qualification for our staff.

Ms COUZENS — So are you getting those people when it is required?

Mr SPRATT — Yes and no. What we have experienced in the last few years is a significant increase in funding into the Mallee for some of these services. The ones that I have mentioned are from 2013 and 2014. Aboriginal Stronger Families is this year. We have looked at an increase, I think, of about nine positions across the Mallee into family services. We have looked at a new increase into child protection services by about 15 staff over the last couple of years. We have probably struggled to keep up with the amount of resources being directed here at the minute. It is all family services in terms of a workforce that is ready to go. So we do a lot of arrangements where people might have a minimum qualification, and they work and they study to upgrade that at the same time.

Ms COUZENS — Do you touch on mental health at all within your organisation?

Mr SPRATT — Within the organisation we do deliver mental health services. Within these particular programs there is an aspect of mental health support, but it is not a focus. We would try and get people to mental health service providers. The last time I looked at the numbers, I think about 90 per cent of families identified poor mental health or mental illness as part of the risk issues for the families, particularly the impact on the child — the impact of the parents' mental health on the child. So we do not have a specific mental health service that sits within that, but it is something we deal with daily.

Ms COUZENS — So who identifies those mental health issues?

Mr SPRATT — It is different at different times. Sometimes it will be at the point of referral, so when we receive a referral it will be identified as a risk factor, or it is identified fairly quickly when we start working with families. I cannot remember a time when we got 12 months in and were not aware of it and then worked it out down the track.

Particularly for our Cradle to Kinder, it is a real time of change for families. We know through some of the research that has been done locally that whilst we have high rates of teen pregnancy, the narrative that is put forward by young mums is that it is a real opportunity to do things differently in their own lives, particularly when we are looking at the vulnerable groups that we work with. That is challenging for people from a mental health perspective. We also find in a lot of the young families that because of the young mother's own experience of childhood, pregnancy can be really traumatising or a really traumatic experience for them. Absolutely we see that.

Ms COUZENS — And do you offer a service for the male partners, for example?

Mr SPRATT — Yes.

Ms COUZENS — So they are part of that?

Mr SPRATT — Yes, they are. It is really interesting from a child protection lens. Obviously we look at the safety of the child as our primary focus. From a child protection context when we look at family violence and the impact of family violence on children, often the courts require a parent to be responsible to respond to family violence, so often where family violence is involved, fathers have moved out. We are certainly not

complaining about that. I am saying that it does sometimes make it difficult to engage fathers, but they are part of what we do, yes.

Ms EDWARDS — Thank you, Jason, for coming in today. I just have a question around your funding. You obviously get a mix of funding, I presume, from state and federal for different services —

Mr SPRATT — Yes, our agency does. Our family services that we are talking about today are state funded.

Ms EDWARDS — And you mentioned referrals and that you are the service that people get referred to, particularly young mums. Where do they get referred from? Is it just child protection, or is it from other areas as well?

Mr SPRATT — Child First is not something that we deliver. It is delivered by our alliance. Another service does provide that. The numbers I gave before: I think about 57 per cent of those referrals come from child protection directly. We get a very small percentage that come from families themselves. We get a very small percentage that come from health services.

Ms EDWARDS — So are GPs included in that?

Mr SPRATT — Yes. I wrote it down.

Ms EDWARDS — Oh, did you?

Mr SPRATT — I did it in bold because I thought you might ask.

Ms EDWARDS — And maternal and child health nurses?

Mr SPRATT — Yes. Maternal and child health for the last 12 months says 1.6 per cent. Early is 3.6 per cent, community health 0.2 per cent, 1 per cent from hospitals and 0.2 per cent from other medical. I think though what happens is that often referrals are made directly to child protection. When there is a concern, they will make the referral to child protection. Child protection will assess that and then determine whether further intervention is needed from their perspective or they make the referral to Child FIRST. So we see high numbers of referrals from child protection. I believe it is because a lot of the health services go directly to child protection, not to Child FIRST.

Ms EDWARDS — You mentioned about the trauma for some women in terms of becoming pregnant given a history of family violence, perhaps Aboriginal and Torres Strait Islander background. What services do you refer those pregnant women to, and the mums and babies who come to you in that first 12-month period? Particularly the under-25 group, I am thinking of. Who do you refer them to? You mentioned education and other health services, and that is one question. The other question I am interested in is: what are they saying to you in terms of the continuity of care and support that they receive throughout their pregnancy and up until that time that their children are, you know, one to two years old? And do they say that they are getting good support in terms of that perinatal period?

Mr SPRATT — The first one you are talking about, where do we refer to, this is going to be a strange answer — different for different people.

Ms EDWARDS — No, that is what we want to hear.

Mr SPRATT — Yes. We tend to find that a direct referral to mental health services is not very effective, not because of the service that is provided, more because of the reluctance of families. Overwhelmingly we find that we have better results when we can get mums earlier in their pregnancy and we have better results when we can get mums earlier in their life as a parent, so when it is their first child, not necessarily their second or third or fourth child, and particularly for our Cradle to Kinder, which is the under 25s.

We find that with the young people, similar to what Lois was talking about before, I suppose, it is relationship based, not necessarily specialist knowledge based in terms of what young people are willing to engage with or willing to listen to. It really does depend on who young people trust in terms of who we refer them to. We do not find if you can provide service A, B or C that tends to matter as much as who the person providing it is. So we find who they are going to trust and what they are willing to get to, and we find that that is the most effective

way of doing things. If there is a gap in terms of the specialist knowledge of those people, we then try I suppose to develop a pathway to get more specialist support. Sometimes that is in a secondary consult from specialists. Sometimes that is trying to have, say, people introduce mums to specialist services. What was the other question?

Ms EDWARDS — The second bit was really in terms of the mothers themselves and what they say to you about, you know, are their needs being met, are they falling through the gaps in service delivery for that perinatal period. A young woman becomes pregnant, for example — what is the first point of call for her given that she might be at risk and from a vulnerable background? What are they saying to you?

Mr SPRATT — Rarely are we working with these families in isolation so we do not get a lot of feedback that says the continuity or the volume of support, for want of a better word, is not there. I am not sure how to answer. We have so many different experiences I suppose.

Ms EDWARDS — Is there some commonality?

Mr SPRATT — To reiterate what I said before, the earlier we can get people, the more likely they are to connect with things that we can offer them. I think sometimes what happens is the impact of — no, let me change that. Particularly the service for mums under 25 is designed to be an early intervention service. It is designed to get in as early as possible in the life of the child to try and support better pathways and better connections for mums and children. What we see is an overwhelming demand on services locally across all LGAs that lead our services to respond to the most vulnerable instead of the earliest intervention, and what that means for us is sometimes we are getting in too late because the demand is so great.

So sometimes, particularly for those young mothers, we would have liked to have been able to respond earlier. When we can do that they are more likely to feel like they can connect with the services. The later you are getting, usually it is because someone is worried as opposed to the parent asking. Particularly for mums who have experienced significant contact with child protection services, they are wary. When we talk about retraumatising and we talk about their own family histories a lot of the time, being able to trust services like ours is really challenging, particularly when you are responding to a referral someone else has made. If I looked at what typically people say, the earlier we get to them, they say it is better; the later we get to them, they say it is worse in terms of continuity and whether there are more or less gaps.

Ms EDWARDS — And just in terms of that connection with the services, I assume — maybe I am wrong, but I would assume — that if you are seeing a young pregnant woman, the referral would be to a midwife or to the local hospital as an initial starting point.

Mr SPRATT — Yes. Maternal and child health, yes, absolutely.

The CHAIR — How long have you been working in this service, Jason?

Mr SPRATT — These programs or me?

The CHAIR — In this sector. How long have you been working in the sector? How old are you?

Mr SPRATT — I did not know I had to bring ID. I am 39. I think 15 years maybe.

The CHAIR — I take it as you are working at the coalface you know what the community requirements are. I just want to drill down and ask you a fairly straightforward question — that is, if the system in this community, in the perinatal services sector, is going to fail or it has got a weak link, where is it? Where are people falling through at the moment, whether it be mums, children or dads?

Mr SPRATT — From a family service perspective, our challenge is being able to identify the risk of the cumulative harm that is starting to children or to young babies and to pregnant mums. We cannot see bruising, scars — those type of things. We are going to fall down if we cannot assess that better, if we cannot identify the risks and articulate those risks to the people around the child. That is probably our biggest challenge from a family service perspective.

When I talk about the most vulnerable being who we respond to, years ago — and others in the room will say the same — we were only worried about the impact of family violence if we saw children hitting other children.

Our work is much more sophisticated than that now, but we tend to respond to children in stuff where there is more physical evidence as opposed to when we can see a trajectory for babies. And when I say 'we', I mean the sector. I am not saying individual people, but sometimes if we cannot see what we are used to looking for and we need to look for different things, we cannot articulate the risk as well. We know that vulnerability does not increase just because a child is born or because they are getting older. We know that unborn babies are extremely vulnerable and cumulative impact can occur right from conception. My belief is that is the biggest challenge — being able to identify and articulate that risk and the impact on those children.

The DEPUTY CHAIR — Thank you, Jason. It is good to have somebody with your background and experience presenting to us today. Can you tell me, what are the main barriers that you think are faced by women in this area, this very broad area, in accessing family support services during that perinatal period?

Mr SPRATT — Location often. Lois and Grant talked to the area that their catchment covers.

The DEPUTY CHAIR — Is that the same? Because you said four local government areas. Is that the same as what Lois and Grant cover?

Mr SPRATT — Yes. They are a part of that as well. They are gone; I keep waving like they are there, but they are not bloody there. I should have looked around. Jeez, I did not look far enough. Grant is still there. We cover — I do not know the numbers — yes and bigger, I suppose. I agree with what they said before. Sometimes we try and apply a mould that fits all and we try and do that in a way that makes service delivery consistent, but sometimes that does not allow for localised differences in workforce and different ways that different communities access services. Our challenge in trying to make a service that has one way to access and one way to connect with but also make it accessible for families with local people is really, really hard.

The DEPUTY CHAIR — Would you say it is different then for the Rural City of Mildura compared to the other three LGAs you cover?

Mr SPRATT — Yes, I think it is different in all the LGAs. Sometimes your ability to provide, or our ability to provide, a response when an issue is raised by a family — there are more specialist options in Mildura than there are in Swan Hill. There are more in Swan Hill than there are in Kerang, and vice versa, but again it is about having local people that people can get to quickly. We know particularly for young vulnerable mums it is not necessarily about sitting and waiting and having a plan in place; it is identifying a risk and being able to access something really, really quickly, because those opportunities have changed and with those young families we do not have massive windows of time. We do not have people who have thought about it for a long period of time typically and have developed their own coordinated plan around how to address whatever issues they have come up with. They identify a concern. They want someone to be able to give them a hand now, and based on how we respond to that often that will impact on how they access services down the track. So often when we have the outreach and assess families who are in other areas it makes it really, really hard for those families. It is another day at work for us. We drive places and we go and do things, but families want to be able to access services quickly, particularly young pregnant mums.

The DEPUTY CHAIR — I think it was when you were talking about the Cradle to Kinder program, the early intervention service for different groups of women under 25, do they come into contact with each other? Are they individual programs? Do you do group work?

Mr SPRATT — We do little bits of group work, but not typically. So we have trialled different group programs but our preference is more to try to connect people to services in the community instead of manufacture. So we look at it as a case management approach and try to link people with what is already out there.

The DEPUTY CHAIR — Could you expand a little bit too on the mothers that are in or have been in foster care? Is that a high number or just the same as every other, like the average compared to?

Mr SPRATT — Over-represented. I do not know the number. I could not know the number. I could go back and I could manually pull it out, but it is not something that is recorded.

The DEPUTY CHAIR — How about the outcomes for that group?

Mr SPRATT — Worse. Worse than the ones who have not been in foster care, but better when we get them earlier.

The DEPUTY CHAIR — So when you do your interventions obviously it is better, but compared to the ones with learning difficulties or the Aboriginal women, do they have better or poorer outcomes or about the same?

Mr SPRATT — Generally poorer.

The DEPUTY CHAIR — So higher risk then, much higher risk.

Mr SPRATT — Higher risk. Interestingly, when we talk about Cradle to Kinder, which is the under-25s, and Stronger Families, which is the risk of going into first time care for the child, the outcomes are really different. For Cradle to Kinder we find that of the 52 there may have been five where the children ended up in foster care, so a really small percentage. For our Stronger Families, which is a placement prevention service, our percentage of children who end up in care is much, much higher. Our view on that is because it is a later catch for those families. So we are over-represented even more so when we look at our Stronger Families cohort of people who have either been in foster care or have been on child protection orders themselves.

Dr CARLING-JENKINS — Thank you for your time, Jason, I really appreciate you coming in and responding to Greg's email. Fascinating programs that you run. I am particularly interested in the long-term engagement that you have of up to four years with some of the women you are working with or some of the families you are working with. You spoke a bit about the qualified workforce. I am wondering about the longevity of your workforce. Do people stick around for those four years, because you work on a relationship, building trust model, community development model. I imagine it would be essential to have a really stable, long-term staff to sustain that.

Mr SPRATT — Yes, so for our Cradle to Kinder program we initially employed three caseworkers, one with MDAS. Of those three, two are still in the position. We are almost through a first cycle. We had people who were referred at the start who are almost about to get out at the other end now, and we have had one change for our Swan Hill staff member, so at this stage —

Dr CARLING-JENKINS — So for that first cycle it has been very stable?

Mr SPRATT — Yes. However, we have had the change from MDAS back to us because of the new program. So in that MDAS retained their staff and we had to recruit a new person, but those families who were already receiving a service from them — we consulted with those people and they remained with MDAS. They did not come back with the staff member, if that makes sense.

Dr CARLING-JENKINS — Sure, so you maintain the continuity for them.

Mr SPRATT — Yes, so they were able to stay with the caseworker, who remained in the program over there.

Dr CARLING-JENKINS — Fantastic. I am quite interested in your work as well with women with learning difficulties and women with disabilities that are over 25. I am just wondering if you could comment more on the difficulties that they face and how you work with them.

Mr SPRATT — Yes. Probably the biggest thing we face is for learning to happen at the same rate as development in the child. So what we find is that we have to augment the way that we communicate with families and deliver information, or to mums with learning difficulties. Early on that is okay because we can refer to health services and stuff like that. It probably impacts more when the child is born and starts to develop and their development is rapid, and by the time we can look at supporting parents to understand cues and understand responses and those types of things, the child has moved into another stage. So we are always chasing our tail with that. That is probably our biggest thing.

Dr CARLING-JENKINS — Are there standard programs that you draw on, or is a lot of this learning on the go?

Mr SPRATT — We try to connect people to disability services where we can, but —

Dr CARLING-JENKINS — Sure. They are not very good at engaging with families, though, often I do not think, particularly with mums with young children.

Mr SPRATT — Not for what we are looking at, no, and a lot of that is based on a parent seeking or a person seeking support from disability services. Our experience is not that the families that we come into contact with are seeking that. They are wanting to look after their kids and they build a relationship with us, and it gets really complicated for those mums when child protection, solicitors and magistrates become involved, so some of the acquiescence that happens for some of those mums is a real challenge for us to be able to support them.

Dr CARLING-JENKINS — Absolutely. I could imagine that is a huge challenge because there is a lot of pressure on women with disabilities not to have children or to give up the children and they fight to keep them, and you are one of the services obviously that is facilitating that and helping them through that process, and then when they have court interventions that must complicate it, as you say.

Mr SPRATT — Yes. Like you say, it is complicated for us. It is, but certainly much more complicated for the families, and again we are talking about people who our experience is do not have significant or do not have consistent attendance at school, so when you might have picked up formal diagnoses of parents early on in life with consistent access to health services, a lot of the parents we come into contact with through these programs in particular have not had that. So sometimes they cannot access disability-specific supports because there is not a diagnosis.

Dr CARLING-JENKINS — Because they have fallen through a gap somewhere.

Mr SPRATT — Yes, so there is then the onus on them or on us I suppose to support them to go to lots of assessments and lots of other things to be able to get some support, but they do not want that. They just want us to give them a hand, so yes, there are some challenges there.

Dr CARLING-JENKINS — Okay, thank you very much, appreciate it.

The CHAIR — Thanks for coming in, Jason. I think we have got one more question.

The DEPUTY CHAIR — Just a quick one. Rachel kind of touched on this about whether you are learning and developing things as you go. With your Cradle to Kinder program, did you base that on another organisation's model or have you grown that yourselves?

Mr SPRATT — When the program guidelines originally came out it was not something that we had implemented. It had been implemented across the state. Our model was something that we had come up with in looking at how we could best support young women in our community I suppose. I say women because they are the ones who are pregnant, so we require the woman. We do not necessarily require the father at the start. So it is a different model than other people provide. Other people do provide a more medical focus to the model and there is a variety, but it is one that we have come up with, yes.

The CHAIR — Thanks for coming in today, Jason, and thanks for the work that you and your team do in this community. It sounds like you cover a lot of bases with a small amount of resources. Thank you for the work you do and for giving us your time today.

Mr SPRATT — No worries. Thank you, everyone.

Witness withdrew.