

TRANSCRIPT

FAMILY AND COMMUNITY DEVELOPMENT COMMITTEE

Inquiry into perinatal services

Geelong — 11 December 2017

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Witnesses

Ms Maree Crellin, Maternal and Child Health Coordinator, City of Greater Geelong – Maternal and Child Health Service.

The CHAIR — Could I welcome to this public hearing Ms Maree Crellin, the Maternal and Child Health Coordinator for the City of Greater Geelong. Thank you for attending here today. Welcome.

Ms CRELLIN — Thank you.

The CHAIR — 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.

We would love to hear from you for 10 or 15 minutes about the maternal and child health care service in Geelong, just bearing in mind that we would love to hear about some differences that the service in Geelong does to cater for your community because we have heard from quite a few maternal and child health services about obviously the standard model.

Ms CRELLIN — Firstly, I wish to thank the Committee for the opportunity to present the maternal and child health perspective on perinatal care for the women and infants in Geelong. I haven't got any PowerPoint presentation and my plan was originally to read what I had submitted. I just want to, firstly, say in the year when maternal and child health is celebrating 100 years of service it is really timely to reflect on how the lives and the needs of families, although really vastly different to what they were in 1917, there is still so much that is the same. It is vital that the value in both social and economic terms of prevention and true early intervention is not diminished or overlooked. So often we hear about early intervention being supporting families just before they'll get into Child Protection, or just before this, where for me early intervention is way, way back on a continuum of service and I think that's the true role of maternal and child health; its core to its service. I think we've got to make sure that that is not diminished or overlooked when we are responding to the needs of vulnerability and that the capacity of services to continue to deliver true universal service is maintained.

As evidence emerges and is introduced into practice there is a risk of these services, such as maternal and child health, and we often hear it with GPs in schools, that really crowded curriculum that we keep on having to absorb more and more and that's usually the cost of other services or other components of the service that has been revalued. Vulnerability comes in a range of guises, which I'm sure you are all aware, and can be intermittent; it can be persistent or chronic and certainly can be resolved with timely and skilled intervention.

The MCH service in Geelong manages the unit within the City of Greater Geelong, which is called Community Child Health, so it's a bit broader than your maternal and child health; we've got our universal maternal and child health service and we respond to — we're heading up towards about 3,000 births a year. We also manage the service with Queenscliffe as well and they have 14 births a year, so there's a bit of a difference in the sizes of the service.

Within the unit we also have our Enhanced Maternal and Child Health Service and we also have three programs that are funded by Department of Health and Human Services. We have the Integrated Family Services; Parenting Assessment and Skill Development and an infant component of the Stronger Families Program, and I'm happy to explain those if you want further details.

The CHAIR — I think we have heard a lot about those programs.

Ms CRELLIN — Today the MCH service continues to keep the infant at the centre of their care, supporting care givers to be the best they can be and keeping in mind what is it like for the infant to experience this parenting? What is the quality of the parenting, what's it really like for the infant? For all of us who are parents, we all know that the transition to parenthood can be one of life's most challenging events and I think often one of the hardest transitions. We talk about children transitioning from kindergarten to school and primary school to secondary school, etcetera, and all our different transitions we make as adults, but I think becoming a parent is probably one of the greatest challenges.

The limitations of the capacity of the maternal and child health service are reflected in the funding model. We talk about we know the importance of providing quality care and education to parents. The core component of the maternal and child health service actually offers 6.75 hours over a four-year period so maternal and child

health achieve a huge amount and it is highly valued by the community. That's basically the funding model based on key ages and stages and additional consultation.

I have been in this position since July 2001. Does the current funding model actually provide the capacity of the service to meet the needs of the community is one question? I well and truly understand that that would have financial implications for both governments as well if it was changed.

Safety of care is enhanced with timely and comprehensive communication between and across service systems. Just listening to the previous presenters, I think they highlighted that as well. Poor communication is a common theme when reviewing cases where the outcome has been less than optimal. Providing adequate tools for services to safely communicate is fundamental. Service providers' responsibility is two-fold: to provide the communication, but also to act on that that we receive as well and to make sure that it's accurate.

The communications system or methods, there's really no common statewide service. We looked locally after the Coroner's report, we did a lot of work, and we looked at what systems are out there for us to communicate safely with GPs and there is a couple out there but there are really no statewide services. There is something called Referral Net which equips staff with information but then that means it's up to local services to get onto that themselves.

The CHAIR — Maree, you are not using one at the moment?

Ms CRELLIN — No, we're not. That comes down to time and communication. Going onto the impact of the loss of the Perinatal Emotional Health Program, we've been involved in that since it first came in and I sat on the steering committee throughout its tenure. In conjunction with the St John of God Raphael service, there was a real continuum of service response to women and their families. The loss of the Perinatal Emotional Health Program left a significant gap in the services that I believe is yet to be filled and certainly increased the need for the maternal and child health to continue to absorb that care of those women. The previous model of PEHP was really flexible and actually it fitted the women rather than the women having to fit the service, which is common across many services where we expect the families to fit with us rather than us being flexible.

I was also involved and sat on from the beginning on the steering committee for the Raphael Centre at St John of God as well and due to a lot of internal changes in St John of God that service has recently changed as well. For most of us, service delivery women could self-refer, or maternal and child health could refer to that service, but that's has now changed and again it's a GP referral. So again picking up on what was spoken to previously. Having to make that GP referral is a real barrier to accessing services as a woman is already vulnerable and at risk and if dealing with the basics of day to day care of her infant, herself and her family is more than she can manage in a day, then organise to go to a GP, there's a real delay and can be a real barrier and, as mentioned before, a financial impost on families.

Ms McLEISH — Is there also a positive in actually going to the GP?

Ms CRELLIN — I certainly recognise the need in GPs needing to be involved in that medical care but it's that first step, that referral. Often maternal and child health would have the woman sitting there and they would actually ring and the woman would be able to talk to Raphael there and then so it's immediate. That connection is already there, but if then you have to leave maternal and child health, go home, make an appointment with your GP, get to the GP, there's often a delay and women are already at risk.

From a service response that offered services across the continuum for maternal and child health, to Raphael, to PEHP, and then to secondary and tertiary I think there's a real gap, especially in that primary to secondary level services. There is also, from our perspective, a gap in secondary level services available to support and intervene for infants at risk or experiencing compromised mental health too. In perinatal, we need to remember and keep in focus the infant, because it's not just the woman that could have mental health compromises but also infants experience it as well. And certainly, recognise that CAMHS service is there but, again, the level of need to get into CAMHS might be too high and there is that gap in secondary service.

It has been widely stated that families are becoming more complex and the universal maternal and child health service achieves amazing results; however, it holds many complex families with no capacity to respond in a meaningful way unless other families miss out. The level of risk held in the universal MCH service is high and increases the risk for both the individual professional and organisation. I really want to acknowledge the

significant increase in investment being made by the state government into the enhanced maternal and child health service and we are eagerly awaiting guidelines so that we can look and review the way that we deal with our multi-disciplinary enhanced service as well. Also, I want to well and truly acknowledge the additional funding going into the universal services that are going into family violence as well. It certainly adds to the capacity of the service.

The CHAIR — Maree, do you mind if we start asking some questions?

Ms CRELLIN — By all means, yes.

Ms EDWARDS — Thank you, Chair. That was a good note to finish on, Maree, I had some questions around family violence in relation to the impact on the role of maternal and child health nurses, particularly in relation to home visits and referral or support that are given to women when you have identified that there are family violence issues amongst your client group, just where that funding is going to support you in terms of your role but also in terms of how you refer, what you do.

Ms CRELLIN — In regards to home visits, initially just as straightaway there's obviously significant occupational health risks to our staff and where we have got our home risk assessment we've got a whole range of safety cards so we have tried to minimise the risk as much as possible.

Ms EDWARDS — Are you aware that there is a risk before you go to visit a family or is it just perhaps something that you find out once you get there?

Ms CRELLIN — We ask before we go when we are confirming the home visit, we ask whether there has been any history, whether there are firearms kept on site, it's just something we have worked on and recently introduced, if there is anyone who has got a history of violence. But going back to communication, often there can be an incident that happens in a maternity service but we are not necessarily aware of that as well before we go out and do a home visit.

Ms EDWARDS — If you actually do a home visit and you identify that there is family violence being experienced and you are the first point of call, what is the next step for you?

Ms CRELLIN — Our next step would be arranging a conversation with the woman to see what her safety plan is and to start that conversation. It would be unusual for the woman to disclose at the home visit. The maternal and child health at the four-week Key Age and Stage has got a specific question but often the partner is still on his paternity leave so we then have to make sure that we ask further down the track. Then referrals are made to the local services and we've got a little card that says notify so we would be able to give that to the woman at the appropriate time.

Ms EDWARDS — How many maternal and child health nurses are there in Geelong?

Ms CRELLIN — We've got 20.5 EFT allocated to the centres plus we've got 1.6, which we use for school holidays, annual leave, and we've also got access to casuals.

Ms EDWARDS — Is that enough for your workforce to cover your needs?

Ms CRELLIN — Yes, and we certainly haven't had any issues with recruitment recently. We never meet the demand for student placements, I think that's one impost that local government meets and for a variety of reasons we can take four maternal and child health students at the one time, but we have to be careful, we want to provide a quality placement for those nurses, but we also want to make sure that we are not reducing the capacity or the quality of service that we provide to the community as well.

Ms McLEISH — Just on the 20.5 EFT, how many people is that?

Ms CRELLIN — Around about 35.

Ms McLEISH — Does anyone work full time?

Ms CRELLIN — There's 10 full timers. We also have a multi disciplinary team within our universal maternal and child health program, we have what we call Child and Family Support Officers and they support

the new parent groups and they also provide support to families with sleep settling, very much within normal development, or what can be expected, but it is additional support. Sleep settling, playing development, managing behave.

Ms McLEISH — A number of the services that we have spoken to that have given evidence at our inquiry have talked about the increase in complexity for birthing mothers, particularly the body mass for diabetes. How does that translate for your services? Does it mean you do something different or what alerts do you have in those instances?

Ms CRELLIN — The greatest impact we have is on babies being discharged from hospital to home when they are less than 2.5 kilos, because they are still very tiny babies. We won't pick them up until they are at least 2.5 kilos, I believe the risk is too high for us as a primary preventative.

Ms McLEISH — Do many babies get discharged at that weight?

Ms CRELLIN — There has been a number of babies that go home under 2.5 kilos. They are still seen as receiving service from the hospital. It certainly raised some issues for us in the private sector, St John of God was sending babies home 2.1 kilos and we were saying we won't pick them up, so families are actually having to access their private health insurance to cover additional domiciliary visits.

Ms McLEISH — And most visits would come through the hospital?

Ms CRELLIN — Through the hospital.

THE CHAIR — Sorry to interrupt. So, the hospital is not providing any external care in the house or helping out at all with checks?

Ms CRELLIN — They go up until the baby is 2.5 kilos and then we would pick them up.

Ms McLEISH — Can you tell me the involvement you have with mothers who have had a stillbirth or an infant death?

Ms CRELLIN — The legislation says that we need to make contact with families from the birth. We made a decision some time ago, especially if we don't know the family, that we actually send a card to a mother who has had a stillborn, expressing our sympathy; we felt it was too much of an intrusion to families, they don't even know that maternal and child health exist, especially if it's their first baby. If we actually know of a family, then the nurse will ring the mother and send a card to express our sympathy.

Ms McLEISH — What sort of take-up do you get?

Ms CRELLIN — Of seeing mothers following? I would say none. We send the card and we send information regarding other services that are out there.

Ms McLEISH — What does make contact mean?

Ms CRELLIN — It can either be a phone call or a card.

Ms McLEISH — So you don't physically have to speak to anybody, the contact is just sending somebody a card?

Ms CRELLIN — And saying if you need us, here we are.

Ms McLEISH — Is that adequate?

Ms CRELLIN — I believe it is.

Ms McLEISH — But no one comes to you?

Ms CRELLIN — No. But we haven't really got — —

Ms McLEISH — So maybe it's not working.

Ms CRELLIN — My sense is that for a mother to come to an appointment, if she has experienced a death—if a mother would ring and would access our service we would certainly offer something to her but it's not something they seek out.

Ms McLEISH — We have heard evidence from those who have dealt with stillbirth and that that sector seems to be a gap so the legislation requires contact but people don't seem to be picking it up.

Ms COUZENS — Thanks for coming along today. In terms of the enhanced home visiting program, how do you determine the vulnerability, which areas or individuals, how is that determined?

Ms CRELLIN — We look at the service guidelines provided by the department which provide a whole range of different risk factors. At this stage the way that our service has been delivered, they need at least a minimum of those two risk factors.

Ms COUZENS — What are the risk factors?

Ms CRELLIN — Risk factors would be mental health, intellectual disability, I've gone blank, sorry.

The CHAIR — It's all right; take your time.

Ms CRELLIN — Substance abuse. Involvement in child protection — the parents may have been involved in the past with child protection. Prematurity. I'll look at my colleague behind me. They would be the main ones. The four main ones are mental health, substance abuse, intellectual disability or child protection.

Ms COUZENS — Is family violence in there?

Ms CRELLIN — Well and truly, yes.

Ms COUZENS — So how many of those clients would you have?

Ms CRELLIN — Our target is 247 for this year.

Ms COUZENS — So you have a target rather than meeting need; is that right?

Ms CRELLIN — The funding is based on targets so it is 247 this year with an average of 17 hours per family.

Ms COUZENS — And is that your target?

Ms CRELLIN — It changes each year depending on what our data is.

Ms COUZENS — So are you working directly in with the Aboriginal community, for example?

Ms CRELLIN — Yes.

Ms COUZENS — Can you explain what you are doing there?

Ms CRELLIN — We are partners in the Mingo Waloom, which is the Aboriginal Best Start. We have supported the Wathaurong community in their Aboriginal Maternal Child Health initiative and prior to that we had a nurse working from Wathaurong as well. We were very much involved in the snake flyer, which maternal and child health have got a caterpillar flyer and we developed a snake flyer and posters.

Ms COUZENS — So is the nurse still going out to Wathaurong?

Ms CRELLIN — They have got a nurse themselves at the moment. And we've been providing support along the way there too.

Ms COUZENS — So Aboriginal people that are not accessing Wathaurong, for example, how are you targeting them across the region?

Ms CRELLIN — We would be inviting them to maternal and child health services.

Ms COUZENS — So there is no specific target around that vulnerability?

Ms CRELLIN — No. Our assumption is that if they are accessing our universal service, then they've got the choice of going wherever they like.

Ms COUZENS — But if you have contact with them initially you don't do any follow up?

Ms CRELLIN — If they have missed an appointment we would well and truly follow them up, yes.

Ms COUZENS — Is there anything else you would do in terms of that vulnerable community? Do you have a plan to target those vulnerable communities or individuals?

Ms CRELLIN — Part of our service improvement plan this year is to try and do an audit to make sure that all of our centres are as culturally inclusive as possible. Again, talking about the flyer, we are hoping to be able to pull those out and adapt the information packs that we give to families. We've got a copy of the apology in all of our centres so we're working towards making sure that our centres are as inclusive as possible.

Ms COUZENS — In terms of the centres, how do you determine where they are located?

Ms CRELLIN — As in where they are built or where families go?

Ms COUZENS — Yes. Some are operated from hybrids.

Ms CRELLIN — Newcomb shares a foyer with the library. As you are aware, the city has got a range of infrastructure plans at the moment, we are working very much towards reducing the number of stand-alone maternal and child health centres that we've got. We've certainly been focusing in our north; there's always been more centres than what there would be in say in a high socio-economic area, believing it increases the accessibility of the services.

Ms COUZENS — Has the service to the Whittington centre been reinstated?

MS CRELLIN — We operate on Tuesdays at Whittington. We actually surveyed families – it was only a short survey looking at families that go to Whittington and those that go to Newcomb. There were some families who didn't want to go to Whittington and some it suited and some it didn't. There was really no real direction either way.

Ms COUZENS — But that service is still being provided?

Ms CRELLIN — Yes.

Ms COUZENS — Thank you.

THE CHAIR — Good morning Roma Britnell, member for South-West Coast.

Ms BRITNELL — Thank you. I have just got a couple of questions on policy issues. You talked before about the occupational health and safety risk of entering houses and you talked about developing a policy. And then I also heard you talk about the low birth weight risk and not taking babies on until they weigh 2.5 kilos. These policies that you are developing, are they coming from a central source and you are adapting to your regional need, or are they something you start from scratch and develop for your service specifically?

Ms CRELLIN — That home risk assessment was something that was included in the new data base and it's something that we have been working on for a long time down where as well.

Ms BRITNELL — Is there a central element to it and you adapt it?

MS CRELLIN — It's a bit of both.

Ms BRITNELL — Where is that coming from? Is that the Department of Health and Human Services?

Ms CRELLIN — Department of Education and Training.

Ms BRITNELL — With regard to the policy, I just want to clarify something. So in the public system there will be domiciliary services up until 2.5 provided by the hospital but in the private system there's the gap that the families have to use private health to access?

Ms CRELLIN — For the hospital to continue to provide a domiciliary service.

Ms BRITNELL — If the family choose not to do that, the baby is not serviced until it reaches its 2.5 kilos?

Ms CRELLIN — Yes.

Ms BRITNELL — I just want to seek clarification on the target issue that you discussed that you've got a target of 247.

Ms CRELLIN — It changes every year.

Ms BRITNELL — So every year you look at your vulnerable client amounts that you saw and then add 10 per cent or do the same and what happens if your demand grows, how do you service that need?

Ms CRELLIN — We don't set the target. The Department of Education and Training sets that target.

Ms BRITNELL — So it targets you to find 247 — —

Ms CRELLIN — We haven't got any trouble finding them. I guess with our outreach service, because we also deliver the integrated family service, we don't deliver a traditional family support service, we provide basically an enhanced maternal and child health program. That has got a target of 105 members as well.

Ms BRITNELL — So if you have no trouble what happens to the people who you can't meet the need of?

Ms CRELLIN — A lot of the time they sit within a universal service. We offer a family this or you can have that. Sometimes the families will continue to access the Key Ages and Stages of the universal maternal child health program, and we offer additional support.

Ms BRITNELL — So the universal one has so many visits per annum?

Ms CRELLIN — 10.

Ms BRITNELL — And the vulnerable families?

Ms CRELLIN — We can offer them additional consults, but that goes back to the funding — —

Ms BRITNELL — So how many usually does a vulnerable family have?

Ms CRELLIN — It would depend on need.

Ms BRITNELL — Thank you.

Ms McLEISH — Just one other question. What is the breast feeding rate like after one month and six months?

Ms CRELLIN — I'm not sure, off the top of my head. Certainly, in my submission you will see that I really believe that breast feeding support is imperative and I think as a community if we are really serious about improving breast feeding rates it really needs an investment similar to other — —

Ms McLEISH — Can you have a guess at what the breast feeding rates are?

Ms CRELLIN — I can provide that to you.

Ms McLEISH — The reason I ask is with KMS, there is 63 percent of women continue to breastfeed after six weeks is the information I have and I wondered how that compared?

Ms CRELLIN — I'm usually pretty good with figures. Around about six months, I believe around 30 and 35 per cent. But more than happy to send that through.

The CHAIR — You're getting nods and smiles.

Ms CRELLIN — Thank you.

The CHAIR — Any other questions from the Committee? Maree, thank you so much and your recall of numbers and data today. Thank you for your time today and thank you for your incredible work.

Ms CRELLIN — Thank you.

Witness withdrew.