TRANSCRIPT

FAMILY AND COMMUNITY DEVELOPMENT COMMITTEE

Inquiry into perinatal services

Melbourne — 18 September 2017

Members

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Mr Bernie Finn

Witnesses

Ms Lynne Smith, Acting Team Leader, Family Services, and
Ms Patti Reilly, Acting Family Health Coordinator, City of Melbourne.
The CHAIR — I welcome to these public hearings Ms Lynne Smith, acting team leader family services, and Ms Patti Reilly, acting family and health coordinator, from the City of Melbourne. Welcome. 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 to have a look at. I now invite you to make a 10 to 15-minute presentation to the committee.

Visual presentation.

Ms SMITH — Thank you. The City of Melbourne welcomes the opportunity to make this submission. Both Patti and I are registered nurses with qualifications in midwifery, maternal and child health and immunisation. Patti also has a qualification in lactation. We acknowledge that there is a great deal of work being done in this area by all involved. We also believe that there is a more holistic approach to perinatal care which facilitated better outcomes for all, particularly vulnerable families and children at risk.

As you can see, our service is part of the broader multidisciplinary healthcare network. At the City of Melbourne we have developed a hub model of care so that all three areas of our team — maternal and child health, family support and counselling, and parenting services — work collaboratively with the aim of better outcomes for all of our children and families. The maternal and child health program is jointly funded by state and local governments.

The City of Melbourne has a funding agreement with the Department of Education and Training to provide the core maternal and child health service to our community. In accordance with the Department of Education and Training framework our service provides 10 key age and stage consultations from birth to three and a half years of age. We also offer further services, including, for example, breastfeeding drop-in clinics, open sessions, new parent groups, playgroups and parenting information programs. The eight maternal and child health centres at City of Melbourne are located in Carlton, Docklands, East Melbourne, Kensington, two centres in North Melbourne, Southbank and the central business district. They are all staffed by maternal and child health nurses.

Under the Child Wellbeing and Safety Act 2005, when a baby is born to a mother residing in the City of Melbourne, the birth notice is sent to the service within 48 hours of the delivery. The new mother is contacted to arrange an initial home visit and subsequent appointments. The City of Melbourne community requires an agile service delivery model as it deals with a range of complex interrelated factors. As you can see up there, they are our cohort of people that access our services. The 2016 census shows our residents came from 159 countries, and 63 per cent of residents came from overseas. China, Malaysia and India made up the largest groups. Also I have got some data from the Australian Bureau of Statistics. In 2013, 35 000 international students were in the City of Melbourne, and 11 000 of them came from China.

I am just trying to build a picture of what we are dealing with. The City of Melbourne community experience isolation, limited or no extended family support, language difficulties, lack of awareness of services, limited access to services and support, lack of access to Medicare, mental health issues, an increase in disclosure of family violence, health outcomes and an increase in developmental delays as well.

Regarding our service, we have got some data which was part of the submission that we put in. So in the 2015–16 financial year, as you can see, we had 1433 enrolled infants. Our birth notifications were 1261, as you can see, but we had 12.6 per cent from other enrolments as well.

Ms EDWARDS — What does that mean?

Ms SMITH — It means that we had more families coming in that first year, so not necessarily from birth notices, as well. They might have birthed somewhere else or they may have come from overseas or something, sometimes in that perinatal period. And 70 per cent of our families in that year were first-time mothers. As a new parent naturally requires additional support, especially in perinatal care — they commonly have high levels of anxiety coupled with some of the complexities mentioned due to isolation, limited or no family support, language challenges, mental health issues or no Medicare cover — it is essential that we ensure there is a seamless transition from one caring centre, the hospital, to the next, community. Many families, we experience,
do not even have an understanding of the maternal and child health service, so when we contact them they did not know that we are even there, so that is the starting platform for us.

Also just from the beginning of this year until now 10 per cent of the birth notifications that we receive from the hospital had incorrect information in them, which created a delay in us getting in to see these families or ensuring that they went to the right council where they were residing. Some of the information on the birth notice might have had an old mobile number that was initially given or an address that was given to the hospital when they first enrolled, so there is a delay in then trying to connect up that family with the right place. As a result the families often are unsupported in the crucial time when they really need that support with newborns.

Ms REILLY — The key issues that we want to discuss with you today are service integration and coordination, limited availability of in-home care, and communication between hospitals and the maternal and child health service. We feel that all these issues impact on the health and wellbeing of whole families in the perinatal period. We know that this period is one of increased risk and vulnerability for all new mothers and babies, with adjustment to parenting and social isolation, especially living in a city or an apartment with no family support nearby or experiencing cultural dislocation. When there are mental health issues — a history of anxiety, depression or other mental health issues that are related to illness — these often emerge post-delivery. And family violence: we know that the perinatal period is one of increased risk of family violence. These three issues that we have identified can affect the timely exchange of information and also the introduction of the maternal and child health service, and this can exacerbate an already existing vulnerability or create the situation for further vulnerabilities to emerge.

The first issue we have identified is inadequate service integration and coordination. The very premature and sick babies experience better discharge planning than healthy babies, but even then it is not without issues. Maternal and child health staff are often informed of the discharge of these babies after the fact and are not included in any discharge planning process. The lack of information can lead to a delay in the maternal and child health service getting into the home to support the transition of care to parents. This can impact on breastfeeding, bonding and the mental health of all family members. This situation is amplified when a special care nursery is situated in a private setting.

One example I have thought of to highlight this with you is low birth weight babies. Babies used to be kept in hospital until they were 2.5 kilograms. That was considered a weight at which they could maintain their temperature and have enough energy to feed well. Now we are finding babies are discharged at 2 kilograms and often do not have enough energy to feed very well. We are not notified that they have been discharged at that low weight, so we have had the experience — and one of our team had the experience last week — of going into the home and finding a very unwell baby that was extremely dehydrated and required readmission for hydration. And because we were not notified — there is no coordination between discharge and pick-up of our service — there was no impetus to get in their early. Had we been informed, we could have sent someone in earlier to prevent that from developing into the situation that it did.

The next issue we have identified is inadequate in-home support. The pressure on all services within the system can mean that Hospital in the Home is available for only a limited time, and this can place pressure on the maternal and child health service to fill the gap. There is no case conferencing or joint discharge planning between hospitals and maternal and child health services, and that can lead to a delay in maternal and child health services being delivered. There are ongoing issues associated with transitioning high-risk, premature infants into allied health services such as occupational therapy, speech therapy and early intervention, and the role of brokering these allied health services often falls onto the maternal and child health nurse. This is an important fact because we know that early intervention is the key to reducing ongoing developmental delay. There is no in-home care for mental health issues and very limited community resources to deal with mental health.

Domiciliary services are under pressure with the current hospital discharge policies. They work hard to communicate with us and they have some flexibility, but this is limited. The lack of any agreed communication pathway between domiciliary services and maternal and child health reinforces the ad hoc nature of communication between the two, making it unreliable.

For families where family violence has been identified, in the hospital there is a decision not to send domiciliary staff in to do a home visit. While this is understandable for the safety of the staff, it leaves women and children
in a more vulnerable position, with fewer people watching out for them, isolating them further at a time that is universally identified as one of extra risk for family violence.

Again private hospitals provide neither Hospital in the Home nor domiciliary services. So women who deliver there have none of those options I have mentioned.

The final issue we have identified is communication, although they are all tied in. Communication between hospital staff and maternal and child health staff is reliant on individual members, and as a result this occurs in an ad hoc manner and is unreliable. There are no robust systems of communication between the two, and there is no shared digital platform. One example of this is when a birth notice is generated. A birth notice is generated for every baby that is born, as Lynne has mentioned. Babies that go to special care nursery have a stamp placed on the birth notice that says ‘admitted to special care nursery, please phone’. They are processed differently within the maternal and child health service because we need a nurse to talk to them and not an admin person who would normally make the appointments. They are processed differently under the assumption that the mother and baby are separated or that the discharge is not imminent, although often that occurs even if a baby has been in a special care nursery for an hour. So this again just highlights the poor communication or the lack of robust communication channels in which that information can be shared.

Another example again is family violence. If family violence has been disclosed while a woman is in the hospital, the domiciliary services do not visit the hospital, rightly, to protect their staff. However, that information is not uniformly shared with our service. An example of this occurred last week, when I was on the phone to a social worker from a tertiary-level hospital who informed me that a mother who was living in our area had had an unborn child protection notification made — so that occurred quite a while ago — and postnatally had disclosed family violence, and as a result their service were not going to go into the home. She was ringing to let me know that. So that was one of the occasions when communication did occur, and I went to make sure that our staff were aware and to let them know that they could go in as a two-nurse home visit, but our home visit had occurred 3 hours earlier. So the communication was made but not in a timely manner that made it worthwhile for the safety of our team.

When the communication is not made in a timely manner, there can be a gap in service provision for these families, and particularly the newborn infants, and that is when they are at their most vulnerable. Poor communication can also be as simple as staff from the obstetric hospital not telling a woman when her appointments are, and if that woman is from a culturally or linguistically diverse background where English is not her first language, navigating the systems to try to find that information on the phone is really challenging. So this again just highlights the poor communication or the lack of robust digital platform, that is time consuming for our team as well.

Ms SMITH — In summary, we acknowledge that Victoria has a world-class child and family service. Nevertheless, our mothers and babies deserve and require a better coordinated service that is less reliant on ad hoc goodwill. There needs to be a systemic change across the multijurisdictional service platform, including stronger interface collaboration, improved communication and robust early identification and assessment of vulnerabilities and risks. It needs to involve acute allied health and community-based support services across the public and private health systems. We need a shared platform. Further consideration could be given to appointing a maternity liaison officer who has detailed knowledge and experience in hospital and community. Thank you once again for the opportunity to speak today, and now we ask if you have any questions for us.

The CHAIR — Thank you, Lynne, and thank you, Patti. We do have some questions. My first one is just to clarify — and I think I know the answer to this, but I just want to have you clarify for me — to improve the gap in service provision and to improve the safety of staff, you would recommend that maternal child and health care nurses or the service is notified pre discharge instead of post discharge, that we have case conferencing and that we have a shared digital platform and some robust systems in place.

Ms SMITH — That is correct. That is what our submission pretty much says.

The CHAIR — Thank you. The other question I have got is just in regards to our international cohort. What supports do women without access to Medicare, being refugees, asylum seekers and women on international student visas, receive?

Ms REILLY — We are it.
Ms REILLY — They have no access. All the early parenting centres, such as Tweddle or the O’Connell Family Centre, you cannot access, and that is where you would go if you had issues with a very unsettled baby or a mother with some depression. They cannot access any of those services. So maternal and child health services is it.

Ms SMITH — They do have private health insurance, some of them, so they can use that to use GPs and other allied health. But predominantly they cannot access —

Ms REILLY — Yes. That system is challenging. The process to do that is made challenging, so often they just do not go through with it.

Ms EDWARDS — Thank you for coming in. I have a couple of questions. How many maternal and child health nurses are there in the City of Melbourne?

Ms REILLY — Twenty-six.

Ms EDWARDS — Covering a population of? What would be your annual case load?

Ms REILLY — Fourteen hundred.

Ms SMITH — Birth notices. We have had other data. I think we did 1422 birth enrolments last year.

Ms REILLY — That represents the babies that are born in the City of Melbourne, so that does not include families that move into the City of Melbourne with children and access the services.

Ms EDWARDS — And what training do maternal and child health nurses have in cultural awareness and languages to support CALD families?

Ms REILLY — We have training that is provided by the department of education twice a year, and often that involves cultural awareness training. Training around cultural awareness with the Aboriginal and Torres Strait Islander group has been quite predominant in our training in the last few years. Around CALD families, we work with Foundation House and other providers of services for CALD families, and our team is encouraged to access that training as well as the training through the council.

Ms EDWARDS — And do you have training to support you as maternal and child health nurses to actually support women and children in family violence situations?

Ms SMITH — Yes, we do. We all did training initially when it was first rolled out in Victoria, and we are going through the CRAF training again at the moment. All of our nurses are doing that training again to refresh their training.

Ms EDWARDS — Where family violence has been identified, what supports do those women receive from you and your services?

Ms REILLY — We have quite a distinct pathway that is followed by all of our team when a mother discloses family violence. It involves ensuring her safety, creating a safety plan, giving her information in whatever way is safe for her to take and offering a referral to our family support and counselling team or to Women’s Health West or another women’s health service. If there is any concern about the safety of the child, the flowchart requires a notification to child protection. So it is very prescriptive. There is a very strong line of action that needs to be followed, and our staff are supported after that by a line manager. They need to speak to a line manager if they have any issues, and then they are supported in that way.

Ms EDWARDS — In terms of the domiciliary staff that you said would not go into family violence situations, are they not trained in family violence?

Ms SMITH — We cannot answer that. That is not our area.

Ms EDWARDS — When that happens, obviously there are women and children falling through the gaps because of that. You would pick up those that are referred to you, but what is the answer to that if the domiciliary staff are not supporting women and children in family violence situations? Who fills the gap?
Ms SMITH — I do not think that they are not supporting them. The families are encouraged to go back into the hospital for that postnatal care.

Ms EDWARDS — Okay. That is what I wanted to know.

Ms REILLY — They just do not get it at home because they do not have the capacity to go into the visit together. That staff member from the domiciliary service would have to go into the home on her own, whereas we have the capacity, if we are informed of the situation, to send two nurses in, and one would be very experienced. So I suppose we are more agile in that sense, whereas they are in a car driving round all day. They do not have the ability to double up.

Ms EDWARDS — So those women and children who might be in that family violence situation have to relocate back to the hospital until such time as — what happens?

Ms SMITH — Our service comes in.

Ms EDWARDS — Until you come in.

Ms REILLY — So instead of getting the routine postnatal domiciliary visit that they would receive if they delivered in a tertiary hospital, which is at least one visit if not two, they are required to re-attend the hospital.

Ms SMITH — That is our understanding of what happens.

Ms REILLY — If there is family violence identified and domiciliary will not go in.

Ms EDWARDS — So that means they are actually reoccupying a hospital bed.

Ms REILLY — No. They do a ward visit, but it is an impost on the woman. Often she has just delivered within the last week.

Ms EDWARDS — Yes, to have to travel back to hospital with the baby. Thank you.

Ms SMITH — Maree, we have got part-time maternal child health nurses as well, not all 26 FTE.

Ms EDWARDS — I was thinking that when you said 26.

Ms McLEISH — What is the EFT?

Ms REILLY — Sixteen. It has just changed.

Ms SMITH — Sixteen EFTs.

Ms McLEISH — Thank you, ladies. Can you begin by telling me your definition of the perinatal period? What do you use?

Ms SMITH — The perinatal period is before the baby is born up to 20 weeks of age.

Ms McLEISH — How far before the baby is born do you look at it? You do not get notified anyway, I suppose.

Ms SMITH — Sorry?

Ms McLEISH — You would not receive the notifications at that point anyway, would you?

Ms REILLY — No, we do not get a notification until the baby is born.

Ms SMITH — No.

Ms McLEISH — So until what period?

Ms SMITH — Up to 20 weeks of age. About the antenatal period are you asking me?
Ms McLEISH — Until 20 weeks.

Ms SMITH — Yes.

Ms McLEISH — We have just seen several definitions, so I just wanted to get that sorted. The time frames that you also mention about the 48 hours and the different things that you do, are they statewide or are they ones that you have put in?

Ms SMITH — That is the legislative requirement.

Ms McLEISH — You do not go for stretch targets at all?

Ms SMITH — That is the legislative requirement. Occasionally we will not receive a birth notice within those 48 hours, so there might be a little bit of leeway.

Ms McLEISH — Something like not sending the workers into the home with family violence, is that something that is standard practice across all municipalities, do you know?

Ms SMITH — That is not our area. We just know about who we work with at the moment and the experience that we have with the hospitals that we work with, so it is hard to speak for the hospital sector across.

Ms McLEISH — One of the things that has been quite clear is that the notification system is not perfect. There is incorrect information and getting it too late. What are the reasons for that happening?

Ms SMITH — I guess, once again, we cannot answer for what is happening in the hospital, how they are engaged in prenatal care and what information is taken down in the hospital. All we know from our experience is that when we get that birth notice often the birth notice has an old mobile number and is not a consistent birth notice. We need to go back to the hospital to try and get another contact number to get in touch with that family. Occasionally also we have to go in and do a cold call: we have got an address, but we have not got an active phone number that we can contact that family on. Once again that puts our staff a little bit at risk. We do not know what we are going in for. We have not had a conversation with the family.

Ms McLEISH — You hope that they live at that address.

Ms SMITH — Often they do not. Our experience in the City of Melbourne also is that sometimes the address is given to birth at particular hospitals because that is where they want to birth, but in fact they do not live there; they live well outside. I am sure you have heard this all through the inquiry. Once again that is the delay in getting the service in, connecting and transferring that to the next local government to pick up that family. Also quite a few of our families in that initial postnatal period will go and reside with their parents or a relative for support, naturally, and we also need to do that. In the ideal world, on discharge, to have that shared information for us could stop that whole delay. The contact should be wherever they are going to be residing.

Ms REILLY — That information is given when a family attends the hospital to enrol to birth there. They are often about 10 weeks pregnant, and 30 weeks later they have the baby and things change but nothing is double-checked. A simple way of preventing a lot of that would just be checking details at the 36-week check.

Ms McLEISH — How do you handle it if somebody who does live, say, in Carlton then goes to reside with their parents who live in Werribee or something like that? What is your role then?

Ms SMITH — Our role is then to contact wherever they are staying. We hand it over to them and say that they will be there for a period of time for maybe the first 12 weeks or for cultural confinement or something with her mother. Then we communicate with the family as well and we have communication with the local government then, so when they come back to us we pick them up again.

Ms McLEISH — And that seems to work seamlessly?

Ms SMITH — It does. It works well.

Ms REILLY — It is a lot of work, though, because you leave messages. It can be time-consuming making the connection between the message leaver and the receiver, and that can delay the introduction of the service to
the family from where they have relocated. All of these things impact how quickly the maternal and child health service can get in to help support the family.

Ms McLEISH — That is really good information to hear. Finally, I have got a question around mental health. We are talking here about mental health support services. We have had a lot of submissions that raise that as an issue. What sorts of services are missing, do you think, for the women, or what would be the number one thing that you would put in place in that area?

Ms REILLY — We are lucky we have access to quite an innovative program that is running through St Vincent’s.

Ms SMITH — We have access to a registrar in psychiatry. It is a good resource for us at the City of Melbourne. If someone has identified with mental health issues, the process then would be that they would need to go to their GP. Maybe it has been disclosed in the postnatal period or during the pregnancy. They might have been accessing psychiatry at the hospital. They might have a little bit of support from the hospital in the immediate postnatal period, but then after that it is for the community to pick up. It is about resourcing and getting a GP to make a referral to a psychiatrist or a psychologist for the family to help in that way.

Ms REILLY — For a family that is quite unwell or for a woman who is quite unwell who is post delivery with a young baby and possibly has no family around, that is a lot of work. That can sound quite simple seeing a GP, but that is a lot of work and often does not occur. Ideally you would have a lot of services that we would be able to refer families to where they could instantly or in a very short time period be picked up and supported to ensure their and their children’s safety.

Ms SMITH — Often they do not have GPs either, so we are a starting point. We have got to get them into that point then to get them a referral.

The CHAIR — Just before we go to Roma, Maree and I were just wondering if the City of Melbourne has access to the electoral role, and does that provide any source of information for addresses and whatnot?

Ms REILLY — That is a good question. I do not know the answer to that, Paul.

The CHAIR — If you do, it could be utilised. I imagine that you would have access to it. It might be a tool you could use. I would love to hear if you actually do have access to it and if it could be used.

Ms SMITH — Sure. We can look into that and provide that for the committee.

Ms REILLY — We have quite a large transient population through the City of Melbourne that arrive here on a one-year contract to work in one of the IT firms, and they are gone 12 months later and have not enrolled in anything.

Ms BRITNELL — I have just a couple of questions, and one goes back to the inefficiencies of data challenges. What ability do you have to be able to use the health department, given you are local government, to actually help you iron out those challenges? Because exactly what you said was the obvious thing occurring to me — that you just get someone to do it at admission time to check the initial, which I would have thought was standard practice in every triage system I have ever seen. Human failings occur, but if you are getting 10 per cent that is quite inefficient and if you are then having to spend a lot of time on the phone before you can even go and do your visit, it is reducing services. What ability do you have to put those sorts of challenges to the health department and ask for their assistance to liaise between the organisations or get that system more efficient?

Ms SMITH — Certainly I think it is something that we should promote more, and I believe that it is not something that has not been already looked into and discussed a lot in our area as well. But it is certainly something that we will take further and have more conversations with them about.

Ms BRITNELL — But do you use the health department to be your conduit between a hospital system that is not working well for you and your system that goes across the whole of the local government for Melbourne?

Ms SMITH — Potentially not as well as we could.
Ms BRITNELL — We are talking about mental health issues and mental illness issues, and there is quite a difference between mental illness and mental health. I think we keep using the term fairly loosely. A person who has gone through a vulnerable period of childbirth, when it is natural to be vulnerable, is all at risk of having mental health issues. Mental illness, you know, is a complication often of — well, postnatal depression is now a mental illness. Do you believe that we have the supports in place? Because I am hearing the challenges around domiciliary care for people in family violence situations. You would have mental health issues in that situation, no doubt. We do not want it to escalate to turn into a mental illness situation. So do we have enough supports now around people to be able to assist us as a society from going from mental health into mental illness or is that where our challenge is possibly at?

Ms REILLY — We do not have enough services. I can only speak from working in the City of Melbourne, but it is a constant challenge to find a service for someone who is vulnerable but does not have a mental health illness but had a traumatic delivery, for example, or even just a normal delivery but it has brought up previous issues. It is challenging to find supports for someone in that situation. At the extreme end of everything, it is easier to accelerate care and wrap someone in services. My experience would be that we do not have enough services that can be responsive to either mental health issues or mental illness.

Ms EDWARDS — Would that be a similar situation for women with disabilities who might give birth — that there are not enough services nor are there enough supports available for a woman with a disability?

Ms SMITH — I was just thinking of an example. We had a woman with no Medicare and she had a disability — an acquired brain injury. That was a really big challenge: who held her and who supported her with the lack of those resources as well. It was just an example. With disability, I guess that there potentially is a bit more support out there, but I do not have the clear evidence to —

Ms EDWARDS — I just have one question in relation to the 2-kilogram release policy. Do you think that needs reviewing or do you just think that it is necessary to have better coordination and communication if possible when babies of that size are being released?

Ms REILLY — I am not sure if it is a policy that the hospitals have changed. It is a trend we have noticed in the last 12 months. I think if we are alerted to the fact that a small baby has been discharged home, we can be quite responsive given we have enough lead-up time. I do not necessarily think that the policy needs to be changed. I am aware that there is pressure on every service, including the obstetric hospitals. Ideally that would be perfect if they stayed in hospital until they were big enough to feed well. But I think just improving the communication between the discharge of a small baby home to us so that we can get in there in a really quick way to make sure that that baby is feeding as it should be or refer them to whatever service to help them do that, that would be sufficient.

Ms EDWARDS — The previous presenter mentioned the provision of neonatal resuscitation being available. Do maternal and child health nurses train for neonatal resuscitation?

Ms REILLY — No.

Ms BRITNELL — Would that be of benefit?

Ms REILLY — We would hopefully never be in a situation where we would have to. We would hope that they would not be in the home, babies that required neonatal resuscitation.

Ms EDWARDS — Even though you have 2-kilogram babies going home?

Ms REILLY — We have first aid and the ability to provide first-level resuscitation care to a child.

Ms SMITH — We do that annually — and anaphylaxis training. As a team we do basic first aid, CPR and anaphylaxis training.

The CHAIR — Thank you so much today for giving us your time and your submission. It has been very informative. We might just get a copy of your stats, if we can, and that presentation as well. Thank you again for coming and giving us your time.

Witnesses withdrew.