IN THE MATTER OF THE ROYAL COMMISSION INTO FAMILY VIOLENCE

ATTACHMENT FD-22 TO STATEMENT OF FRANCES MARIE DIVER

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This is the attachment marked '**FD-22**' produced and shown to **FRANCES MARIE DIVER** at the time of signing her Statement on 3 August 2015.

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Attachment FD-22

Continuity of care

A communication protocol for Victorian public maternity services and the Maternal Child Health Service

2004

Victoria
The Place To Be

Continuity of care

A communication protocol for Victorian public maternity services and the Maternal Child Health Service

2004

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Foreword

This protocol between the Department of Human Services, on behalf of Victoria's public maternity services, and the Municipal Association of Victoria (MAV), on behalf of local government as providers of maternal child health (MCH) services, is designed to assist continuity of care for recent mothers and their babies during this significant period in their lives.

To achieve this aim, the protocol seeks to strengthen partnerships between maternity and MCH services; to improve coordination, collaboration and communication; and to clarify each service's roles and responsibilities. The development of the protocol was guided by the Partnership Protocol between the Department of Human Services and MAV, October 2002, that provides an overarching framework for the development of future relationships, agreements and service coordination activities undertaken by the Department of Human Services and local governments.

For the majority of women accessing these services, the implementation of the protocol should support a straightforward and satisfactory process. For those women who have significant clinical and/or psycho-social vulnerabilities or risk factors, or require additional support, the protocol will assist maternity and MCH services to maintain a high level of collaboration to ensure the health and wellbeing of mothers and babies.

Designed as an overarching framework, the protocol will guide local maternity and MCH service providers to establish collaborative relationships and promote good practice to achieve optimal outcomes.

We thank and commend the working group that developed this protocol and maternity and MCH staff who provided advice and contributed to its development.

Signed:

P. M. Faulkner

Patricia Faulkner
Secretary
Department of Human Services

Signed:

Rob Spence
Chief Executive Officer
Municipal Association of Victoria

Acknowledgements

This protocol was developed by the Municipal Association of Victoria (MAV); the Programs Branch, Metropolitan Health and Aged Care Services Division, Department of Human Services, in partnership with representatives of Victorian public hospitals providing maternity services; and the Family and Community Support (FACS) Branch, Community Care Division, Department of Human Services. A working party met from June 2003 to June 2004 and provided valuable input and liaison with their respective stakeholder groups.

Working Party

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1. Introduction

The State Government, through the Department of Human Services, contributes funding for primary, secondary and tertiary services for individuals and families. These hospital and community based services aim to provide appropriate and timely clinical care, support and protection for all members of the community.

The quality of care and the health and wellbeing of families and communities is strongly linked to collaboration and partnerships between service sectors. Maternity services and MCH services are part of the service continuum providing antenatal, intrapartum and postnatal care for women and babies.

It is important that all families who are experiencing this potentially stressful time in their lives are supported through a responsive service network. For the majority of families, this process, supported by the protocol, should be straightforward.

However, a smaller group of families, presenting with a number of significant clinical and psycho-social risk factors, will require additional assistance. It is essential that effective communication and coordination processes support care planning, including referrals when appropriate to other specialist services. These services may include, for example, mental health, drug and alcohol, family support and child protection.

This protocol is designed to support effective continuity of care for pregnant women, recent mothers and their babies, particularly the most vulnerable in our society, through improved coordination, collaboration and communication between maternity and MCH services across the state. On a community level, the protocol is a resource to provide an overarching framework to complement local initiatives and protocols and support further work to resolve local issues.

Aims of the protocol

This protocol aims to:

- enhance continuity of care for recent mothers and their babies from pregnancy through early parenthood, as provided by maternity and MCH services (this aim will be realised through improved care planning supported by effective communication and collaboration)
- promote and strengthen professional partnerships between maternity and MCH services
- clarify processes to identify and actively engage families, with emphasis on those who are vulnerable or at risk
- promote mutual understanding of the respective roles and responsibilities of MCH and maternity services
- promote standardised and complementary approaches to the transfer of information between maternity and MCH services.

Principles underpinning the protocol

The principles underpinning this protocol focus on the interface between maternity and MCH services and include:

- Effective continuity of care provided by maternity and MCH services within the local community support recent mothers and their babies during the first few weeks following birth.
- Shared philosophical basis and common focus between services supports more effective service provision.
- Coordinated service to recent mothers and babies is dependent upon maternity and MCH services working collaboratively and with a clear understanding of each other's roles and responsibilities.
- Provision of preventive services or early intervention through collaborative care planning is usually more effective than the later provision of targeted or statutory services. The best interests of recent mothers and babies are usually met through family-centred practice.
- Information provided to families should be accessible and culturally sensitive, including use of interpreter services.
- Information exchange between maternity and MCH services should occur with the knowledge and consent of the mother, unless this action would put the baby at significant risk of harm. In this instance, the welfare of the baby takes precedence.

2. Overview of maternity services

The role of maternity services relates to all aspects of care associated with birth and involves antenatal, intrapartum and postnatal care. Although women give birth in a variety of settings, including private or public hospitals and at home, this protocol applies to the MCH service interface with public hospitals.

Safe, effective, consumer-focused maternity care is a high priority. There are unique challenges in this area, particularly around achieving a balance between having access to appropriate levels of medical expertise and avoiding over-intervention or a cascade of interventions when this is not required.

The department's objectives for maternity services are to:

- promote measurable improvements in the continuity and quality of antenatal, intrapartum and postnatal care, individualised to the needs of particular women
- provide women with increased birthing options and with evidence-based information on the benefits and risks associated with different options
- encourage improvements in models of care in line with best available evidence
- improve outcomes through appropriate performance measures and service audits.

2.1 Public hospital maternity services

Public hospital maternity services are expected to provide:

- care during pregnancy and childbirth that reflects best available evidence on effectiveness
- continuity of care, with respect to hospital care and integration with the community provision of antenatal and postnatal care and support
- care that is responsive to women with diverse needs
- arrangements for monitoring, review and improvement in the quality of care
- greater opportunities for consumers to make informed choices, participate in decision-making and provide feedback.

2.2 Discharge from hospital and postnatal domiciliary care

Hospitals are required to ensure adequate postnatal care for women, their babies and their families according to clinical and psycho-social needs. This is defined as providing, as a minimum:

- at least one postnatal home visit or other contact for all women following discharge from hospital
- at least two postnatal home visits or more, if required, for women and their babies with diverse needs, such as women with substance abuse issues, newly arrived migrants, young single mothers, and women with disabilities
- at least two or more postnatal home visits for women with complications arising from the birth or immediate postnatal period
- discharge planning, including communication of concerns regarding families to the MCH service.

3. Overview of maternal child health services

The MCH service is a universal primary care service for Victorian families with children from birth to school age. MCH nurses registered in Victoria are nurse midwives with required additional qualifications in maternal and child health.

In response to recent research findings, including an understanding of the way risk factors often cluster together for some vulnerable families, the MCH service is aiming to provide an interdisciplinary, integrated response across program boundaries in the provision of its core services. The MCH service is provided in partnership with local government and comprises:

- The **universal maternal and child health service**, which aims to ensure a comprehensive, focused approach to the early detection, intervention and prevention of physical, emotional and psycho-social issues affecting young children and their families. It includes 10 key consultations from birth to 3 years and additional services for families with diverse needs. The service provides monitoring of babies' growth and development, referral to a broad range of service providers, advice regarding health, safety and parenting issues, maternal wellbeing and family functioning. The program is provided in local community settings and, where possible, is located with other child and family services.
- The **enhanced maternal and child health service**, which aims to provide a more intensive level of support for children and families at risk of poor outcomes, particularly where there are multiple risk factors or indications of a significant level of risk for children. Service approaches may need to draw on a range of expertise to respond appropriately to the needs of these children and their families.
- The **Maternal and Child Health Line**, which is funded by the Department of Human Services and, although not a crisis-response service, operates as a 24-hour, seven-day a week telephone advisory and support service for families with young children. This service is staffed by MCH nurses and is an adjunct to universal and enhanced MCH services.

4. Protocol overview

The protocol highlights the expected points of information exchange between maternity and MCH services and notes which party is responsible for initiation, follow up and documentation of this communication. At each of these communication points, services should consider:

- **What can to be done to ensure effective continuity of care for recent mothers and their babies?**
- **What are the specific roles and responsibilities of each service at this point in time?**
- **What information needs to be supplied to the mother and/or to other professionals?**
- **How should information be communicated to ensure effective coordination, accuracy, and accountability?**

The protocol is arranged by the stages of maternity and MCH service that women experience, including:

- antenatal care
- postnatal – prior to discharge from the hospital
- neonatal/special care unit
- domiciliary service
- at discharge from maternity services

The protocol is furthered categorised within each of the above stages according to particular communication and collaboration requirements, including:

- all women and their babies – expectations of communication exchange between maternity and MCH staff required to support **all** women
- vulnerable families with medical and/or psycho-social high risk issues (vulnerable families) – recommendations for **enhanced** levels of partnership and collaboration between maternity and MCH staff beyond general expectations for all women
- families experiencing a stillbirth/neonatal death – processes for timely communication between maternity and MCH staff to ensure adequate support for families experiencing a stillbirth or neonatal death.

Boxed text is provided to differentiate points of communication exchange from descriptions of services' roles and responsibilities.

Both maternity and MCH staff are expected to document all referral consultations and discussions relevant to the ongoing care and support of the mother and her baby, including medical issues, risk and protective factors, clinical and psycho-social issues, community supports and referrals and care planning agreements. MCH staff will record notes in the centre-held record. Maternity staff will note information in patient files, the Child Health Record (CHR), or other formats as appropriate.

A summary of communication methods and information requirements included in the protocol is contained in an accompanying wall chart, *Maternity and Maternal Child Health Services communication matrix.*

5. Antenatal care

5.1 All pregnant women

Antenatal care may be provided in a variety of settings, including public antenatal clinics (either at the hospital or in the community), through shared care arrangements, which usually involve both general practitioners and midwives, or privately through obstetricians and/or general practitioners.

It is expected that hospital staff providing antenatal care will routinely:

- provide the pregnant woman with information about the MCH service, including any opportunity to meet with the MCH nurse prior to giving birth
- inform the parents about the purpose of the Child Health Record.

5.2 Vulnerable families

If clinical and/or psycho-social issues are identified during the antenatal period, it is strongly recommended that the antenatal service provider directly contact the woman's specific MCH service to discuss relevant information to inform care planning and ensure continuity of care.

The woman's MCH service may have historical information about the family, including risk factors or support services required after previous births, for example mental health services. The antenatal service provider can advise the MCH nurse of current risk factors identified during the antenatal period.

The MCH nurse may contact or visit vulnerable families prior to birth to provide information about the MCH service and to promote engagement, thereby encouraging continuity of care during the transition from maternity to MCH services. Contact is especially recommended when:

- the woman consents and requests contact
- there are concerning medical or psycho-social issues present
- the woman attends an antenatal clinic designed to address particular needs, for example, clinics for women with alcohol and drug issues.

6. Postnatal care prior to discharge from hospital

6.1 All mothers and their babies

Well mothers and their babies will usually remain in hospital for between one and four days. After the mother returns home and until there is a handover from the maternity service to the MCH service, all mothers and their babies will be supported in a coordinated manner by maternity services, usually the domiciliary service, and the MCH service. The length and service intensity of this transition period is dependent on the mother's individual needs and necessitates good communication between maternity and MCH services to ensure continuity of care.

6.1.1 Local government communication contact point

To ensure timely and appropriate communication between maternity and MCH services, each local government authority (LGA) should establish a single point of communication for:

- receipt of the birth notice
- information about the appropriate MCH centre and MCH nurse
- information about the established process if the MCH nurse cannot be contacted in a timely manner.

Information left on the MCH staff's telephone answering machine is to alert MCH staff to contact the caller. If the identified MCH staff cannot be contacted within an acceptable timeframe, staff at the LGA contact point can direct the caller to an alternate professional, for example, the MCH coordinator.

6.1.2 Birth notice

Under the *Victorian Health Act 1958* s.160 (1) (d), maternity services (birth hospitals) are legislated to provide local governments with notice of all births in Victoria.

Birth notices are posted, emailed or faxed (to a dedicated and secure machine) to the appropriate LGA for distribution to the appropriate MCH nurse in the mother's locality, as designated by the LGA.

To assist communication, prior to the birth notice being issued, staff at the birth hospital should ensure any previously collected information, including home address and telephone number, is accurate.

The birth notice, as specified in the Sixth Schedule of the Victorian Health Act, provides available information about the mother's usual place of residence, the gender of the baby, whether alive or dead, whether born at full term or premature and time and date of birth (Appendix 6).

In compliance with the *Victorian Health Act 1958* s.160 2 (b) (i):

> upon receipt of such a notice (the birth notice), the municipal clerk shall forthwith send such notice or a copy thereof.... to the nurse whose duty it is to visit or communicate with the house to which the notice relates

6.1.3 Child Health Record

The Child Health Record (CHR) is an important communication tool and source of information about the baby and mother and becomes the property of the mother (Appendix 7).

It is essential that midwives and medical staff at the birth hospital complete the relevant sections of the CHR, including any additional hospital discharge information and any treating doctor's summary. Staff insert all relevant documentation in the front sleeve of the CHR. Staff at the birth hospital also ensure the CHR contains MCH service contact information for the mother, any known domiciliary midwife visits, and any other scheduled appointments.

To assist effective care planning in all cases, hospital staff should provide a hospital contact in the CHR. The MCH nurse can then contact the birth hospital to discuss any presenting issues.

6.2 Vulnerable families

Beyond the recommended communication strategies discussed for all women prior to discharge from hospital, additional strategies need to be employed when developing care plans for this vulnerable group. Collaboration between maternity and MCH services is vital to ensure effective discharge planning and continuity of care.

Additionally, if the mother and/or baby are unwell or there are significant additional care issues, one or the other or both may remain in hospital or be transferred to another hospital for an extended time. When they return home, their clinical and psycho-social support needs may be more complex and, therefore, require more intensive coordinated care than is usually the case.

Birth notice

At a minimum, if additional information about the mother and/or baby needs to be provided to the MCH nurse, hospital staff should supply a hospital contact name and number on the birth notice to promote care planning between the maternity and MCH services.

In all cases, when a mother and/or baby are either unwell or there are significant psycho-social issues present, communication must occur between maternity and MCH services staff to ensure a coordinated return to the community. This can occur prior to the mother's discharge home or, if the hospital midwife is also undertaking the mother's postnatal domiciliary care, the domiciliary midwife may contact the MCH nurse early in her postnatal domiciliary involvement.

Maternity staff should telephone the MCH service and speak directly to the mother's MCH nurse as identified through the designated LGA communication point (see 6.1.1). Issues for discussion should include:

- discharge care planning
- domiciliary midwives' visiting schedule
- details of other services involved with the family
- other information, especially if relevant to worker safety issues.

If the MCH nurse is unavailable and it is important to convey the information immediately, for example if there is a worker safety issue or the baby is deceased, the LGA contact point can advise an alternate professional contact.

If significant risk factors for mothers and/or their babies are present, birth hospital staff are expected to make appropriate referrals to address patient needs. It is, therefore, strongly recommended that maternity staff complete a written referral to the MCH service to support prior verbal contact.

Maternity staff should forward the written referral to the MCH service prior to the woman's discharge from hospital, or if the hospital midwife is also undertaking the mother's postnatal domiciliary care, the written referral can be completed early in the postnatal domiciliary involvement. The MCH nurse will acknowledge receipt of written referrals (Appendix 3).

The complexity of the presenting clinical and psycho-social issues determines the care planning process and informs decisions about referrals to other services. The following risk factors chart can inform decisions, including the amount, type and format of information that is provided by the birth hospital. An expanded risk and protective factors matrix is provided in Appendix 5.

Guide to risk factors

Child	Parents	Family	Community
low birth weight	young mother <20yrs	isolated	poverty
prematurity	birth complications	chaotic	geographic isolation
born drug dependent	mental health issues	homelessness, transient	
feeding/sleeping issues	substance abuse issues		
disability	family violence		
multiple births	single parent		
	other child died or removed		
	Child Protection history		
	intellectual disability		
	poor impulse control		
	maternal ambivalence		

For particularly vulnerable families, the ongoing care needs of the baby and the psycho-social needs of the family are best addressed through a partnership approach between health and community services including:

- universal services, which include maternity and MCH services; and medical services including general practitioners, paediatricians and community health centres
- targeted services for more vulnerable families, including early parenting centres, early intervention services, drug treatment, mental health, and family support services
- statutory child protection service for children identified as being at significant risk of harm. As most maternity and MCH staff are nurses, as well as midwives, and therefore are mandated to report incidents of physical and sexual abuse, their organisations will have procedures to guide this process (Appendix 4).

It is appropriate for the service that has the relevant information about issues as they relate to the mother and her baby to initiate or convene a care planning meeting. In the early weeks after birth, this is usually the maternity and/or MCH service.

However, it is important that the service that has the most relevant clinical or ongoing role with the family, for example, a mental health or drug treatment service, accepts case coordination or case management consistent with their service's current intervention planning. Once the mother's condition is stabilised, planning may include her discharge to another, more appropriate service, for example, her general practitioner. Any change in case management should be communicated to all services supporting the mother.

6.3 Families experiencing a stillbirth/neonatal death

It is vital that the MCH service be aware that a family has experienced a stillbirth/neonatal death prior to the MCH nurse contacting the family to ensure appropriate supports can be offered to the family during this highly stressful time.

Maternity staff should telephone the MCH service and directly inform the relevant MCH nurse or MCH coordinator about the circumstances of the stillbirth/neonatal death prior to sending the birth notice, if possible, or as soon as practicable after the death occurs.

7. Neonatal/special care units

7.1 Vulnerable families

A premature or unwell baby may spend varying lengths of time in neonatal/special care units. If only a short stay is required, the baby may return to the general maternity ward or nursery prior to discharge. Other babies may remain in the neonatal/special care unit or be transferred to regional hospitals for more extended stays prior to going home. These babies require comprehensive discharge and care planning which may include Hospital in The Home (HITH) and/or domiciliary services over an extended period of time. For these vulnerable babies and their families, good communication and coordinated care is vital.

Birth notice

The birth notice will indicate when a baby is in the neonatal/special care unit. Hospital staff should provide a contact telephone number. Upon receipt of the birth notice, the MCH nurse rings the designated hospital contact to discuss the health issues, estimated discharge date and discharge planning.

The MCH nurse contacts and may visit the mother prior to the baby's discharge to support the mother, attend to any of her health needs, and to assist with planning for the baby's arrival home.

Neonatal/special care unit staff telephone the MCH nurse one to two days prior to the baby's discharge home or transfer to another hospital to discuss finalised discharge plans. This is to enable a timely, coordinated maternity and MCH service response.

Information provided by neonatal/special care unit staff to the MCH nurse includes:

- details of any planned transfer and contacts at new location
- schedules for HITH and/or domiciliary service
- baby's health care needs
- general practitioner's details and appointments
- any other special needs, for example, need for interpreter
- any specific psycho-social issues present and if the neonatal or hospital social worker will contact the MCH nurse to consult further.

7.2 Families experiencing a neonatal death

A number of very premature, extremely low-weight and sick babies may die during their stay in neonatal/special care units.

Maternity staff should telephone the MCH service and directly inform the relevant MCH nurse or MCH coordinator about the circumstances of the baby's death as soon as practicable after the death occurs.

8. Domiciliary service

8.1 All mothers and their babies

Hospitals are required to ensure adequate postnatal care for women and their babies according to their clinical and psycho-social needs. At a minimum this service includes:

- at least one home visit following mother's discharge
- two or more visits as required for mothers with diverse needs.

The domiciliary service contacts all mothers and offers to arrange a visit upon discharge regardless of whether her baby has been discharged at the same time or remains in hospital. These early days post discharge are an important time that requires communication and collaboration between maternity and MCH services. The domiciliary midwife documents her notes in the CHR.

Following the first postnatal domiciliary midwife visit, it is good practice for the domiciliary midwife to contact the MCH service to discuss service coordination. This communication aims to avoid duplication of service and to clarify the domiciliary service discharge plan, including any additional relevant information concerning the mother and/or baby.

The domiciliary midwife contacts the MCH service, either directly if the MCH nurse and centre are known or through the designated LGA contact.

8.2 Vulnerable families

Vulnerable families may receive two or more postnatal domiciliary home visits if required to address diverse needs, such as substance abuse issues, newly arrived migrants, unsupported young mothers, and women with disabilities. Additional visits may also be scheduled for women with complications arising from the birth.

If the family is known to have significant medical or psycho-social risk factors, the domiciliary midwife speaks directly to the MCH nurse to develop a coordinated care plan. Care planning and coordination between the domiciliary and MCH services should preferably take place prior to the mother's discharge from hospital with reviews during this period of coordinated care.

The domiciliary midwife documents her contacts with the family in the CHR.

9. At discharge from maternity services

9.1 All mothers and their babies

Upon receipt of the birth notice, the MCH service is responsible for an initial contact with the family. Prior to this initial contact, if a hospital contact number is included on the birth notice, the MCH nurse rings the birth hospital for a verbal referral. As per all consultations and referral discussions, the MCH nurse records relevant information in the centre-held record.

Although the MCH nurse's initial contact with the family may be during the domiciliary care service period, it most usually occurs after the mother is discharged from the maternity (domiciliary) service.

After the recent mother's and baby's discharge from maternity (domiciliary) services, the MCH service takes on the responsibility to provide a primary care service for the baby until school entry. MCH nurses will also take on the responsibility for making referrals to any additional services required, including the enhanced MCH service.

9.2 Vulnerable families

Families often find the process of transferring from one service to another problematic. The family's introduction to the new service may be characterised by a loss of engagement or withdrawal from the new service altogether. This risk is heightened if the family is also experiencing additional stresses and vulnerabilities.

If there are significant ongoing clinical or psycho-social issues present, prior to discharge from maternity (domiciliary) services, a joint MCH and maternity (domiciliary) service visit to the family at point of handover or a meeting with relevant community agencies and the family is considered good practice.

If the baby has required significant, ongoing medical care in the home, prior to the baby being discharged from the maternity (HITH/domiciliary) service, staff in the neonatal/special care unit complete all relevant sections of the CHR including documentation (neonatal health record, discharge plan and copy of discharge summary letter). Staff in the neonatal/special care unit telephone the MCH nurse to plan for the baby's ongoing care needs.

A case conference or a joint handover visit to the family by the MCH nurse and maternity (HITH/domiciliary) staff is encouraged as good practice.

10. Maternal child health telephone communication

To assist effective communication between maternity and MCH services and to provide consistency across the state, MCH services are encouraged to establish a succinct telephone answering machine message including:

- identification of MCH centre and nurse
- centre hours/when message will be received
- where to access emergency care if the baby is unwell
- how to access the MCH Telephone Line.

MCH staff document all significant information exchanged between maternity and MCH services, including telephone calls and answering machine messages.

11. Liaison between maternity and MCH services

Continuity of care is facilitated when the relevant services and staff have opportunities to share information and professional perspectives more generally beyond specific clinical and care planning issues. Liaison between maternity and MCH services should be promoted through:

- case coordination and care planning with families when there are significant clinical and/or psycho-social vulnerabilities or risk factors
- network meetings held on a regular basis for discussion of specific or general issues that have arisen in clinical practice
- interdisciplinary training or professional development opportunities.

12. Privacy

There must be compliance with a number of Acts, including the *Information Privacy Act 2000* , *Health Records Act 2001* and *Mental Health Act 1986* whenever personal information about clients or staff is collected, stored, transmitted, shared, used or disclosed. Further information about privacy requirements including the requirement for consumer consent is contained in websites noted in Appendices 2 and 8.

When a health professional assess a child is in need of protection as outlined in the *Children and Young Persons Act (CYPA) 1989* (s. 67) and makes a notification to Child Protection in good faith, the CYPA 1989 supersedes all other legislation. The provision of information to a protective intervener does not constitute unprofessional conduct or breach professional ethics or make that person subject to any liability.

However, this legal protection granted by the *CYPA 1989* does not extend to individuals reporting concerns about a baby prior to birth, therefore consultations must be conducted with either the mother's agreement or on a non-identifying basis (Appendix 4).

13. Disputes/complaints

Any disputes or complaints in relation to an operational issue should, in the first instance, be dealt with between the relevant maternity and MCH staff. The aim of the contact will be discussion and resolution of the concern.

If staff concerned cannot resolve the problem, the following process should occur:

- staff contact, either verbally or in writing, their direct line manager
- if the problem remains unresolved, each service's line management will decide on a course of action to resolve the problem with reference to their relevant service agreement.

14. Review of protocol

The Department of Human Services will undertake a statewide review of the protocol during its first year of implementation. The review will include collection of quantitative and qualitative data from service users and service providers. The analysis of the data and methodology employed will be provided to local areas to assist replication of the review in their local service area.

15. Appendices

1. Definitions
2. Useful websites/contact details
3. Maternity services referral summary for MCH service
4. Child Protection in Victoria
5. Risk and protective factors – chart
6. Information contained on the birth notice
7. The Child Health Record
8. Privacy information

Appendix 1

Definitions

Communication between professional groups can be affected by use of language and particular interpretations and meanings that terms have for individuals and groups. The following definitions have been included to promote a common understanding of terms that are used extensively throughout the protocol document.

Recent mothers

Refers to those women who have recently had a baby regardless of the number of other births they have had. The term is used in preference to the term 'new mothers', which connotes first time mothers.

Vulnerable families

Families are considered 'vulnerable' when they most commonly present with a number of cumulative clinical, psycho-social and environmental risk factors. Risk factors are seen as indicators of vulnerability that may, **in some instances**, result in harm. Risk factors may relate to the baby and/or family characteristics and circumstances and commonly include: baby's low birth weight or failure to thrive, medical conditions, mental health issues, drug and alcohol abuse, homelessness, unsupported youth, and family violence. Generally, the greater number of risk factors present indicates a heightened vulnerability, however, the presence of even one critical risk factor, for example a mother with a psychiatric illness who is refusing medication, may place the family in a highly vulnerable state.

When considering the degree of vulnerability within a family, it is important to balance the identified risk factors with the family's demonstrated strengths and the presence of protective factors that may go some way towards mediating the risks involved. For example, a substance-using, teenage mother may be planning to reside with a supportive grandmother. This balanced approach will result in a more realistic determination of vulnerability and inform decision-making regarding type and level of appropriate intervention.

Risk/high risk and safety

The concept of general risk factors is discussed above. A situation may be considered to be at **high** risk when the cumulative risk has, or is likely to, result in significant harm to the development of the baby, as defined in the *Children and Young Person's Act (CYPA) 1989*. A good guide to the level of risk present is to consider that, if nothing were done to lessen the present risk and to increase the level of safety for the baby, would it be reasonable to notify Child Protection (Appendix 4).

Family

Although throughout the protocol the term 'recent mother' is used to indicate the baby's primary caregiver, it is acknowledged that the father or other family member may assume this role for all or part of the time. It is also acknowledged that maternity and MCH services programs include fathers/male partners and other relevant family members.

Family-centred practice

Maternity and MCH services work to ensure the best health and wellbeing outcomes for pregnant and recent mothers and their babies. The term 'family-centred practice' reinforces the professional belief that the baby's health and developmental needs are best met within a family that is well supported to meet their own and their baby's needs.

Appendix 2

Useful websites/contact details

Child Protection including regional contact details
www.dhs.vic.gov.au/commcare (select Child Protection)

Children of Parents with a Mental Illness **www.copmi.net.au**
A resource centre for information relating to the care and management of families where a parent has a mental illness including:

- *The best for my baby: managing mental health during pregnancy and early parenthood* - a parent booklet
- *Parents baby care plan* - a guide to planning for baby if a parent becomes unwell

Directory of health and community support services
www.health.vic.gov.au (select Primary health knowledge/Primary Care Partnerships)

Department of Human Services Early Years programs **www.dhs.vic.gov.au/commcare**

Health Act
www.dms.dpc.vic.gov.au (select Victorian Law Today)

Health Records Act 2001 and privacy principles **www.health.vic.gov.au**

High Risk Infants (HRI) Project **www.dhs.vic.gov.au/commcare**

Maternal and Child Health Service Program Standards (under review) Department of Human Services, Family and Community Support

Maternal Child Health Line **chnline@dhs.vic.gov.au/** telephone: 13 22 29

Maternity services **http://www.maternity.health.vic.gov.au**

Mental Health Act in relation to privacy requirements for mental health professionals
www.dms.dpc.vic.gov.au (select Victorian Law Today)

Models of coordination
Hume Moreland PCP, *Going home with a baby: coordinating effective service response*
www.pcphumemoreland.infoxchange.net.au

Easen, Patrick, Atkins, Madeleine and Dyson, Alan: Interprofessional collaboration and conceptualizations of practice, *Children and Society* Vol 14 (2000) pp. 355-367
www3.interscience.wiley.com/cgi-bin/fulltext/76501838/PDTSTART

Privacy information
www.dhs.vic.gov.au/privacy/ippg/collection/collectnotify
www.dhs.vic.gov.au/privacy/ippg/concepts/gainingconsent

Women@Home Royal Women's Hospital telephone and email contact for MCH nurses
www.rwh.org.au
Phone or fax: 9344 2324

Appendix 3

Maternity services referral summary for MCH service

The included templates were developed by Women's Health in the North and the Hume Moreland Primary Care Partnership after consultation with public health maternity services and MCH nurses. They are included as a suggested format only.

- Referral cover sheet
- Referral summary
- Referral acknowledgement
- Consumer consent form

Referral cover sheet–confidential

insert LOGO of
M&CH Service (LGA)

Maternity Services to MCH Services

Date	...../...../.....		**No. of pages:**	(including this page)
From	Name:		Phone number:	
	Role/Position:		Mobile (optional):	
			Email:	
	Location:		MCHS LGA:	
To	Name:		Fax number:	
	(Central contact point in LGA, rather than specific M&CHN)			
Referral priority status	☐ **Urgent** – Cannot Wait ☐ **Routine** – Attend in date order			
Reply	Please acknowledge receipt of this referral (using the Referral Acknowledgement form) within: ☐ **24 hours** – *For urgent referrals only* ☐ **within 5 working days** - *For routine and all other referrals* ☐ **please call**			

Attachments:

Maternity Services Referral Summary (required)		Discharge Summary	
Consumer Consent Form (required)		Neonatal Discharge Summary	

Other Information:

Signature..... Date...../...../.....

Position.....

Confidential

The information contained in this facsimile is privileged and cannot be disclosed to any other party. If you have received this facsimile in error, copying or distribution is prohibited. Please notify the sender immediately on the listed number and return the original. Thank you for your cooperation.

Maternity services referral summary–confidential

insert LOGO of
M&CH Service (LGA)

1. Referral details

Please be advised of the referral:	**Date sent:** ...../...../.....	
UR number:		
Consumer's name:		
Consumer's DOB:	...../...../.....	
Date of discharge:	...../...../.....	
Location if not discharged:	Mother:	
	Baby:	
Discharge destination:		
Address:		
Phone:		
Scheduled domiciliary visits:		Dom team contact name: Phone:
Existing support services:		
Other referrals accepted:	HITH	PAC
Aboriginal or Torres Strait Islander: ☐ Yes ☐ No		
Country of birth:		Ethnicity:
Interpreter required:	Language/dialect:	Gender: ☐ female ☐ either male or female
Cultural requirements:		
Recent arrival (within 2 yrs): ☐ Yes ☐ No		

2. Additional support needs

Psychosocial issues identified:

☐ Disability ☐ intellectual ☐ physical ☐ sensory ☐ other, please specify.....

☐ Mental health issues ☐ Substance use

☐ Living arrangements ☐ Homelessness(or at risk of homelessness)

☐ Family violence ☐ Child protection involved

☐ Young mother ☐ Limited social support

☐ Lack of engagement with baby ☐ History of previous loss, eg stillbirth, multiple miscarriage

Health issues identified:

Baby ☐ Prematurity ☐ Disability ☐ LBW (<2.3kg) ☐ Breastfeeding/attachment issues

Mother ☐ Complications of pregnancy, labour and/or birth ☐ Multiple births

3. Please make comments

Consumer consent for referral been given: ☐ Yes ☐ No

Copy sent to domiciliary team: ☐ Yes ☐ No

Date: ...../...../.....

Referral Acknowledgement–confidential

insert LOGO of
M&CH Service (LGA)

Maternal and Child Health Services

Date	...../...../..:.....		**No. of pages:**	(including this page)
From	Name:		Phone number:	
	M&CH Centre:		Mobile (optional):	
			Fax number:	
To	Name:		Agency/Site:	
	Role/Position:		Fax number:	
Reply	Referral sent by you on:	...../...../.....		
	UR number:			
	Consumer name:			
	Consumer's DOB:	...../...../.....		

Referral accepted	☐ (please ✓)	
Action taken	☐ Home visit arranged for: ...../...../.....	
Referral not accepted	☐ (please ✓)	
Reason	☐ Consumer declined service	☐ Consumer not located at address provided
Action taken	☐ Referred back to sender	☐ Forwarded on to:

Notes

Signature..... Date...../...../.....

Position.....

Confidential

The information contained in this facsimile is privileged and cannot be disclosed to any other party. If you have received this facsimile in error, copying or distribution is prohibited. Please notify the sender immediately on the listed number and return the original. Thank you for your cooperation.

Consumer Consent

To specified Use/Disclosure of Information

Agency Contact Details

(✓ tick when completed)

To ensure the consumer is able to make an informed decision about consent to the disclosure of their information, the practitioner should:

1. Discuss with the consumer the proposed referral to other services/agencies ☐
2. Explain that the consumer's information will only be released to these services if the consumer has agreed and advise that the referral for service can still proceed if the consumer does not want information disclosed ☐
3. Provide the consumer with information about privacy, such as the brochure *Your Information–It's Private* ☐
4. Provide the consumer with a copy of this form, once completed ☐

Section 1: Proposed Information Uses and Disclosures

The following service(s) are recommended. It is also recommended that relevant information is forwarded to the agency(s) that provide these services, in order that consumers receive the best possible care.

Type of Service Examples: - Physiotherapy - Specialist consultant	**Name of Agency** Examples: - Any agency - Nominated clinic	**Type of Information** *(including limits as applicable)* Examples: - All relevant information - Test results only

Section 2: Record of Consumer Consent

2 (A) Written Consumer Consent **OR** 2 (B) Verbal Consent

2 (a)

My practitioner has discussed with me how, when and why certain information about me may need to be provided to other agencies.

I understand the recommendations and I give my permission for the information to be shared as detailed above.

Signed:.....*Date:* .../.../...
(Consumer OR Authorised Representative)

Consumer Name: .....

Witnessed:.....

Practitioner Name:.....
(Practitioner)

Role: .....

2 (b)

Practitioner Use Only

Verbal consent should only be used where it is not practicable to obtain written consent.

I have discussed the proposed referrals with the consumer. I am satisfied that the consumer understands the proposed uses and disclosures, and has provided their informed consent to these.

Signed:..... Date:.../.../...
(Practitioner)

Practitioner Name:.....

Role: .....

Department of Human Services

Office Use Only: If information becomes superseded, indicate below and record updated information on a new form. The information of this form has been superseded.

Date: ...../...../..... Name: ..... Sign: .....

Victoria The Place To Be

Appendix 4

Child Protection in Victoria

The role of Child Protection

Child Protection has a particular role prescribed by the *Children and Young Persons Act 1989.*

Child Protection has responsibility for those children who are at risk of significant harm, and their families. Child Protection provides child-centred, family-focused services to protect children from significant harm as a result of abuse or neglect within the family unit.

It is the responsibility of Child Protection to:

- receive notifications from people who believe on reasonable grounds that a child is in need of protection
- provide advice to people who report such concerns
- investigate matters where it is believed that a child is at risk
- refer families to community services and provide tertiary services to assist families
- take matters before the Children's Court if the child's safety cannot be assured within the family
- supervise children on legal orders granted by the Children's Court.

Identification of risk

The Victorian Risk Framework's Risk Factors Warning List is available on the Department of Human Services website. A chart of risk and protective factors is included to assist maternity and MCH staff working with vulnerable families (Appendix 5).

Making a notification/pre-birth report to Child Protection

Notification to Child Protection

Any person who believes on reasonable grounds that a child is in need of protection may notify Child Protection of that belief and of the reasonable grounds for it. Further, any person registered under the *Nurses Act 1993* is mandated to report to Child Protection such a belief in relation to sexual or physical abuse. Further information about making a notification may be found in each service's protocols with Child Protection.

Pre-birth report to Child Protection

Although Child Protection can accept a report prior to the birth of a baby considered likely to be at high risk of harm post birth, and work with the family and professionals to plan for support after birth, the *C&YPA 1989* does not apply to information received prior to birth and reporters are not covered by the legislation's immunity provisions.

A person making a report must consider their ability to provide information without the consent of the mother. Under the *Information Privacy Act 2000*, if a pre-birth report is made, Child Protection is obliged to inform the mother that health information pertaining to her is held by the Department of Human Services and that she can have access to this information.

Child Protection contact details

Check the Department of Human Services website for most recent data: www.dhs.vic.gov.au

24-hour Crisis Line, all areas - 131 278

Regional offices - Metropolitan

Eastern
Intake Unit - 1300 360 391

North and West
Intake Unit - (03) 9471 1644

Southern
Intake Unit - 1300 655 795

Regional Offices - Rural

Gippsland
Intake Unit - 1800 020 202

Grampians
Intake Unit - 1800 000 551

Hume
Intake Unit - 1800 650 227

Loddon Mallee
Bendigo - (03) 5430 2333

Barwon-South Western
Geelong - (03) 5226 4540
Warrnambool - (03) 5561 9444

Appendix 5

Risk and protective factors

The risk and protective factors listed in this table are commonly identified across research and literature spanning fields as diverse as health, criminology, education, family functioning and child abuse.

The greater the number of risk factors, the greater the likelihood of increased impact. However, the variation between individuals in relation to their degree of vulnerability to these risk factors is also high and, generally, the protective factors cited below reduce the risk of harm.

Risk factors–from antenatal period to about five years

Child characteristics	Parents and their parenting style	Family factors and life events	Community factors
Low birth weight	Single parent	Poverty	Socioeconomic disadvantage
Prematurity	Young maternal age	Family instability, stress, conflict or violence	Housing and urban conditions–unhealthy cities
Prenatal exposure to toxins or infections	Postnatal depression mental illness	Marital disharmony	Neighbourhood violence and crime
Poor maternal nutrition	Drug and alcohol misuse	Divorce	Lack of support services
Prone sleeping position	Parental smoking	Disorganised	Social or cultural discrimination
Birth injury	Inconsistent discipline	Large family size/rapid successive pregnancies	Community behaviour norms
Exposure to stress	Lack of stimulation of child	Absence of father	
Disability	Lack of sensitivity, and affection	Very low level of parental education	
Low intelligence	Criminality	Social isolation	
Chronic illness	Separation from or rejection of child	Long term unemployment	
Delayed development	Abuse or neglect	War/natural disasters	
Difficult temperament	Poor supervision	Death of family member	
Poor attachment	Lack of parenting knowledge	Family history of ADHD	
Poor social skills		Frequent relocations	
Poor problem solving			
Disruptive behaviour			
Hazardous environment			
Unsupervised play			
Impulsivity			
Poor self-esteem			
Alienation			

Protective factors–from antenatal period to about five years

Prenatal and child characteristics	Parents and parenting style	Family factors and life events	Community factors
Good antenatal care and maternal nutrition	Maternal health and wellbeing is good	Family harmony and stability	Supportive social relationships and networks
Breastfeeding established early	Healthy lifestyle	Consistency of primary carers	Participation in community activities
Full immunisation	Reasonable awareness and use of health and community services	Nurturing environment	Family-friendly work environments and culture
Social skills	Competent stable care	Positive relationships with extended family	Cultural identity pride
Secure attachment	Positive attention from both parents	Small family size	
Easy temperament, active, alert and affectionate	Supportive relationship with other adults	Spacing siblings >2 years	
At least average intelligence	Positive communication between parent and child		
Attachment to family	Father's involvement in parenting		
Independence, self-help	Mother's education and competence		
Good problem solving skills			
Ambition			
Positive self-concept Self efficacy			

Sources: Centre for Community Child Health 2000; National Crime Prevention 1999; Cohen et al. 1999; Zubrick et al. 2000; Shonkoff & Meisels 2000

Appendix 6

Information contained on the birth notice

1. Mother's name
2. Mother's address
3. Mother's telephone number
4. Baby's date and time of birth
5. Alive or stillborn
6. Gender
7. Full term or premature
8. Name and place of birth
9. Accoucheur
10. Signature or address of notifier (usually the hospital where delivery occurred)

Appendix 7

The Child Health Record

Staff at the birth hospital comprehensively complete the relevant sections of the Child Health Record (CHR) prior to the mother's discharge. Sections to be completed include:

1. Using your Child Health Record
2. Child's personal family details
3. Family medical history
4. Birth details
5. Vitamin K and Hepatitis B
6. Newborn examination
7. Hearing Risk Factor Screening Assessment

Triplicate copies of the CHR book pages are removed and placed in the hospital patient file as standard practice.

Appendix 8

Privacy information

Information Privacy Act 2000

The Information Privacy Act regulates the collection and handling of personal information in Victoria and is applicable to all Victorian public sector agencies including local government. The Act requires that organisations must inform a person that information is being collected and the purpose for the collection of this information.

Health Records Act 2001

As from 1 July 2002, the Health Records Act regulates the collection and handling of health information in Victoria. The Act contains provisions which:

- establish a framework to protect the privacy of a person's health information
- provide people with an enforceable right of access to their own health information.

Organisations subject to the Health Records Act include any organisation that holds health information or health reports concerning clients or customers, including Victorian Government departments, local government, schools, kindergartens, child care centres and MCH services. The Act requires that organisations must have the person's consent to collect health information and to inform the person that they may have access to the information collected. However, section 7 also provides that where a provision under the Health Records Act is inconsistent with a provision in another Act, that other provision takes precedence.

Both the Information Privacy Act and the Health Records Act each contains a set of Privacy Principles to which organisations most adhere and which relates to the collection, use, disclosure, quality security, retention and transfer of, and access to, people's personal and health information. Further information regarding the Information Privacy Act and the 10 Information Privacy Principles can be found at **www.privacy.vic.gov.au**. Further information regarding the Health Records Act and the 11 Health Privacy Principles can be found at: **www.health.vic.gov.au**.

Further information regarding notifying a person about the collection of information and gaining consent from a person can be found at:

www.dhs.vic.gov.au/privacy/ippg/collection/collectnotify

www.dhs.gov.au/privacy/ippg/concepts/gainingconsent

Mental Health Act 1986

The Mental Health Act (S 120A) regulates the 'disclosure' of mental health information by relevant psychiatric services and therefore takes precedence over the Health Records Act for the purposes of disclosure. Section 120 establishes a broad principle of confidentiality, but then prescribes a number of specific circumstances when identified client information may be disclosed to external organisations and individuals including:

- with the consent of the client
- for the further treatment of a person with a mental disorder.

Freedom of Information Act 1982

The Freedom of Information Act regulates a person's access to their own health information where it is held by public sector agencies including local and State Government departments.

Children and Young Persons Act 1989

Neither the Information Privacy Act nor the Health Records Act relieves mandated professionals of their obligation to report child abuse to Child Protection. The Children and Young Persons Act, (s. 67) states that giving of information to a protective intervener does not constitute unprofessional conduct or breach of professional ethics, or make that person subject to any liability.

16. Addendum: Women attending specialist chemical dependency units

1. Introduction and background
2. Roles and responsibilities
3. Antenatal period
4. Postnatal care and discharge planning
5. Domiciliary care/Hospital in the Home
6. Ongoing role of MCH service
7. Appendices
    1. DirectLine 1800 136 385
    2. Specialist Chemical Dependency Units
    3. Journal article

1. Introduction and background

A protocol has been developed to enhance the partnership between maternity services and the Maternal Child Health Service (MCH service). Although the generic protocol supports all recent mothers, including those with complex needs, for a small number (approximately 400 per year) of highly vulnerable and at-risk mothers who attend specialised chemical dependency units (SCDU) within public maternity services, more specific guidelines are needed to promote continuity of care commencing during the antenatal period. These guidelines form an addendum to the original protocol.

The addendum highlights additional opportunities to strengthen collaboration and partnership between maternity and MCH services when working with this very vulnerable and high priority group of pregnant women, recent mothers and their babies.

The addendum complements the protocol and should be read in conjunction with that document. Although the addendum outlines **minimum** standards across all SCDU services and participating MCH services, it also documents examples of best practice when working with women who have alcohol and drug issues.

In this document, boxed text is provided to differentiate points of communication exchange from descriptions of service roles and responsibilities. The boxed information within the addendum is also cross-referenced to the corresponding sections of the protocol.

It is recommended that each local service area use this addendum to develop specific guidelines and protocols to address regional issues.

2. Roles and responsibilities

2.1 Specialist chemical dependency units

The role of specialist chemical dependency units (SCDU) within maternity services is to provide timely and appropriate multidisciplinary care for pregnant women with drug and alcohol issues and their babies. The SCDU do this by providing:

- specialist clinical services for women requiring intensive pregnancy care due to drug or alcohol complexities
- advocacy for women with alcohol and drug issues and their babies.

The Women's Alcohol and Drugs Service (WADS) at the Royal Women's Hospital, funded by the Department of Human Services, has additional roles, including providing:

- professional statewide education and support for health professionals and service providers
- obstetric, neonatal and social evaluation and research.

2.2 Maternal and Child Health Service

The role of the universal MCH service is to engage with all families in Victoria with children from birth to school age, to take account of strengths and vulnerabilities, and to provide timely contact and ongoing primary health care to improve babies' and young children's health, development and wellbeing.

The enhanced MCH service actively responds to children and families at risk of poor outcomes, particularly children for whom there is a significant level of multiple risk factors or indicators. The enhanced MCH service provides a focused and intensive support to these vulnerable families. Please refer to the protocol for more detail about this service.

3. Antenatal period

Care and support during the antenatal period is especially vital for these vulnerable women with alcohol and drug issues. Beyond the necessary, and sometimes specialist, medical care required, there needs to be an emphasis on comprehensive planning for the mother and baby prior to their discharge back into their community. This planning should to be undertaken in a sensitive manner, including keeping the number of support people to a minimum and involving the pregnant woman as much as possible in the planning process.

Refer to protocol section 5.2

It is strongly recommended that SCDU antenatal services contact the pregnant woman's MCH service prior to birth to involve the MCH nurse in the planning process. This contact may include maternity services staff making a written referral, making telephone contact or including the MCH nurse at planning meetings.

MCH services' internal processes vary in relation to referral to their enhanced MCH service. It is, therefore, recommended that each SCDU and their relevant MCH services develop their own local protocol to ensure this group of women has access to an appropriate and timely allocation process. The referral protocol should aim to minimise the number of people involved with the family during this stressful time.

Refer to protocol section 5.2

The MCH nurse will make every effort to participate in the discharge planning process, including having contact with the pregnant woman during the antenatal period to provide information about the MCH service and to promote engagement.

4. Postnatal care and discharge planning

This group of vulnerable women and their babies is characterised by unstable living arrangements, transience, shifting family dynamics, social isolation and complex health problems. It is essential that any discharge planning commenced during the antenatal period is reviewed after the baby's birth and prior to discharge from the hospital.

Refer to protocol section 6.2

Prior to the mother and her baby being discharged from the hospital, the SCDU maternity staff will telephone the MCH service and speak directly to the nominated MCH nurse. If the baby has been transferred to a neonatal unit or special care nursery, and the mother discharged from hospital, the neonatal unit or special care nursery staff will also contact the MCH nurse prior to the baby going home.

Issues to discuss will include:

- discharge planning, including a coordinated MCH–postnatal domiciliary service visiting schedule
- details of other services involved with the family, especially drug treatment services and contacts
- other relevant information.

Refer to Protocol 6.1.1 for information about contacting the MCH service via local government.

In accordance with Victorian Privacy Principles and the birth hospital's protocols, SCDU maternity staff will make a written referral to the MCH service to support and confirm their verbal contact. The written referral will generally be made prior to discharge. However, if the SCDU midwife is also undertaking the mother's postnatal domiciliary care, the written referral may be completed early in the postnatal domiciliary service period. The MCH nurse will acknowledge receipt of written referrals.

The maternity service will provide the MCH nurse with comprehensive information about these recent mothers and their babies including:

- details of birth and the baby's health status
- strengths and concerns (see protocol appendix 5 for chart of risk factors)
- anticipated discharge date for both mother and baby
- primary carer's details (if not the mother)
- Child Protection involvement and status details
- general practitioner (GP) details
- community agencies, especially drug treatment services, supporting mother and baby or referrals made.

An example only of a referral format is provided in appendix 3 of the protocol and can be amended within the 'comments' box to include the above details.

5. Domiciliary care/Hospital in the Home

If the baby has spent time in the neonatal unit or the special care nursery, the baby may go home in the care of the Hospital in the Home (HITH) program. Postnatal domiciliary/HITH visits and MCH visits should be coordinated. If MCH staff have not made contact with the mother prior to this time, one joint visit is considered good practice.

Refer to protocol section 8.2

If the postnatal domiciliary/HITH service home visits cannot occur due to concerns about staff safety, the postnatal domiciliary/HITH staff will immediately telephone the MCH service and plan alternative arrangements. This may include reference to local protocols and consultation with Child Protection to ensure the safety of the baby.

Refer to protocol section 8.2

The postnatal domiciliary/HITH staff will contact the MCH nurse after their last visit, usually by telephone, to review the family's situation.

If the MCH nurse has not yet visited the home, the postnatal domiciliary/HITH service discharge summary may include:

- environment – housing, bedding, SIDS risk factors, temperature, safety issues
- mother's current health and wellbeing including ongoing alcohol and drug issues
- baby – weight and physical examination results
- baby's feeding
- treatment/medication for baby
- parental/baby interaction
- referrals made and care planning.

6. Ongoing role of the MCH service

The first few days and weeks post discharge into the community is a critical time for mothers with alcohol and drug issues and their babies. As noted, they are often socially isolated and returning to an environment lacking in supports. Effective communication and collaborative planning between maternity and MCH services and other community supports is essential.

If the MCH nurse is unable to visit on the date agreed in the coordinated visiting schedule, the MCH nurse will report this by telephone to the SCDU maternity staff or neonatal unit to enable collaborative planning.

If MCH staff are unable to locate the mother during the period of coordinated involvement with the SCDU, MCH staff will report this to the SCDU maternity staff for agreed action, including consultation with Child Protection as appropriate. Refer to protocol appendix 4 regarding the role of Child Protection.

When the postnatal domiciliary/HITH service involvement ends, it becomes the responsibility of the MCH service to engage with the mother and baby as required by the Birth Notification Act. The MCH service should identify these clients as high priority and, dependent on local resources, it is usually appropriate for the enhanced MCH service to be involved.

Home or centre contact should be scheduled to occur within the first few days after completion of postnatal domiciliary/HITH care to ensure continuing continuity of care for these vulnerable families and to support them to confidently and safely care for their babies.

7. Appendices

1. DirectLine 1800 136 385
2. Specialist Chemical Dependency Units
3. Journal article

1. DirectLine 1800 136 385

DirectLine is a statewide telephone service that provides 24-hour, seven-day counselling, information and referral to alcohol and drug treatment and support services throughout Victoria. DirectLine is a free, anonymous and confidential service and is available to anyone in Victoria who is affected by an alcohol or drug problem, including:

- people using drugs
- families, relatives or friends of someone using drugs
- health and welfare professionals
- anyone in the community who has been affected by an alcohol or drug problem.

DirectLine counsellors can provide:

- immediate counselling and support, including crisis intervention
- support in dealing with the impact of drug use on the family and relationships
- assistance to develop strategies to deal with an alcohol or drug problem
- information and referral to treatment and support services across Victoria.

2. Specialist Chemical Dependency Units

The following Victorian public hospitals have Specialist Chemical Dependency Units within their maternity services:

Hospital	Telephone contact
Dandenong Hospital	9554 1000
Frankston Hospital	9784 7777
Mercy Hospital for Women	9270 2222
Box Hill Hospital	9895 3333
Monash Medical Centre	9594 6666
Royal Women's Hospital	9344 2000
Sunshine Hospital	8345 1333
Angliss Hospital	9764 6111
Geelong Hospital	5226 1600

3. Journal article

How great is the risk of abuse in babies born to drug-using mothers? Street, K., Harrington, J., Chiang, W., Cairns, P. and Ellis, M.

https://www.swetswise.com/link/access_db?issn=0305-1862&year=2004&vol=00030&iss=00004>