T R A N S C R I P T

FAMILY AND COMMUNITY DEVELOPMENT COMMITTEE

Inquiry into perinatal services

Warragul — 8 December 2017

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Ms Marilyn Humphrey, maternal and child health coordinator, Baw Baw Shire maternal and child health services.

The CHAIR — Welcome, Marilyn I just have to say a couple of things. All evidence at this hearing taken by the committee is protected by parliamentary privilege as provided by the Constitution Act 1975 and is subject to the provisions of the Parliamentary Committees Act 2003 and other relevant legislation. Any comments you make outside the hearing will not be afforded such privilege. It is a contempt of Parliament to provide false evidence. These proceedings will be recorded, and you will be sent a proof copy of the transcript. I now invite you to spend 10 to 15 minutes telling us about your submission, and if there is a presentation as well maybe, and we will ask some questions after that, if that is okay.

Ms HUMPHREY — I have prepared some written information, so I will just read that if that is alright. My role is as coordinator of maternal and child health nursing and supported playgroup at Baw Baw shire. I commenced in this role in 2012, and prior to this I had worked in midwifery for several years.

I have taken a definition of the perinatal period from 22 weeks gestation to the completion of the fourth week of life. There are several out there, but that is the one that I have worked from.

Maternal and child health nurses in Victoria are registered general nurses/midwives and have a graduate diploma and possible masters qualification in family and community health. To maintain registration it is necessary for us to complete 40 hours of professional development on an annual basis.

The services that I coordinate are located within the family and children's services department. That also includes the preschool field officer, central enrolments for kindergarten and family day care. The Baw Baw shire covers an area of 4027 square kilometres, with a population of just over 49 000. That was from the 2016 census. This represents an increase of 13.1 per cent from the 2011 census, with the largest age group being from 40 to 69 years of age. The nought to four-year-olds represent just over 6 per cent of the population in Baw Baw shire. The largest employing area is health care and social assistance, followed by agriculture, forestry, retail, trade, education and training.

Maternal and child health nursing is a primary healthcare service for families with children from birth up to six years of age. Support is provided in the areas of parenting, health, learning and development, promotion of health, wellbeing and safety, social supports and referrals to other services. The current universal program provides for 10 consultations at various stages of a child's development, seven of which occur during the first year of life, with three of these occurring in the perinatal period. Parents are given the opportunity to discuss their concerns and speak about their parenting experiences, with the goal of optimising their child's health, learning and development. There is capacity for additional visits to be provided if required.

Parent groups are inclusive of but not limited to first-time parents. These groups build parenting capacity, offer support and encourage parents to develop an appreciation of their babies' unique personalities and their needs. The underpinning philosophy is based on research that has shown that secure children exhibit increased empathy and greater self-esteem, better relationships with parents and peers, enhanced school readiness and an increased capacity to handle emotions when compared with children who are not secure. The belief is that parents and caregivers are their children's first and foremost teachers, and they are encouraged to share a sense of wonder and delight in their new baby.

Another program delivered through our service is the Circle of Security. This is a relationship-based early intervention program designed to enhance attachment security between parents and children. The duration of the course is eight weeks.

The enhanced nursing service responds assertively to the needs of children of families at risk of poor outcomes where there are multiple risk factors. It provides a more intensive level of support, including case management in some circumstances. The service is provided predominantly in the home, and parents are supported in identifying babies' early cues and communication to build on family secure relationships and focus on strengths.

Some of the issues that might initiate a referral into the enhanced service are drug and alcohol issues, mental health issues, family violence, families known to child protection, homelessness, unsupported parents under 24 years of age, low-income socially isolated single-parent families, parent-and-baby bonding and attachment issues, a parent with an intellectual disability, children with a physical or intellectual disability and infants at increased risk due to prematurity, low birth weight, drug dependency and failure to thrive. The funded hours of

service for the enhanced nursing are 17 hours in rural areas, and it is designed to cover roughly about 10 per cent of the families with children up to the age of one year.

Our Play Matters supported playgroup is centred around parents and children participating in a range of experiences to build and strengthen the connection between them, to develop an increased understanding of their children's communication through observing specific behaviours and to implement new parenting approaches working in partnership with facilitators, being mindful of individual family goals.

There is a statewide 24-hour telephone support service which is available to all families. This service provides information and advice and links families back into the universal services and other health services as well.

There are seven maternal and child health centres in the Baw Baw shire, with a regular five-days-a-week service in the major towns of Drouin, Warragul and Trafalgar. Yarragon is provided with a bimonthly service, and the outlying areas of Neerim South, Willow Grove, Erica and Rawson are serviced according to need, which is usually monthly to bimonthly, depending on the need.

The staffing level at Baw Baw shire maternal and child health is seven nurses working in the universal service, one enhanced nurse and two supported playgroup and parent group facilitators. This is an equivalent or EFT of five in the universal service, 0.7 in enhanced, 0.3 for parent group facilitators and one EFT for playgroup. We have one EFT admin support as well. We are very lucky to have that; it is great.

The staffing levels have been very, very consistent with an excellent retention rate. However, the workforce is ageing, and there have been two retirements in the last year. At our last recruitment there were seven applications for nursing positions, with five being from the metropolitan area So we are very well situated because we can attract people from the city area, which has been great for us.

Ms McLEISH — And that was for just one position?

Ms HUMPHREY — Yes.

The CHAIR — Sorry to interrupt you, Marilyn, but what do you think is attracting people to come out of the city to take jobs here in the region?

Ms HUMPHREY — Can I just say with the last two nurses that we appointed they were totally impressed by our interview process and as soon as they left they said that they wanted to work at Baw Baw shire. That was the answer that they gave me. We have very good conditions. The EBA is very reasonable in our provision for nurses and provides a very generous allowance for professional development, with the opportunity for scholarship funding for students as well. So we are pretty lucky.

The CHAIR — What scholarships are you talking about there, Marilyn?

Ms HUMPHREY — For students who wish to take up maternal and child health nursing.

The CHAIR — Are they through a certain university?

Ms HUMPHREY — No, either one.

The birth rate on average has been about 555 per year from 2008 to 2015, with an increase to 575 in the 2015–16 year and then to 611 in 2016–17. Currently to the end of November the birth rate is 258, with a prediction of 600-plus for the financial year 2017–18, so we have got a bit of steady growth happening. Most of the birth notices come from West Gippsland Hospital, with some from St John of God and Casey Hospital in Berwick, and we have a small number from the metropolitan hospitals. There are four paediatricians practising in Warragul.

The Aboriginal and Torres Strait Islander people represent 1 per cent of the population in Baw Baw shire, and there is a 68.56 per cent participation rate in the maternal and child health service. This is in no small part due to the relationships forged with community elders and the Best Start partnership. The focus of the Aboriginal Best Start is to ensure that local Aboriginal communities and organisations are given every possible opportunity to support positive outcomes for their children and families. Work continues, with links to the Koori midwife, the

Aboriginal health co-op and the kindergarten enrolment officer, to ensure that children are enrolled with the maternal and child health service, and we continue to increase the participation rate.

There is an increasing volume of evidence to support strengthening health and wellbeing in the perinatal period with the implementation of surveillance and services to mitigate the adverse effects of toxic stress during this time. The focus of the ideas for change presented today relate to and address terms of reference 1, 2 and 5, and the observations and suggestions are the result of discussions that I had with the staff that I manage.

Firstly, emotional health is high on the agenda, with many women and men experiencing postnatal depression, anxiety and depression. Parents often struggle with the transition to parenthood, and if there are pre-existing mental health problems, this compounds the difficulties and impacts in a negative way on the attachment and ongoing relationship with their baby. The grandparents of this generation are often working and are of limited support, and sometimes are giving outdated advice about the care of babies. Families need support with adjustment to becoming parents, particularly fathers, because they tend to get a bit left out sometimes, and extended family members, if that is appropriate, as well. The feeling is that this process could begin in the antenatal period, with a discussion about the changes that will occur with the arrival of the new baby. There also needs to be counselling available during this period, with a reinstatement of funding for the perinatal emotional health program, employing appropriately qualified staff to support families with complex needs.

The Agnes parent and infant unit at Latrobe Regional Hospital is providing an excellent service in dealing with a range of mental health issues and assisting parents with unsettled babies, but is impeded by lengthy waiting lists and limited space. The philosophy of care used in that unit is based on current evidence of the Solihull approach and provides support for families at a time of transition to parenthood. Maternal and child health nurses find this an incredibly valuable referral source, and consideration needs to be given to expanding this service.

The second area was the discharge of smaller, vulnerable babies. We know that with the pressure on hospital nurseries for beds, babies are being discharged earlier and at lower weights, often without adequate support in the home. The feeling is that an extension of the home visiting midwifery service would be appropriate to bridge the gap between hospital care and the maternal and child health service. Sometimes it is just not always possible for us to —

Ms BRITNELL — What are the birth weights that are acceptable for discharge? Has that changed? What have they been, and what are they?

Ms HUMPHREY — Look, sometimes babies as small as 2 kilos are coming out now, with the expectation that we can do daily visits or visit them immediately, but that is not always possible because of our existing workloads. They are wanting babies weighed on a daily basis, too. Sometimes if they need that closer surveillance, they need to be still in hospital, if they are needing that closer monitoring, because they often come with a package of other health issues as well. It is not just the weight and the growth.

The third area was breastfeeding support. It is well recognised that breastfeeding is the best source of nutrition for babies, with the World Health Organization stating that breastfeeding is beneficial to infants, mothers, families and society, and it is viewed as the biological and social norm for feeding infants and young children. It is recommended that infants are exclusively breastfed until six months of age, when solids are introduced, with the continuation of breastfeeding until 12 months of age and beyond for as long as the mother and child desire. There is certainly a wealth of research supporting the benefits of feeding, for both mother and baby.

We have a limited breastfeeding support service available locally, with two days a week, and the response from the maternal and child health nurses is that women with breastfeeding problems need assistance immediately from appropriately qualified staff to support the continuation of feeding and prevent them resorting to the use of formula and bottles.

The CHAIR — And that breastfeeding assistance service, who provides that and how is it funded?

Ms HUMPHREY — I think it is government funded, and it is provided through the West Gippsland Hospital. It is a separate entity, but it has very strong links with the hospital.

The CHAIR — And do you believe breastfeeding rates are going up?

Ms HUMPHREY — Look, my understanding is that they have been fairly stationary for a very long time. Even since the advent of lactation consultants and breastfeeding support services, there has not been much of a shift. But I think the roles of women have changed enormously. People are not just sitting at home now looking after babies. I think the feminists of the 70s and 80s told us we could have it all, but they did not tell us we had to do it all as well, and therein lies the problem.

Ms BRITNELL — Exactly. I think they are regretting it.

Ms HUMPHREY — Yes. So it is difficult; it is really difficult. The recommendation is to expand the current service to five days a week with an on-call phone advice service and possible consultation available for after hours as well. I do not know whether that is economically viable, but that would be very good if we could have that happen.

The last area that I would like to address is family violence. Research demonstrates that family violence often commences or intensifies during pregnancy and is associated with increased rates of miscarriage, low birth weight, premature birth, fetal injury and — worst-case scenario — death. Babies that experience family violence often have increased periods of crying and show signs of anxiety and irritability. They also have feeding and settling issues. In rural communities, people are likely to know each other, and victims can have associated feelings of embarrassment and shame, making them reluctant to disclose violence. The remoteness and associated isolation of rural areas makes access to services difficult.

Family violence services seem to have stressed resources, and they are not always accessible and available. We find that women are moved into the area and often placed in inadequate housing with minimal furniture and they have had to leave all their possessions behind. They feel insecure, not always knowing how to access assistance and unsure of their legal rights. So that is difficult. Our recommendation would be to establish safe and comfortable housing with adequate furniture and provisions to accommodate the needs of the family, also with the provision of staff to assist them with kindergarten and school enrolments to ensure a seamless transition for the family and bring a sense of normalcy to what is a time of great upheaval and stress.

Also one of the big issues is access to legal aid. I was just thinking if it would be possible to have some funding available to interested local law firms that could be providing support and advice to these women, because that is one of the biggest problems. They are just so unsure, and there are often threats being made against them by the perpetrator about what they can and cannot do, and access to children and all that sort of thing.

Ms McLEISH — Is there not a legal aid service in Warragul? Because I saw a big sign —

Ms HUMPHREY — There is a legal aid service, but women seem to say that they have difficulty accessing it.

Ms McLEISH — That is an issue in itself.

Ms HUMPHREY — Yes, it is a problem.

Ms McLEISH — That can be taken up, too.

Ms HUMPHREY — Yes.

The CHAIR — The government just announced $8 million in our family violence package for community legal centres only this week. So if people do not feel comfortable in this region to actually access it, it is not going to be used very well.

Ms COUZENS — But that is specifically for family violence, too.

The CHAIR — Correct.

Ms HUMPHREY — It might sort of open up some other options and just make more services available, too, so that people can sort of get there. That is just sort of from what people tell us. We do screening for family violence at various stages. The four-week consultation is sort of delegated to the health of the women and screening for family violence, but we will do it at other times if we feel that there is a need as well, when we see families.

The CHAIR — Thanks, Marilyn. Do you mind if we ask you some questions now?

Ms HUMPHREY — No, not at all.

Ms BRITNELL — I just want to take the family violence discussion a little bit further. Just then you said that you are quite flexible with regard to how often you will do assessments if you have a suspicion, inkling or concern. Are you finding that your need to address the subject of women in challenging situations, where you are concerned about them, more frequent than you did earlier in your career?

Ms HUMPHREY — I would say yes. I think the recognition of what family violence actually is — because oftentimes somebody will come in and say, 'It was just a bit of a shove' or 'It's nothing' — is a problem.

Ms BRITNELL — From the professional side or from the women in the community?

Ms HUMPHREY — From the client side. I think the professionals are very clear about it. We have had quite a bit of education about family violence, and there is about to be some more being rolled out as well.

Ms BRITNELL — I hear you saying that you are seeing more of it and that we are getting more skills from both sides, both from the client being able to say it is not okay and from the professionals to help recognise it, but are we actually able to signpost people to services to assist as well as we need to be able to, given the increase in demand?

Ms HUMPHREY — Look, I think the services that are in existence are probably under pressure and possibly under-resourced. That is what we are sort of hearing, they have not always got enough people on the ground. Just recently I had seen a family that had been moved into the area and their Quantum worker was on leave, so they were sort of just in limbo. They were wanting to get children moved into kindergarten and schools but were not sure how to go about that process because the worker was on leave and they were waiting for someone else to come or their worker to return. So that is sort of not ideal. We need somebody to sort of be in there straightaway to do that, because the children feel a bit lost, I suppose, in what is a difficult situation.

Ms BRITNELL — You also talked about a good relationship with the Aboriginal communities locally. So it was Ramahyuck, and who else were the services —?

Ms HUMPHREY — Best Start, the Koori midwife.

Ms BRITNELL — So KMS. Is it through Ramahyuck? Is that the only Aboriginal health service that you work with?

Ms HUMPHREY — Yes.

Ms BRITNELL — Are there any Koori staff that you work closely with that are trained in midwifery, or are there any maternal child health nurses?

Ms HUMPHREY — No.

Ms BRITNELL — So the KMS worker is an Aboriginal?

Ms HUMPHREY — No, it is the same girl that the West Gippsland people were talking about. We are very sort of interconnected here.

The CHAIR — Which is not a bad thing. Tracey obviously does a good job.

Ms BRITNELL — You talked about 68 per cent attendance for maternal child health for the milestone assessments in the Aboriginal community. Where has that come from? I assume it is the Best Start program that you are working with to improve that; have I got that right?

Ms HUMPHREY — Yes.

Ms BRITNELL — How does that actually assist? What is the actual process there that is making you get better results, and what is the aim to get toward?

Ms HUMPHREY — I think our aim is to achieve an 80 per cent participation rate.

Ms BRITNELL — By a time frame of?

Ms HUMPHREY — I do not think we will make it by this year, but maybe by the end of next financial year. Because of where we are situated with family and children's services, we have a central kindergarten enrolment. So we can sort of crosscheck lists and if children are not registered on maternal and child health, we can make contact with them and offer them appointments and visits. That works through the midwife and the co-op as well, so we have sort of got the three systems going to be able to crosscheck and make sure that kids are registered with maternal and child health. It also sometimes allows us to pick up people that are moving into the area, because we can be aware of new babies. But sometimes if people are moving in, they sort of get a bit lost, and they are not directly linked to our system.

Ms BRITNELL — With the increases in family violence and the challenges, are you finding the workforce challenges as well — visiting people in the homes — more risky, or is their concern around the staff's safety?

Ms HUMPHREY — I would say no, because we go in in a very non-confrontational way. We are there to walk the journey with the family. It is very different role, say to DHHS, who are going in possibly to remove children or question child-rearing practices and that sort of thing. It is very much walking the journey with the family. If you can sometimes just implement a small change, then that is a gain. We are not going to change the world. I think just sort of working with that attitude, we do not find that threatens. I have worked at Baw Baw for six years, and I have worked as a maternal and child health nurse for, I think, 13 altogether, and I have never felt that my safety is under threat, and certainly none the nurses that I have worked with currently. They would all support me in that.

Ms BRITNELL — Just one last question about the Circle of Security program. Who funds that if it is free? Where is that funding coming from?

Ms HUMPHREY — We fund it from our enhanced service, so we can kind of work with the money. The enhanced nurse does have a contribution to the program. We have two facilitators, because sometimes it is also about the parents' experience of how they were parented, too. Sometimes it brings up some uncomfortable issues for people, so it is good to be able to have two facilitators to be able to debrief with and bounce ideas off as well.

Ms COUZENS — Thank you for coming along today. I appreciate the information. I was pleased to hear that you have good collaboration with the Aboriginal services and community, which is fantastic. It needs to happen. Are your staff doing cultural training as part of that work?

Ms HUMPHREY — Yes, we have done it across the organisation in the past. Probably about 18 months ago we did it, 18 months to two years.

Ms COUZENS — And is that updated on a regular basis?

Ms HUMPHREY — Yes. We probably need to think about updating again because we have not done it for a little while.

Ms COUZENS — On average, how long would you be working with a particular family? Is there, you know, a target period of time or is it just as required?

Ms HUMPHREY — With the universal service, we are funded to provide 10 visits and there is a flexible component where we can see people more frequently if they need to.

Ms COUZENS — Is that the at-risk funding that is attached to that?

Ms HUMPHREY — For the universal service, the funding is 50 per cent from the government and 50 per cent from council. The enhanced service is entirely funded through the government.

Ms BRITNELL — Is that for your low-birth babies and stuff?

Ms HUMPHREY — Yes, for the at-risk, people with increased vulnerabilities. At the moment we are funded to see people with children up to the age of one, but obviously we continue on if the need is there. We cannot just abandon people and say, you know, 'Too bad, so sad, but you're on your own now'. So we do keep going. But there is a lot of, as you would be aware, money being put into the early years, and the service is going to be expanded up to and including the age of three.

Ms COUZENS — Have you had the opportunity to have a look at how that all comes together with that additional funding?

Ms HUMPHREY — Not yet. It is very early days, and we have a wonderful principal nurse at DET who is doing a lot of work on that. It has been great to have a maternal and child health nurse in DET. She works very closely with the MAV policy adviser as well, so it has really been fantastic for our service, and they are both dynamic women.

Ms COUZENS — You also referred earlier to having a good EBA and scholarships and those sorts of things. Do you know what is different about your EBA that is attracting people, compared to other EBAs around the state?

Ms HUMPHREY — I really could not answer that because I do not know. A lot of the other nurses outside of our council would not be aware of what our EBA is, and as I said, we have had a lot of stable staff for a very long time from within the area. It is only just with our last recruitment that we attracted two girls from outside, but they are certainly out there singing our praises. We will probably be recruiting again in the new year, so it will be interesting to see what we get. And people are keen to be travelling this way because it is much less traffic than going towards Melbourne now. It is just so hectic there; it is never quiet anymore.

Ms McLEISH — The congestion.

Ms HUMPHREY — Yes, absolutely.

Ms COUZENS — Within your EBA, are there specific scholarships highlighted?

Ms HUMPHREY — It is sort of a fairly open clause, I think, and it just says that scholarships will be made available if we have students that are interested in following through maternal and child health. But there are scholarships offered from government level now as well because of the ageing workforce and the shortage of maternal and child health nurses. So there is funding out there if people wish to access it, and they would be made aware of that when they apply to the universities. There are two, RMIT and La Trobe, that currently do maternal and child health.

Ms COUZENS — And are you doing anything specific to attract new maternal and child health workers to your area?

Ms HUMPHREY — I guess we have not done a lot because we have had a consistent and stable staff up to now and we have been managing, and we have got a bank of six relief staff as well.

Ms COUZENS — But if you have got an ageing workforce, obviously there has to be that —

Ms BRITNELL — Not until they go, though. You cannot sit around waiting.

Ms HUMPHREY — Yes, it is difficult.

Ms COUZENS — Yes, but they can be trained up.

The CHAIR — But have you got a plan?

Ms HUMPHREY — I guess my plan is that if people are interested, I am certainly open to speaking to them and encouraging them that there will be positions becoming available. We are not precious about that, but it is very, very difficult because until you get the resignation in your hand you can't —

Ms COUZENS — But I think that is one of the difficulties, that we are not planning ahead. We are waiting until there are not enough skills left there instead of looking at our secondary school students and going in. I

know this is not your fault, but I am just saying that if we planned better, we could be encouraging young people to look at that as a career, because they have to go through quite a lengthy training process.

Ms HUMPHREY — It is a long path to get here.

Ms BRITNELL — Marilyn, this is quite different, though, because it is not like nurses who can go and work anywhere. There are only so many maternal and child health nurse positions, aren't there? So if you trained in maternal and child health post grad, you may not actually get a role, especially if you are living in the country, for 15 years. So it is one of the hardest areas for succession planning in the health environment, I would have suggested. What are your thoughts on that?

Ms HUMPHREY — Yes, I would agree, and there has been some discussion about reducing the qualifications. But I was talking to the senior nurse lecturer at RMIT, and we both sort of felt that it is not the way to go because we have one of the best services in the country and other states are looking at us to see what we do and how we do it.

Ms BRITNELL — It has been a challenge for the last 30 or 40 years. It has not changed.

Ms HUMPHREY — I guess it has been as long as I have been in nursing, and that is all I have ever done for my whole working life. We have always had periods when everyone has gone, 'There's no staff', and, 'What are we going to do?', but then all of a sudden — it is a bit like the birth rate; it goes up and down — people seem to appear and you seem to be able to staff whatever it is you need to staff.

Ms BRITNELL — It is a well-sought-after job.

Ms HUMPHREY — Yes.

Ms McLEISH — I want to ask about the process of women being referred to the maternal and child health service through the hospital, how streamlined that is and whether you receive all the information that you require.

Ms HUMPHREY — It is legislated that anyone who is with a birthing woman, whether you are in a hospital or you are a private midwife, is obligated to notify the council wherever that woman lives. I would say we have a very good relationship with the hospital and they are very good at ringing and conveying information. Our obligation, once we receive that birth notice, is to make contact with that woman within seven days and organise a home visit with her. The only time that would not happen is if the baby is detained in hospital or there are some other problems. But the hospital is usually really good at letting us know, and because we have such fantastic admin support they are really good and they will alert me and say, 'Look, we haven't seen baby X. We need to follow that up'. So it is just fantastic. I cannot speak highly enough about the two women who do it.

Ms McLEISH — When we had the hospital people in here earlier, they were talking about the screening that they do by the midwives that happens at the various points during pregnancy. They screen for anxiety and depression and they screen for family violence. I think you mentioned that you do those screenings later on. Do you not know that they have been screened already for those things?

Ms HUMPHREY — Yes, we do. We are aware that they do it, and they would certainly notify us when the women are being discharged if they have any concerns about what has gone before. The other avenue that we follow is we have high-risk infant meetings with the child protection, Child First, social worker and med staff. That covers the unborn report. It sort of puts people on the radar that might have additional needs as well. That is where we kind of get to hear.

Ms McLEISH — So all of that work that they do during that antenatal period does get conveyed to you. Do you believe that is the case statewide? You are shaking your head.

Ms HUMPHREY — I would say probably not. I mean, in the country it is different because the nursing network is fairly small and we often know people. We have worked with people in other areas, so I think that facilitates the communication. Because we have meetings together and information is shared, I think that makes a difference, too.

Ms McLEISH — How often do you have the meetings together?

Ms HUMPHREY — Monthly.

Ms McLEISH — In the instance of a very ill baby or a stillbirth or a death after birth, do you have anything to do with those mothers? Do they get referred to you at all?

Ms HUMPHREY — Usually what happens is, if it is a mother that is known to us, I will ring the hospital and ask if it is appropriate for us to be involved.

Ms McLEISH — How do you hear about that?

Ms HUMPHREY — It is usually recorded on the birth notice.

Ms McLEISH — So they still send you the birth notice?

Ms HUMPHREY — Yes, they send a birth notice. So we would see that, and I would just ring and ask if it is appropriate for us to be involved. Sometimes mothers will say no; sometimes they want us involved. So we just leave it up to the mum, particularly if it is a first-time mum too. Sometimes the hospital do some follow-up and, if they have another baby, they just want to start with a clean slate. So it is very much up to the mum to decide what she would like to do.

Ms McLEISH — Is that statewide practice, because I recall I think that we had previous evidence from somebody who said that was not the case — that if a baby was a stillbirth or had died, there was no referral to maternal and child health, but in this instance you say down here there is.

Ms HUMPHREY — You would send a birth notice if the pregnancy is viable. If it is under 20 weeks, then that is a different story, but if it is over 20 or 22 weeks, you would still be sending out a birth notice to maternal and child health.

The CHAIR — I concur; I heard that as well.

Ms McLEISH — So that was not the case? That is why I am wondering if it is something different here.

Ms BRITNELL — It is the state system. Isn't it statewide?

Ms HUMPHREY — That is right. We are legislated to do that. I think it is under the Children and Young Persons Act. I cannot remember the year, I am sorry, but we certainly are legislated to do that. We might be a bit more flexible in our approach, but I guess if we are working from a strength-based practice, then rather than assuming what a mother needs or wants it is better to perhaps just put the idea out there and let her decide what is appropriate for her. We always say, if they decline involvement with the service — because it is a voluntary service — 'You know our number, and if you wish to contact us in the future, you're most welcome'. We never close the door.

Ms McLEISH — Thank you for that. That was just a case of sometimes you hear conflicting evidence.

Ms HUMPHREY — Yes, of course. I imagine so.

Ms McLEISH — I just want to touch very quickly on, as you mentioned — and we have heard many times — the skills required and the qualifications and study to become a midwife and then to be a maternal and child health nurse. If local midwives wanted to take that next step, how far away do they have to do the training? You have mentioned La Trobe, I think, and RMIT. Do they have to go to those campuses in the city, or are there closer campuses?

Ms HUMPHREY — It depends on how they choose to do the course. They can study it part-time or full-time. If it is part-time, it is over two years; if it is full-time, it is a year, but it is a pretty intensive year. They would be able to do a lot of the work as external students.

The CHAIR — If you could just let us ask a couple of questions for a couple of more minutes and we will be out of your hair. I just wanted to ask about the Agnes centre at LRH. We heard a little bit about it yesterday, but I do not think we are clear on what services it actually provides. Can you give us that information?

Ms HUMPHREY — I will do my best. It began primarily with a focus on mental health issues but I guess has evolved into looking at sleep and settling issues, because most people would say that, if a mum or a parent comes in with sleep and settling issues, there is usually something behind that. So now they are taking in those families as well, which has been great for us because we know what the women are getting. They have a mixed skill set there. As well there is a psychologist, a psychiatrist and a maternal and child health nurse. They have some midwives and nurses as well, so it is a varied skill set. They do some work with parenting courses as well. The Solihull Approach is based around I suppose containment, reciprocity and behaviour management, so they are the three concepts.

The CHAIR — Beautiful, thank you. The other thing I would just like to ask about is that you were speaking about postnatal depression before and how it affects men and women, which we do not hear enough about frankly. I just wanted to ask what services are available here to assist men.

Ms HUMPHREY — We have done a couple of Circle of Security courses for men, and with the men we have had 100 per cent attendance to the point that if they could not attend, they were ringing to do catch-up classes. So it was really good. We did a couple of groups of about 10.

The CHAIR — You do not hear that much anywhere, do you?

Ms HUMPHREY — No. The work demands of these fellows was a bit variable. We did it in the evening for men, but some of them were doing shiftwork, so they were able to come in during the day and do catch-ups. We are pretty lucky in this area because we have got a really stable workforce in the medical field. The paediatric service is just outstanding, and the GPs are a very stable group. There is not a lot of movement, so families can link in with a doctor and carry through with that same doctor for quite some time, and they seem to provide good follow-up. The women come out and they have got a two-week appointment and a six-week appointment all locked in, and I guess that support is there for men if they need it. We try to be inclusive of the men in our service. We are probably not doing as well with that as we could be, but there is certainly some work being done at a higher level looking at how we can engage the fathers in a better, more appropriate way. So hopefully we will make some headway with that, but certainly if we were to see fathers and we felt there were issues, we would look at appropriate referral sources for them.

The CHAIR — Thanks, Marilyn. Thank you so much for coming in today and sharing your huge depth of knowledge with us.

Ms HUMPHREY — Thank you very much for having me. It was great.

Witness withdrew.