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Family and Community Development
Committee

**Inquiry into perinatal
services**

Final Report

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Family and Community Development Committee

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Committee functions

The Family and Community Development Committee is constituted under section 11 of the *Parliamentary Committees Act 2003*.

The Committee's functions are to inquire into, consider and report to the Parliament on:

- a. any proposal, matter or thing concerned with:
 - i. the family or the welfare of the family;
 - ii. community development or the welfare of the community;
- b. the role of Government in community development and welfare, including the welfare of the family.

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This report is available on the Committee's website.

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Terms of Reference

Inquiry into perinatal services

Received from the Legislative Council on 16 September 2015:

That this House, pursuant to section 33 of the *Parliamentary Committees Act 2003*, requires the Family and Community Development Committee to inquire into, consider and report no later than 30 June 2016* on the current situation relating to the health, care and wellbeing of mothers and babies in Victoria during the perinatal period, including —

1. the availability, quality and safety of health services delivering services to women and their babies during the perinatal period;
2. the impact that the loss of Commonwealth funding (in particular, the National Perinatal Depression Initiative) will have on Victorian hospitals and medical facilities as well as on the health and wellbeing of Victorian families;
3. the adequacy of the number, location, distribution, quality and safety of health services capable of dealing with high risk and premature births in Victoria;
4. the quality, safety and effectiveness of current methods to reduce the incidence of maternal and infant mortality and premature births;
5. access to and provision of an appropriately qualified workforce, including midwives, paediatricians, obstetricians, general practitioners, anaesthetists, maternal and child health nurses, mental health practitioners and lactation consultants across Victoria;
6. disparity in outcomes between rural and regional and metropolitan locations; and
7. identification of best practice.

* The reporting date was extended to 8 December 2017 by resolution of the Legislative Council on 12 April 2016. The reporting date was further extended to 31 March 2018 by resolution of the Legislative Council on 6 September 2017. The reporting date was further extended to 20 June 2018 by resolution of the Legislative Council on 20 February 2018.

Chair's foreword

The Perinatal Services Inquiry engaged in the significant task of examining the quality and safety of perinatal services in Victoria, including services dealing with high risk and premature births, and the quality and safety of current methods to reduce infant and maternal mortality.

The Committee examined the healthcare and wellbeing of mothers and babies throughout the entire perinatal period and received submissions from healthcare professionals, community members, and families, as well as holding regional hearings. We looked at the availability, quality, and safety of services for women and babies, disparity in outcomes between those that live in regional areas and metropolitan areas, and the challenges of retaining an appropriately qualified workforce across the state.

In Victoria, there have recently been many significant changes to perinatal services with regard to hospital monitoring and accountability, particularly with the creation of Safer Care Victoria. While Victoria's perinatal mortality rate is currently the lowest adjusted rate in 16 years and is lower than the national average, there are still gains to be made. Perinatal mortality rates remain higher among certain groups, such as Aboriginal and Torres Strait Islander babies and specific migrant groups. The Committee heard that positive results in these areas were certainly obtainable and solutions were available.

Throughout the Inquiry, the voices of families, nurses, midwives, support groups and health professionals have reinforced over and over again that there are improvements that can be made to Victoria's perinatal services sector, particularly in the areas of mental health, regional access to services, Aboriginal and Torres Strait Islander perinatal mortality rates, and poor breastfeeding rates. Furthermore, a common theme throughout the Inquiry was the need for honest and open discussion regarding the challenges, particularly Aboriginal and Torres Strait Islander, mental health and workforce challenges.

The Committee heard evidence of distressing situations ranging from separation at birth, medical procedures taking place without advice or warning, and a lack of support resulting in long term implications for mother, baby, family, along with a potentially significant impact on the health system. Our hearings also witnessed accounts of successful models of continuity of care, bereavement services and Victoria's perinatal services operating well, with its workforce going above and beyond to look after babies and families.

The impact that the loss of Commonwealth funding (in particular, for the National Perinatal Depression Initiative) will have on Victorian hospitals and medical facilities as well as on the mental and emotional health and wellbeing of Victorian families was obvious, as was the invaluable positive contribution of community groups to this sector. The Committee was inspired by some of the experiences and case studies we heard, and by some of the selfless contributions made to our Victorian communities

by organisations such as The Babes Project. The recommendations in this report are focused on strengthening the early intervention and full support provided by these services throughout the perinatal period.

The Committee heard of positive experiences for women in rural and regional Victoria, however the nature of the Inquiry highlighted limitations in these areas. The Committee was impressed by innovative programs developed locally and tailored to the circumstances of the rural and regional setting. Across the board, but especially in regional areas, the perinatal workforce includes a range of health practitioners who face major challenges, including but not exclusive to, a shortage of midwives and nurses, population growth, and workplace stress. The Inquiry certainly heard evidence of shortages of an appropriately qualified workforce, including midwives, paediatricians, obstetricians, general practitioners, anaesthetists, maternal and child health nurses, mental health practitioners and lactation consultants. The shortage of specialists, Maternal and Child Health nurses, nurses, and midwives was especially prevalent in regional areas where attraction and retention are issues.

On behalf of the Committee I would like to acknowledge our committed and passionate perinatal workforce and thank everyone who contributed to the Inquiry through over 100 written submissions and 90 appearances in person at public hearings, including the babies and toddlers who accompanied witnesses.

The Committee thanks the Secretariat – Mr Joel Hallinan, Executive Officer, Dr Greg Gardiner, Executive Officer, Ms Rachel Macreadie, Research Officer, Dr Pamie Fung, Inquiry Officer, and Ms Helen Ross-Soden, Administration Officer – for their outstanding research and support to the Committee.

I would like to thank my fellow Committee Members, Deputy Chair Ms Cindy McLeish MP, Ms Maree Edwards MP, Ms Chris Couzens MP, Dr Rachel Carling-Jenkins MP, Mr Bernie Finn MP and Mrs Roma Britnell MP, for their commitment to the Inquiry and to improving the health and wellbeing of women, babies, and families during the critical perinatal period.

Paul Edbrooke, MP
Chair

Executive summary

Throughout the Inquiry the Committee heard evidence from mothers, health practitioners, researchers, Victorian Government departments and others on the current situation relating to the health and wellbeing of mothers and babies during the perinatal period, and the delivery of perinatal services. The Committee received over 100 submissions and heard from over 90 witnesses at public hearings. This included seven public hearings in the regional centres of Warrnambool, Bendigo, Wangaratta, Mildura, Bairnsdale, Warragul, and Geelong.

The evidence told a story of a perinatal services system that generally offers high quality care, but a system that also has gaps that need to be addressed. These gaps include the provision of perinatal mental health care, shortages in the perinatal workforce, and a lack of breastfeeding support.

The Committee sees the need for a greater focus on, and integration of, perinatal mental health services. This is especially important as societal shifts in support structures have left some mothers and families more vulnerable to emotional and mental health problems during the perinatal period. The Committee sees this as an area in which Victoria can improve greatly, and its recommendations on this issue include the development of a Perinatal Mental Health Plan.

The perinatal workforce in Victoria is facing major challenges. This includes a shortage of midwives and nurses which needs to be immediately addressed. The Committee sees a strong midwifery workforce as essential to ensuring good perinatal health for mothers, babies, and families. The Committee is also concerned by evidence of the shortage of perinatal health practitioners across a range of professions in rural and regional Victoria. The Committee makes recommendations aimed at growing a sustainable midwifery, nursing, and rural and regional workforce.

The Committee also heard that more can be done to improve breastfeeding rates and support for breastfeeding women across Victoria's perinatal services. The Committee found that while the benefits of breastfeeding are well documented, many women were not given the information and support they needed by health practitioners to achieve successful outcomes. The Committee makes a range of recommendations to improve breastfeeding support for Victorian women.

In addition to the issues mentioned above, the eight chapters of this report examine and describe Victoria's current perinatal services, including oversight mechanisms and clinical governance initiatives, such as Safer Care Victoria, and regional perinatal mortality and morbidity committees. The Committee also describes the models of care available to women in Victoria, and makes recommendations to encourage models with positive outcomes. Further, the Committee examines the Maternal and Child Health Service, and particular programs for communities that face greater challenges in accessing high quality perinatal healthcare, such as rural and regional communities, Aboriginal and Torres Strait Islander communities, and culturally and linguistically diverse communities.

Chapter One: The quality and safety of perinatal services in Victoria

In Victoria, there have recently been many significant changes to perinatal services with regard to hospital monitoring and accountability. The chapter examines these changes, particularly the creation of Safer Care Victoria and its role in driving state-wide quality improvement in partnership with clinicians.

The chapter also examines the collection and reporting of perinatal data, regional perinatal mortality and morbidity committees, the Consultative Council on Obstetric and Paediatric Mortality and Morbidity, the Capability Framework for Victorian maternity and newborn services, and patient transfers through the Paediatric Infant Perinatal Emergency Retrieval Service.

The Committee found that the regional perinatal mortality and morbidity committees have value in providing not only an early warning alert system for services that are struggling, but also ongoing professional development and learnings from other services. The Committee recommends the Government provide ongoing funding to these committees, and support their ability to contribute to standardised reporting mechanisms for inclusion in Department of Health and Human Services practices.

The Committee found that some aspects of Victoria's perinatal services require review, including the state's neonatal intensive care units, which are facing capacity challenges, and the Paediatric Infant Perinatal Emergency Retrieval Service, which provides an important part of perinatal services in Victoria.

The Committee heard a great deal of evidence about early discharge of women following birth, and that this practice may compromise the health, safety and wellbeing of mothers and their babies, and inhibit the establishment of breastfeeding. The Committee recommends a review of discharge policies in all public hospitals with a view to ensuring that women receive postnatal support both in the hospital and in the community.

The Committee also makes recommendations around health promotion, parenting support groups, and bedside information for clinicians.

Chapter Two: Models of care for mothers and their babies

Throughout the Inquiry, the Committee heard about many different models of care for women during the perinatal period, including hospital clinic care, shared maternity care, team midwifery care, midwifery-led continuity of care, and planned homebirths. There was strong support during the Inquiry among mothers and health professionals for continuity of care models. The chapter provides a discussion of the different models of perinatal care for mothers and their babies, with a particular focus on the role of midwives.

The Committee makes recommendations to increase the availability of different models of care to mothers. In particular, the Committee recommends the Victorian Government examine the feasibility of expanding midwifery-led continuity of care programs, including the program enabled by allowing private midwives admitting

rights at the Northern Hospital. Related to choice of care, the Committee heard of instances where women had not been given informed consent for some procedures, and recommends a state-wide review of hospital policies and procedures with respect to rights for birthing mothers, including the right to informed consent.

The Committee found that more can be done to support breastfeeding women in Victoria, and makes recommendations to encourage breastfeeding rates through a public health campaign, training on breastfeeding support for health professionals, and an increased focus on lactation education and support in midwifery and nursing university courses. The Committee also makes recommendations to establish day stay lactation clinics within Victoria's public health system and advocate for Medicare rebates for lactation consultant visits.

Chapter Three: Perinatal mental health services

The Committee received a substantial amount of evidence concerning mental health during the perinatal period. The Committee heard evidence that the experience of mothers in the perinatal period in recent years is different to that of previous generations. A societal shift away from support from relatives, neighbours, friends, and the community can leave parents experiencing social isolation, a risk factor for developing mental illness. The Committee wishes to emphasise that there is a need and desire for mothers and families in the perinatal period to have access to the kind of personal, emotional support that is less prevalent now than it was in generations past.

The chapter examines the prevalence of mental illness during the perinatal period and its impact on the mother, the baby, the family, and the wider community, and the treatment services available in Victoria. The chapter also examines risk factors for developing perinatal mental health disorders, such as family violence and bereavement.

The Committee found that perinatal mental health services are in need of greater support from government. Evidence to the Committee told of services that are ad hoc and unintegrated, with a lack of an overarching state-wide plan to integrate perinatal mental health services into broader perinatal health services. The Committee makes a recommendation that the Victorian Government establish a Perinatal Mental Health Plan, as an adjunct to the 10-year Mental Health Plan. The Committee further recommends evaluating the demand for Early Parenting Centres and mother baby units, with a view to expanding these services to meet demand.

The chapter discusses the loss of Commonwealth funding for the National Perinatal Depression Initiative (NPDI) and the subsequent reduction in Perinatal Emotional Health Programs (PEHP) in Victoria's regions. The Committee heard of the substantial impact this has had on women in rural and regional areas, and recommends the reinstatement of Commonwealth NPDI funding, along with ongoing Victorian Government funding to continue and expand PEHP.

The Committee makes a number of other recommendations to improve Victoria's perinatal mental health services, including improved screening for mental illness and training for health practitioners.

Chapter Four: Perinatal services in rural and regional Victoria

The Committee heard that women in rural and regional areas had a higher risk profile in the perinatal period, due to factors such as higher rates of obesity and smoking. Women in these areas also face barriers presented by distance from health services, and the associated travel. In addition, the Committee heard that there are difficulties attracting and retaining a perinatal workforce in rural and regional Victoria, with workforce shortages being a significant issue for rural and regional health services.

The Committee was impressed by innovative local programs to address the challenges faced by women and families in rural and regional Victoria, and highlights examples of these programs in the chapter. However, more needs to be done at a state-wide level to support these women in the perinatal period.

The chapter discusses rural and regional women's experiences of accessing perinatal health and mental health services and the impact of the Capability Framework for Victorian maternity and newborn services on rural and regional health services, which the Committee recommends reviewing. The chapter also discusses the closure of smaller birthing services in the regions, access to perinatal mental health services, the potential to further develop telehealth, and the work of one of Victoria's bush nurses.

The Committee heard that it is vital to ensure the rural and regional workforce is supported by higher capability services, and makes recommendations to provide support and training opportunities for the rural and regional workforce. The Committee also recommends support for women and families that need to travel away from home to higher capability services.

Chapter Five: Workforce capacity in perinatal services

The perinatal workforce in Victoria includes a variety of health practitioners. The Committee heard throughout the Inquiry of the role played by midwives, nurses, doctors, including obstetricians and gynaecologists, maternal and child health nurses, mental health practitioners, lactation consultants, and others in providing perinatal care. Victoria's perinatal workforce is facing major challenges, including a shortage of midwives and nurses, population growth, and a shortage of health practitioners, particularly doctors, in rural and regional Victoria.

The Committee makes a range of recommendations to support and grow Victoria's perinatal workforce across a range of professions. In relation to the rural and regional workforce, the Committee recommends that the Victorian Government implement a comprehensive strategy to provide an appropriately qualified perinatal workforce in rural and regional Victoria in the short, medium and long term. The Committee also recommends a review and increase of incentives to attract practitioners to rural and regional Victoria, and that specialist training colleges put in place strategies to grow the specialist medical perinatal workforce in rural and regional Victoria.

In relation to the midwifery and nursing workforce, the Committee recommends that the Victorian Government develop and implement a plan to ensure provision of an appropriately qualified midwifery and perinatal nursing workforce. This plan needs to include short and long-term measures, and address pathways to

qualification, support for continuing professional development, and support for the emotional and mental health of midwives and nurses. The Committee makes further recommendations to support the training of midwives and nurses both at university and as part of continuous professional development, as well as a review of the impact of single-qualification midwifery on rural and regional health services.

The Committee also makes recommendations to increase availability of the perinatal mental health workforce, improve lactation support and build the lactation consultant workforce, and address challenges in the genetics services and sonographer workforces.

Chapter Six: Maternal and Child Health Service

The Committee heard that the Maternal and Child Health (MCH) Service supports families and their children with an emphasis on parenting, health promotion, early detection and intervention, and social support. However, the challenges and expectations of a changing community are placing an increased pressure on Victoria's MCH Service and workforce.

The chapter describes the experience of mothers using the MCH Service, challenges facing the MCH workforce, including staff attrition through retirement, pathways for treatment referral available to MCH nurses, and communication between hospitals and MCH Service providers.

In light of the increased pressures on the MCH Service and workforce, the Committee recommends an examination of the model of the MCH Service, with consideration to providing a more holistic approach encompassing the mental, social, emotional, and physical health of the family. Further recommendations in the chapter support this through specific initiatives such as greater support for fathers, and funding for programs that promote antenatal support for vulnerable families.

The Committee heard evidence of gaps in communication between health services and the MCH Service. To address this issue, the Committee recommends protocols that provide for increased communication and joint discharge planning.

Chapter Seven: Perinatal services for Aboriginal and Torres Strait Islander communities

The Committee heard that there have been improvements to perinatal outcomes for Aboriginal and Torres Strait Islander mothers and babies, however, there remain significant disparities in health and perinatal outcomes between Aboriginal and Torres Strait Islander communities and non-Aboriginal and Torres Strait Islander communities. The chapter discusses the issues leading to disparities and examines barriers to accessing maternity and perinatal services.

The chapter also discusses positive initiatives that the Committee heard about during the Inquiry, including Aboriginal and Torres Strait Islander birthing rooms, Koori Maternity Services, initiatives to increase attendance at the MCH Service, and scholarships to encourage an Aboriginal and Torres Strait Islander workforce.

The Committee makes recommendations to improve perinatal services for Aboriginal and Torres Strait Islander families, including expanding Koori Maternity Services and Aboriginal birthing rooms across the state. The Committee also recommends ensuring the perinatal health workforce receives cultural awareness training and that funding be provided for transport associated with perinatal services for Aboriginal and Torres Strait Islander families living in rural and remote areas.

Chapter Eight: Perinatal services for culturally and linguistically diverse communities

Throughout the Inquiry, the Committee heard evidence that women from culturally and linguistically diverse (CALD) and refugee communities face disadvantages and barriers in accessing perinatal services. These women often experience social isolation and are particularly vulnerable to developing mental health conditions during the perinatal period. They also often struggled to receive the support and services they need. They may also have difficulty communicating and navigating health and social services. Likewise, the Committee heard that health professionals were often inexperienced in working with families from CALD backgrounds, and interpreters were not used often enough to support women.

The chapter examines the perinatal services provided to women from CALD communities in terms of access, birthing options, communication, hospital staff training, and support services. It also discusses evidence that the Committee heard about avenues to better support and empower these communities through the use of technology, training, and continuity of care models.

The Committee also heard of a gap in perinatal healthcare for temporary visa holders and recommends that the Victorian Government work with the Council of Australian Governments (COAG) to ensure the safety of mothers and babies.

The Committee believes that the use of interpreters is fundamental to empowering women from CALD communities in medical decision making. The Committee recommends interpreters be used for every consultation with a woman who needs one, as well as a review of the use of interpreters in public hospitals, and a strategy to recruit more interpreters.

The Committee heard of the benefit that continuity of care models can provide to women from CALD and refugee backgrounds, and recommends development of a policy that gives priority for continuity of care models to women from CALD communities. The Committee also recommends training in cultural awareness and engagement for maternity and mental health staff, and that translated information is up-to-date, culturally sensitive, and accessible for those with low levels of literacy.

Acronyms

ABA	Australian Breastfeeding Association
ACCO	Aboriginal community controlled organisation
AHMAC	Australian Health Ministers' Advisory Council
ANZNN	Australian and New Zealand Neonatal Network
BFHI	Baby Friendly Health Initiative
BMI	Body mass index
CALD	Culturally and linguistically diverse
CCOPMM	Consultative Council on Obstetric and Paediatric Mortality and Morbidity
COAG	Council of Australian Governments
COPE	Centre of Perinatal Excellence
COSMOS	COmparing Standard Maternity care with One to one midwifery Support
CPD	Continuing professional development
DET	Department of Education and Training
DHHS	Department of Health and Human Services
EFT	Equivalent full time
EPDS	Edinburgh Postnatal Depression Scale
GP	General practitioner
HMHB	Healthy Mothers, Healthy Babies
IBCLC	International Board Certified Lactation Consultant
ICU	Intensive care unit
KAS	Key Ages and Stages
KMS	Koori Maternity Service
LGA	Local government area
MAIF Agreement	Marketing in Australia of Infant Formulas Agreement
MAV	Municipal Association of Victoria
MBS	Medicare Benefits Schedule
MCH	Maternal and Child Health
MCWH	Multicultural Centre for Women's Health
NETS	Newborn Emergency Transport Service, now part of PIPER
NHMRC	National Health and Medical Research Council
NICU	Neonatal intensive care unit
NPDI	National Perinatal Depression Initiative
PANDA	Perinatal Anxiety and Depression Australia
PEER	Panel of External Expert Reviewers
PEHP	Perinatal Emotional Health Program
PERS	Perinatal Emergency Referral Service, now part of PIPER
PETS	Paediatric Emergency Transport Service, now part of PIPER
PIPER	Paediatric Infant Perinatal Emergency Retrieval Service
PMR	Perinatal mortality rate
PROMPT	Practical Obstetric Multi-Professional Training

Acronyms

PSPI	Perinatal Services Performance Indicators
PTSD	Post-traumatic stress disorder
RACP	Royal Australasian College of Physicians
RANZCOG	Royal Australian and New Zealand College of Obstetricians and Gynaecologists
RANZCP	Royal Australian and New Zealand College of Psychiatrists
RWH	The Royal Women's Hospital
VPDC	Victorian Perinatal Data Collection
VPTAS	Victorian Patient Transport Assistance Scheme
WHO	World Health Organization

Recommendations

1 The quality and safety of perinatal services in Victoria

RECOMMENDATION 1.1: The Victorian Government, in consultation with health practitioners, conduct a review of Neonatal Intensive Care Units (NICU) in Victoria, taking into account the challenges identified in this report. 10

RECOMMENDATION 1.2: The Victorian Government commit to ongoing funding to support the work of regional perinatal mortality and morbidity committees and to ensure that these committees are available in each health region of the state. 24

RECOMMENDATION 1.3: The Victorian Government support regional perinatal mortality and morbidity committees to contribute to standardised reporting mechanisms for inclusion in Department of Health and Human Services practices. . . . 24

RECOMMENDATION 1.4: The Victorian Government review the Paediatric Infant Perinatal Emergency Retrieval Service’s (PIPER) performance, capacity, outcomes, and relationships with other health services. 29

RECOMMENDATION 1.5: The Victorian Government expand the Retrieval and Critical Health Information System (REACH) website to include obstetric care and maternity bedstate. 30

RECOMMENDATION 1.6: The Victorian Government commit to ongoing funding for education and health promotion campaigns to address the risks of smoking, alcohol and drugs in pregnancy and the risks to infants and mothers. 42

RECOMMENDATION 1.7: The Victorian Government fund an education and health promotion campaign highlighting the risks of obesity and gestational diabetes for pregnant women and infants. 42

RECOMMENDATION 1.8: The Victorian Government review discharge policies in all public hospitals with a view to ensuring that women receive postnatal support both in the hospital and in the community. 48

RECOMMENDATION 1.9: The Victorian Government develop a framework for recurrent funding for existing parenting support groups. 52

2 Models of care for mothers and their babies

RECOMMENDATION 2.1: The Victorian Government, through the Department of Health and Human Services, examine the feasibility of expanding the midwifery-led continuity of care programs that are offered through the public health system. 71

RECOMMENDATION 2.2: The Victorian Government, through the Department of Health and Human Services, engage with public hospitals to examine the feasibility of other hospitals around the state expanding the admitting rights for private midwives. 74

RECOMMENDATION 2.3: The Victorian Government, through the Department of Health and Human Services, examine the feasibility of expanding and strengthening the current shared care models that are offered through the public health system.. . . . 77

RECOMMENDATION 2.4: The Victorian Government, through the Department of Health and Human Services, conduct a state-wide review of public hospitals' policies and procedures with respect to the rights of birthing mothers, including the right to informed consent. 82

RECOMMENDATION 2.5: The Victorian Government fund the expansion of antenatal classes across the public health system, and those classes include a focus on education on the social, physical and emotional changes that come with having a baby. 85

RECOMMENDATION 2.6: The Victorian Government prioritise a public health promotion campaign to encourage breastfeeding and increase breastfeeding rates across Victoria. 89

RECOMMENDATION 2.7: The Victorian Government develop and fund specific training for health professionals, including midwives and GP obstetricians, on supporting mothers to breastfeed. 90

RECOMMENDATION 2.8: The Victorian Government request lactation education and support be included in the core syllabus in university training for nurses and midwives, including Maternal and Child Health nurses, by making submissions to the Australian Nursing and Midwifery Education Council's reviews of nursing and midwifery education standards. 90

RECOMMENDATION 2.9: The Victorian Government support hospitals to become accredited with the Baby Friendly Health Initiative. 93

RECOMMENDATION 2.10: The Victorian Government fund and establish day stay lactation clinics across the Victorian public health system, with flexibility of delivery to best suit the needs of communities. 102

RECOMMENDATION 2.11: The Victorian Government use its position on the Council of Australian Governments (COAG) to advocate for:

- the creation of a new Medicare item so that breastfeeding mothers can receive Medicare rebates for consultations with lactation consultants;
- a review of the Marketing in Australia of Infant Formulas: Manufacturers and Importers Agreement 1992 to expand the Agreement and ensure that all industry participants selling formula in Australia are parties to the Agreement. 106

3 Perinatal mental health services

RECOMMENDATION 3.1: The Victorian Government create a Perinatal Mental Health Plan, as an adjunct to the 10-year Mental Health Plan, as a matter of priority to address the perinatal mental health needs of mothers, fathers and families.

- The Perinatal Mental Health Plan will include as a key element a public awareness campaign, created in collaboration with key stakeholders, to promote perinatal mental health, and services.
- The Plan will include specific goals and outcomes for Aboriginal and Torres Strait Islander communities and culturally and linguistically diverse communities. **115**

RECOMMENDATION 3.2: The Victorian Government establish a taskforce of key stakeholders to consult with relevant health professionals and implement a state-wide program that ensures that all pregnant women will be screened for anxiety and depression by a health professional throughout pregnancy, as envisioned in the Australian Clinical Practice Guideline for Mental Health Care in the Perinatal Period.

- Screening to be conducted using a standard assessment tool.
- Screening to be repeated throughout the pregnancy.
- The taskforce to investigate and recommend action to ensure that all health professionals have available clear referral pathways and services for treatment for women and families who are identified as having, or at risk of having, perinatal mental health issues.
- The program include a state level accountability process. **134**

RECOMMENDATION 3.3: The Victorian Government work with key stakeholders to ensure that the perinatal health workforce has the training and assessment tools to conduct perinatal mental health screening during pregnancy. **134**

RECOMMENDATION 3.4: The Victorian Government engage with Victorian hospitals, key providers and stakeholders to develop a training package on bereavement care for health practitioners. **138**

RECOMMENDATION 3.5: The Victorian Government work with and support the organisations that support families grieving pregnancy loss or newborn death, including creating linkages between health services and those organisations. **138**

RECOMMENDATION 3.6: The Victorian Government evaluate the demand for Early Parenting Centres across the state with a view to expanding this service to provide effective coverage for mothers, babies and families.. . . . **139**

RECOMMENDATION 3.7: The Victorian Government evaluate the demand for mother baby units across the state with a view to expanding this service to meet the current level of unmet demand.. . . . **141**

RECOMMENDATION 3.8: The Victorian Government provide ongoing funding for the existing Perinatal Emotional Health Programs (PEHP), and fund the expansion of the program state-wide to be delivered as a key element of supporting women at risk of, or experiencing, mental health illness in the perinatal period. **151**

RECOMMENDATION 3.9: The Victorian Government use its position on the Council of Australian Governments (COAG) to continue to advocate for the reestablishment of Commonwealth National Perinatal Depression Initiative (NPDI) funding. 151

RECOMMENDATION 3.10: The Victorian Government fund the expansion of perinatal mental health programs for fathers.

- The Department of Health and Human Services collaborate with key stakeholders and service providers to identify and develop best practice programs to support the mental health of fathers in the perinatal period.. . . . 156

4 Perinatal services in rural and regional Victoria

RECOMMENDATION 4.1: The Victorian Government review the Victorian Patient Transport Assistance Scheme to provide greater support to rural and regional women who need to travel long distances to access maternity services including on their discharge from hospital. 168

RECOMMENDATION 4.2: The Victorian Government work with public health services including social workers to provide expanded travel and accommodation support for rural and regional families when mothers and babies are receiving care away from home. 168

RECOMMENDATION 4.3: The Victorian Government support rural and regional maternity services through increased funding and staffing, to allow women in rural and regional areas the choice of giving birth in their own community, taking into account the safety of mothers and babies, and the Capability Framework for Victorian maternity and newborn services in that region. 171

RECOMMENDATION 4.4: The Victorian Government put systems in place to facilitate maintenance of skill sets of rural and regional obstetricians and GP obstetricians through enabling them to do short-term placements at higher capability hospitals. 171

RECOMMENDATION 4.5: The Victorian Government review how the Capability Framework for Victorian maternity and newborn services impacts maternity and neonatal services in regional Victoria. 182

RECOMMENDATION 4.6: The Victorian Government consider adopting a consistent neonatal pack to enable emergency care, including neonatal resuscitation, to be administered to newborn infants in rural and regional health services, such as the New South Wales’ Good Egg Packs. 183

RECOMMENDATION 4.7: The Victorian Government facilitate the development of shared policies and protocols in obstetric and neonatal care for health services across Victoria. 183

RECOMMENDATION 4.8: The Victorian Government enable and ensure ongoing training opportunities to health practitioners in rural and regional areas to be sufficiently skilled to provide emergency perinatal care. 199

RECOMMENDATION 4.9: The Victorian Government investigate increasing the availability of telehealth options for perinatal healthcare, particularly in rural and regional Victoria. 204

RECOMMENDATION 4.10: The Victorian Government undertake planning to ensure a sufficient level of perinatal healthcare in remote areas of Victoria through consultation with the current bush nurses.. . . . 205

5 Workforce capacity in perinatal services

RECOMMENDATION 5.1: The Victorian Government use its position on the Council of Australian Governments (COAG) and work with the Australian Medical Council to achieve a change in accreditation standards that requires specialist training colleges to put in place strategies to enhance and grow the rural and regional specialist perinatal workforce. 215

RECOMMENDATION 5.2: The Victorian Government review and increase the incentives in place for attracting and retaining perinatal health practitioners in rural and regional Victoria, to establish a more effective range of incentives to support a sustainable workforce.. . . . 215

RECOMMENDATION 5.3: The Victorian Government develop and implement a comprehensive strategy to provide an appropriately qualified perinatal workforce in rural and regional Victoria in the short, medium and long term.. . . . 216

RECOMMENDATION 5.4: The Victorian Government use its position on the Council of Australian Governments (COAG) to advocate for an increase in the number of Commonwealth Supported Places for midwifery courses at Victorian universities, with a focus on regional universities beyond the major regional centres.. . . . 224

RECOMMENDATION 5.5: The Victorian Government increase the funding for scholarships to support the development of Victoria’s midwifery workforce, with a focus on scholarships for rural and regional areas. 225

RECOMMENDATION 5.6: The Victorian Government work with regional universities to develop innovative solutions to enable experts from agencies critical to the education of midwives to present at regional and rural universities. 225

RECOMMENDATION 5.7: The Victorian Government increase the size and number of Training and Development grants available to support the implementation of the employment model for postgraduate midwifery students. 228

RECOMMENDATION 5.8: The Victorian Government review the impact on rural and regional health services of single-qualification midwifery.. . . . 229

RECOMMENDATION 5.9: The Victorian Government review existing successful programs that provide ongoing training for midwives in rural and regional Victoria to develop accessible continuing professional development that would be valuable for other midwives across the state. 230

RECOMMENDATION 5.10: The Victorian Government provide reimbursement, including for travel and accommodation, to enable midwives to attend the mandatory training for their specialty required to satisfy their continuing professional development responsibilities.. **230**

RECOMMENDATION 5.11: The Victorian Government provide increased ongoing funding to continue and expand programs, such as the Maternity Connect Program, that increase the capability of Victoria’s midwifery and perinatal nursing workforce across the state. **231**

RECOMMENDATION 5.12: The Victorian Government, in consultation with midwives and relevant stakeholders, develop and implement a plan to ensure access to and provision of an appropriately qualified midwifery workforce across Victoria. The plan should include:

- short term measures to address the current shortage;
- long term measures to ensure a sustainable workforce;
- pathways to qualification;
- support for continuing education and professional development; and
- greater support for the emotional and mental health of midwives.. **232**

RECOMMENDATION 5.13: The Victorian Government, in consultation with nurses and relevant stakeholders, develop and implement a plan to ensure access to and provision of an appropriately qualified perinatal nursing workforce, with a focus on neonatal nurses, across Victoria. The plan should include:

- short term measures to address the current shortage;
- long term measures to ensure a sustainable workforce;
- pathways to qualification;
- support for continuing education and professional development; and
- greater support for the emotional and mental health of nurses.. **235**

RECOMMENDATION 5.14: The Victorian Government, in creating and implementing a Perinatal Mental Health Plan as per Recommendation 3.1, increase the availability of the perinatal mental health workforce in the public health system, including maternity hospitals, mother baby units, and Early Parenting Centres. **242**

RECOMMENDATION 5.15: The Victorian Government provide incentives to support clinical placements and secondments for psychologists and psychology students who wish to gain experience and qualifications in perinatal mental health. **243**

RECOMMENDATION 5.16: The Victorian Government fund improved lactation support services in Victoria including ongoing lactation education for midwives and neonatal nurses and delivery of a best practice model to ensure consistency of advice. **244**

RECOMMENDATION 5.17: The Victorian Government investigate unmet need and develop a strategy to build lactation consultant workforce capability and access across the state. **244**

RECOMMENDATION 5.18: The Victorian Government give consideration to including an appropriately qualified genetics workforce in its short and long term projections and planning for perinatal services. 245

RECOMMENDATION 5.19: The Victorian Government work with key stakeholders to develop a funding model to support public and private employers to take on sonographer trainees. 247

6 Maternal and Child Health Service

RECOMMENDATION 6.1: The Victorian Government support the collaborative delivery of the Maternal and Child Health Service with Department of Health and Human Services programs aimed at young children and their families.

- This support to include developing training packages/learning experiences based on existing collaborative models that would be valuable for other Maternal and Child Health Service providers around the state. 256

RECOMMENDATION 6.2: The Victorian Government review and enhance the programs provided by the Maternal and Child Health Service to engage and support fathers. 261

RECOMMENDATION 6.3: The Victorian Government support all Maternal and Child Health centres to demonstrate a commitment to ensuring that every mother is supported to make informed choices about infant feeding during her transition to motherhood. 267

RECOMMENDATION 6.4: The Victorian Government and the Department of Education and Training work with local government to examine the Child Development Information System to ensure and strengthen access and delivery of information to best serve families using the Maternal and Child Health Service. 270

RECOMMENDATION 6.5: The Victorian Government provide reimbursements of costs to allow Maternal and Child Health nurses to attend the training required to satisfy their continuing professional development responsibilities. 272

RECOMMENDATION 6.6: The Victorian Government develop and promote updated protocols to complement birth notifications such that the responsible person under the *Child Wellbeing and Safety Act 2005* (Vic) must provide, along with a birth notification, relevant information regarding the health and care of the mother and child.

- This protocol should include particular provisions for providing information regarding premature, high risk, and low birth weight babies, risk factors for or existence of mental illness, risk factors for or existence of family violence, breastfeeding difficulties, and transitioning into any required allied services.
- In the case of low birth weight babies on discharge, the responsible person or their delegate should be required to engage in joint discharge planning with the relevant Maternal and Child Health Service provider. 291

RECOMMENDATION 6.7: The Victorian Government fund programs to promote antenatal contact with vulnerable families by the Maternal and Child Health Service. 291

RECOMMENDATION 6.8: The Victorian Government use its position on the Council of Australian Governments (COAG) to advocate, as a priority, to improve and streamline processes for the communication of birth notifications or their equivalent in other jurisdictions when a child is born outside of its home state. 292

RECOMMENDATION 6.9: The Victorian Government require health services and Maternal and Child Health Service providers to implement systems to ensure delivery and receipt of accurate birth notifications occurs promptly.

- Systems to include reporting mechanisms which can confirm appropriate action on all birth notifications, and communication protocols between health services and Maternal and Child Health Service providers.
- The Victorian Government to investigate a method for hospitals to communicate birth notifications that takes advantage of the Child Development Information System used by the vast majority of local government Maternal and Child Health Services.. . . . 292

RECOMMENDATION 6.10: The Victorian Government, through the Department of Education and Training and in consultation with Maternal and Child Health Service providers and nurses, examine the model of the Maternal and Child Health Service to strengthen and provide a more holistic approach to perinatal care encompassing mental, social, emotional and physical health of the family.. . . . 292

7 Perinatal services for Aboriginal and Torres Strait Islander communities

RECOMMENDATION 7.1: The Victorian Government fund all Aboriginal community controlled organisations to provide pre-conception and sexual health education to Aboriginal and Torres Strait Islander clients in order to address smoking rates and other contributors to perinatal mortality. 298

RECOMMENDATION 7.2: The Victorian Government review intrastate transfers and transport with a view to providing more support to Aboriginal and Torres Strait Islander families living in rural and remote areas, and to provide funding for Aboriginal and Torres Strait Islander health services to facilitate transport and transfers.. . . . 303

RECOMMENDATION 7.3: Consistent with the *Korin Korin Balit-Djak Aboriginal health, wellbeing and safety strategic plan 2017-2027*, the Victorian Government identify areas not currently serviced by Koori Maternity Service programs with a view to expanding programs and funding, in collaboration with Aboriginal community controlled organisations and other mainstream services.. . . . 306

RECOMMENDATION 7.4: The Victorian Government conduct a review of Aboriginal birthing rooms across the state to expand and develop training packages/learning experiences that would be valuable for other maternity services around the state. 308

RECOMMENDATION 7.5: The Victorian Government conduct ongoing assessment of the various pilot programs being delivered in partnership with Maternal and Child Health Services to ensure that postnatal care of Aboriginal and Torres Strait Islander women and children is culturally appropriate, accessible and meeting the needs of Aboriginal and Torres Strait Islander families in their communities. **311**

RECOMMENDATION 7.6: The Victorian Government ensure that all mental health workers providing perinatal care are trained in cultural awareness and engagement with Aboriginal and Torres Strait Islander communities.. . . . **312**

RECOMMENDATION 7.7: The Victorian Government mandate and provide funding to ensure maternity service staff at Victorian public hospitals receive training in cultural awareness and engagement and supporting Aboriginal and Torres Strait Islander women and families.. . . . **314**

RECOMMENDATION 7.8: The Victorian Government conduct a public education campaign targeted at Aboriginal and Torres Strait Islander communities to raise awareness of scholarships that are currently available for Aboriginal and Torres Strait Islander health professional trainees.

- This campaign should also include a funded schools-based element to support and encourage Aboriginal and Torres Strait Islander students and school leavers. **317**

RECOMMENDATION 7.9: The Victorian Government work with and fund Aboriginal community controlled organisations across the state to develop early intervention programs to improve the health and wellbeing of Aboriginal and Torres Strait Islander women, their babies and their families throughout the perinatal period. . . . **320**

8 Perinatal services for culturally and linguistically diverse communities

RECOMMENDATION 8.1: The Victorian Government work with the Consultative Council on Obstetric and Paediatric Mortality and Morbidity to ensure that a comprehensive and routine data set is collected to understand the barriers facing culturally and linguistically diverse communities.. . . . **326**

RECOMMENDATION 8.2: The Victorian Government work with the Council of Australian Governments (COAG) to address the highlighted gap in perinatal healthcare for temporary visa holders to ensure the safety of mothers and babies. . . **328**

RECOMMENDATION 8.3: The Victorian Government in consultation with culturally and linguistically diverse communities review the process for creating translated information on Victorian Government materials to ensure that it is up-to-date, accessible and culturally appropriate.

- The Victorian Government review the accessibility of translated information on its websites so that culturally and linguistically diverse communities with low levels of English and low levels of literacy can access information, including using visual and aural information. **331**

RECOMMENDATION 8.4: The Victorian Government review the use of interpreters in public hospitals, and work with the Department of Health and Human Services and maternity hospitals to ensure that interpreters are being used for every consultation with a woman who needs an interpreter.. . . . 335

RECOMMENDATION 8.5: The Victorian Government put in place a strategy to recruit more interpreters and bicultural health workers in the area of women’s health, particularly female interpreters, interpreters of emerging languages and interpreters in rural and regional areas.. . . . 335

RECOMMENDATION 8.6: The Victorian Government work with the Department of Health and Human Services and public maternity hospitals on developing a policy that gives priority for continuity of care models to women from culturally and linguistically diverse communities. 337

RECOMMENDATION 8.7: The Victorian Government mandate and provide funding, including the extra cost that regional hospitals will incur, to ensure maternity service staff at Victorian public hospitals receive training in cultural awareness and engagement and supporting women and their families from culturally and linguistically diverse and refugee backgrounds. 338

RECOMMENDATION 8.8: The Victorian Government ensure that all mental health workers in the perinatal field are trained in cultural awareness and engagement with culturally and linguistically diverse communities.. . . . 341

Introduction

The Parliament of Victoria's Legislative Council directed the Family and Community Development Committee to inquire into perinatal services on 16 September 2015. The Terms of Reference for the Inquiry required the Committee to examine the availability, quality, and safety of health services during the perinatal period, including services for high risk and premature births, methods to reduce maternal and infant mortality and premature births, and the difference in services between rural and regional and metropolitan locations. The Committee was also asked to look at the impact of the loss of Commonwealth funding of the National Perinatal Depression Initiative, the provision of an appropriately qualified workforce across Victoria, and identification of best practice. The full Terms of Reference can be found on page xi.

Definition of 'perinatal'

The Committee found that there was no consistent or agreed definition of when the perinatal period begins and ends. The World Health Organization (WHO) uses a narrow definition of the perinatal period which it defines as commencing at 22 weeks gestation and as ending at seven days after birth.ⁱ The Centre of Perinatal Excellence (COPE) defines the perinatal period more broadly as starting at conception and ending at one year after birth.ⁱⁱ Some submissions used narrower definitions of 20 weeks gestation to four weeks after birth,ⁱⁱⁱ while other submissions used broader definitions of conception to a year or more after birth.^{iv}

The Committee discussed the various definitions of the perinatal period and agreed that a broad definition would be useful for the Inquiry. For the purposes of gathering evidence and making recommendations, the Committee adopted a working definition for the Inquiry of the perinatal period as being from conception to 12 months after birth.^v

Conduct of the Inquiry

Submissions

On 28 April 2017, the Committee released a call for submissions for the Inquiry. The call for submissions was advertised in over 30 Victorian metropolitan and regional newspapers. The call for submissions was also made on the Committee's website,

i World Health Organization (WHO), 'Maternal and perinatal health', accessed 24 May 2018, <http://www.who.int/maternal_child_adolescent/topics/maternal/maternal_perinatal/en>.

ii M-P Austin, N Highet and the Expert Working Group, *Mental Health Care in the Perinatal Period: Australian Clinical Practice Guideline*, Centre of Perinatal Excellence (COPE), Melbourne, 2017, p. 13.

iii See, for example, Mr Wale Oladimeji, submission no. 1, p. 1; City of Melbourne, submission no. 21, p. 1.

iv See, for example, Royal Australian and New Zealand College of Psychiatrists, submission no. 25, p. 3; Caroline Chisholm Society, submission no. 29, p. 7.

v Note that for some statistics presented by witnesses to the Inquiry, the perinatal period is defined differently.

via a media release, and on Facebook. The Committee also wrote to a wide range of individuals and organisations inviting them to make a submission to the Inquiry. The Committee created and distributed brochures and posters publicising the Inquiry.

The Committee received 104 written submissions from a range of individuals and organisations. The authors of these submissions included:

- mothers;
- parenting support services;
- breastfeeding support services;
- healthcare providers;
- midwives;
- obstetricians;
- mental health practitioners;
- local councils; and
- researchers.

A full list of the submissions can be found in Appendix One.

Public hearings

For the Inquiry the Committee held 12 public hearings – five in Melbourne, and a further seven hearings in the following regional cities:

- Warrnambool;
- Bendigo;
- Wangaratta;
- Mildura;
- Bairnsdale;
- Warragul; and
- Geelong.

At these public hearings the Committee heard from over 90 witnesses. The Committee heard from mothers, healthcare providers, local councils, mental health practitioners, midwives, parenting support services, Aboriginal and Torres Strait Islander service providers, obstetricians, breastfeeding support services, government departments and statutory bodies, and bereavement support services. The full list of public hearings and witnesses can be found at Appendix Two.

Social media

Throughout the Inquiry, and with the assistance of the Parliament's Communications and Public Engagement team, the Committee made use of social media to provide updates on the Inquiry, and to advertise public hearings. A number of short videos were created and posted on the Parliament of Victoria's Facebook page. The videos

featured witnesses who spoke at public hearings, and had several thousand views. The videos can be viewed on the Committee's website (<https://www.parliament.vic.gov.au/fcdc/article/4014>).

Australasian Marcé Society for Perinatal Mental Health 2017 conference

The Australasian Chapter of the Marcé Society for Perinatal Mental Health held its biennial conference in Brisbane from 26 to 28 October 2017. The conference's theme was *When the Bough Bends, Resilience in the Perinatal Period*. Ms Rachel Macreadie, Research Officer, attended the conference and gained valuable insight into the latest developments in perinatal mental health. The Australian Clinical Practice Guideline for Mental Health Care in the Perinatal Period was launched at the conference.^{vi} The Committee discusses perinatal mental health services in Chapter Three.

vi M-P Austin, N Highet and the Expert Working Group, *Mental Health Care in the Perinatal Period: Australian Clinical Practice Guideline*, Centre of Perinatal Excellence (COPE), Melbourne, 2017.

The quality and safety of perinatal services in Victoria

AT A GLANCE

Background

Under the terms of reference for the Inquiry, the Committee was tasked with examining the quality and safety of perinatal services in Victoria, including services dealing with high risk and premature births, and the quality and safety of current methods to reduce infant and maternal mortality. In Victoria, there have recently been many significant changes to perinatal services with regard to hospital monitoring and accountability.

This chapter examines these changes, particularly the creation of Safer Care Victoria and its role in driving state-wide quality improvement in partnership with clinicians. The chapter also examines the collection and reporting of perinatal data, regional perinatal mortality and morbidity committees, the Consultative Council on Obstetric and Paediatric Mortality and Morbidity, the Capability framework for Victorian maternity and newborn services, and patient transfers through the Paediatric Infant Perinatal Emergency Retrieval Service. High risk pregnancies and their management, early hospital discharge, and support services for families are also discussed.

Terms of reference addressed

This chapter addresses the following terms of reference:

1. the availability, quality and safety of health services delivering services to women and their babies during the perinatal period;
3. the adequacy of the number, location, distribution, quality and safety of health services capable of dealing with high risk and premature births in Victoria;
4. the quality, safety and effectiveness of current methods to reduce the incidence of maternal and infant mortality and premature births;
5. access to and provision of an appropriately qualified workforce, including midwives, paediatricians, obstetricians, general practitioners, anaesthetists, maternal and child health nurses, mental health practitioners and lactation consultants across Victoria; and
7. identification of best practice.

Under the terms of reference for the Inquiry, the Committee was tasked with examining the quality and safety of perinatal services in Victoria, including services dealing with high risk and premature births, and the quality and safety of current methods to reduce infant and maternal mortality. In Victoria, there have recently been many significant changes to perinatal services with regard to hospital monitoring and accountability.

This chapter examines these changes, particularly the creation of Safer Care Victoria and its role in driving state-wide quality improvement in partnership with clinicians. The chapter also examines the collection and reporting of perinatal data, regional perinatal mortality and morbidity committees, the Consultative Council on Obstetric and Paediatric Mortality and Morbidity, the Capability framework for Victorian maternity and newborn services, and patient transfers through the Paediatric Infant Perinatal Emergency Retrieval Service (PIPER). High risk pregnancies and their management, early discharge policies, and support services for families are also discussed.

In 2016, 79,319 women in Victoria gave birth to 80,549 babies, which was an increase of two per cent from 2015.¹ Most women giving birth in Victoria gave birth at public hospitals.² A significant part of the evidence to the Inquiry concerned the maternity services provided by Victorian public hospitals, both from the perspectives of health professionals, and from mothers. The Committee heard that the experience of women giving birth at Victorian public hospitals was generally positive, with Victorian maternity and neonatal services providing some of the best care in Australia.

Nonetheless, there are improvements that can be made to the delivery of services which will be examined in each of the following chapters. At a public hearing in Melbourne, Ms Kate Ravenscroft told the Committee about her experience of giving birth at a Victorian public hospital. She noted that it would have been helpful for her to receive more communication in her care:

Just taking that time to communicate well, to keep people informed and to respect your patients as participants in the process results in a completely different care experience.³

Professor Euan Wallace, Chief Executive Officer of Safer Care Victoria, told the Committee at a public hearing in Melbourne that while Victoria had some of the best perinatal outcomes in the world, there was variation in both care provision and health outcomes:

It is fair to say that 2016 saw the best perinatal outcomes across the state in our state's history. If you compare us with other jurisdictions in Australia or other jurisdictions internationally, we have among the best perinatal outcomes anywhere in the world.

However — and it is an important 'however' — there is variation. There is variation in both care provision and variation in health outcomes for both mothers and babies. There is variation over time, variation between groups of women and variation

1 Consultative Council on Obstetric and Paediatric Mortality and Morbidity (CCOPMM), *Victoria's mothers, babies and children 2016*, Melbourne, 2017, p. 43.

2 Ms Kym Peake, Secretary, Department of Health and Human Services, Family and Community Development Committee public hearing – Melbourne, 27 November 2017, transcript of evidence, pp. 2, 4.

3 Ms Kate Ravenscroft, Family and Community Development Committee public hearing – Melbourne, 4 September 2017, transcript of evidence, p. 3.

between hospitals and regions. It is that variation that piques the interest of Safer Care, because as I have said already, where there is variation there are opportunities for improvement.⁴

1.1 The Capability Framework for Victorian maternity and newborn services

There are 54 public maternity and newborn services which provide access to pregnancy care.⁵ Victoria has a tiered maternity and newborn service with six levels of neonatal care and maternity care in Victoria. This section sets out the six levels of maternity care as outlined in the *Capability framework for Victorian maternity and newborn services* (2010) (the Capability Framework) and the six levels of neonatal care as outlined in *Defining levels of care for Victorian newborn services* (2015). A discussion of the evidence received by the Committee in relation to the levels of care will follow.

1.1.1 Maternity care

The Department of Health and Human Services *Capability framework for Victorian maternity and newborn services* (2010) sets out the role and service level of each public maternity and newborn service in metropolitan, regional and rural areas.⁶ It also describes the relationships between maternity and newborn services at the state-wide level and the services required at each level of care.⁷

Around two-thirds of Victorian women birth within their local community.⁸ The Capability Framework states that where possible mothers and babies should receive antenatal and postnatal care close to where they live, however it acknowledges that where there is an increased level of risk, 'it is important that the care is provided in a facility which has the capability level that matches the level of risk'.⁹ Normal risk births can be managed at Level 2 to Level 6 services and normal risk pregnancies can be managed at any level of service.¹⁰ The service levels are as follows for maternity care:

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- 4 Professor Euan Wallace, Chief Executive Officer, Safer Care Victoria, Family and Community Development Committee public hearing – Melbourne, 27 November 2017, transcript of evidence, p. 7., pp. 2-3.
 - 5 Ms Kym Peake, Secretary of the Department of Health and Human Services, Family and Community Development Committee public hearing – Melbourne, 27 November 2017, transcript of evidence, p. 4.
 - 6 Department of Health and Human Services, 'Maternity and newborn care in Victoria', Victorian Government, accessed 7 March 2018, <<https://www2.health.vic.gov.au/hospitals-and-health-services/patient-care/perinatal-reproductive/maternity-newborn-services/maternity-newborn-care>>.
 - 7 Department of Health, *Capability framework for Victorian maternity and newborn services*, Victorian Government, Melbourne, 2010, p. 1.
 - 8 Ms Kym Peake, Secretary of the Department of Health and Human Services, Family and Community Development Committee public hearing – Melbourne, 27 November 2017, transcript of evidence, p. 4.
 - 9 Department of Health, *Capability framework for Victorian maternity and newborn services*, Victorian Government, Melbourne, 2010, p. 3.
 - 10 *Ibid.*, p. 1.

Table 1.1 Levels of maternity care

Primary maternity services	Level 1	Small, generally rural services that provide comprehensive antenatal and postnatal care. Women travel to larger services to give birth but return to their local community after delivery.
	Levels 2 & 3	These services provide care including birthing services to low- or normal-risk pregnancies and births. Level 3 services provide emergency caesarean sections.
Secondary maternity services	Levels 4 & 5	Services at these levels provide care to women with medium-risk pregnancies and births with moderate complications. Regional health services are generally level 5.
Tertiary maternity services	Level 6	Tertiary services are all located in the metropolitan area and provide care to women with complex pregnancies and births requiring neonatal intensive care. Depending on the statewide demand for complex specialist care, these tertiary services also provide lower complexity care for local women.

Source: Victorian Government, Department of Health and Human Services, 'Maternity and newborn care in Victoria'.¹¹

The following three tertiary hospitals provide maternity services for the most complex pregnancies across the state: Mercy Hospital for Women, Heidelberg; Monash Medical Centre, Clayton; and The Royal Women's Hospital, Parkville. These three services and the Royal Children's Hospital provide specialist neonatal intensive care (NICU) for newborns across the state, with the Royal Children's Hospital and Monash Medical Centre providing surgical services and other paediatric subspecialty services. There are also plans to open a fifth NICU at Sunshine Hospital.¹² For more information on NICUs see section 1.1.3.

At a public hearing in Melbourne, Ms Kym Peake, Secretary of DHHS told the Committee about the Capability Framework and how it had developed over the years. She noted that the Victorian Auditor-General's 2011 report, *Maternity Services: Capacity*, concluded that DHHS had relied on self-assessments by health services about their capabilities, however since the release of *Targeting Zero: Supporting the Victorian hospital system to eliminate avoidable harm and strengthen quality of care: Report of the review of hospital safety and quality assurance in Victoria* (Duckett review) in October 2016 there has been 'more system leadership'.¹³ Ms Peake said:

Capability frameworks are something that we have put a lot of effort into, starting from really 2011 but updated in 2015 to describe the minimum requirements for planned care across six levels and to assist health services to provide maternity and newborn care that responds to the changing needs of the community. These tools also ensure women are provided consistent care from services with the same capability, regardless of where they live. The recent Auditor-General report commented on the fact that in the last 12 months we have really sought to play a stronger role as system managers who not only rely on health services that devolve governments to

11 Department of Health and Human Services, 'Maternity and newborn care in Victoria', Victorian Government, accessed 7 March 2018, <<https://www2.health.vic.gov.au/hospitals-and-health-services/patient-care/perinatal-reproductive/maternity-newborn-services/maternity-newborn-care>>.

12 Associate Professor Rod Hunt, Director, Newborn Intensive Care, Royal Children's Hospital, Family and Community Development Committee public hearing – Melbourne, 18 September 2017, transcript of evidence, p. 3.

13 Ms Kym Peake, Secretary, Department of Health and Human Services, Family and Community Development Committee public hearing – Melbourne, 27 November 2017, transcript of evidence, pp. 7-8. See also: Victorian Auditor-General's Office, *Maternity Services: Capacity*, Melbourne, Victorian Government, 2011.

self-assess against those capability frameworks but to undertake annual reviews so that we can provide confidence to the whole system and the community that people are operating within their capability.¹⁴

Mr Terry Symonds, Deputy Secretary of the Health and Wellbeing Division at DHHS, told the Committee that the Capability Framework had made health services more consistent:

The capability framework has helped with [making services across the state more consistent], so a level 3 service in one part of the state offers the same service as a level 3 in a different part of the state, and the department works with them to make sure they are the same. That does not mean that supply is as high as it should be or access is as high as it should be, but I would say we now have a much more consistent measurement and description of services so we know that apples are apples and know what we are talking about in different parts of the state, and that allows us, I think, to plan to fill those gaps with additional workforce, for example.¹⁵

Associate Professor Rod Hunt, Director of Newborn Intensive Care at the Royal Children's Hospital, told the Committee at a public hearing in Melbourne:

The principles driving the development of this framework were ensuring quality and safety, providing women with greater choice and more control of their birthing experience, and achieving the right balance between primary level care and access to appropriate medical expertise when required.¹⁶

1.1.2 Neonatal care

Like maternity services, neonatal services are also classified according to six levels of care set out in the document, *Defining levels of care for Victorian newborn services, 2015*.¹⁷ This document replaced the previous *Neonatal Service Guidelines, defining levels of care in Victorian hospitals, 2005* which set out three levels of care. The document states that the classifications for newborn services and maternity services do not directly correlate and thus it is important to consider both the needs of the mother and the anticipated needs of the baby when determining the most clinically appropriate location for a woman to receive care.¹⁸ The service levels are as follows for newborn care:

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- 14 Ms Kym Peake, Secretary of the Department of Health and Human Services, Family and Community Development Committee public hearing – Melbourne, 27 November 2017, transcript of evidence, p. 4.
 - 15 Mr Terry Symonds, Deputy Secretary, Health and Wellbeing Division, Department of Health and Human Services, Family and Community Development Committee public hearing – Melbourne, 27 November 2017, transcript of evidence, p. 8.
 - 16 Associate Professor Rod Hunt, Director, Newborn Intensive Care, Royal Children's Hospital, Family and Community Development Committee public hearing – Melbourne, 18 September 2017, transcript of evidence, p. 3.
 - 17 Department of Health and Human Services, *Defining levels of care for Victorian newborn services, 2015*, Victorian Government, Melbourne, 2015.
 - 18 *Ibid.*, p. 2.

Table 1.2 Levels of neonatal care

Primary newborn services	Level 1	Provides care for well, uncomplicated, term newborns (postnatal care only) <ul style="list-style-type: none"> • care of newborn $\geq 37 + 0$ weeks gestation • usually correlating to newborn birthweight $\geq 2,500$ grams.
	Level 2	Provides care for mildly unwell, uncomplicated newborns at birth or during immediate postnatal period <ul style="list-style-type: none"> • care of newborn $\geq 37 + 0$ weeks gestation • usually correlating to newborn birthweight $\geq 2,500$ grams <p>May accept care of newborns marginally below the gestational age/birthweight listed above, when clinically appropriate or following specialist consultation with emergency retrieval or tertiary service.</p>
Secondary newborn services	Level 3	Provides care for mild-moderately unwell, uncomplicated newborns <ul style="list-style-type: none"> • care of newborn $\geq 34 + 0$ weeks gestation • usually correlating to newborn birthweight $\geq 2,000$ grams <p>Includes growing preterm and convalescing newborns and infants</p> <p>May accept care of newborns marginally under the gestational age/birthweight listed above, when clinically appropriate or following specialist consultation with emergency retrieval or tertiary service.</p>
	Level 4	Provides care for moderately unwell, uncomplicated newborns <ul style="list-style-type: none"> • care of newborn $\geq 32 + 0$ weeks gestation • usually correlating to newborn birthweight $\geq 1,500$ grams <p>Includes growing preterm and convalescing newborns and infants</p> <p>May accept care of newborns marginally under the gestational age/birthweight listed above, when clinically appropriate or following specialist consultation with emergency retrieval or tertiary service.</p>
	Level 5	Provides care for moderately unwell or preterm newborns, including some moderately complex newborns <ul style="list-style-type: none"> • care of newborn $\geq 31 + 0$ weeks gestation • usually correlating to newborn birthweight $\geq 1,250$ grams <p>Includes growing preterm and convalescing newborns and infants</p> <p>May accept care of newborns marginally under the gestational age/birthweight listed above, when clinically appropriate or following specialist consultation with emergency retrieval or tertiary service.</p>
Tertiary newborn services	Level 6A	Provides continuous life support and comprehensive multidisciplinary care for extremely premature newborns and those with non-surgical critical illness.
	Level 6B	Provides continuous life support and comprehensive multidisciplinary care for extremely high-risk newborns and those with complex and critical conditions, and provides statewide specialist services.

Source: Department of Health and Human Services, 'Newborn care in Victoria', Victorian Government, accessed 7 March 2018, <<https://www2.health.vic.gov.au/hospitals-and-health-services/patient-care/perinatal-reproductive/maternity-newborn-services/newborn-care-in-victoria>>.

Ms Kym Peake, Secretary of DHHS, told the Committee at a public hearing in Melbourne that improvements to the framework around newborn services and investment in Levels 5-6 cots has resulted in fewer babies needing to be transferred interstate to access Level 6 care:

Our work on the newborn capability framework improved clinical definitions of which babies need level 6 care and consistent investment in both level 6 cots and services with level 5 capability, including in bigger regional centres, means that I think we are in a much better position now than we have been in the past in terms

of the newborn system. We now have an additional 21 level 6 cots funded into the system since 2011–12, so where it was once necessary to send babies interstate from time to time because of capacity constraints in our level 6 units we have not seen that being necessary for the last three years.¹⁹

Throughout the Inquiry, the Committee heard from a range of maternity services in public hearings throughout Victoria, including the following health services:

- Orbost Regional Health - Level 1 maternity (previously Level 2 maternity)
- Bairnsdale Regional Health Service – Level 3 maternity, Level 2 neonatal
- West Gippsland Hospital – Level 4 maternity, Level 3 neonatal
- South West Healthcare – Level 4 maternity, Level 3 neonatal
- Northeast Health Wangaratta – Level 4 maternity, Level 3 neonatal
- Mildura Base Hospital – Level 4 maternity, Level 3 neonatal
- Latrobe Regional Hospital – Level 5 maternity, Level 4 neonatal
- Bendigo Health – Level 5 maternity, Level 4 neonatal
- Albury Wodonga Health – Level 5 maternity, Level 4 neonatal
- University Hospital Geelong/Barwon Health – Level 5 maternity and neonatal
- Northern Hospital – Level 5 maternity and neonatal
- Mercy Hospital for Women (Heidelberg) – Level 6 maternity and neonatal
- Monash Medical Centre – Level 6 maternity and neonatal
- The Royal Women’s Hospital – Level 6 maternity and neonatal.

1.1.3 Neonatal intensive care units (NICU)

As mentioned above, there are four neonatal intensive care units in Victoria: The Royal Women’s Hospital, Mercy Hospital for Women, Monash Medical Centre and The Royal Children’s Hospital, all of which are located in the metropolitan region. There are 108 neonatal intensive care cots funded in Victoria.²⁰ Infants who require neonatal surgery are cared for at either the Royal Children’s Hospital or Monash Medical Centre. There are plans to open a fifth NICU at Sunshine Hospital in late 2018.²¹ The Committee heard that a fifth NICU at Sunshine Hospital is welcomed, especially as the Sunshine Hospital is now birthing in excess of 5,000 women.²² The Committee heard that there was significant stress for staff in NICUs and that there are generally neonatal intensive care nurse workforce shortages, which will be discussed in Chapter Five.

¹⁹ Ms Kym Peake, Secretary, Department of Health and Human Services, Family and Community Development Committee public hearing – Melbourne, 27 November 2017, transcript of evidence, p. 5.

²⁰ Associate Professor Rod Hunt, Director, Newborn Intensive Care, Royal Children’s Hospital, Family and Community Development Committee public hearing – Melbourne, 18 September 2017, transcript of evidence, p. 3.

²¹ Ibid.; Mercy Health, submission no. 40, p. 2.

²² Professor Michael Permezel, Immediate Past-President, Royal Australian and New Zealand College of Obstetricians and Gynaecologists, Family and Community Development Committee public hearing – Melbourne, 4 September 2017, transcript of evidence, p. 2.

The Committee heard positive feedback from mothers and fathers whose babies were in neonatal intensive care. At a public hearing in Melbourne, the Committee heard from Ms Kate Ravenscroft about her experience with her daughter in NICU:

My daughter was in the neonatal intensive care unit for three days, and each day our daughter's doctor met with me and my husband and explained to us what was happening for our daughter, how her health was, what care they were providing, what that meant and what they expected in terms of how long she would be in hospital. They just really took that time to keep us involved and informed. We felt really respected and supported by the entire team in the neonatal intensive care unit. The nurses were available; they were really responsive. We could ask any questions at any time. We could get support if we were concerned about anything or did not understand anything. One of the nurses arranged for the lactation consultant in the hospital to visit me by our daughter's bedside in the neonatal intensive care unit to support the establishment of breastfeeding, because we did not have an ordinary start to breastfeeding with her being in NICU. The nurses taught us how to take her temperature and involved us as much as possible in her care so we really felt part of things. At every moment it really felt like all of the medical professionals involved in her care were deeply invested in us and in ensuring the best possible outcomes for us as a family.²³

The Committee heard from Professor Michael Permezel, Immediate Past-President, Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG), who said that it is the RANZCOG's view that DHHS had done really well managing NICU beds, nonetheless, 'the time has come for a significant expansion'.²⁴ Professor Permezel said that there is a general lack of NICU beds and sometimes a lack of maternity beds where the NICU bed is located.²⁵

In their submission to the Inquiry, RANZCOG stated that prioritising perinatal care in Victoria means ensuring that the capacity of NICUs and Special Care Nurseries is urgently addressed:

There is a continuing serious shortage of maternal and neonatal beds at hospitals equipped with a Neonatal Intensive Care Unit such that women are unable to be transferred when there is an indication to do so. This puts undue pressure on the PIPER consultant to recommend that a patient remain in a rural or outer urban centre not equipped to manage problems should they occur.

All Melbourne units, especially perinatal units, are running well above their normal rated ICU/Ventilator capacity most of the time. Units are often operating above capacity with no increase in space, equipment, staff or infrastructure. When a baby is admitted under such circumstances the risks to that baby are significantly greater, but the admission of that baby also increases the risk that other babies will die or suffer complications.²⁶

²³ Ms Kate Ravenscroft, Family and Community Development Committee public hearing – Melbourne, 4 September 2017, transcript of evidence, p. 3.

²⁴ Professor Michael Permezel, Immediate Past-President, Royal Australian and New Zealand College of Obstetricians and Gynaecologists, Family and Community Development Committee public hearing – Melbourne, 4 September 2017, transcript of evidence, p. 2.

²⁵ Ibid. See also: Ms Julie Wright, Operational Director of Women's and Children's services, Albury Wodonga Health, Family and Community Development Committee public hearing – Wangaratta, 25 October 2017, transcript of evidence, p. 3; Dr Simon Fraser, Chief Medical Officer and Paediatrician, Latrobe Regional Hospital, Family and Community Development Committee public hearing – Warragul, 8 December 2017, transcript of evidence, p. 12.

²⁶ Royal Australian and New Zealand College of Obstetricians and Gynaecologists, submission no. 35, p. 4.

The Committee heard that Victoria has always had a lower number of NICU beds per 1,000 live births than other states.²⁷ Dr Andrew Watkins, Neonatologist at the Mercy Hospital for Women, told the Committee that NICUs were often working above their rated capacity.²⁸ Dr Watkins was critical of DHHS, stating that NICUs were expensive to run and that the Department had been reluctant to prioritise NICUs.²⁹

Dr Michael Rasmussen, Clinical Services Director at Mercy Hospital for Women (Mercy Health), told the Committee about the increasing acuity of babies in NICU:

There is a high demand in NICU occupancy at the Mercy. NICU in 2016–17 was 121.7 per cent, so there are more babies than beds. The acuity of the patients is increasing. The doctors will say more often that the unit is full, and I am sure you are aware of that. Why is that? There are more and more treatments that we can do to help babies these days with improved outcomes. There is also the lower gestation at which babies can survive — it has just come down and down and down. When I was in New Guinea the limit for survival was 32 weeks. In Victoria it is 24 weeks, and some bubs at just under 24 weeks are able to survive. These babies stay in the hospital for a long, long time.³⁰

The Committee also heard that NICUs were often running over capacity due to the high number of level 3-5 babies that sit within level 6 NICUs.³¹ Associate Professor Rod Hunt, Director of Newborn Intensive Care at the Royal Children's Hospital, told the Committee:

[I]f we look at the NICUs in their entire capacity, levels 3 to 6, we can see that capacity runs between 90 and 100 per cent for all the four NICUs, and in fact, I agree with Dr Watkins, there are a certain number of days per year where occupancy runs between 100 and 110 per cent. This is because in every level 6 NICU there has to be provision for downscaling of care before babies can be deemed safe to be transferred out to a more peripheral centre. ... the level 5 babies that sit within a level 6 NICU are grossly over-represented and sit within most of the NICU cots, so this means that level 5 capacity within level 6 NICUs is grossly out of whack.³²

Associate Professor Michael Stewart, Director of Paediatric Infant Perinatal Emergency Retrieval Service (PIPER) told the Committee that Victoria has 'probably got adequate level 6 NICU cots' and that NICUs are often fully occupied with babies that are not NICU acuity:

We have revamped the definition of NICU because management has changed over time and we have now actually simplified the care of a lot of babies who previously used to be called 'intensive care'. That is critical for nursing because intensive care is one-to-one and high dependency is one-to-two. I think, when we have been looking at this recently, no hospital has hit 100 per cent occupancy of level 6 babies since we changed the definition in June last year, but the nurseries are still almost fully

27 Dr Andrew Watkins, Neonatologist, Family and Community Development Committee public hearing – Melbourne, 18 September 2017, transcript of evidence, p. 3.

28 Ibid.

29 Ibid., p. 4.

30 Dr Michael Rasmussen, Clinical Services Director, Mercy Hospital for Women (Mercy Health), Family and Community Development Committee public hearing – Melbourne, 16 October 2017, transcript of evidence, p. 4.

31 Associate Professor Rod Hunt, Director, Newborn Intensive Care, Royal Children's Hospital, Family and Community Development Committee public hearing – Melbourne, 18 September 2017, transcript of evidence, p. 3.

32 Ibid.

occupied most of the time. So we do need to think for the tertiary part of it that they do need some additional neonatal capacity to look after these still complex but not intensive care patient populations.³³

Associate Professor Hunt told the Committee that there needed to be more specialists in regional and rural Victoria and incentives to work in these areas so that Level 5 babies and Level 3 to 5 babies can be safely down-transferred.³⁴ Workforce issues related to rural and regional Victoria will be discussed in Chapters Four and Five.

Based on the evidence it heard, the Committee is concerned that NICUs in Victoria are facing significant capacity challenges, with NICUs sometimes operating above 100 per cent occupancy. The Committee heard of a need for expansion of NICU beds generally, a lack of maternity beds alongside NICU beds, and challenges in transferring babies who could be cared for at Level 3 to 5 facilities out of NICUs. The Committee believes more work needs to be done to determine the factors leading to these challenges, including population growth, and how best to address them. Accordingly, the Committee recommends:

RECOMMENDATION 1.1: The Victorian Government, in consultation with health practitioners, conduct a review of Neonatal Intensive Care Units (NICU) in Victoria, taking into account the challenges identified in this report.

Maternity and Newborn Emergencies program (MANE)

The Royal Women's Hospital launched the Maternity and Newborn Emergencies (MANE) program in February 2017, delivered in partnership with The Royal Children's Hospital for introduction into 12 rural hospitals.³⁵ The program is designed to improve capability to manage maternal and newborn emergencies by providing training from specialist staff to interdisciplinary teams.

About the MANE program, Associate Professor Stewart told the Committee that the MANE program's mandate is to visit every level 2 to 4 maternity hospital in the state at least once every three years to deliver a two-day program on obstetric and neonatal emergencies.³⁶ The program, which is funded by DHHS and was developed in response to the Duckett review, will be examined again in Chapter Four.

1.1.4 The impact of the Capability Framework on health services

Throughout the Inquiry, the Committee heard that regional areas were often stretched and sometimes operated outside their capability level due to a range of reasons including an increase in complex births, delays in organising patient transfers, and the closure of smaller health services.

³³ Associate Professor Michael Stewart, Director, Paediatric Infant Perinatal Emergency Retrieval Service, Family and Community Development Committee public hearing – Melbourne, 5 February 2018, transcript of evidence, p. 10.

³⁴ Associate Professor Rod Hunt, Director, Newborn Intensive Care, Royal Children's Hospital, Family and Community Development Committee public hearing – Melbourne, 18 September 2017, transcript of evidence, pp. 3-4.

³⁵ The Royal Women's Hospital, submission no. 75, p. 5.

³⁶ Associate Professor Michael Stewart, Director, Paediatric Infant Perinatal Emergency Retrieval Service, Family and Community Development Committee public hearing – Melbourne, 5 February 2018, transcript of evidence, p. 9.

The Committee heard that one effect of the Capability Framework was that some health services could no longer provide care to high risk women, which increased the demand and workload on neighbouring services. In their submission to the Inquiry, Bendigo Health (a Level 5 maternity, Level 4 neonatal service) stated:

Bendigo Health accepts women from 32 weeks or babies from 1500gms. There has been a significant impact on the provision of service in Bendigo Health however, as a result of the mandating of the Victorian Capability Framework with the outlying areas no longer providing care to women of high risk. As a result these women are being referred to Bendigo Health for antenatal care, birth and paediatric care, increasing the number of high risk women being cared for in Bendigo Health.³⁷

As discussed below in relation to high risk pregnancies and obesity, the Committee heard that the implementation of defined maternity capabilities meant that Level 5 hospitals now had greater responsibility for high risk pregnancies.³⁸ Dr Nicola Yuen, Director of Obstetrics and Gynaecology at Bendigo Health, told the Committee at a public hearing in Bendigo that these Level 5 hospitals are placed in a position of providing more support and collaboration with smaller hospitals:

[T]he impact of the maternity capability framework has had quite a significant effect on the services that we deliver. The capability framework has had an effect on the smaller hospitals, meaning that they are seeking advice and support from the regional referral centre — this being Bendigo — around patients that exceed their capability. We are collaborating quite extensively with the smaller referral centres to ensure that we are supporting them to meet their capability, therefore ensuring that women receive at least some of their care closer to home, reducing the travel for some of them.³⁹

Ms Jodie Ashworth, General Manager of Surgery, Women's and Children's, Operating Theatres and ICU and Chief Nursing Officer at Northern Health, told the Committee that they struggled to bring babies in the catchment of Northern Health back to Northern Health once they have finished care in a NICU, particularly from the Mercy, and that it was about establishing the reputation and credibility of Northern Health, which now has a Level 5 maternal and neonatal capability. She said:

Quite often our babies will be at the Mercy hospital and would be appropriate to transfer back to Northern, but every nursery is staffed to a certain level and everyone is trying to keep their occupancy up. Sometimes we feel we are not utilised to our full capability, but that is just about us. As I said, we have recently employed a number of new neonatologists. We do have neonatologists on call 24 hours now. We have not always been like that. It is just about building the trust and rapport with the tertiaries and, I suppose, letting the frozen moment happen and letting our babies come home because we have the capability to manage them that then frees them up to do the work that tertiaries should be doing best, which is NICU and level 6 work.⁴⁰

³⁷ Bendigo Health, submission no. 44, p. 1.

³⁸ Ms Suzanne Hartney, Neonatal Nurse and Midwife, Family and Community Development Committee public hearing – Bendigo, 24 October 2017, transcript of evidence, p. 7.

³⁹ Dr Nicola Yuen, Director, Obstetrics and Gynaecology, Bendigo Health, Family and Community Development Committee public hearing – Bendigo, 24 October 2017, transcript of evidence, p. 3.

⁴⁰ Ms Jodie Ashworth, General Manager, Surgery, Women's and Children's, Operating Theatres and ICU and Chief Nursing Officer, Northern Health, Family and Community Development Committee public hearing – Melbourne, 5 February 2018, transcript of evidence, pp. 7-8.

In regional hospitals the Committee heard that it was sometimes difficult to transfer women to a Level 6 service if they had certain risk factors as women did not want to travel to Melbourne to access tertiary care. Ms Julianne Clift, Director of Nursing at South West Healthcare, told the Committee at a public hearing in Warrnambool that it can be a challenge to have the conversation that the mother and the baby need to be transferred.⁴¹ Likewise, Ms Julie Wright, Operational Director of Women's and Children's Services at Albury Wodonga Health, told the Committee at a public hearing in Wangaratta:

[E]ven if you did say, 'You probably need to go to Melbourne because this is the capability framework we are trying to encourage', if they know they can go to Albury, they will go. You can tell someone, 'Look, it would be great for you to see a doctor in Melbourne in relation to this, or even make an appointment'. It does not actually mean they will attend. We even see that sometimes locally, where a woman has not gone and seen the obstetrician. To them, if they do not understand the importance — if it is not well explained and even when sometimes it is — women have their own reasons: they are busy, they live too far out of town or 'I went to my doctor, I thought that would be okay'.⁴²

Ms Suzanne Hartney, a neonatal nurse and midwife, told the Committee at a public hearing in Bendigo that it is difficult to transfer babies to a lower level of care hospital and that this created a 'domino effect', delaying the transfer of babies from higher levels of care:

It is now more difficult to transfer babies back to a lower level of care hospital that we have previously been able to, thereby prolonging our length of stay in Bendigo and Shepparton, and subsequently impacting on bed availability. The domino effect of this is the delayed transfer of babies back from Melbourne and tertiary centres, which also then impacts on their bed status. It can be very difficult to find appropriate staff when we go above eight babies, with the 50 per cent rule applying in many cases. We are reviewing our escalation policy at present, and a flow chart for retaining agency staff has recently been developed to aid us in obtaining staff when we require not only just the second person but also if we need the third person because our bed numbers have increased above the ratios.⁴³

The capabilities of health services are re-assessed annually which takes into account how many procedures outside the service's capability have occurred over a 12-month period, changes in workforce, and changes in risk profile.⁴⁴ The Committee heard that it was difficult for some health services and communities when changes to service level meant ceasing birthing. This often resulted in the loss of workplace skills and increased the distance women had to travel to give birth.⁴⁵ The effect on rural and remote services, such as Orbost Regional Health, Kerang District Health, and Healesville Hospital, will be discussed in Chapter Four.

⁴¹ Ms Julianne Clift, Director of Nursing, South West Healthcare, Family and Community Development Committee public hearing – Warrnambool, 11 October 2017, transcript of evidence, p. 3.

⁴² Ms Julie Wright, Operational Director of Women's and Children's Services, Albury Wodonga Health, Family and Community Development Committee public hearing – Wangaratta, 25 October 2017, transcript of evidence, p. 9.

⁴³ Ms Suzanne Hartney, Neonatal Nurse and Midwife, Family and Community Development Committee public hearing – Bendigo, 24 October 2017, transcript of evidence, pp. 3-4.

⁴⁴ Ms Kym Peake, Secretary, Department of Health and Human Services, Family and Community Development Committee public hearing – Melbourne, 27 November 2017, transcript of evidence, pp. 7-8.

⁴⁵ For example, see: Ms Meryn Pease, Chief Executive Officer, Orbost Regional Health, Family and Community Development Committee public hearing – Bairnsdale, 7 December 2017, transcript of evidence.

1.2 The Victorian Perinatal Data Collection

The Victorian Perinatal Data Collection (VPDC) is a population-based surveillance system that collects and analyses detailed information on obstetric conditions, procedures and outcomes, neonatal morbidity, and congenital anomalies relating to every birth in Victoria, in order to contribute to improvements in the health of mothers and babies.⁴⁶

Birth reports to the VPDC cover more than 100 data items, complying with the National Perinatal Minimum Data Set.⁴⁷ The birth reports are sent to the National Perinatal Epidemiology and Statistics Unit (NPESU) for the production of its annual report on Australia's mothers and babies.⁴⁸ Along with the annual report, this data is used by many agencies who contributed to the Committee's Inquiry.

1.3 Australian and New Zealand Neonatal Network

The Australian and New Zealand Neonatal Network (ANZNN) was established in 1994 as 'a collaborative network that monitors the care of high risk newborn infants by pooling data to provide quality assurance for this resource consuming care'.⁴⁹ Since 1994, ANZNN monitors the mortality and morbidity of infants admitted to neonatal intensive care units (NICUs) across Australia and New Zealand through developing a minimum data set and data collection system. All NICUs have contributed to the network's audit of babies since 1995. More recently, the special care units at Sunshine Hospital and Northern Hospital in Victoria have joined the network.⁵⁰

Regarding the ANZNN, the submission from the Melbourne Children's Campus, which incorporates the University of Melbourne's Department of Paediatrics, the Murdoch Children's Research Institute, and The Royal Children's Hospital, stated:

The ANZNN provides a mechanism within which all NICU's in Australia and New Zealand can compare outcomes on a range of morbidities associated with prematurity, and this benchmarking will stimulate the development of care bundles by centres with the best outcomes, so that all centres can optimise their outcomes from premature birth.⁵¹

The Melbourne Children's Campus recommended that resources and infrastructure be provided to collect data through the Australian and New Zealand Neonatal Network (ANZNN) of babies in level 3-5 nurseries. The submission stated that this would enable 'benchmarking, better resource allocation and monitoring of outcomes

⁴⁶ Department of Health and Human Services, 'Victorian Perinatal Data Collection', Victorian Government, accessed 30 January 2018, <<https://www2.health.vic.gov.au/hospitals-and-health-services/quality-safety-service/consultative-councils/council-obstetric-paediatric-mortality/perinatal-data-collection>>.

⁴⁷ Ibid.

⁴⁸ Ibid.

⁴⁹ The University of New South Wales, 'Australian and New Zealand Neonatal Network (ANZNN)', 27 February 2018, accessed 1 March 2018, <<https://npesu.unsw.edu.au/data-collection/australian-new-zealand-neonatal-network-anznn>>.

⁵⁰ Australian and New Zealand Neonatal Network (ANZNN), 'Member units', accessed 1 March 2018, <<https://www.anznn.net/membership/memberunits>>.

⁵¹ Melbourne Children's Campus, submission no. 31, p. 4. See also: Royal Australasian College of Physicians, submission no. 71, p. 3.

including increased safety'.⁵² Their submission explained that at present, the four NICUs all collect and submit data to the ANZNN but that level 3-5 nurseries do not, which makes it difficult to transfer level 5 babies out to peripheral centres.⁵³ The Melbourne Children's Campus submission stated:

With current focus on more efficient utilisation of NICU cots (through tighter definition of NICU patients) and transfer of babies with less intensive care needs out to level 3 - 5 nurseries, it will be important that a minimum dataset is collected by these special care nurseries so that outcomes, beyond those currently reported in the Perinatal Services Performance Indicator report, can be measured, compared and improved upon.⁵⁴

1.4 Consultative Council on Obstetric and Paediatric Mortality and Morbidity (CCOPMM)

The Consultative Council on Obstetric and Paediatric Mortality and Morbidity (CCOPMM) was established in 1962 under the *Health Act 1958* (Vic) and now functions under the *Public Health and Wellbeing Act 2008* (Vic).⁵⁵ CCOPMM analyses and reports on all maternal deaths, stillbirths, and deaths of children under 18 years in Victoria.⁵⁶ CCOPMM reviews all perinatal deaths and has a stillbirth committee (babies not born alive from 20 weeks of gestation onwards) and a neonatal death committee (babies born alive but who do not survive beyond 28 days of life).⁵⁷ CCOPMM advises the Minister and DHHS on strategies to improve clinical performance and avoid preventable deaths.⁵⁸

CCOPMM now produces an annual report (the three reports prior to 2016 were biennial) with comprehensive data on all maternal, perinatal and paediatric mortality and morbidity, and birthing outcomes.⁵⁹ The reports highlight 'areas of clinical risk to inform practice, health policy and system planning' and make recommendations to health policy makers, health services, health providers, and consumers.⁶⁰ The latest report, *Victoria's Mothers, Babies and Children 2016*, was the 55th survey of perinatal deaths in Victoria.⁶¹

52 Melbourne Children's Campus, submission no. 31, p. 4.

53 Ibid. See also: Associate Professor Rod Hunt, Director, Newborn Intensive Care, Royal Children's Hospital, Family and Community Development Committee public hearing - Melbourne, 18 September 2017, transcript of evidence, p. 4.

54 Melbourne Children's Campus, submission no. 31, p. 4. See also: Associate Professor Rod Hunt, Director, Newborn Intensive Care, Royal Children's Hospital, Family and Community Development Committee public hearing - Melbourne, 18 September 2017, transcript of evidence, p. 4.

55 See *Public Health and Wellbeing Act 2008* (Vic), Division 3.

56 Department of Health and Human Services, 'Functions of the CCOPMM', Victorian Government, accessed 30 January 2018, <<https://www2.health.vic.gov.au/hospitals-and-health-services/quality-safety-service/consultative-councils/council-obstetric-paediatric-mortality/functions-of-ccopmm>>.

57 Consultative Council on Obstetric and Paediatric Mortality and Morbidity (CCOPMM), *Victoria's mothers, babies and children 2016*, Melbourne, 2017, p. 95.

58 Department of Health and Human Services, 'Consultative Council on Obstetric and Paediatric Mortality and Morbidity', Victorian Government, accessed 6 March 2018, <<https://www2.health.vic.gov.au/hospitals-and-health-services/quality-safety-service/consultative-councils/council-obstetric-paediatric-mortality>>.

59 Consultative Council on Obstetric and Paediatric Mortality and Morbidity (CCOPMM), *Victoria's mothers, babies and children 2016*, Melbourne, 2017.

60 Department of Health and Human Services, 'Victoria's Mothers, Babies and Children 2016', Council on Obstetric and Paediatric Mortality and Morbidity', Victorian Government, accessed 6 March 2018, <<https://www2.health.vic.gov.au/hospitals-and-health-services/quality-safety-service/consultative-councils/council-obstetric-paediatric-mortality/mothers-babies-children-report>>.

61 Consultative Council on Obstetric and Paediatric Mortality and Morbidity (CCOPMM), *Victoria's mothers, babies and children 2016*, Melbourne, 2017.

The legislative functions of CCOPMM are contained in section 46 of the *Public Health and Wellbeing Act 2008* (Vic) and are listed in Appendix 5.

There are four substantive sub-committees which report to CCOPMM:

- Maternal Mortality and Morbidity Sub-committee
- Stillbirth Sub-committee
- Neonatal Mortality and Morbidity Sub-committee
- Child and Adolescent Mortality and Morbidity Sub-committee.⁶²

At a public hearing in Melbourne, Professor Euan Wallace described the process of reporting both deaths and near misses,⁶³ and the functions and responsibilities of CCOPMM, Safer Care Victoria, and the regional perinatal mortality and morbidity committees:

The processes vary depending on what the event was. All deaths are reviewed by CCOPMM. CCOPMM has a stillbirth committee and a neonatal death committee, and depending on the death, if it is a stillbirth or a neonatal death it is reviewed by one of those committees. So all perinatal deaths are reviewed by CCOPMM. They are also reported through to us, but given that we have got a committee infrastructure that looks after those reviews, we leave them with CCOPMM. There are some non-deaths — so-called sentinel events — and there is a sentinel event reporting program.

Then there are some events that are neither a death nor a sentinel event, and one would expect that those are then reported through the regional [mortality and morbidity] committees ...⁶⁴

Professor Wallace noted that Safer Care Victoria began rebuilding their instant reporting process to where all serious events, whether they are in maternity or elsewhere, are reported to Safer Care. Professor Wallace stated that they are ‘probably three-quarters of the way’ to having a coherent coordinated approach to incident reporting, which is an improvement from the previous year.⁶⁵ He told the Committee that training staff has been crucial to a better reporting process:

It is not unique to Victoria, but one of the things that was highlighted by an external review of incident reporting in Victoria that the department commissioned before we were established was that our health services often struggle with ‘What should I report? To whom should I report? How do I get experts to review it?’. We have established two new structures — one is an expert academy and one is called PEER — where we will train clinicians, physios, surgeons, nurses, midwives et cetera in safety system review, human factor review and so on, so that the sector more broadly has a skill set that it can call upon to review incidents when those arise and a

⁶² Ibid., p. 101.

⁶³ A near miss is defined as ‘an incident that did not cause harm’ and attracts the lowest incident severity rating (ISR) on the ISR scale used by the Victorian Health Incident Management System. See Safer Care Victoria, *Supporting patient safety: Sentinel Event Program triennial report 2013 to 2016*, Victorian Government, Melbourne, 2017, pp. 31, 34.

⁶⁴ Professor Euan Wallace, Chief Executive Officer, Safer Care Victoria, Family and Community Development Committee public hearing – Melbourne, 27 November 2017, transcript of evidence, p. 7.

⁶⁵ Ibid., pp. 7-8.

better reporting mechanism — something that the Auditor-General has called for and that we have responded to — creating a much better oversight of centralised incident reporting.⁶⁶

The Committee is aware of the role of regional perinatal mortality and morbidity committees and believes they are well placed to play a significant role in developing and maintaining reporting mechanisms. The Committee will discuss this further and make a recommendation in section 1.5.3 below.

1.5 Hospital monitoring and accountability

In Victoria, there have recently been many significant changes to perinatal services with regard to hospital monitoring and accountability. In March 2015, CCOPMM notified the Department of Health and Human Services (DHHS) of a ‘cluster of perinatal deaths’ that had occurred at Djerriwarrh Health Service during 2013 and 2014.⁶⁷ Following this, several reviews were undertaken which resulted in the creation of a new hospital monitoring and accountability framework and a new agency, Safer Care Victoria.

Following CCOPMM’s notification, a review was subsequently undertaken by senior obstetrician Professor Euan Wallace which found that seven of the deaths were avoidable or potentially avoidable, with many of the deaths ‘involving common and recurring deficiencies in care’.⁶⁸ The review by Professor Wallace also identified that the Djerriwarrh Health Service had inadequate clinical governance and was not responding in a timely manner to adverse outcomes.⁶⁹

Following this review, the Secretary of DHHS requested the Australian Commission on Safety and Quality in Health Care (ACSQHC) to conduct an independent review into the Department’s actions ‘in detecting, responding to and managing perinatal deaths’ at Djerriwarrh.⁷⁰ ACSQHC found that the Department’s response to the CCOPMM notification in 2015 and to early warning signs about Djerriwarrh was appropriate, with the exception of their response to concerns raised about the safety of Djerriwarrh’s obstetric team by the Australian Nursing and Midwifery Federation in early 2014.⁷¹ ACSQHC did identify significant issues in the Department’s capacity to detect and appropriately respond to emerging critical issues.

66 Ibid., p. 8. ‘PEER’ stands for Panel of External Expert Reviewers, which Safer Care Victoria is looking to establish to provide a pool of independent reviewers who can participate in reviews commissioned by health services. See Safer Care Victoria, *Safer Care Victoria Academy and Panel of External Expert Reviewers (PEER) A consultation paper*, Victorian Government, Melbourne, 2017.

67 S Duckett, Chair, *Targeting Zero: Supporting the Victorian hospital system to eliminate avoidable harm and strengthen quality of care: Report of the review of hospital safety and quality assurance in Victoria*, Victorian Government, Melbourne, 2016, p. vii.

68 E M Wallace, *Report of an Investigation into Perinatal Outcomes at Djerriwarrh Health Services*, 2015, accessed 7 March 2018, <<https://www2.health.vic.gov.au/-/media/Health/Files/Collections/Research%20and%20reports/E/DJERRIWARRH%20-%20WALLACE%20REPORT%20-%20EXECUTIVE%20SUMMARY>>, cited in Ibid.

69 E M Wallace, *Report of an Investigation into Perinatal Outcomes at Djerriwarrh Health Services*, 2015, accessed 7 March 2018, <<https://www2.health.vic.gov.au/-/media/Health/Files/Collections/Research%20and%20reports/E/DJERRIWARRH%20-%20WALLACE%20REPORT%20-%20EXECUTIVE%20SUMMARY>>.

70 S Duckett, Chair, *Targeting Zero: Supporting the Victorian hospital system to eliminate avoidable harm and strengthen quality of care: Report of the review of hospital safety and quality assurance in Victoria*, Melbourne, Victorian Government, 2016, p. vii.

71 Ibid.

The Minister for Health then requested that DHHS commission a review of hospital safety and quality assurance in Victoria (the Duckett review). The panel, chaired by Dr Stephen Duckett, was asked to provide advice about how DHHS systems could be improved to achieve best practice.⁷² The report, *Targeting Zero: Supporting the Victorian hospital system to eliminate avoidable harm and strengthen quality of care: Report of the review of hospital safety and quality assurance in Victoria*, released in October 2016, contained a number of recommendations involving structural reform and the establishment of new organisational structure. The report stated:

The panel found that the department's oversight of hospitals is inadequate. It does not have the information it needs to assure the Minister and the public that all hospitals are providing consistently safe and high-quality care. For example, it does not have a functional incident management system for hospital staff to report patient harm. It has over-relied on accreditation when the evidence suggests that is not justifiable. It makes far too little use of the routine data at its disposal to monitor patient outcomes and investigate red flags suggesting poor care. Its expert committees are fragmented and many are not resourced to detect problems in a timely manner or to follow up to stop them happening again.⁷³

The report also stated that DHHS's overarching governance of hospitals was inadequate and that its support of hospitals to discharge their responsibilities with respect to safety and quality improvement was also inadequate.⁷⁴ The report drew attention to previous audits which had made similar findings but had not resulted in 'the required change':⁷⁵

Our review is not the first to identify these problems. Since 2005 the Victorian Auditor-General's Office has conducted three performance audits on patient safety. The most recent found that the department is not effectively providing leadership or oversight of patient safety, is failing to adequately perform important statewide functions and is not prioritising patient safety. Some of the systematic failures noted in its 2016 audit were first identified over a decade ago in the 2005 audit.⁷⁶

Ms Kym Peake, Secretary of the Department of Health and Human Services, told the Committee at a public hearing in Melbourne:

[W]e are deeply conscious that our maternity system has failed some Victorian families, identified by the Consultative Council on Obstetric and Paediatric Mortality and Morbidity. The cluster of perinatal deaths at Djerriwarrh Health Services during 2013 and 2014 began what has become one of the most significant overhauls of our quality and safety systems in health in many decades. Dr Stephen Duckett and his panel's review of our health system, *Targeting Zero*, really found that as a department we could and should do more in our oversight functions to make sure that we are providing system-wide oversight of quality and safety across our health services, to make sure that we are collecting and sharing better data about quality and safety across the system and using a more systematic approach to quality

72 Ibid.

73 Ibid., pp. xi-xii.

74 Ibid., p. xii.

75 Ibid., p. iv.

76 Ibid., p. xii.

improvement across our system. A large focus of our last year has been responding to the findings and recommendations of *Targeting Zero*, which again Professor Wallace will talk in much more detail about.⁷⁷

On the Duckett review's finding that DHHS had 'over-relied on accreditation when the evidence suggests that is not justifiable',⁷⁸ Mr Terry Symonds, Deputy Secretary, Health and Wellbeing Division, Department of Health and Human Services, told the Committee:

I would say, and again I will refer back to Stephen Duckett's review — one of the issues he called out is whether or not the accreditation process is rigorous enough. So, yes, they are all the same, but again it does not mean it could not be better. The accreditation process has been questioned at times for being overly reliant on documentation and good policy rather than getting under the hood and looking at what the actual quality of practice is like. Safer Care Victoria and the Australian commission are thinking about ways that the accreditation process could be a bit more assertive, I suppose, but that applies equally across the entire country, I would say.⁷⁹

The Government accepted in principle all the recommendations of the Duckett review and outlined a broad plan of action in its publication, *Better, Safer Care: Delivering a world-leading healthcare system*.⁸⁰ This action plan included establishing Safer Care Victoria, described in section 1.5.1 below.

1.5.1 Safer Care Victoria

Safer Care Victoria is a new agency which was opened on 1 January 2017.⁸¹ As mentioned above, Safer Care Victoria was set up in response to the recommendations of the Duckett review.⁸² Safer Care Victoria is the 'peak state authority' for leading quality and safety improvements in healthcare and 'was established to oversee and support health services to provide safe, high quality care to patients every time, everywhere'.⁸³ The five priority areas of Safer Care Victoria are: partnering with patients, families, and carers; partnering with clinicians; leadership; review, and response; and improvement and innovation.⁸⁴

77 Ms Kym Peake, Secretary of the Department of Health and Human Services, Family and Community Development Committee public hearing – Melbourne, 27 November 2017, transcript of evidence, p. 3.

78 S Duckett, Chair, *Targeting Zero: Supporting the Victorian hospital system to eliminate avoidable harm and strengthen quality of care: Report of the review of hospital safety and quality assurance in Victoria*, Melbourne, Victorian Government, 2016, p. xii.

79 Mr Terry Symonds, Deputy Secretary, Health and Wellbeing Division, Department of Health and Human Services, Family and Community Development Committee public hearing – Melbourne, 27 November 2017, transcript of evidence, p. 8.

80 Victorian Government, Department of Health and Human Services, *Better, Safer Care: Delivering a world-leading healthcare system*, Victorian Government, Melbourne, 2016.

81 Professor Euan Wallace, Chief Executive Officer, Safer Care Victoria, Family and Community Development Committee public hearing – Melbourne, 27 November 2017, transcript of evidence, p. 2.

82 S Duckett, Chair, *Targeting Zero: Supporting the Victorian hospital system to eliminate avoidable harm and strengthen quality of care: Report of the review of hospital safety and quality assurance in Victoria*, Melbourne, Victorian Government, 2016, p. xiii.

83 Department of Health and Human Services, 'About Safer Care Victoria', Victorian Government, accessed 7 March 2018, <<https://www2.health.vic.gov.au/hospitals-and-health-services/safer-care-victoria/about>>.

84 Ibid.

Professor Euan Wallace, Chief Executive Officer of Safer Care Victoria, explained that the role of Safer Care Victoria is one of leadership in quality and safety improvement for health services across the state and to provide advice to the Minister and DHHS.⁸⁵ He told the Committee at a public hearing in Melbourne:

The mission, the aim of Safer Care Victoria is about providing outstanding health care for all Victorians, always. The challenge for us as an agency of course is that we do not have the privilege of having our hands on any Victorian patients, so we have to deliver this through supporting our 84 health services. We will do this by enabling services to deliver safe, high-quality care and experiences, not just for patients, their carers and families but also for staff, because we know that staff experiences themselves lead directly into quality of patient care and outcomes.⁸⁶

Safer Care Victoria produces the Victorian *Perinatal Services Performance Indicators* (PSPI) which is a report that aims to improve outcomes by reporting of benchmarking data which allows health services to compare results and monitor variation against their peers.⁸⁷ The reports contain ten performance indicators of perinatal care in Victorian health services which span the antenatal, intrapartum and postnatal periods, such as first antenatal visit, fetal growth restriction, smoking in pregnancy, Apgar score, outcomes for first-time mothers, vaginal birth after caesarean section, readmission during the postnatal period, breastfeeding, and term infants needing additional care.⁸⁸ The benchmarking data in the reports are to assist health services, maternity care providers, and DHHS to identify best practice in relation to maternity and newborn care, and provide information on the safety and quality of newborn and maternity care in Victoria.⁸⁹

Safer Care Victoria and DHHS ‘work with the least performing health services to understand the drivers for their reported performance, identify opportunities for improvement, and share positive examples of good practice where applicable’.⁹⁰ The data in the report comes from the Victorian Perinatal Data Collection (VPDC), the Victorian Admitted Episodes Dataset (VAED), and the Victorian Healthcare Experience Survey (VHES).⁹¹ The Committee heard that hospitals and health services regularly used the PSPI to measure their performance against other hospitals and health services.⁹² Each hospital’s performance on each indicator is marked by its position on an interquartile range.

85 Professor Euan Wallace, Chief Executive Officer, Safer Care Victoria, Family and Community Development Committee public hearing – Melbourne, 27 November 2017, transcript of evidence, p. 2.

86 Ibid.

87 Department of Health and Human Services, ‘Victorian Perinatal Services Performance Indicators’, Victorian Government, accessed 7 March 2018, <<https://www2.health.vic.gov.au/hospitals-and-health-services/patient-care/perinatal-reproductive/maternity-newborn-services/vic-perinatal-services-performance-indicators>>.

88 Safer Care Victoria, *Victorian Perinatal Services Performance Indicators 2016-17*, Department of Health and Human Services, Melbourne, 2018, p. 2.

89 Ibid., p. 3.

90 Safer Care Victoria, *Victorian Perinatal Services Performance Indicators 2015-16*, Department of Health and Human Services, Melbourne, 2017, p. 3.

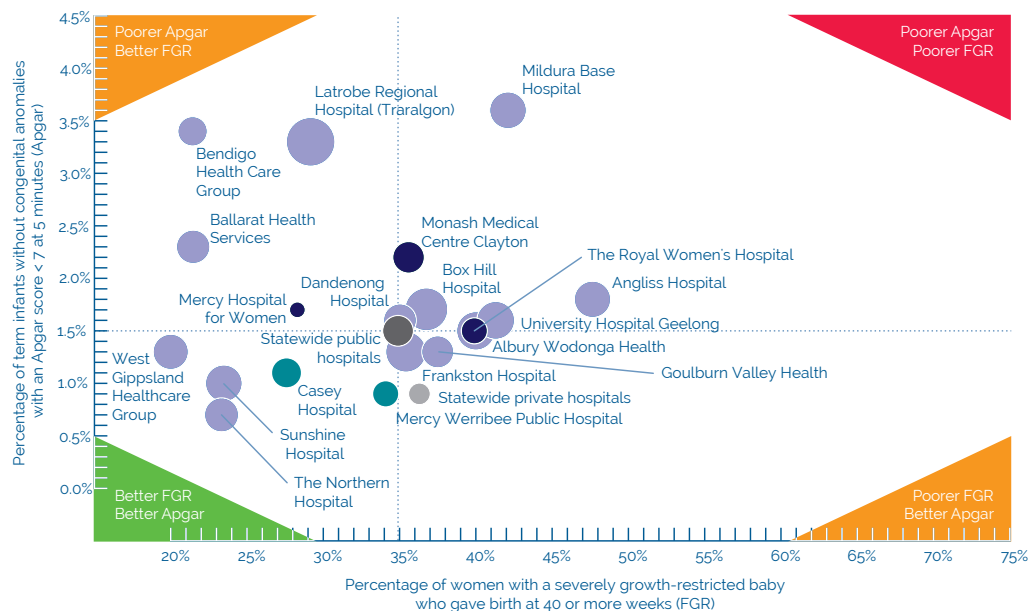
91 The VPDC and VAED data collections are managed by DHHS and the VHES is conducted on behalf of DHHS by Ipsos, an independent contractor. Safer Care Victoria, *Victorian Perinatal Services Performance Indicators 2016-17*, Department of Health and Human Services, Melbourne, 2018, p. 7. See also: Department of Health and Human Services, ‘Victorian Healthcare Experience Survey - VHES’, accessed 16 March 2018, <<https://www2.health.vic.gov.au/hospitals-and-health-services/quality-safety-service/patient-experience-survey>>.

92 Associate Professor Ryan Hodges, Interim Program Director, Women’s and Newborn Program, and Head of Obstetrics and Perinatal Services, Monash Health, Family and Community Development Committee public hearing – Melbourne, 16 October 2017, transcript of evidence, p. 3.

At a public hearing in Melbourne, Associate Professor Ryan Hodges, Interim Program Director, Women’s and Newborn Program, and Head of Obstetrics and Perinatal Services, Monash Health, described to the Committee how the PSPI worked with the indicator of low birthweight, describing a graph used in Safer Care Victoria’s *Perinatal Services Performance Indicators 2015–2016* report:

It is a good summary graph as to the performance of our hospital services in Victoria. Essentially you want to be on the bottom left, so if you are in the bottom left that means you are better able to detect small babies. Small babies are those that are starving and at risk of stillbirth. If you are in the bottom left, these are babies that are born with better Apgar scores. They are born healthier; they are better able to breathe and transition to air breathing. Then the smaller the circle, the lower your perinatal mortality rate, so these are less stillbirths, less babies dying in the nursery.⁹³

Figure 1.1 32-week gestation standardised perinatal mortality ratio with results for fetal growth restriction and Apgar, 2015



Source: Safer Care Victoria, *Victorian Perinatal Services Performance Indicators 2015-16*, Department of Health and Human Services, Melbourne, 2017, p. 18.

While it is still a relatively new agency, the Committee heard positive feedback of the work of Safer Care Victoria. Ms Jodie Ashworth, General Manager of Surgery, Women’s and Children’s, Operating Theatres and ICU and Chief Nursing Officer at Northern Health, told the Committee at a public hearing in Melbourne:

I think the work that Safer Care Victoria is doing in partnering rurals to metro is absolutely essential. It is a great piece of work. We are very fortunate to have Euan Wallace involved in that. We are working on the governance side at the moment of

⁹³ Ibid. Note: ‘The Apgar score is an assessment of a newborn’s wellbeing at birth based on five physiological attributes at one and five minutes (and longer if applicable): colour (circulation), breathing, heart rate, muscle tone and reflexes.’ See Department of Health and Human Services, *Victorian perinatal services performance indicators 2013-14*, Victorian Government, Melbourne, 2016, p. 63.

linking those partnerships. We also need to work on the workforce side, so what those shared models for collaborative midwifery and obstetric practice look like between somewhere like Northern and Kilmore.⁹⁴

At a public hearing in Melbourne, Dr Michael Rasmussen, Clinical Services Director at Mercy Hospital for Women (Mercy Health), spoke highly of the mechanisms in place to improve maternity safety and quality:

In relation to access to quality, safe and effective care, there is a vast array of fantastic work being done out there with the support of the state government, with CCOPMM, Safer Care Victoria, the Victorian prenatal mortality reports and so forth ... There is a huge amount of stuff out there, and the potential for it to improve and expand and grow is unlimited. Units need to be pushed to utilise their own maternity indicators. It is incumbent on us to keep pushing for a statewide dashboard of obstetric and paediatric indicators so we can better assess how we are doing and better compare between units and so forth. The improved audit of obstetric interventions is an increasing issue.⁹⁵

Ms Kym Peake, Secretary of the Department of Health and Human Services, told the Committee at a public hearing in Melbourne:

Through the work of the creation of Safer Care Victoria and the Victorian Agency for Health Information we are very focused ... on supporting strong leadership in hospital governance with good clinical leaders, effective boards and rigorous oversight; sharing excellence in good practice across our health system so that, where one hospital does something well, other hospitals can follow; and collecting better data about patients' experiences as well as their outcomes and feeding that back to improve patient care.⁹⁶

1.5.2 Perinatal mortality rate

Victoria's perinatal mortality rate (PMR) is currently 8.8 per 1,000 which is the lowest adjusted PMR in 16 years and is lower than the national average of 9.6 per 1,000.⁹⁷ The perinatal mortality rate (PMR) refers to the number of perinatal deaths (stillbirths or early neonatal deaths) per 1,000 total births. According to the Consultative Council on Obstetric and Paediatric Mortality and Morbidity (CCOPMM), the leading cause of adjusted stillbirth is congenital anomalies, and for newborns up to the age of 28 days, congenital anomalies and spontaneous preterm birth were the two most common causes of perinatal mortality.⁹⁸

Associate Professor Rod Hunt, Director, Newborn Intensive Care, at The Royal Children's Hospital, told the Committee that while the PMR was low, there was room for improvement:

⁹⁴ Ms Jodie Ashworth, General Manager, Surgery, Women's and Children's, Operating Theatres and ICU and Chief Nursing Officer, Northern Health, Family and Community Development Committee public hearing – Melbourne, 5 February 2018, transcript of evidence, p. 6.

⁹⁵ Dr Michael Rasmussen, Clinical Services Director, Mercy Hospital for Women (Mercy Health), Family and Community Development Committee public hearing – Melbourne, 16 October 2017, transcript of evidence, p. 4.

⁹⁶ Ms Kym Peake, Secretary, Department of Health and Human Services, Family and Community Development Committee public hearing – Melbourne, 27 November 2017, transcript of evidence, p. 3.

⁹⁷ *Ibid.*, p. 2.

⁹⁸ Consultative Council on Obstetric and Paediatric Mortality and Morbidity (CCOPMM), *Victoria's mothers, babies and children 2016*, Melbourne, 2017, p. 11.

I think there are still gains to be made in the perinatal mortality rate, nationally and internationally. It is a very competitively low rate, but as I showed from the graph of causes of preventable death there are still gains to be made, particularly around hypoxic-ischemic deaths and fetal growth restriction. There is currently work being undertaken in those areas through the department of health and through the college of physicians and the college of obstetricians and gynaecologists rolling out education programs so that clinicians within the sector are able to better identify fetal growth restriction and deliver babies at a time when their survival is optimised.⁹⁹

Furthermore, perinatal mortality rates remain higher among certain groups, such as Aboriginal and Torres Strait Islander babies and specific migrant groups (babies of women born in North Africa, the Middle East, or southern and central Asia), which will be addressed in Chapters Seven and Eight.

1.5.3 Regional perinatal mortality and morbidity committees

In 2016, six regional perinatal mortality and morbidity committees were established across Victoria. These committees meet monthly and ‘systematically review and audit all deaths and other clinical outcomes for mothers and babies in their region’.¹⁰⁰ As noted in Safer Care Victoria’s *Victorian Perinatal Services Performance Indicators 2015-16* report:

The regional committees do not replace the existing requirements of health services to investigate and report adverse outcomes. Instead, they act as another layer of review for rural health services, which will benefit those that do not have the critical mass and expertise to undertake this work independently. The Royal Women’s Hospital is supporting and facilitating the establishment of the committees.¹⁰¹

At a public hearing in Melbourne, the Committee heard from Ms Kym Peake, Secretary of the Department of Health and Human Services, who said that the committees had been successful in bringing together medical staff, general practitioners, midwives and others to ‘confidentially review cases and plan improvements’.¹⁰² She noted:

Those committees were established after the events at Bacchus Marsh to ensure that our smaller rural hospitals or rural services are supported to review any adverse outcomes, share learnings and strengthen clinical practice.¹⁰³

On the importance of regional perinatal mortality and morbidity committees, Professor Euan Wallace said that while the Committees have a ‘regionalised review of adverse outcomes’, they ‘have done much more than that’:

99 Associate Professor Rod Hunt, Director, Newborn Intensive Care, Royal Children’s Hospital, Family and Community Development Committee public hearing – Melbourne, 18 September 2017, transcript of evidence, p. 5.

100 Safer Care Victoria, *Victorian Perinatal Services Performance Indicators 2016-17*, Department of Health and Human Services, Melbourne, 2018, p. 37.

101 Ibid.

102 Ms Kym Peake, Secretary, Department of Health and Human Services, Family and Community Development Committee public hearing – Melbourne, 27 November 2017, transcript of evidence, p. 3.

103 Ibid.

They have made much stronger relationships between practitioners and between small, rural, subregional and regional hospitals.

...

Those are key committees because they share not just learnings from deaths but from near misses and they give an early warning alert system to say, 'Actually, we've got a service that's struggling here or has difficulties'.¹⁰⁴

The Committee heard about the success and value of these regional committees at a public hearing in Wangaratta. Dr Will Twycross, Procedural GP in Obstetrics, Anaesthetics, and Accident and Emergency, told the Committee that the regional perinatal mortality and morbidity meetings had given smaller health services a closer link to larger services:

One good outcome of the increase in governance is that I think a really good model for governance is a model we have here, which is that the director of medical services in Wangaratta is the director of medical services in Mansfield, and the senior obstetrician in Wangaratta runs ... the morbidity and mortality meetings, so we have a really close link to Wangaratta. When we ring them up, we know who we are talking to.¹⁰⁵

At a public hearing in Wangaratta, Dr Leo Fogarty, Director of Obstetrics at Northeast Health Wangaratta, explained to the Committee how their regional perinatal mortality and morbidity committee worked:

We have a meeting with the three smaller regional hospitals at Albury, Wodonga and Wangaratta, which happens every three months. We all think this is an excellent initiative. It has given us great opportunities for learning in all directions, up and down, from Professor Permezel, who is our peer support person, down to us and back in the other direction. I think some of the messages get back to Melbourne that we have been struggling to get back to Melbourne for a long time. It is a fantastic learning opportunity.¹⁰⁶

Several witnesses expressed concern about ongoing funding for the regional committees.¹⁰⁷ Dr John Elcock, Director of Medical Services, Northeast Health Wangaratta, told the Committee:

My understanding is they are currently on time-limited funding, which will run out at the end of this year. These committees have been incredibly effective in terms of sharing learning and understanding across health services and also providing a vehicle for central capture of key issues. Having the central leadership of those committees we think is a key issue in terms of ensuring that they continue to function, and function well, and provide a vehicle for key issues to be raised through bodies such as Safer Care Victoria.¹⁰⁸

¹⁰⁴ Professor Euan Wallace, Chief Executive Officer, Safer Care Victoria, Family and Community Development Committee public hearing – Melbourne, 27 November 2017, transcript of evidence, pp. 6, 7.

¹⁰⁵ Dr Will Twycross, Procedural GP in Obstetrics, Anaesthetics, and Accident and Emergency, Family and Community Development Committee, public hearing – Wangaratta, 25 October 2017, transcript of evidence, p. 7.

¹⁰⁶ Dr Leo Fogarty, Director of Obstetrics, Northeast Health Wangaratta, Family and Community Development Committee public hearing – Wangaratta, 25 October 2017, transcript of evidence, p. 3.

¹⁰⁷ For example, *Ibid.*, pp. 3-4; Dr John Elcock, Director of Medical Services, Northeast Health Wangaratta, Family and Community Development Committee public hearing – Wangaratta, 25 October 2017, transcript of evidence, p. 5.

¹⁰⁸ Dr John Elcock, Director of Medical Services, Northeast Health Wangaratta, Family and Community Development Committee public hearing – Wangaratta, 25 October 2017, transcript of evidence, p. 5.

Ms Julie Wright, Operational Director of Women’s and Children’s Services at Albury Wodonga Health, also expressed concern about the time limited funding, stating that these meetings were ‘very well supported and provide excellent clinical review and discussion’:

These meetings, which have brought a lot to the regional centres — and great discussion, great support, for our rural counterparts — do take a lot of time, investment and review, and having that centrally coordinated party in Melbourne cannot be underestimated. The funding does go through to 30 June 2018, and at this point there is no funding beyond that. We have been informed it needs to remain sustainable. However, to do anything well — and this does need to be done well; it is about understanding the histories, and I am quite involved in this at the Albury Wodonga Health end — it does need time and investment.¹⁰⁹

In their submission, the Royal Australasian College of Physicians stated that the meetings are valuable but noted that there can be potential conflicts of interest:

Regional perinatal morbidity meetings have been implemented recently and the RACP believes these provide a valuable mechanism for continued improvement of care of newborns in regional centres. These have been welcomed by regional paediatricians as a mechanism for reviewing provision of care especially where adverse events have occurred. However, the RACP recommends that strategies should be implemented to ensure that they remain appropriately resourced. Potential conflicts stemming from the clinician investigating their own care should be addressed.¹¹⁰

The Committee heard about the value of regional perinatal mortality and morbidity committees in providing not only an early warning alert system for services that are struggling, but also ongoing professional development and learnings from other services. The Committee believes that the role of regional perinatal mortality and morbidity committees is crucial to ensuring that capacity and skills are maintained across regional perinatal services. Accordingly, the Committee recommends that:

RECOMMENDATION 1.2: The Victorian Government commit to ongoing funding to support the work of regional perinatal mortality and morbidity committees and to ensure that these committees are available in each health region of the state.

RECOMMENDATION 1.3: The Victorian Government support regional perinatal mortality and morbidity committees to contribute to standardised reporting mechanisms for inclusion in Department of Health and Human Services practices.

1.5.5 National Strategic Approach to Maternity Services

On 22 September 2017, it was agreed at the Australian Health Ministers’ Advisory Council meeting to start a new process to develop a National Strategic Approach to Maternity Services (NSAMS).¹¹¹ On 2 March 2018, the Australian Government released

¹⁰⁹ Ms Julie Wright, Operational Director of Women’s and Children’s Services, Albury Wodonga Health, Family and Community Development Committee public hearing – Wangaratta, 25 October 2017, transcript of evidence, p. 4.

¹¹⁰ Royal Australasian College of Physicians, submission no. 71, p. 3.

¹¹¹ Department of Health, ‘Maternity services’, updated 15 February 2018, Australian Government, accessed 8 March 2018, <<http://www.health.gov.au/internet/main/publishing.nsf/Content/pacd-pdb-maternity>>.

new national medical guidelines for the care of pregnant women.¹¹² The Australian Government also announced a new National Strategic Approach to Maternity Services, led by the Commonwealth Chief Nursing and Midwifery Officer, Professor Debra Thoms.¹¹³ The strategy will be finalised by mid-2019.¹¹⁴

1.6 Patient transfers through PIPER

The Committee heard that the Newborn Emergency Transport Service (NETS) was established in 1976 as a collaborative service between the Royal Women's Hospital, the Mercy Hospital, the Monash Medical Centre, the Royal Children's Hospital, the ambulance service, and the then Health Commission.¹¹⁵ In 1979, the Paediatric Emergency Transport Service (PETS) commenced operation. In 2006, the Perinatal Emergency Referral Service (PERS) was established, which was 'basically a hotline for consultation for clinicians caring for mothers/pregnant women who develop acute problems during pregnancy and usually problems that raise the risk of delivering a baby who will need neonatal intensive care'.¹¹⁶

Since 2011, the Royal Children's Hospital has had the governance of the three services (NETS, PERS and PETS) and together they have been combined into a single, state-wide emergency referral and retrieval service for Victoria's women, newborn babies and children referred to as the Paediatric Infant Perinatal Emergency Retrieval Service (PIPER).¹¹⁷ Today these three elements of PIPER continue as PIPER Neonatal, PIPER Perinatal and PIPER Paediatrics.

At a public hearing in Wangaratta, the Committee heard from Ms Megan Rickard, whose newborn son was flown to the Royal Women's Hospital in Melbourne:

This was without a doubt the single most traumatic and mentally debilitating thing that has ever happened to me. Max was taken away, I was informed that I could not go with him and I was not able to see him for the next three days. In the end I actually discharged myself from hospital and I had to get my sister to drive me down to Melbourne to meet with my son, something that I believe should not have had to happen. A recommendation from me would be to provide medical transport to and from major hospitals in the event that a mother and child have to be separated.¹¹⁸

112 Department of Health, *Clinical Practice Guidelines: Pregnancy Care*, 2018 edition, Australian Government, Canberra, 2018; Hon. Greg Hunt, Minister for Health, 'Better maternity services for Australian women', media release, 2 March 2018.

113 Hon. Greg Hunt, Minister for Health, 'Better maternity services for Australian women', media release, 2 March 2018.

114 Ibid.

115 Associate Professor Michael Stewart, Director, Paediatric Infant Perinatal Emergency Retrieval Service, Family and Community Development Committee public hearing – Melbourne, 5 February 2018, transcript of evidence, p. 2.

116 Ibid.

117 The Royal Children's Hospital (RCH) took over the governance of the Newborn Emergency Transport Service (NETS) and the Perinatal Emergency Referral Service (PERS) on 1st September 2011 after 35 years at The Royal Women's Hospital. See The Royal Children's Hospital, 'About PIPER', accessed 17 May 2018, <<https://www.rch.org.au/piper/about>>.

118 Ms Megan Rickard, Family and Community Development Committee public hearing – Wangaratta, 25 October 2017, transcript of evidence, p. 2.

At a public hearing in Melbourne, the Committee heard from Professor Michael Permezel, the Immediate Past-President of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists, who explained how PIPER works and noted the delays in transfers that can occur:

[W]hen I am in Wangaratta and they have a complex patient they ring PIPER to find out where the patient should go, where the bed is. PIPER then tries to ring around all the hospitals to find out the most appropriate place. There may be nowhere and the woman remains in Wangaratta maybe for days until something is sorted out.¹¹⁹

PIPER facilitates 1,700 transfers for women and babies each year.¹²⁰ At a public hearing in Melbourne, the Committee heard from Associate Professor Michael Stewart, the Director of PIPER, who explained what PIPER does, which includes facilitating emergency patient transfers and non-emergency back transfers, monitoring access to beds, providing advice from a specialty-specific retrieval consultant, education, outreach, and research.¹²¹ Associate Professor Stewart stated that the consultants tailor advice to the capability of referring hospitals and that they ‘try not to mention bed-finding at all’ in the conversation, even though it is their ‘single biggest problem’.¹²² He told the Committee:

[W]e like to think we provide a one-stop shop philosophy of care. For clinicians who are meeting women or babies with conditions that are really outside the scope of their clinical capability and their health service capability, we provide rapid access to a specialty-specific — so obstetric or neonatology or paediatric, in the case of children — retrieval consultant.

We are a consultant-led service. When you ring us, you do not get trainees; you get put through to a consultant usually in 1 to 5 minutes. We prioritise the clinical issues over the logistics. So we might be very busy, we know that the hospitals are very busy, we might know ambulances are very busy, but that is not the referrer’s problem. Our focus is on the clinical problem that is being presented and trying to assess that as thoroughly as we can to determine what is the most appropriate course, and then we worry about how we manage to transfer that patient if that is what is required.¹²³

Regarding bed-finding, Associate Professor Stewart told the Committee about some of the challenges in his work, including the delay in finding a receiving hospital for a patient transfer, noting that a few times a year, it would take 35 or 40 phone calls at 3:00am before a solution was negotiated.¹²⁴ While Ambulance Victoria could be mobilised quickly to respond and pick up a patient, Associate Professor Stewart said that Ambulance Victoria are ‘very reluctant, appropriately, to mobilise without a receiving unit’.¹²⁵ He stated:

119 Professor Michael Permezel, Immediate Past-President, Royal Australian and New Zealand College of Obstetricians and Gynaecologists, Family and Community Development Committee public hearing – Melbourne, 4 September 2017, transcript of evidence, p. 3.

120 Associate Professor Michael Stewart, Director, Paediatric Infant Perinatal Emergency Retrieval Service, Family and Community Development Committee public hearing – Melbourne, 5 February 2018, transcript of evidence, p. 3. Ms Kym Peake, Secretary of the Department of Health and Human Services, Family and Community Development Committee public hearing – Melbourne, 27 November 2017, transcript of evidence, p. 5.

121 Associate Professor Michael Stewart, Director, Paediatric Infant Perinatal Emergency Retrieval Service, Family and Community Development Committee public hearing – Melbourne, 5 February 2018, transcript of evidence, pp. 3-4.

122 Ibid., p. 4.

123 Ibid., pp.3-4.

124 Ibid., p. 10.

125 Ibid., p. 5.

The single biggest issue we have internally and possibly from a systems perspective as well at the moment is the time it takes us to confirm a receiving unit when everyone agrees we have got an urgent, high-risk maternal transfer in front of us. ... in 2015–16 [the median time it took to confirm a bed] was 47 minutes. That means in half the cases it takes longer than 47 minutes to actually confirm a bed. And if we look at the 90th centile, that is 168 minutes — you are getting up close to 3 hours. So for about 10 per cent of urgent PERS transfers there is a delay getting out to 3 hours in confirming a bed.¹²⁶

The Committee heard that many hospitals organised their own interhospital transfers without going through PIPER, which PIPER encourages.¹²⁷ Associate Professor Stewart mentioned that there were some ‘excellent models of regional or subregional networks’, such as in Wangaratta, Wodonga, and the south-west, however he also noted that a lot of regional health services acted like silos:

Even with adjoining regional services, when they get full and want to transfer out patients that would normally be their capability, they ring us. They do not go to their neighbour and say, ‘We’re really busy today. Can you help us out in the nursery or in the maternity side of things?’. We need to get that working better.¹²⁸

At a public hearing in Wangaratta, the Committee heard again that some hospitals bypass PIPER and organise their own interhospital transfers.¹²⁹ Dr Leo Fogarty, Director of Obstetrics, Northeast Health Wangaratta, told the Committee that while PIPER was a vast improvement on the previous situation, there was often unavailability of beds which left the health service in a position in which they had to act outside their capability:

PIPER organising transfers for us is a vast improvement on the previous situation we had of having to ring around three different tertiary hospitals, which is something I remember from 10 or 15 years ago. Most of the problems we have with PIPER and with transfers are, I am sure, due to the unavailability of sufficient neonatal intensive care beds in Melbourne. But we also do have some PIPER clinicians on the other end of the phone in Melbourne who do seem to have very little understanding of our situation and our staffing and our capabilities. As a result of difficulties with transferring patients, we are now fairly regularly left to deal with situations which are outside our capability framework, such as holding on to very premature babies because there is nowhere for them to go in Melbourne.¹³⁰

At a public hearing in Bairnsdale, Ms Bernadette Hammond, Director of Clinical Operations and Chief Nurse and Midwife at Bairnsdale Regional Health Service, described to the Committee some of the challenges with having high risk pregnancies outside their capability:

¹²⁶ Ibid.

¹²⁷ Ms Jodie Ashworth, General Manager, Surgery, Women’s and Children’s, Operating Theatres and ICU and Chief Nursing Officer, Northern Health, Family and Community Development Committee public hearing – Melbourne, 5 February 2018, transcript of evidence, p. 8; Associate Professor Michael Stewart, Director, Paediatric Infant Perinatal Emergency Retrieval Service, Family and Community Development Committee public hearing – Melbourne, 5 February 2018, transcript of evidence, p. 6.

¹²⁸ Associate Professor Michael Stewart, Director, Paediatric Infant Perinatal Emergency Retrieval Service, Family and Community Development Committee public hearing – Melbourne, 5 February 2018, transcript of evidence, p. 6.

¹²⁹ Dr Leo Fogarty, Director of Obstetrics, Northeast Health Wangaratta, Family and Community Development Committee public hearing – Wangaratta, 25 October 2017, transcript of evidence, p. 3.

¹³⁰ Ibid.

Sometimes if we have someone present who is outside our capability, we might ring two, three or four places before we can find a bed. We are working on pathways across the region, so then the escalation of care will be that the level 4 has to take them, then the level 5, which is Sale and LRH [Latrobe Regional Hospital]. There are no questions asked. If they do not have a bed, then they will have to sort something out at their end — transfer someone out or move someone, which generally can be done. So it is a more timely response, I suppose, from them. In the past we might have had delays of 4 hours sometimes. We might have been making multiple phone calls.¹³¹

Ms Hammond said that sometimes they cannot find a bed at another hospital and they end up birthing women at their service who are high risk and outside their capability. She stated: ‘It does not mean we will not manage them as best we can, but it is not the best place for them’.¹³²

Ms Julie Wright, Operational Director of Women’s and Children’s Services at Albury Wodonga Health, told the Committee that Albury Wodonga Health transferred out 25 babies on average annually and about the same number of mothers with baby in utero, which was very expensive for the health service:

One of the other things I would just like to point out in relation to transfers that at Albury Wodonga Health we have probably tried to understand a little bit more of is, ‘If we were not so far from Melbourne, would it cost as much?’. The average transfer for a baby or a mother from Albury-Wodonga is around \$5000, and just depending on the nature of the transfer — occasionally it is twins — it could be up to \$7500, \$8000. It is a significant amount of money. Most of our mothers and babies would be retrieved by air. Again, we need to always factor in that we are probably 5 hours away. There have been times when we have been able to notify them ahead — if someone comes in in imminent labour — and on occasions we have actually had them there in the birth suite ready to accept a baby. So it can work exceptionally well.¹³³

The Committee recognises the challenges for regional hospitals in meeting the costs of hospital transfers due to greater distances from larger hospitals.

Professor Michael Permezel recommended that an inquiry into PIPER be conducted, looking into how PIPER is currently working and how it could function better.¹³⁴ He told the Committee:

It has been running for quite a few years now under different names, but we feel that it is time we should look into how that is working and how it could work better. It is a fairly simple process. There is not currently a mechanism; there is a bit of frustration out there, partly the NICU, but it is not just the lack of NICU beds, and I think an inquiry into how PIPER is currently working and how it could function better would be very helpful.¹³⁵

131 Ms Bernadette Hammond, Director of Clinical Operations/Chief Nurse and Midwife, Bairnsdale Regional Health Service, Family and Community Development Committee public hearing – Bairnsdale, 7 December 2017, transcript of evidence, p. 4.

132 Ibid., p. 9.

133 Ms Julie Wright, Operational Director of Women’s and Children’s Services, Albury Wodonga Health, Family and Community Development Committee public hearing – Wangaratta, 25 October 2017, transcript of evidence, p. 3.

134 Professor Michael Permezel, Immediate Past-President, Royal Australian and New Zealand College of Obstetricians and Gynaecologists, Family and Community Development Committee public hearing – Melbourne, 4 September 2017, transcript of evidence, pp. 3, 10.

135 Ibid., p. 3.

Ms Fiona Faulks, Deputy Director of Nursing, Women’s and Children’s Services at Bendigo Health, told the Committee that it was important to be self-sufficient while waiting for a specialist team to arrive:

[B]y the time we have an unstable neonate within our neonatal service or an unstable woman, we can be between 2 and 6 hours away from having a specialist team arrive to assist us. So really, certainly in the initial phases, we need to be able to be self-sufficient for a period of time, and that is not always easy. I know that our rural partners have similar problems in that they approach PIPER to assist with a transfer and there is a long period of time often that they need to wait until that assistance arrives.¹³⁶

At a public hearing in Warrnambool, Ms Janene Facey, Maternity Nurse Unit Manager at South West Healthcare, told the Committee that there can be pressure from PIPER to take babies back:

Our special care nursery is staffed from our ward ratios, so there are no governing ratios for our special care nursery. It becomes an issue when we have got babies with extra special needs, like CPAP [continuous positive airway pressure], and that is where we get a little bit of pressure from Melbourne. Last week, for example, we had six babies in our nursery, which is our capacity, and we had one on CPAP. We had the pressure from PIPER to take another baby back to Warrnambool. We just did not have the resources. There have been a couple of phone calls on a couple of occasions from PIPER just inquiring as to why we would have a resource issue. We had a resource issue on this particular day for these particular reasons. It does not happen all the time — it is pretty rare — but I suppose it is about just having that respect for the regional hospitals when they say they are at capacity and cannot do a transfer back.¹³⁷

The work done by PIPER is an important part of perinatal services in Victoria. Evidence to the Committee told of the difficult position PIPER is often in as the facilitator of transfers, and the pressures health services on either side of PIPER feel when dealing with transfers. The Committee also heard of interhospital transfers outside of the PIPER system, and how strong relationships between hospitals that allow these transfers is something that PIPER encourages.

In light of this evidence, and noting that the current governance arrangement of PIPER has been in place since 2011, the Committee sees the need for a review of PIPER, to evaluate how it can best foster positive perinatal outcomes for babies and their families. Accordingly, the Committee recommends that:

RECOMMENDATION 1.4: The Victorian Government review the Paediatric Infant Perinatal Emergency Retrieval Service’s (PIPER) performance, capacity, outcomes, and relationships with other health services.

¹³⁶ Ms Fiona Faulks, Deputy Director of Nursing, Women’s and Children’s Services, Bendigo Health, Family and Community Development Committee public hearing – Bendigo, 24 October 2017, transcript of evidence, p. 5.

¹³⁷ Ms Janene Facey, Maternity Nurse Unit Manager, South West Healthcare, Family and Community Development Committee public hearing – Warrnambool, 11 October 2017, transcript of evidence, p. 9.

Retrieval and Critical Health Information System (REACH)

The Committee heard that there are issues with the Retrieval and Critical Health Information System (REACH) website, which is a website accessible by approved hospitals and DHHS that contains bedstate information, and recently replaced the VicPIC website.¹³⁸ Dr Andrew Watkins, a neonatologist at the Mercy Hospital for Women, explained to the Committee his reservations about the REACH website:

Recently the department has put intensive care on the REACH website and is no longer using the VicPIC website, which has been a valuable tool because (a) it has given a good running idea of who has got beds and who has not and (b) it includes maternity data, as in who has got capacity to deal with the mother. And of course babies have a habit of coming out of mothers. The REACH website, which is the website used for adult intensive care, coronary care, ambulance services et cetera, does not contain any evidence about obstetric care — it does not contain any information about obstetric capacity — so when we are looking on the computer to see where to put the mother, where to put the next baby or when we are negotiating where to put them, we do not have that information or we can only get it by a fairly cumbersome ring around.¹³⁹

In their submission to the Inquiry, RANZCOG also raised concerns about the website:

Our capacity to manage the system safely and effectively has been significantly compromised by the recent decision to close the VICPIC site, used for monitoring NICU and Obstetric capacity and to shift to the REACH website used for other ICU services in Victoria. This website does not contain information about Maternity bedstate, which impairs our capacity to determine where to send a high risk mother (who may herself be at significant medical risk) while trying to keep her close to her baby and to avoid overloading any particular perinatal unit.¹⁴⁰

The Committee is concerned that the REACH website does not contain the obstetric and maternity beds data that was contained on VicPIC, and therefore recommends that:

RECOMMENDATION 1.5: The Victorian Government expand the Retrieval and Critical Health Information System (REACH) website to include obstetric care and maternity bedstate.

¹³⁸ Dr Andrew Watkins, Neonatologist, Family and Community Development Committee public hearing – Melbourne, 18 September 2017, transcript of evidence; Associate Professor Rod Hunt, Director, Newborn Intensive Care, Royal Children’s Hospital, Family and Community Development Committee public hearing – Melbourne, 18 September 2017, transcript of evidence; Dr Michael Rasmussen, Clinical Services Director, Mercy Hospital for Women (Mercy Health), Family and Community Development Committee public hearing – Melbourne, 16 October 2017, transcript of evidence.

¹³⁹ Dr Andrew Watkins, Neonatologist, Family and Community Development Committee public hearing – Melbourne, 18 September 2017, transcript of evidence, p. 3.

¹⁴⁰ Royal Australian and New Zealand College of Obstetricians and Gynaecologists, submission no. 35, p. 4.

1.7 High risk pregnancies and their management

The Capability Framework states that obstetric complications may occur in any pregnancy at any time, ‘however women with certain conditions, either solely or in combination, place them “at risk”.’¹⁴¹ The Framework notes that both maternal and perinatal morbidity and mortality are increased in cases of high risk pregnancies.

A high risk pregnancy means that a woman or baby has an increased chance of a health problem and requires extra monitoring and greater care in the management of the pregnancy. Risk factors for high risk pregnancies are numerous and include obesity, age, socioeconomic status, gestational diabetes, multiple gestation, pre-eclampsia, pre-existing illnesses, alcohol use, and cigarette smoking.¹⁴²

Certain groups have an increased prevalence of high risk pregnancies. The Committee heard that Aboriginal and Torres Strait Islander pregnancies are more likely to be classified as high risk, which will be discussed in detail in Chapter Seven.¹⁴³ Furthermore, women living in rural and regional areas were more likely to be obese or smoke during pregnancy, and these areas also have higher rates of teenage pregnancies.¹⁴⁴

1.7.1 Premature births

A premature birth refers to a birth which is less than 37 weeks gestation. Babies born before 37 weeks comprised 8.3 per cent of all babies.¹⁴⁵ According to CCOPMM, nine per cent of the 75 deaths in post-neonatal infants (28–364 days of age) in 2016 were due to prematurity.¹⁴⁶ Babies born prematurely or with low birthweight have a higher risk of sudden and unexpected death, and in 2016, 39 per cent of the 23 babies who died of sudden unexpected death in infancy (SUDI) were born preterm.¹⁴⁷

With advances in medicine and technology, the Committee heard that babies can survive at 24 weeks, which is a much lower gestational age than was previously possible.¹⁴⁸ In his submission, Dr Andrew Watkins, a neonatologist, wrote:

Thirty years ago up to 50% of extremely premature NICU patients would not have needed this extended period of nursery care, due to death in the first week of life.

¹⁴¹ Department of Health, *Capability framework for Victorian maternity and newborn services*, Victorian Government, Melbourne, 2010, p. 29.

¹⁴² See *Ibid.*, pp. 29-31 for a longer list of broad risk categories before conception, during the pregnancy and at labour and birth.

¹⁴³ Loddon Mallee Aboriginal Reference Group, submission no. 66.

¹⁴⁴ Professor Euan Wallace, Chief Executive Officer, Safer Care Victoria, Family and Community Development Committee public hearing – Melbourne, 27 November 2017, transcript of evidence, p. 6.

¹⁴⁵ Consultative Council on Obstetric and Paediatric Mortality and Morbidity (CCOPMM), *Victoria’s mothers, babies and children 2016*, Melbourne, 2017, p. 44.

¹⁴⁶ Forty seven per cent were due to congenital anomaly and 19 per cent were due to sudden infant death syndrome. See *Ibid.*, p. 11.

¹⁴⁷ *Ibid.*, p. 30.

¹⁴⁸ Dr Michael Rasmussen, Clinical Services Director, Mercy Hospital for Women (Mercy Health), Family and Community Development Committee public hearing – Melbourne, 16 October 2017, transcript of evidence, p. 4.

Improvements in assisted ventilation, the availability of artificial surfactant and a general improvement in care have significantly improved the lives of infants and families, but have also increased pressure on bedstate.¹⁴⁹

Premature babies can be cared for at a secondary or tertiary newborn service (Level 3 to Level 6). The Committee heard that there are several factors that can increase the likelihood of a premature birth, such as previous preterm birth, pregnancy with twins or other multiples, problems with the uterus, cervix or placenta, chronic conditions such as high blood pressure and diabetes, and stressful life events. Other factors include smoking and drug use during pregnancy.

Associate Professor Ryan Hodges, Interim Program Director, Women's and Newborn Program, and Head of Obstetrics and Perinatal Services, Monash Health, told the Committee at a public hearing in Melbourne:

Usually viability would start at 24 weeks and we would have an expectation of good long-term outcomes from 25 weeks and beyond. But I have to make a very important point here that the counselling needs to be individualised. If you look at the causes of preterm birth, there is a large variety of causes. Some babies are growth restricted, for example, so it is not just gestational age, it is also birth weight and it is also the sex of the baby: we know that girls do better than boys. Then what is the mother's health. Are there any other comorbidities? So it is quite complex. But for any woman who is at risk of preterm birth, we think we would rather our experts give counselling to those couples, so we would see them at 23 weeks, 24 weeks, of course.¹⁵⁰

The Committee also heard that family violence contributes to a number of indicators for poor birth outcomes, including premature birth.¹⁵¹ Family violence will be discussed further in Chapter Three. Premature births are also more common in rural and regional areas than in metropolitan areas.¹⁵² Furthermore, Aboriginal and Torres Strait Islander babies were 45 per cent more likely than non-Aboriginal and Torres Strait Islander babies to be born prematurely (11.5 per cent).¹⁵³ Perinatal services for Aboriginal and Torres Strait Islander communities will be discussed further in Chapter Seven.

The Committee heard that families with babies in NICUs need greater support, particularly those families who are placed a long way from their home residence and support system.¹⁵⁴ The Australian Psychological Society recommended strengthening the support available for high risk and premature births in their submission to the Inquiry:

¹⁴⁹ Dr Andrew Watkins, submission no. 62, p. 2.

¹⁵⁰ Associate Professor Ryan Hodges, Interim Program Director, Women's and Newborn Program, and Head of Obstetrics and Perinatal Services, Monash Health, Family and Community Development Committee public hearing – Melbourne, 18 September 2017, transcript of evidence, p. 9.

¹⁵¹ Ms Marilyn Humphrey, Maternal and Child Health Coordinator, Baw Baw Shire Maternal and Child Health Services, Family and Community Development Committee public hearing – Warragul, 8 December 2017, transcript of evidence, p. 5; Hume City Council, submission no. 69, p. 13.

¹⁵² Mr Wale Oladimeji, submission no. 1, p. 3.

¹⁵³ Consultative Council on Obstetric and Paediatric Mortality and Morbidity (CCOPMM), *Victoria's mothers, babies and children 2016*, Melbourne, 2017, p. 35. See also: Ms Mandy Miller, Midwife, Koori Maternity Service, Wathaurong Aboriginal Cooperative, Family and Community Development Committee public hearing – Geelong, 11 December 2017, transcript of evidence, p. 4.

¹⁵⁴ Sands Australia, submission no. 86, pp. 6-7.

There is a paucity of mental health support for families dealing with high-risk and premature birth. Research suggests that there are high rates of PTSD and psychological distress amongst parents in the Neonatal Intensive Care Unit (Kim et al 2015).

Mental health support and follow up for families once they have left hospital is also lacking, yet improvements in medical technology mean that younger babies are now being saved but these babies are often sicker and are at increased risk of developmental difficulties.¹⁵⁵

Mental health support for families will be discussed in Chapter Three, and the challenges facing regional and rural families with babies in tertiary centres will be addressed in Chapter Four.

1.7.2 Obesity

The Committee heard that there were increasing numbers of high risk pregnancies due to maternal risk factors such as obesity and gestational diabetes and that many hospitals had difficulties addressing the challenges that these risk factors present.¹⁵⁶ In their College Statement, the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) note that obesity in pregnancy is ‘now one of the most important challenges in obstetric care’.¹⁵⁷

At a public hearing in Warrnambool, Dr Liz Uren, Obstetrician and Gynaecologist at South West Healthcare, told the Committee about some of the challenges caring for obese mothers:

[O]besity is one of those things that creates high-risk obstetrics for us, and it just makes generally looking after the pregnancy more difficult, even just being able to visualise the foetus with abnormalities, growth issues or anything like that. It just makes life more difficult — monitoring them in labour and that sort of thing.¹⁵⁸

The Committee also heard that obesity often resulted in the mother needing to birth earlier.¹⁵⁹ At a public hearing in Wangaratta, Dr Will Twycross referred to the growing obesity epidemic and its contribution to maternal mortality:

We actually may have seen the best of maternal mortality unless we can do something about obesity. Obesity is really about public policy, with respect, if you will forgive me. Obesity or the politics of food is really at the place where the politics of tobacco was 20 or 30 years ago.¹⁶⁰

¹⁵⁵ Australian Psychological Society, submission no. 80, p. 14.

¹⁵⁶ Dr Leo Fogarty, Director of Obstetrics, Northeast Health Wangaratta, Family and Community Development Committee public hearing – Wangaratta, 25 October 2017, transcript of evidence, p. 6.

¹⁵⁷ Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) Management of Obesity in Pregnancy, College Statement, C-Obs 49, 1st endorsed March 2013, reviewed November 2016, accessed 6 February 2018, <https://www.ranzcog.edu.au/RANZCOG_SITE/media/RANZCOG-MEDIA/Women's%20Health/Statement%20and%20guidelines/Clinical-Obstetrics/C-Obs_49_Management-of-Obesity-in-Pregnancy-Review-Sep-2013.pdf?ext=.pdf>.

¹⁵⁸ Dr Liz Uren, Obstetrics and Gynaecology, South West Healthcare, Family and Community Development Committee public hearing – Warrnambool, 11 October 2017, transcript of evidence, p. 8.

¹⁵⁹ Ms Julianne Barclay, Maternity Services Officer, Australian Nursing and Midwifery Federation (Victorian Branch), Family and Community Development Committee public hearing – Melbourne, 18 September 2017, transcript of evidence, p. 4.

¹⁶⁰ Dr Will Twycross, Procedural GP in Obstetrics, Anaesthetics, and Accident and Emergency, Family and Community Development Committee, public hearing – Wangaratta, 25 October 2017, transcript of evidence, p. 5.

Dr Michael Rasmussen, the Clinical Services Director at the Mercy Hospital for Women (Mercy Health), told the Committee at a public hearing in Melbourne that there was growing demand on obstetric and paediatric services in Werribee and that they are seeing increased complexity and morbidity in their patients:

[O]besity in particular is a big issue for us. We only have capability to deal with women up to a certain weight at the moment, and women who exceed that weight have to transfer their care to Sunshine or the Women's or the Mercy. It used to be an uncommon event; now it is a not uncommon event and it is an issue throughout the state.¹⁶¹

The Committee heard from Bendigo Health about how obesity and diabetes was changing their risk profile at their hospital to the point where they now have a higher ratio of high risk pregnancies to normal risk pregnancies. Furthermore, because a number of smaller hospitals in the region do not deliver women with a body mass index (BMI) over 40 as it would breach the capability of their hospital, Bendigo Health now sees increasing numbers of women due to Bendigo Health being a Level 5 in the Capability Framework, discussed above.¹⁶²

The Committee also heard that Mildura Base Hospital, a Level 4 in the Capability Framework, was transferring patients with a BMI above 50 to tertiary centres. Dr Nikhil Patravali, Director of Obstetrics and Gynaecology at Mildura Base Hospital, told the Committee at a public hearing in Mildura that this was not always well received by patients:

Early this year we had to send a memorandum to the community saying that for any woman above 50 BMI we just do not have the capability to deliver here, and we have then spoken to lots of tertiary units that have now accepted that any woman above 50 BMI would then get transferred out, which perhaps does not go down very well, as you can imagine, with patients. It is slightly discriminatory, but I think looking at risk stratification you have to do what is safe for people. That has always been an issue.¹⁶³

The Committee heard that obesity is a public health issue that needs to be addressed before women get pregnant, as interventions during pregnancy are generally too late.¹⁶⁴ A recent study in *The Medical Journal of Australia* found that many adverse perinatal outcomes attributable could be averted if overweight and obese women reduced their BMI:

¹⁶¹ Dr Michael Rasmussen, Clinical Services Director, Mercy Hospital for Women (Mercy Health), Family and Community Development Committee public hearing – Melbourne, 16 October 2017, transcript of evidence, p. 2.

¹⁶² Dr Nicola Yuen, Director, Obstetrics and Gynaecology, Bendigo Health, Family and Community Development Committee public hearing – Bendigo, 24 October 2017, transcript of evidence, p. 7. See also: Ms Suzanne Hartney, Neonatal Nurse and Midwife, Family and Community Development Committee public hearing – Bendigo, 24 October 2017, transcript of evidence, p. 7.

¹⁶³ Dr Nikhil Patravali, Director, Obstetrics and Gynaecology, Mildura Base Hospital, Family and Community Development Committee public hearing – Mildura, 9 November 2017, transcript of evidence, p. 4.

¹⁶⁴ For example, Ms Fiona Faulks, Deputy Director of Nursing, Women's and Children's Services, Bendigo Health, Family and Community Development Committee public hearing – Bendigo, 24 October 2017, transcript of evidence, p. 7.

Were overweight and obese women to have moved down one BMI category during 2010–2014, 19% of pre-eclampsia, 15.9% of macrosomia, 14.2% of gestational diabetes, 8.5% of caesarean deliveries, 7.1% of low for gestational age birthweight, 6.8% of post partum haemorrhage, 6.5% of admissions to special care nursery, 5.8% of prematurity, and 3.8% of fetal abnormality could have been averted.¹⁶⁵

Dr Yuen told the Committee that the impact of obesity in pregnancy is ‘still very much a developing area for obstetrics’.¹⁶⁶ Dr Yuen is involved in the development of guidelines around obesity management in pregnancy with Safer Care Victoria in the maternity handbook. She told the Committee:

Talking to my colleagues, it is still very much an area where the evidence is still being discovered. I think out of that we are gaining a little bit more focus on those issues around health promotion and health management prior to pregnancy. It is obviously a difficult field for us because by the time they get to us they are already pregnant.

It is obviously something which we are very keen to manage. It is certainly something which we promote within our gynaecology clinics with women seeking fertility treatment or investigations for subfertility, but I think it is something that will probably garner a little bit more traction over the next couple of years as we begin to understand a little bit more about the risk of obesity in pregnancy.¹⁶⁷

1.7.3 Gestational diabetes

The CCOPMM *Victoria’s mothers, babies and children 2016* report found that women giving birth at 28 or more weeks’ gestation who had gestational diabetes mellitus (GDM) had a perinatal mortality rate of 2.0 per 1,000 births compared with 3.0 per 1,000 for those without GDM.¹⁶⁸ At a public hearing in Wangaratta, Dr Leo Fogarty, the Director of Obstetrics at Northeast Health Wangaratta, told the Committee that the increase in gestational diabetes was due to obesity, women having babies later in life, and that the definition of gestational diabetes had changed, bringing in a larger number of women.¹⁶⁹ Importantly, while one of the risks of obesity is an increased risk of developing gestational diabetes, not all women with gestational diabetes are obese.¹⁷⁰

Dr Nicola Yuen, Director of Obstetrics and Gynaecology at Bendigo Health, told the Committee at a public hearing in Bendigo that at Bendigo Health, women who are identified as having gestational diabetes enter a multidisciplinary care model which involves a dietician, a diabetes educator, an endocrinologist, and an obstetrician.¹⁷¹ These women also require additional midwifery support in the last part of their

165 K Cheney, R Farber, A L Barratt, K McGeechan, B de Vries, R Ogle and K I Black, ‘Population attributable fractions of perinatal outcomes for nulliparous women associated with overweight and obesity, 1990–2014’, *Med J Aust*, vol. 208, no. 3, p. 119.

166 Dr Nicola Yuen, Director, Obstetrics and Gynaecology, Bendigo Health, Family and Community Development Committee public hearing – Bendigo, 24 October 2017, transcript of evidence, p. 6.

167 Ibid.

168 Consultative Council on Obstetric and Paediatric Mortality and Morbidity (CCOPMM), *Victoria’s mothers, babies and children 2016*, Melbourne, 2017, p. 11.

169 Dr Leo Fogarty, Director of Obstetrics, Northeast Health Wangaratta, Family and Community Development Committee public hearing – Wangaratta, 25 October 2017, transcript of evidence, p. 6.

170 Dr Nicola Yuen, Director, Obstetrics and Gynaecology, Bendigo Health, Family and Community Development Committee public hearing – Bendigo, 24 October 2017, transcript of evidence, p. 11.

171 Ibid., p. 9.

pregnancy and often lactation support to get the women expressing antenatally for colostrum, thereby mitigating the risk of hypoglycaemia for babies born to mothers with diabetes.¹⁷² Postnatally, the women are referred to their GP with a request for a six-week glucose tolerance test to 'ensure that their diabetes is not ongoing beyond pregnancy' and they receive counselling in hospital after their baby is born about the high risk of future pregnancies.¹⁷³

Diabetes in pregnancy also causes issues for neonates. Ms Fiona Faulks, the Deputy Director of Nursing, Women's and Children's Services at Bendigo Health, told the Committee that at Bendigo Health they see a high number of neonates being admitted to their special care nursery with hypoglycaemia and needing care and monitoring.¹⁷⁴

1.7.4 Smoking

Safer Care Victoria's *Victorian Perinatal Services Performance Indicators 2016-2017* report states that women who smoke while pregnant have 'an increased risk of ectopic pregnancy, miscarriage, placenta praevia and pre-term labour, and are more likely to give birth to a low-birthweight baby compared with non-smokers'.¹⁷⁵ In 2016, nine of the 23 infants who died from sudden unexpected death in infancy (SUDI) were exposed to maternal smoking in pregnancy and/or after birth.¹⁷⁶ The report also states that:

Low-birthweight babies are more vulnerable to infection and other short- and long-term health problems. The damaging effects of maternal cigarette smoking on the unborn baby include reduction of oxygen supply, restricted growth and development, increased risk of cleft lip and cleft palate, and increased heart rate and disruption of the baby's breathing movements in utero (Quit Victoria 2013).

Smoking in pregnancy is a preventable cause of significant obstetric and perinatal complications, and adverse outcomes. Pregnancy is therefore an important time for health professionals to implement strategies and interventions to assist women to quit smoking, particularly given that women are motivated to protect their baby's health.¹⁷⁷

The smoking cessation rate refers to 'the percentage of women who quit smoking after 20 weeks' gestation among those who smoked before 20 weeks' gestation'.¹⁷⁸ In 2016, the state-wide rate of smoking cessation during pregnancy was 26.1 per cent, with the overall smoking cessation rate in public hospitals being 24.4 per cent, and the overall smoking cessation rate in private hospitals being 66.1 per cent.¹⁷⁹

172 Ibid.

173 Ibid., pp. 9-10.

174 Ms Fiona Faulks, Deputy Director of Nursing, Women's and Children's Services, Bendigo Health, Family and Community Development Committee public hearing – Bendigo, 24 October 2017, transcript of evidence, p. 10.

175 Safer Care Victoria, *Victorian Perinatal Services Performance Indicators 2016-2017*, Department of Health and Human Services, Melbourne, 2018, p. 49.

176 Consultative Council on Obstetric and Paediatric Mortality and Morbidity (CCOPMM), *Victoria's mothers, babies and children 2016*, Melbourne, 2017, p. 30.

177 Safer Care Victoria, *Victorian Perinatal Services Performance Indicators 2016-2017*, Department of Health and Human Services, Melbourne, 2018, p. 49.

178 Ibid., p. 9.

179 Ibid., p. 49.

Speaking to the Committee at a public hearing in Melbourne about prevention programs around pregnancy, Associate Professor Rod Hunt of the Royal Children's Hospital told the Committee:

Certainly the safety and quality committee are actively involved in the measurement of outcomes and risk factors like smoking during pregnancy and are keenly driving programs that look to prevent or minimise smoking during pregnancy as a key risk factor for adverse neonatal outcomes. That would be one example of prevention.¹⁸⁰

The Committee heard that smoking rates are higher in rural and regional areas, with smoking in the second half of pregnancy being three times more common than in metropolitan areas.¹⁸¹ Smoking rates during pregnancy are also significantly higher in Aboriginal and Torres Strait Islander communities.¹⁸² At a public hearing in Warragul, the Committee heard from Dr Simon Fraser, the Chief Medical Officer and Paediatrician at Latrobe Regional Hospital, who said:

The smoking rate in Gippsland sits across the region at about 27 or 28 per cent, compared with the state of Victoria, which I think is half of that. Certainly for our women in the first half of pregnancy the smoking rate is very close to that; it is about 25 per cent. We are able to get that down to about 20 per cent in the second half of pregnancy. If you look at the perinatal service indicators, that is significantly greater than other health services, particularly private hospitals. That is an area that requires ongoing support. The region is involved in a lot of work being done in trying to reduce smoking rates throughout the region, particularly with support from funding following the Hazelwood mine fire.¹⁸³

Red Nose recommended in their submission that there be increased education across Victoria to health professionals, parents, and carers around the risks of smoking during pregnancy and after birth to 'aid in the decrease in rates of preterm births, low birth rates and SUDI'.¹⁸⁴

¹⁸⁰ Associate Professor Rod Hunt, Director, Newborn Intensive Care, Royal Children's Hospital, Family and Community Development Committee public hearing – Melbourne, 18 September 2017, transcript of evidence, p. 7.

¹⁸¹ Professor Euan Wallace, Chief Executive Officer, Safer Care Victoria, Family and Community Development Committee public hearing – Melbourne, 27 November 2017, transcript of evidence, p. 6. See also: Australian Nursing and Midwifery Federation (Victorian Branch), submission no. 67, p. 17; Ms Meryn Pease, Chief Executive Officer, Orbost Regional Health, Family and Community Development Committee public hearing – Bairnsdale, 7 December 2017, transcript of evidence, p. 4; Mr Wale Oladimeji, submission no. 1, p. 4.

¹⁸² Consultative Council on Obstetric and Paediatric Mortality and Morbidity (CCOPMM), *Victoria's mothers, babies and children 2016*, Melbourne, 2017, p. 35; Loddon Mallee Aboriginal Reference Group, submission no. 66, p. 1; Ms Brianna Ellis, General Manager, Gippsland and East Gippsland Aboriginal Co-operative, Family and Community Development Committee public hearing – Bairnsdale, 7 December 2017, transcript of evidence, p. 3.

¹⁸³ Dr Simon Fraser, Chief Medical Officer and Paediatrician, Latrobe Regional Hospital, Family and Community Development Committee public hearing – Warragul, 8 December 2017, transcript of evidence, p. 3.

¹⁸⁴ Red Nose, submission no. 98, p. 5.

1.7.5 Drug and alcohol use

The Committee heard about the risks associated with drug and alcohol use during pregnancy and in the postnatal period, and the challenge of managing drug and alcohol use for health services.¹⁸⁵ Drug and alcohol use has a detrimental effect on a developing baby and can lead to premature births¹⁸⁶ and a baby being born with fetal alcohol syndrome or addiction.

Drug and alcohol use also compromises a parent's ability to care for their child. The latest CCOPMM report included a case study of a two-month-old baby who was found deceased after his parents had consumed alcohol and taken the baby to their bed during the night for feeding and settling.¹⁸⁷ The report recommended that adults under the influence of alcohol or drugs or sedating medication should be kept away from babies.¹⁸⁸

Drug and alcohol abuse also affects maternal health. In 2016, substance dependency was a known contributing factor in three maternal deaths from psychosocial causes.¹⁸⁹

Ms Maryanne Purcell, Maternal and Child Health Nurse Coordinator at Warrnambool City Council, told the Committee at a public hearing in Warrnambool that families often had a 'cluster' of vulnerabilities:

I think there is an increasing amount of, certainly, ice use, and it causes havoc with families. You tend to find a lot of the vulnerable families would have those clusters of vulnerabilities, where there is domestic violence, there is illicit drug use or alcohol use, and then they are socially and economically disadvantaged as well. So they do tend to cluster together.¹⁹⁰

The Committee also heard that some women with complex social issues, such as drug and alcohol use, presented to the hospital in labour with minimal or no antenatal care.¹⁹¹ Dr Kimberley Sleeman from Mildura O&G Clinic told the Committee that these women placed 'a very great strain on the already limited resources' of their unit:

Often it is multifactorial issues, and if they have not engaged in any antenatal care during the pregnancy, they have not booked into the hospital, they turn up and have their baby, and then it becomes apparent that it is not safe to send this baby home and because there has not been any planning, because often people may choose to disengage with services because they are worried about what is going to happen ...¹⁹²

¹⁸⁵ Centre of Perinatal Excellence (COPE), submission no. 4, p. 21; The Babes Project, submission no. 8, p. 1; Caroline Chisholm Society, submission no. 29, p. 19; Royal Australian and New Zealand College of Obstetricians and Gynaecologists, submission no. 35, p. 4.

¹⁸⁶ Ms Mandy Miller, Midwife, Koori Maternity Service, Wathaurong Aboriginal Cooperative, Family and Community Development Committee public hearing – Geelong, 11 December 2017, transcript of evidence, p. 10.

¹⁸⁷ Consultative Council on Obstetric and Paediatric Mortality and Morbidity (CCOPMM), *Victoria's mothers, babies and children 2016*, Melbourne, 2017, p. 31.

¹⁸⁸ *Ibid.*, p. 32.

¹⁸⁹ *Ibid.*, p. 15. See also: Australian Nursing and Midwifery Federation (Victorian Branch), submission no. 67, p. 3.

¹⁹⁰ Ms Maryanne Purcell, Maternal and Child Health Nurse Coordinator, Warrnambool City Council, Family and Community Development Committee public hearing – Warrnambool, 11 October 2017, transcript of evidence, p. 8.

¹⁹¹ Dr Kimberley Sleeman, Mildura O&G Clinic, Family and Community Development Committee public hearing – Mildura, 9 November 2017, transcript of evidence, p. 3.

¹⁹² *Ibid.*, pp. 3, 7.

The Committee heard that women who have been assessed as having a history of drug use or an abusive partner/family member will be asked to return to hospital for a check-up rather than having a home visit from midwives due to safety concerns for midwives and other staff.¹⁹³ The Australian Nursing and Midwifery Federation (Victorian Branch) stated in their submission that these women ‘are arguably more in need of a home visiting service than many others due to their inability to leave home’ and that the system ‘must provide flexibility for these women’.¹⁹⁴ This issue will be examined in detail in Chapter Six in relation to maternal and child health nurses.

At a public hearing in Melbourne, the Committee heard about the Centre for Women’s Mental Health at the Royal Women’s Hospital working with vulnerable women, including those who have experienced drug and alcohol abuse.¹⁹⁵ Professor Louise Newman AM, the Director of the Centre for Women’s Mental Health, told the Committee that hospitals are ‘facing greater numbers of acute presentations with drug and alcohol issues’,¹⁹⁶ especially ice, and that there were often other social risk factors that were present with drug and alcohol issues, such as homelessness, relationship breakdowns, and interpersonal violence:

We have a day a week of a psychiatrist looking at our women’s alcohol and drug service, so some of the very high-risk women across the state, often women affected by ice use during pregnancy, with major psychiatric issues related to substance abuse and huge risks for parenting and babies. That is actually quite a low EFT to provide a backup service for them.¹⁹⁷

Like smoking, the Committee heard that there were higher rates of alcohol and drug use during pregnancy in rural and regional areas, and in Aboriginal and Torres Strait Islander communities.¹⁹⁸ Ms Julie Wright, Operational Director of Women’s and Children’s Services at Albury Wodonga Health, told the Committee that they were seeing increased complexity in their patients including increased drug use.¹⁹⁹ The Committee also heard that rural and regional areas lacked sufficient support services to care for pregnant women with drug and alcohol issues. In their submission, Albury Wodonga Health drew attention to the difficulties in accessing drug and alcohol services for women in rural and regional communities:

In rural and regional communities there is lack of access to drug and alcohol support services for women with alcohol and drug related health issues when planning pregnancy, during their pregnancy, and postnatally. There is a definite need for specific tailored programs for this group of women in rural and regionals areas, this need extends to resources, skill and knowledge and an appropriate funding source.²⁰⁰

¹⁹³ Australian Nursing and Midwifery Federation (Victorian Branch), submission no. 67, p. 9. See also: Ms Alana Cooper, submission no. 94, p. 1.

¹⁹⁴ Australian Nursing and Midwifery Federation (Victorian Branch), submission no. 67, p. 9.

¹⁹⁵ Professor Louise Newman AM, Director, Royal Women’s Hospital Centre for Women’s Mental Health, Family and Community Development Committee public hearing – Melbourne, 16 October 2017, transcript of evidence, p. 1.

¹⁹⁶ *Ibid.*, p. 10.

¹⁹⁷ *Ibid.*, p. 9.

¹⁹⁸ Ms Raylene Harradine, Chief Executive Officer, Bendigo and District Aboriginal Co-operative, and Chair, Loddon Mallee Aboriginal Reference Group, Family and Community Development Committee public hearing – Bendigo, 24 October 2017, transcript of evidence, p. 2.

¹⁹⁹ Ms Julie Wright, Operational Director of Women’s and Children’s Services, Albury Wodonga Health, Family and Community Development Committee public hearing – Wangaratta, 25 October 2017, transcript of evidence, p. 7.

²⁰⁰ Albury Wodonga Health, submission no. 55, p. 1.

At a public hearing in Warrnambool, Dr Liz Uren told the Committee about the lack of services for women in Warrnambool and the difficulty accessing available services in Melbourne:

We also have trouble having an appropriate for-pregnancy drug and alcohol service in Warrnambool. That is just fairly difficult. There is one drug and alcohol physician in the hospital, and his expertise with pregnancy is limited. We had a woman recently who we were hoping to transfer up to the Royal Women's drug and alcohol unit because she was on a large dose of morphine. We were just not managing her as well as we should have been, and we really were refused access to that bed because presumably they did not have one. She ended up in Melbourne eventually because she had to be delivered at 26 weeks gestation, but it was really not an appropriate thing to happen here.²⁰¹

Dr Uren noted that while the drug and alcohol problem is 'not a new problem', it is 'becoming a bit more difficult to manage at times':

There are certain drugs that are more difficult, and there is a bit more alcohol being used. I think everyone has got the same problem everywhere, but we do not have the backup services. That is the reason why it is a bit more difficult here.²⁰²

Ms Helen Lees, the Maternal and Child Health Clinical Coordinator at the City of Greater Bendigo, told the Committee at a public hearing in Bendigo that the main issues that women face in Bendigo in the perinatal period are mental health issues, drug and alcohol issues, and family violence.²⁰³ Regarding drug and alcohol support services, she also said:

At Bendigo to my knowledge we do not have a dedicated antenatal clinic for women with drug and alcohol issues like the service that operates out of the women's hospital. It would be good to see maybe satellite programs in the regions for this program, as I believe that service is very comprehensive for these women and their babies. Our referral of [complex pregnancy care] clients from Bendigo Health indicates an increasing number of antenatal mothers with drug and alcohol issues.²⁰⁴

The Committee heard that the new Bendigo Health nursery had parent zone rooms and facilities for mothers and babies who require support 'due to a history of substance abuse during the pregnancy' and these quieter rooms are used 'for those babies that are withdrawing'.²⁰⁵

²⁰¹ Dr Liz Uren, Obstetrics and Gynaecology, South West Healthcare, Family and Community Development Committee public hearing – Warrnambool, 11 October 2017, transcript of evidence, p. 3.

²⁰² *Ibid.*, p. 10.

²⁰³ Ms Helen Lees, Maternal and Child Health Clinical Coordinator, City of Greater Bendigo, Family and Community Development Committee public hearing – Bendigo, 24 October 2017, transcript of evidence, p. 7.

²⁰⁴ *Ibid.*, p. 4.

²⁰⁵ Ms Suzanne Hartney, Neonatal Nurse and Midwife, Family and Community Development Committee public hearing – Bendigo, 24 October 2017, transcript of evidence, p. 2.

In October 2016, Uniting Care ReGen opened a state-wide voluntary Mother and Baby drug and alcohol withdrawal service, funded by DHHS.²⁰⁶ This service, the first of its kind in Victoria, accommodates up to four mothers and their babies at Curran Place in Ivanhoe.²⁰⁷

As discussed later in Chapter Three, on 1 November 2017 several changes were made to Medicare Benefits Schedule Items related to obstetric services, and new items were introduced, based on recommendations of the Medicare Benefits Schedule Review Taskforce, which put a greater emphasis on managing and screening for drug and alcohol use during pregnancy.²⁰⁸ These changes to Items 16522, 16590, and 16591 acknowledge that patients with a mental health disorder, drug use, or domestic violence experiences may require more comprehensive care and thus attract a higher MBS fee.²⁰⁹

A new item 16407 (Postnatal consultation) was also introduced to include screening for drug and alcohol use in a postnatal attendance lasting at least 20 minutes between four and eight weeks after birth. While these mental health services are to be offered to all patients, patients who choose not to undertake the assessment are not to be disadvantaged in their care.²¹⁰ These changes have been positively received by stakeholders, including the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG).²¹¹

1.7.6 Health promotion

The Committee heard that pre-pregnancy public health promotion campaigns are needed to reduce risk factors such as obesity, poor diet, smoking, alcohol and drug use and diabetes.²¹² In their submission, the Australian Nursing and Midwifery Federation (Victorian Branch) recommended that the Victorian Government fund Community Health Centres to ‘embed Women’s Health programs co-ordinated by women’s health nurses and midwives to provide pre pregnancy advice, education and referral’, noting that:

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- 206** Uniting Care ReGen, ‘Mother and baby unit’, accessed 17 May 2018, <<http://www.regen.org.au/treatment-support/withdrawal/mother-and-baby>>.
- 207** Hon. Martin Foley, Minister for Mental Health, ‘New service to put mothers on the right path’, media release, 21 November 2016.
- 208** Department of Health, ‘Changes to MBS items for obstetrics services’, Australian Government, accessed 18 May 2018, <<http://www.mbsonline.gov.au/internet/mbsonline/publishing.nsf/Content/Factsheet-ObstetricsServices>>.
- 209** Medicare Benefits Schedule Review Taskforce, *Report from the Obstetrics Clinical Committee*, 2016, accessed 17 May 2018, <[http://www.health.gov.au/internet/main/publishing.nsf/content/24913E0474E75768CA2580180016A033/\\$File/MBS-Obstetrics.pdf](http://www.health.gov.au/internet/main/publishing.nsf/content/24913E0474E75768CA2580180016A033/$File/MBS-Obstetrics.pdf)>.
- 210** Department of Health, ‘Changes to MBS items for obstetrics services’, Australian Government, accessed 18 May 2018, <<http://www.mbsonline.gov.au/internet/mbsonline/publishing.nsf/Content/Factsheet-ObstetricsServices>>.
- 211** Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) ‘RANZCOG welcomes Medicare-funded mental health support for pregnant women’, media release, November 2017, RANZCOG website, accessed 17 May 2018, <<https://www.ranzcog.edu.au/news/RANZCOG-welcomes-Medicare-funded-mental-health-sup>>.
- 212** Ms Heather Daly, Midwife and Community Health Nurse, Family and Community Development Committee public hearing – Bairnsdale, 7 December 2017, transcript of evidence, p. 3. See also: Mr Wale Oladimeji, submission no. 1, p. 4.

In terms of women and their babies in the perinatal period, the benefit of programs such as Quit Smoking, pre pregnancy dietary and activity advice to reduce BMI, and fertility and family planning advice is known to improve maternal and neonatal outcomes.²¹³

The Committee is concerned about the increasing trend in the number of high risk pregnancies and the effect of high risk pregnancies on maternal and neonate health. The Committee also heard of the impact of this trend on health services. The Committee understands that lifestyle changes related to risk factors of obesity, smoking, and drug use need to be made prior to pregnancy. Accordingly, the Committee recommends that:

RECOMMENDATION 1.6: The Victorian Government commit to ongoing funding for education and health promotion campaigns to address the risks of smoking, alcohol and drugs in pregnancy and the risks to infants and mothers.

Given the emerging trend of obesity and gestational diabetes and the complexities these result in for infants and mothers, such as morbidity and mortality, the Committee recommends that:

RECOMMENDATION 1.7: The Victorian Government fund an education and health promotion campaign highlighting the risks of obesity and gestational diabetes for pregnant women and infants.

1.7.7 Caesarean sections

The *Victorian Perinatal Services Performance Indicators 2015-16* states that interventions during labour and birth, particularly for women having their first baby, should be limited to women who have a clear medical or psychosocial indication.²¹⁴ The World Health Organization (WHO) states, in their statement on caesarean section rates, that since 1985, the ‘international healthcare community has considered the ideal rate for caesarean sections to be between 10% and 15%’.²¹⁵ Nonetheless, the WHO states that ‘Every effort should be made to provide caesarean sections to women in need, rather than striving to achieve a specific rate’.²¹⁶

In 2016, one in three Victorian women gave birth by caesarean section.²¹⁷ The proportion of women giving birth by caesarean section has increased over the last three decades from 15.3 per cent in 1985 to 34.0 per cent in 2016.²¹⁸ As stated in the latest CCOPMM report:

213 Australian Nursing and Midwifery Federation (Victorian Branch), submission no. 67, p. 12.

214 Safer Care Victoria, *Victorian Perinatal Services Performance Indicators 2015-16*, Department of Health and Human Services, Melbourne, 2017, p. 24.

215 World Health Organization, ‘WHO Statement on Caesarean Section Rates’, 2015, p. 1, accessed 26 February 2018, <http://www.who.int/reproductivehealth/publications/maternal_perinatal_health/cs-statement/en>.

216 Ibid., p. 4.

217 Consultative Council on Obstetric and Paediatric Mortality and Morbidity (CCOPMM), *Victoria’s mothers, babies and children 2016*, Melbourne, 2017, p. 47.

218 Ibid.

Caesarean section is a life-saving procedure for mothers and babies in some circumstances. There is concern, however, that the high rate indicates that many caesareans are carried out for less compelling reasons. Despite improvements in surgical and anaesthetic techniques, the use of prophylactic antibiotics and ready access to blood banks, there remain increased maternal and neonatal risks. The short-term risks include surgical complications (bladder, ureteric and bowel damage), anaesthetic complications, increased blood loss with the need for blood transfusion, pulmonary embolus and infection.²¹⁹

The report notes that caesarean sections can restrict daily living in the postoperative period, increase difficulties in establishing breastfeeding, and increase postnatal depression.²²⁰ The reasons for the increased rate of caesarean sections include maternal obesity, medico-legal concerns, women having babies at an older age, breech births, twins, and perceived convenience.²²¹

The Committee also heard that some services, particularly regional centres, opted for caesarean sections to ensure a good birth outcome.²²² Ms Bernadette Hammond, Director of Clinical Operations and Chief Nurse and Midwife at Bairnsdale Regional Health Service, told the Committee at a public hearing in Bairnsdale:

I think sitting in my position and looking from where I am, there are probably more nervousness around better outcomes. As I said, we are a low-risk service and we have GP obstetricians. They do not have a specialist next door that would be perhaps more experienced and more inclined to say, 'That's okay, they could wait' or 'We could do this' or 'We could try that'. We probably opt for a caesar sooner rather than later to ensure a good birth outcome.²²³

The Committee also heard that increasing caesarean rates was also related to workforce issues and the skill of staff. At a public hearing in Warragul, Ms Kathy Kinrade, Director of Clinical Operations, Nursing and Midwifery at West Gippsland Healthcare Group, told the Committee that they traditionally had one of the highest success rates of vaginal birth after caesarean section, however 'that was very dependent on the obstetrician' who has since left the service:

We now have a workforce that is not so skilled, so caesarean section is sometimes now undertaken because it is safer.²²⁴

The Committee heard that a continuity of care model, discussed in Chapter Two, resulted in women needing less intervention, such as caesarean sections and inductions.²²⁵

219 Ibid.

220 Ibid.

221 Ibid., pp. 44, 47.

222 Ms Bernadette Hammond, Director of Clinical Operations/Chief Nurse and Midwife, Bairnsdale Regional Health Service, Family and Community Development Committee public hearing – Bairnsdale, 7 December 2017, transcript of evidence, p. 8.

223 Ibid.

224 Ms Kathy Kinrade, Director, Clinical Operations, Nursing and Midwifery, West Gippsland Healthcare Group, Family and Community Development Committee public hearing – Warragul, 8 December 2017, transcript of evidence, p. 6.

225 Ms Hannah Quanchi, Owner and Director, My Midwives Melbourne, Family and Community Development Committee public hearing – Melbourne, 4 September 2017, transcript of evidence, p. 3; Australian Nursing & Midwifery Federation (Victorian Branch), submission no. 67, p. 16; Ms Ofri Marton, submission no. 56, p. 3.

1.7.8 Inductions

Induction of labour refers to the use of interventions such as medications or the rupture of membranes to assist the process of labour to begin. The CCOPMM report stated that an increasing proportion of women had labour induced, which was 30.8 per cent of all women who gave birth in 2016 compared with 28.8 per cent in 2015, with induction rates being similar for women admitted as public and private patients.²²⁶ In their report, CCOPMM recommended that:

Induction of labour should be considered where there is a persistent maternal perception of decreased fetal movements or where there are suspected or actual concerns for fetal wellbeing. The decision to expedite the birth needs to be weighed against the risk to the mother and baby at that particular gestation.²²⁷

The Committee heard that inductions happen for a range of reasons, including gestational diabetes, fetal growth restrictions, obesity, pre-eclampsia, and because the pregnancy is greater than 41 weeks.²²⁸ Like caesarean sections, witnesses during public hearings around Victoria also discussed risk management as contributing to increasing rates of inductions. Ms Julianne Clift, Director of Nursing, South West Healthcare, stated at a public hearing in Warrnambool:

There is nothing worse than having a delivery go wrong and losing a baby, so people are going to tend probably more towards caution to make sure that you have a safe outcome.²²⁹

Ms Rachael Lee, Practice Coordinator at South West Healthcare, also told the Committee:

The education surrounding what to look out for to avoid a stillbirth has meant that with the interaction between the patients and ourselves in clinic alone we have seen a tenfold increase in phone calls from women worrying about foetal movements. For us that is something we have to act on, so that increases the outpatient assessments. It means that women are more nervous. If someone complains that their baby's movements have decreased or they have got any concerns, there is less room for movement in allowing women to continue their pregnancy past term. I think we are just accepting that.²³⁰

At a public hearing in Geelong, Ms Kylie Cole, a registered nurse and midwife, told the Committee that the number of inductions were 'skyrocketing', stating that 'now it seems that any woman who complains about decreased movements even once at term gets booked in for an induction'.²³¹

²²⁶ Consultative Council on Obstetric and Paediatric Mortality and Morbidity (CCOPMM), *Victoria's mothers, babies and children 2016*, Melbourne, 2017, p. 43.

²²⁷ *Ibid.*, p. 24.

²²⁸ For example, Ms Julianne Clift, Director of Nursing, South West Healthcare, Family and Community Development Committee public hearing – Warrnambool, 11 October 2017, transcript of evidence, p. 2; Ms Kylie Cole, Registered Nurse and Midwife, Family and Community Development Committee public hearing – Geelong, 11 December 2017, transcript of evidence, p. 7.

²²⁹ Ms Julianne Clift, Director of Nursing, South West Healthcare, Family and Community Development Committee public hearing – Warrnambool, 11 October 2017, transcript of evidence, p. 8.

²³⁰ Ms Rachael Lee, Practice Coordinator, South West Healthcare, Family and Community Development Committee public hearing – Warrnambool, 11 October 2017, transcript of evidence, p. 10.

²³¹ Ms Kylie Cole, Registered Nurse and Midwife, Family and Community Development Committee public hearing – Geelong, 11 December 2017, transcript of evidence, p. 7.

1.8 Early discharge from maternity units

The Committee heard that there has been an increasing trend to discharge mothers early from hospitals in order to free up hospital beds. The Committee received evidence that early discharge often placed stress on families,²³² impacted the health and wellbeing of mothers and their babies, increased the workload of maternal and child health nurses, and impacted breastfeeding rates.

In her submission, Ms Lydia Morgan told the Committee about wanting to stay longer in hospital after the birth of her children:

My only gripe on both occasions was being kicked out of hospital 2 days after my [caesarean section] both times despite my request to stay for 1 further night after my second birth. I say kicked out as that is how it felt, the cleaners were sent in to vacate my room! I ended up in hospital 3 days after I left and I have heard this [story] of women being told to leave or that they are ready to go when really they [shouldn't] because beds are needed or staff shortages.²³³

In his submission to the Inquiry, Dr Joe Garra, a GP in Werribee who has been involved in the antenatal, intrapartum and postnatal care of approximately 3,000 women, wrote that the early discharge of women, especially first time mothers, is an issue:

Women are often discharged within 48 hours of having their baby and this is before their milk has come in. The early discharge is entirely for economic reasons as hospitals try to make the most of casemix funding. It is ironic that “good” coders who can maximise the funding for each patient are treated like gold by hospital administrators. It is the major negative of casemix funding. It would not be unusual for me to have an argument with the bed manager as to why I was saying that a mum wasn't ready to go home. The response was always, but she's gone over her limit, or we need the bed. It is a system wide problem with not an easy fix.²³⁴

The Committee received evidence from local councils, such as Hobsons Bay City Council and the City of Whitehorse, that early discharge of new mothers and babies impacts on the health and wellbeing of families.²³⁵ The Committee heard that early discharge, especially of first time mothers and of low birthweight babies, also increased the workload of maternal and child health nurses as they required additional monitoring in the community. Ms Maryanne Purcell, a Maternal and Child Health Nurse Coordinator at Warrnambool City Council, told the Committee at a public hearing in Warrnambool that early discharge often coincided with the additional need for maternal and child health nurse visits.²³⁶

²³² Dr Kimberley Sleeman, Mildura O&G Clinic, Family and Community Development Committee public hearing – Mildura, 9 November 2017, transcript of evidence, p. 3.

²³³ Ms Lydia Morgan, submission no. 3, p. 1.

²³⁴ Dr Joe Garra, submission no. 15, pp. 1-2.

²³⁵ Hobsons Bay City Council, submission no. 26, p. 1; Whitehorse City Council, submission no. 46, p. 1.

²³⁶ Ms Maryanne Purcell, Maternal and Child Health Nurse Coordinator, Warrnambool City Council, Family and Community Development Committee public hearing – Warrnambool, 11 October 2017, transcript of evidence, p. 5.

The early discharge of low birthweight babies impacted on local councils and often resulted in either the baby being readmitted or the maternal and child health service having to provide additional services. In their submission, the City of Whitehorse stated that a significant percentage of low birthweight babies experience feeding difficulties:

In some cases the mother will be advised to immediately return to the hospital or alternatively see her GP or the paediatrician. In other cases the MCH nurse will be required to undertake increased monitoring of the mother and child to ensure that the child's progress is positive and medical intervention is not required. The MCH program is a tightly funded service and has limited capacity to undertake more frequent visits to monitor the weight of the infant. It is noted that communication is often non-existent or poor between hospital midwifery services and LGA MCH programs.²³⁷

Their submission stated that communication between hospital midwifery services and local government maternal and child health services 'is often non-existent or poor'.²³⁸ They recommended that 'improvements be made to the hospital discharge process to ensure the discharge planning process is more mindful of the difference between the hospital and domestic environment'.²³⁹ They also stated that the discharge process for low birthweight babies 'needs to incorporate a better resourced domiciliary support service as well as transition and communication plan with the local MCH service to facilitate an agreed handover arrangement'.²⁴⁰

Early discharge also impacted other health services such as lactation services. At a public hearing in Wangaratta, the Committee heard from Ms Cate Gemmill, Lactation Consultant at Northeast Health Wangaratta, who told the Committee that their service fills a lot of gaps with early discharge:

Women are discharged home potentially 24 hours or 36 hours after delivery. They go home, sleep in their own bed and then are coming back to the lactation clinic the next day. We are never too far away for their next appointment. Maternal and child health may not pick them up until day 7 or day 8, so that is a critical time for surveillance of the infant, when they can potentially be jaundiced or have other difficulties, so we definitely want to make sure that we are fully extending our duty of care to mother and baby in that time. As I said, our care is time sensitive, so we want to make sure that even though early discharge is now routine, it does not equate to less support. Early discharge policies or influences have not kept pace with community expectation, and often people are quite surprised when women are sent home the next day after having their baby. The presence of our clinic provides a soft place for them to fall and a softer landing, if you like, and it reassures their extended family that they are still receiving support.²⁴¹

²³⁷ Whitehorse City Council, submission no. 46, p. 1.

²³⁸ Ibid.

²³⁹ Ibid.

²⁴⁰ Ibid.

²⁴¹ Ms Cate Gemmill, Lactation Consultant, Northeast Health Wangaratta, Family and Community Development Committee public hearing – Wangaratta, 25 October 2017, transcript of evidence, p. 3.

Following discharge from hospital, the Committee heard that women may receive one to three domiciliary visits, depending on how early they have been discharged, before being handed over to the maternal and child health service.²⁴² The importance of having a home visiting midwifery service was mentioned by several people who gave evidence before the Committee as a way to prevent women from falling through any gaps in care and monitoring following discharge from hospital. Ms Marilyn Humphrey, Maternal and Child Health Coordinator at Baw Baw Shire Maternal and Child Health Services, told the Committee at a public hearing in Warragul:

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.²⁴³

Likewise, Ms Susan Day, President of the Australian Breastfeeding Association, told the Committee at a public hearing in Melbourne:

Often mothers are discharged hours or within a day after birth, which is prior to their milk coming in. When you have early discharge it is really important to have continuity of care, so home visiting service in those early days. We certainly know that even in places where they do have maternal and child health nurses visiting after birth, that is not equitable across the state. For people in regional and rural areas there might only be one in their area, and sometimes that staff member is away on holidays and things like that. So we have gaps in the current services, and where there are gaps, women fall through those gaps.²⁴⁴

At a public hearing in Warrnambool, Ms Barbara Glare from the Warrnambool Breastfeeding Centre told the Committee:

[B]reastfeeding problems come back to the shorter hospital stays ... with the high intervention rates in birth, high caesarean rates, women are leaving hospital actually not that well; they are not that well. On top of that they have to establish breastfeeding at home, largely by themselves. There needs to be another professional on that team to help them with breastfeeding.²⁴⁵

The Committee understands that hospitals are under increased pressure to discharge women due to bed shortages, however the Committee is concerned that early discharge may compromise the health, safety and wellbeing of mothers and their babies, especially new mothers and low birthweight babies. The Committee heard that early discharge, particularly before breastfeeding has been established, can place stress on families and inhibit the establishment of breastfeeding. The Committee heard that early discharge also increased the workload of maternal and child health nurses and other community services. Thus, the Committee recommends that:

²⁴² Ms Helen Lees, Maternal and Child Health Clinical Coordinator, City of Greater Bendigo, Family and Community Development Committee public hearing – Bendigo, 24 October 2017, transcript of evidence, p. 3. See also: Hospital to Home, submission no. 18, p. 4.

²⁴³ Ms Marilyn Humphrey, Maternal and Child Health Coordinator, Baw Baw Shire Maternal and Child Health Services, Family and Community Development Committee public hearing – Warragul, 8 December 2017, transcript of evidence, p. 4.

²⁴⁴ Ms Susan Day, President, Australian Breastfeeding Association, Family and Community Development Committee public hearing – Melbourne, 4 September 2017, transcript of evidence, p. 12.

²⁴⁵ Ms Barbara Glare, President and Lactation Consultant, Warrnambool Breastfeeding Centre, Family and Community Development Committee public hearing – Warrnambool, 11 October 2017, transcript of evidence, p. 5.

RECOMMENDATION 1.8: The Victorian Government review discharge policies in all public hospitals with a view to ensuring that women receive postnatal support both in the hospital and in the community.

1.9 Support services for families

Throughout the Inquiry, the Committee heard about many support services for families, which will be mentioned throughout this report. The Enhanced Maternal and Child Health Service helps families who may need extra support, and will be discussed in detail in Chapter Six. Early parenting centres, mother baby units and other programs related to emotional and mental health are discussed in Chapter Three. Programs specifically for Aboriginal and Torres Strait Islander communities, such as Aboriginal Cradle to Kinder, will be discussed in Chapter Seven, and programs for culturally and linguistically diverse (CALD) communities, such as doula supports, will be discussed in Chapter Eight. This section outlines some of the programs for vulnerable mothers, babies and families, such as Cradle to Kinder, Healthy Mothers, Healthy Babies, and Child FIRST. It also examines some of the pregnancy support groups that the Committee heard from throughout the Inquiry.

1.9.1 Healthy Mothers, Healthy Babies

The Committee heard about the Healthy Mothers, Healthy Babies (HMHB) program at public hearings in Warrnambool, Bairnsdale, Bendigo, Warragul and Melbourne. The Healthy Mothers, Healthy Babies program targets pregnant women who are unable to access antenatal care services or who need extra support because they have greater health risks.²⁴⁶ These risks could be as a result of factors such as socioeconomic status, age, mental health, culturally and linguistically diverse background, Aboriginal and Torres Strait Islander descent, health behaviours, distance from services and history of engagement with child protection services. The program is delivered through local community services and works with women while they are pregnant until they are effectively engaged with maternal and child health services.

1.9.2 Other programs for families

The Committee heard about programs similar to the Healthy Mothers, Healthy Babies program which support mothers and families, such as Olivia's Place in Warragul, Zoe Support Australia in Mildura, the Gianna Centre in Bendigo, the Caroline Chisholm Society, St Kilda Mums, and The Babes Project.²⁴⁷ Ms Helen Parker, Director of The

²⁴⁶ Department of Health and Human Services, 'Healthy Mothers, Healthy Babies', Victorian Government, accessed 15 May 2018, <<https://www2.health.vic.gov.au/primary-and-community-health/community-health/population-groups/children-youth-and-families/healthy-mothers-healthy-babies>>.

²⁴⁷ Mrs Kirsten Finger, Co-Founder, Olivia's Place, Family and Community Development Committee public hearing – Warragul, 8 December 2017, transcript of evidence; Ms Anne Webster, Executive Director, Zoe Support Australia, Family and Community Development Committee public hearing – Mildura, 9 November 2017, transcript of evidence; Ms Anne O'Brien, Volunteer, Gianna Centre, Family and Community Development Committee public hearing – Bendigo, 24 October 2017, transcript of evidence; Dr Jennifer Weber, Transition Manager, Pregnancy and Support Service, Caroline Chisholm Society, Family and Community Development Committee public hearing – Melbourne, 27 November 2017, transcript of evidence; Ms Jessica Macpherson, Chief Executive Officer, St Kilda Mums, Family and Community Development Committee public hearing – Melbourne, 27 November 2017, transcript of evidence; Ms Helen Parker, Director, The Babes Project, Family and Community Development Committee public hearing – Melbourne, 5 February 2018, transcript of evidence.

Babes Project, told the Committee at a public hearing in Melbourne that her program and the Healthy Mothers, Healthy Babies program are similar and that when the HMHB program is full, they often refer to The Babes Project.²⁴⁸

The Babes Project is a registered charity which ‘runs a holistic Perinatal [sic] support service’, is based in Frankston and Croydon and has supported more than 400 women in the last six years.²⁴⁹ Their submission to the Inquiry stated that The Babes Project supports women through ‘[w]eekly appointments, and a range of practical workshops, classes and events, address a gap in current perinatal services and empower pregnant and new mums to take confidence in their motherhood’.²⁵⁰ Of the women supported by The Babes Project, three-quarters are first time mothers, more than three-quarters have experienced mental health issues, nearly one-quarter are teenagers, one in four has experienced family violence, and more than one in three has a history of drug and alcohol abuse.²⁵¹

Ms Parker told the Committee that they work with hospitals and communicate with hospitals regularly, receiving 42 per cent of referrals from hospitals and 12 per cent from other organisations, including maternal and child health services. Ms Parker told the Committee:

As you would have heard so much in this inquiry, the hospitals have limitations, so we want to find out what these limitations are and work with them. There is no point us doing exactly what other people are doing. It is about how to work together for the benefit of the women and children.²⁵²

The Committee heard that The Babes Project wants to expand to other areas, such as Sunshine and Geelong, to fill gaps in those areas, however they need funding to do so.²⁵³ At a public hearing in Melbourne, the Committee heard from Ms Andreza Rodriguez, who has been supported by The Babes Project and travels from Sunshine to Croydon to access the service. Ms Rodriguez told the Committee:

My experience with The Babes Project has been amazing so far. They are all about supporting pregnant women and babies — crying babies — until they are up to one year. In this project you have the chance to meet all the other mothers and babies. We have not only material support but also emotional support. We come from very different backgrounds. In my case, as you can see I am not from here so I do not have any family here, so when I found out that I was pregnant the first thing I did is google ‘Support pregnant women’ and found them.²⁵⁴

Olivia’s Place in Warragul was founded in 2012 to provide pregnancy support to families. They are a registered charity, providing all services free of charge, and the service is staffed by volunteers. They offer material support (including baby bundles which are given to families in the area regardless of background), emotional

²⁴⁸ Ms Helen Parker, Director, The Babes Project, Family and Community Development Committee public hearing – Melbourne, 5 February 2018, transcript of evidence, p. 3.

²⁴⁹ The Babes Project, submission no. 8, p. 1.

²⁵⁰ Ibid.

²⁵¹ Ibid.

²⁵² Ms Helen Parker, Director, The Babes Project, Family and Community Development Committee public hearing – Melbourne, 5 February 2018, transcript of evidence, p. 3.

²⁵³ Ibid., p. 7.

²⁵⁴ Ms Andreza Rodriguez, Family and Community Development Committee public hearing – Melbourne, 5 February 2018, transcript of evidence, p. 2.

1 support, social supports (such as teenage mother groups), parenting sessions, and financial support.²⁵⁵ At a public hearing in Warragul, the Committee heard from the Co-Founder of Olivia's Place, Mrs Kirsten Finger, who explained that they support vulnerable families as well as families who are not experiencing a period of vulnerability:

We have sort of two arms of what we do. We have our benevolent services supporting families experiencing periods of vulnerability. We do that through consultation, emotional support and material aid, and we enhance access to other services in the areas supporting families. Then we also have general community programs, which are run to try and improve support and knowledge and equip new parents for the journey of parenting. We recognise that parenting is an overwhelming journey no matter your background — whether you are experiencing a period of vulnerability or not — and we feel and believe that a lot of families do not have access to services unless they meet certain criteria for disadvantage. So we run some parenting education programs and sessions and do things like provide the public parent room and some family-friendly community projects for families.²⁵⁶

Mrs Finger told the Committee that HMHB makes up 40 per cent of their service referrals.²⁵⁷ Mrs Carmel Riley, the President of Olivia's Place, told the Committee that they currently have around 15 or 16 HMHB program families actively being additionally supported by Olivia's Place:

It is worth noting as well that we are very active in trying to engage more with both state and federal government and primary health networks. We are awaiting at the moment hopefully a response from the Department of Health and Human Services in relation to the expansion of the Healthy Mothers, Healthy Babies program, which is a fantastic and needed expansion. What we were not able to go through with you before is that since the pilot of Healthy Mothers, Healthy Babies commenced in Latrobe city earlier this year it nearly doubled the demand for our service. So we are needing to prepare ourselves. We would like to be potential applicants for delivery of that service but also need to understand how we are going to be able to respond to that expansion.²⁵⁸

In Mildura, the Committee heard from Ms Anne Webster, the Executive Director of Zoe Support Australia, who told the Committee about their work with young mothers, aged 13 to 25, many of whom experienced family violence and child protection while growing up.²⁵⁹ Most mothers that they work with have diagnosed mental health conditions, and many have either drug and alcohol issues or partners with drug and alcohol issues. Ms Webster told the Committee:

We work closely with almost every agency and institution in Mildura as we can to provide the best specialist services to our mums. We encourage other services to come to our centres because that is where the mothers are comfortable.²⁶⁰

255 Mrs Kirsten Finger, Co-Founder, Olivia's Place, Family and Community Development Committee public hearing – Warragul, 8 December 2017, transcript of evidence, pp. 2, 3, 7.

256 *Ibid.*, p. 2.

257 *Ibid.*, p. 9.

258 Mrs Carmel Riley, President, Olivia's Place, Family and Community Development Committee public hearing – Warragul, 8 December 2017, transcript of evidence, p. 9.

259 Ms Anne Webster, Executive Director, Zoe Support Australia, Family and Community Development Committee public hearing – Mildura, 9 November 2017, transcript of evidence, p. 2.

260 *Ibid.*

Zoe Support Australia works to reduce barriers around education and professional services and sixty-six per cent of mothers they work with are now re-engaged with education.²⁶¹ Ms Webster told the Committee that one of the challenges they face is funding as they are funded through philanthropic organisations, have not secured government funding, and are ‘severely under-resourced in terms of staff’.²⁶²

The Caroline Chisholm Society is a charitable organisation, which is both privately and government funded, and was established in 1969. The Caroline Chisholm Society offers support to pregnant women and parents with children up to school age through a range of programs for families in need, including counselling, material aid, housing, and in-home family support.²⁶³ The Caroline Chisholm Society has supported over 1,000 families each year in the last five years and it is estimated to have supported up to 25,000 families since they were established. The most prevalent issues faced by families they saw were poverty, risk of homelessness, social isolation, mental health concerns, and family violence.²⁶⁴

At a public hearing in Bendigo, the Committee heard from Ms Anne O’Brien from the Gianna Centre, which is another registered charity which provides family support, education, and referrals to other services, including support during and after pregnancy, emergency relief and material aid, professional referrals, pre and post-abortion care, and stillbirth, miscarriage and newborn death support.²⁶⁵ The Gianna Centre has been operating for over 13 years and the majority of clients are referred by health, welfare and other government agencies.²⁶⁶ Ms O’Brien told the Committee about the difficulty funding their service:

Funding for the above and other services on offer through the Gianna Centre is a huge challenge. Our committee of management has received a number of calls over the years from families and individuals outside of central Victoria, asking if Gianna centres are located elsewhere. We believe there is a real need for this type of service in both metropolitan and rural areas. Whilst a number of successful grants have allowed us the opportunity to fund parenting programs, provide new baby car restraints and build the Gianna memorial wall, the challenge to meet rent and day-to-day running expenses can at times be overwhelming. To date that has been achieved by donations, running cake stalls, sausage sizzles and other fundraisers. This then puts further drain on our volunteers.²⁶⁷

At a public hearing in Melbourne, the Committee heard from Ms Jessica Macpherson, the Chief Executive Officer of St Kilda Mums, which is a community organisation that recycles nursery equipment, clothes, and other baby essentials, which are passed on to social workers and maternal and child health nurses.²⁶⁸ The organisation also has a

²⁶¹ Ibid.

²⁶² Ibid., p. 3.

²⁶³ Caroline Chisholm Society, submission no. 29.

²⁶⁴ Ibid., p. 1. See also: Dr Jennifer Weber, Transition Manager, Pregnancy and Support Service, Caroline Chisholm Society, Family and Community Development Committee public hearing – Melbourne, 27 November 2017, transcript of evidence.

²⁶⁵ Ms Anne O’Brien, Volunteer, Gianna Centre, Family and Community Development Committee public hearing – Bendigo, 24 October 2017, transcript of evidence, p. 2.

²⁶⁶ Ibid.

²⁶⁷ Ibid., p. 3.

²⁶⁸ St Kilda Mums also operate in Ballarat as Eureka Mums and in Bendigo they support a group called Sunshine Bendigo. See Ms Jessica Macpherson, Chief Executive Officer, St Kilda Mums, Family and Community Development Committee public hearing – Melbourne, 27 November 2017, transcript of evidence, p. 2.

program called Safe Start through which they place emergency material aid in several hospitals so that maternity hospital social workers have access to, for example, a portable cot.²⁶⁹ Ms Macpherson told the Committee:

We are a community organisation entirely funded by philanthropic donations and the community at large. Last financial year we helped 13 510 babies and children to the age of 12 years. We provided \$5.2 million worth of material aid, and we distributed 40 000 items. We collect donations of prams, cots and car restraints, clothing and toys, breast pumps, formula — you name it — anything baby-related. We make sure everything is clean and safe, and we pass everything on to social workers and maternal and child health nurses.²⁷⁰

The Committee was pleased to hear about the success of parenting support organisations operating in Melbourne and in regional Victoria, such as Olivia's Place, Zoe Support, the Gianna Centre, the Caroline Chisholm Society, St Kilda Mums and The Babes Project, most of which receive no government funding. The Committee wants to ensure that these organisations are supported to continue their work and expand to other areas, particularly where these organisations are filling gaps in other government services and taking on clients that would be missed due to other programs such as Healthy Mothers, Healthy Babies being oversubscribed. Accordingly, the Committee recommends:

RECOMMENDATION 1.9: The Victorian Government develop a framework for recurrent funding for existing parenting support groups.

1.9.3 Cradle to Kinder

Cradle to Kinder is an antenatal and postnatal support service in Victoria that has provided intensive family and early parenting support to vulnerable mothers and their children since 2012. The program provides support from pregnancy until the child reaches four years old. According to the Department of Health and Human Services, the program 'helps parents to build their own self-reliance and sustainability through access to education, vocation training and employment'.²⁷¹ The Cradle to Kinder program is for pregnant women under 25 where:

- there are a number of indicators of vulnerability or concerns about the wellbeing of an unborn or newborn child and child protection is not involved, or
- a report to child protection or a referral to Child FIRST has been received for an unborn child and the referrer has significant concerns about the wellbeing of the unborn child, or
- the person involved is in out-of-home care (or has been), is an Aboriginal woman or a woman who has a learning difficulty.²⁷²

²⁶⁹ The project is currently run at the following hospitals: The Royal Women's Hospital, Sandringham Hospital, The Northern Hospital, The Royal Children's Hospital, The Royal Women's Hospital, Werribee Mercy Hospital and Sunshine Hospital. See St Kilda Mums, 'Our Service', accessed 13 March 2018, <<https://www.stkildamums.org/pages/our-service>>.

²⁷⁰ Ms Jessica Macpherson, Chief Executive Officer, St Kilda Mums, Family and Community Development Committee public hearing – Melbourne, 27 November 2017, transcript of evidence, p. 2.

²⁷¹ Department of Health and Human Services, 'Cradle to Kinder and Aboriginal Cradle to Kinder', updated 18 November 2017, Victorian Government, accessed 21 February 2018, <<https://services.dhhs.vic.gov.au/cradle-kinder-and-aboriginal-cradle-kinder>>.

²⁷² Ibid.

There is also an Aboriginal Cradle to Kinder, which will be discussed further in Chapter Seven.

At a public hearing in Mildura, Mr Jason Spratt, Manager of Family Services at Mallee Family Care, told the Committee about the Cradle to Kinder program, noting that out of 52 families there may only be five where the children end up in care, which is much lower than other programs like Stronger Families, perhaps because Cradle to Kinder is an ‘early catch’ rather than a ‘placement prevention service’.²⁷³ He described the program to the Committee:

The idea of the [Cradle to Kinder] service is to work with particular cohorts of mothers that had been identified as being at high risk of further contact with child protection services. It is designed to work with mums from the second trimester of pregnancy up to six weeks of age of the child as the entry point. The three target areas for mothers are mothers who are in or have been in foster care, mothers who identify as Aboriginal and mothers with a learning difficulty.²⁷⁴

1.9.4 Child protection

The Victorian Child Protection Service is specifically targeted to children at risk of harm or where families are unable or unwilling to protect them.²⁷⁵ Child protection’s functions include investigating matters where it is alleged that a child is at risk of harm and providing accommodation and services, including adoption and permanent care, to children in need.²⁷⁶ The Committee heard that child protection involvement was often distressing for parents.²⁷⁷ The Committee heard that referrals are often made to child protection, particularly from health services, who then make an assessment and determine whether further intervention is needed or they make a referral to Child FIRST.²⁷⁸

The Committee heard from Ms Ailsa Carr, the Executive Manager of Family, Youth and Children’s Services at Gippsland Lakes Community Health, at a public hearing in Bairnsdale, who told the Committee that one of the main challenges they have is that there are quite significant levels of child protection involvement with families in their region, and high levels of family violence.²⁷⁹ Ms Carr noted that most of the child death inquiries that they have been involved in have been children under 12 months.²⁸⁰

²⁷³ Mr Jason Spratt, Manager, Family Services, Mallee Family Care, Family and Community Development Committee public hearing – Mildura, 9 November 2017, transcript of evidence, p. 8.

²⁷⁴ *Ibid.*, p. 2.

²⁷⁵ Department of Health and Human Services, ‘Child protection’, last updated 5 February 2018, Victorian Government, accessed 7 March 2018, <<https://services.dhhs.vic.gov.au/child-protection>>.

²⁷⁶ *Ibid.*

²⁷⁷ Ms Ursula Kiel, Senior Clinician, St John of God Raphael Services, Family and Community Development Committee public hearing – Bendigo, 24 October 2017, transcript of evidence, p. 7; Ms Helen Lees, Maternal and Child Health Clinical Coordinator, City of Greater Bendigo, Family and Community Development Committee public hearing – Bendigo, 24 October 2017, transcript of evidence, p. 6; Mr Jason Spratt, Manager, Family Services, Mallee Family Care, Family and Community Development Committee public hearing – Mildura, 9 November 2017, transcript of evidence, p. 6.

²⁷⁸ Mr Jason Spratt, Manager, Family Services, Mallee Family Care, Family and Community Development Committee public hearing – Mildura, 9 November 2017, transcript of evidence, p. 5.

²⁷⁹ Ms Ailsa Carr, Executive Manager, Family, Youth and Children’s Services, Gippsland Lakes Community Health, Family and Community Development Committee public hearing – Bairnsdale, 7 December 2017, transcript of evidence, p. 3.

²⁸⁰ *Ibid.*

Several people spoke to the Committee about the multi-sector high risk infant panel with child protection, which allows for closer client monitoring, supervision and case planning.²⁸¹ Ms Carr told the Committee:

Our other challenge is that because of high levels of child protection involvement, child protection has huge workload demands, and sometimes there are challenges in respect of their capacity. They will always respond in an emergency, but I guess it is that ongoing case management. The benefits around that, which Bernadette also mentioned, are that we do have a monthly high-risk infant meeting. That has been working extremely well. It has been around for quite some period of time, but I would say certainly in the last 12 to 18 months it has really started to function at a high level with quite a bit of comprehensive planning happening pre-birth so that plans can be put in place for when the baby is born along with the supports that the mum might need. As Bernadette mentioned, that is a multidisciplinary meeting with representation from ourselves and child protection.²⁸²

The Committee heard that some unborn babies were subject to child protection orders and that child protection was not able to open an active child protection case until the baby had been born, due to the *Children, Youth and Families Act 2005* (Vic).²⁸³ The high risk infant panel allowed for plans to be developed for an unborn baby at risk and for child protection to ‘open it as an actual case and be part of that’.²⁸⁴ Ms Carr explained:

There is a limit to what child protection can do antenatally, so that allows those families to be talked about in a multidisciplinary way before the baby is born, and then assessments continue to be made so that when the baby is born we can determine what is the most appropriate pathway.²⁸⁵

281 Ms Marilyn Humphrey, Maternal and Child Health Coordinator, Baw Baw Shire Maternal and Child Health Services, Family and Community Development Committee public hearing – Warragul, 8 December 2017, transcript of evidence, p. 9; Ms Ailsa Carr, Executive Manager, Family, Youth and Children’s Services, Gippsland Lakes Community Health, Family and Community Development Committee public hearing – Bairnsdale, 7 December 2017, transcript of evidence, p. 3; Ms Helen Lees, Maternal and Child Health Clinical Coordinator, City of Greater Bendigo, Family and Community Development Committee public hearing – Bendigo, 24 October 2017, transcript of evidence, p. 3.

282 Ms Ailsa Carr, Executive Manager, Family, Youth and Children’s Services, Gippsland Lakes Community Health, Family and Community Development Committee public hearing – Bairnsdale, 7 December 2017, transcript of evidence, p. 3.

283 Ibid. See also: Ms Marilyn Humphrey, Maternal and Child Health Coordinator, Baw Baw Shire Maternal and Child Health Services, Family and Community Development Committee public hearing – Warragul, 8 December 2017, transcript of evidence, p. 9; Ms Patti Reilly, Acting Family Health Coordinator, City of Melbourne, Family and Community Development Committee public hearing – Melbourne, 18 September 2017, transcript of evidence, p. 4.

284 Ms Ailsa Carr, Executive Manager, Family, Youth and Children’s Services, Gippsland Lakes Community Health, Family and Community Development Committee public hearing – Bairnsdale, 7 December 2017, transcript of evidence, pp. 3, 9. See also: Ms Marilyn Humphrey, Maternal and Child Health Coordinator, Baw Baw Shire Maternal and Child Health Services, Family and Community Development Committee public hearing – Warragul, 8 December 2017, transcript of evidence, p. 9.

285 Ms Ailsa Carr, Executive Manager, Family, Youth and Children’s Services, Gippsland Lakes Community Health, Family and Community Development Committee public hearing – Bairnsdale, 7 December 2017, transcript of evidence, p. 9.

Ms Helen Lees, Maternal and Child Health Clinical Coordinator at the City of Greater Bendigo, is a representative on the high risk infant panel at child protection for that area and told the Committee at a public hearing in Bendigo that a large number of the families that are involved with child protection also have a history of having been in out-of-home care themselves.²⁸⁶ She told the Committee:

Time is what is needed to engage the most vulnerable in our community. For many vulnerable families meeting Maslow's hierarchy of needs is the priority, so having a roof over their heads and food to eat. Therefore our white middle class approach with an emphasis on education is incongruent with where they are at and requires a respectful, consistent and persistent approach to have an impact for their children. It is about helping families to meet their primary needs and allowing them space to think about other things that we regard as valuable, like reading, talking and playing with their children.²⁸⁷

At a public hearing in Wangaratta, the Committee heard criticism of the decentralisation of child protection services over the last year where a notification is now made to Box Hill instead of Wangaratta. Ms Liz Flamsteed, the Head of the Innovation Fund Project in Antenatal Engagement at the Rural City of Wangaratta, told the Committee that on one occasion she had to make eleven phone calls from 2:00pm to 11:00am the next day to make a child protection notification in a situation in which a child was potentially in danger.²⁸⁸

Ms Flamsteed reported a lack of communication and information sharing between child protection and local councils. She gave an example of a situation in which a child protection worker did not notify the council that the mother had relocated and the council had not been informed so they could transfer her notes.²⁸⁹ Ms Flamsteed noted that 'historically that mum will not engage because she is vulnerable' and will 'just ignore the service'.²⁹⁰ She also noted that the maternal and child health service was often not informed immediately when a baby was placed in the care of a foster carer:

On two occasions I have had the foster carer ring me and say, 'I have got a new baby', and I have not heard about it. So a foster carer who I know well in Wangaratta will ring me: she has got a premature, eight-week-old baby in her care as of 24 hours ago, could we organise a visit? No one has rung me — 24 hours later they will — but the mum, the foster carer, has rung me first. So there is a real disparity ...²⁹¹

²⁸⁶ Ms Helen Lees, Maternal and Child Health Clinical Coordinator, City of Greater Bendigo, Family and Community Development Committee public hearing – Bendigo, 24 October 2017, transcript of evidence, p. 8. See also: Ms Ailsa Carr, Executive Manager, Family, Youth and Children's Services, Gippsland Lakes Community Health, Family and Community Development Committee public hearing – Bairnsdale, 7 December 2017, transcript of evidence, p. 9; Mr Jason Spratt, Manager, Family Services, Mallee Family Care, Family and Community Development Committee public hearing – Mildura, 9 November 2017, transcript of evidence, p. 6; Ms Anne Webster, Executive Director, Zoe Support Australia, Family and Community Development Committee public hearing – Mildura, 9 November 2017, transcript of evidence, p. 2.

²⁸⁷ Ms Helen Lees, Maternal and Child Health Clinical Coordinator, City of Greater Bendigo, Family and Community Development Committee public hearing – Bendigo, 24 October 2017, transcript of evidence, p. 3.

²⁸⁸ Ms Liz Flamsteed, Head of Innovation Fund Project in Antenatal Engagement, Rural City of Wangaratta, Family and Community Development Committee public hearing – Wangaratta, 25 October 2017, transcript of evidence, p. 8.

²⁸⁹ *Ibid.*, p. 9.

²⁹⁰ *Ibid.*

²⁹¹ *Ibid.*

The Committee heard of the failings in communication between service providers and government agencies, and the consequences of these failings for mothers and infants. The systems and processes must be in place to ensure coordinated, transparent, and timely information sharing between service agencies. The Committee notes that the *Children Legislation Amendment (Information Sharing) Act 2017* (Vic), passed by the Parliament in 2018, looks to address the issues with information sharing.

1.9.5 Child FIRST

Child FIRST (Child and Family Information, Referral and Support Team) provides support and assistance to vulnerable children, young people and their families where there are concerns about the wellbeing of the child or young person (0-17 years), including families with an unborn child. Child FIRST was established under the *Children, Youth and Families Act 2005* (Vic) to be a community-based point of entry for all Family Services support programs, and thus provide a central referral point.²⁹² Child FIRST teams are located in 22 sites in Victoria and are delivered by community service organisations.²⁹³

The Committee heard about Child FIRST at a public hearing in Mildura where Mr Jason Spratt told the Committee how it operates in his area:

Effectively what it is is a partnership between government and local service providers to deliver family services across the catchment. It is split up into Child First, which is the entry point. They assess referrals that come in, which tend to be where someone has identified a concern for children or the impact of something that is going on within the family that is having an impact on the children and looking at possible supports to try to divert families away from a more tertiary response or a child protection response.

The back end of that is family service providers, so Child First becomes the conduit into family services.²⁹⁴

Mr Spratt noted that in the last 12 months, Child FIRST in the Mallee responded to over 1,600 referrals and only about 500 of those were substantive referrals requiring a response, with about 41 or 42 per cent of those referrals (around 300 new families) being referred to family service providers.²⁹⁵

²⁹² Department of Health and Human Services, 'Child and family services information, referral and support teams', last updated 5 January 2018, Victorian Government, accessed 23 February 2018, <<https://services.dhhs.vic.gov.au/referral-and-support-teams>>.

²⁹³ Department of Health and Human Services, 'Child FIRST and family services', Victorian Government, accessed 16 May 2018, <<https://services.dhhs.vic.gov.au/child-first-and-family-services>>.

²⁹⁴ Mr Jason Spratt, Manager, Family Services, Mallee Family Care, Family and Community Development Committee public hearing – Mildura, 9 November 2017, transcript of evidence, p. 3.

²⁹⁵ Ibid.

AT A GLANCE

Background

Throughout the Inquiry, the Committee heard about many different models of care for women during the perinatal period, including hospital clinic care, shared maternity care, team midwifery care, midwifery continuity of care, and planned homebirths. There was strong support during the Inquiry among mothers and health professionals for the continuity of care model.

This chapter provides a discussion of the different models of perinatal care for mothers and their babies, with a particular focus on the role of midwives, breastfeeding, the Baby Friendly Health Initiative, and antenatal programs. It was a common theme that the health and wellbeing of the mother and family requires more support to create successful health outcomes.

Terms of reference addressed

This chapter addresses the following terms of reference:

1. the availability, quality and safety of health services delivering services to women and their babies during the perinatal period;
3. the adequacy of the number, location, distribution, quality and safety of health services capable of dealing with high risk and premature births in Victoria;
4. the quality, safety and effectiveness of current methods to reduce the incidence of maternal and infant mortality and premature births;
5. access to and provision of an appropriately qualified workforce, including midwives, paediatricians, obstetricians, general practitioners, anaesthetists, maternal and child health nurses, mental health practitioners and lactation consultants across Victoria; and
7. identification of best practice.

Throughout the Inquiry, the Committee heard about many different models of care for women during the perinatal period, including hospital clinic care, shared maternity care, team midwifery care, midwifery continuity of care, and planned homebirths. There was strong support during the Inquiry among mothers and health professionals for the continuity of care model.

This chapter provides a discussion of the different models of perinatal care for mothers and their babies, with a particular focus on the role of midwives, breastfeeding, the Baby Friendly Health Initiative, and antenatal programs. It was a common theme that the health and wellbeing of the mother and family requires more support to create successful health outcomes.

2.1 Models of care

Midwives are the main health professionals who care for women during pregnancy, labour and birth. The National Institute for Health and Care Excellence (NICE) Guidelines recommend one-to-one midwife care for each woman in established labour.²⁹⁶ Obstetricians are medical doctors with special training and skills to look after mothers and babies during pregnancy, labour and after the birth. Women attending public hospitals for their pregnancies and labour will generally see a public obstetrician only if they have a high risk pregnancy.²⁹⁷ General practitioners (GPs) are often the first person a woman will see when they find out they are pregnant. Some GPs have additional qualifications in obstetrics and are able to offer shared care, discussed in section 2.4.1 below.

There are many different models of care available to women during pregnancy and there can be overlap between private and public models of care with women receiving different aspects of care privately and other aspects in a public hospital. Most Victorian women receive their antenatal, pregnancy, birth, and postnatal care within the public hospital system with many public hospitals offering a range of models, such as hospital clinic care, shared maternity care, team midwifery care, caseload midwifery care, and planned homebirths. In 2016, 73.5 per cent of women giving birth were public patients in public hospitals.²⁹⁸

The Committee heard that public hospitals allocate women to a model of care based on their history, any coexisting health issues, and the availability of that model with regard to workforce considerations.²⁹⁹ Women who have low risk pregnancies generally have around seven to ten antenatal appointments with a hospital midwife or doctor, a shared care GP, an obstetrician, or a private midwife.³⁰⁰

²⁹⁶ National Institute for Health and Care Excellence (NICE), 'Safe midwifery staffing for maternity settings', 27 February 2015, NICE Guidelines, p. 14.

²⁹⁷ Better Health Channel, 'Who's who during pregnancy, birth and newborn care', Victorian Government, accessed 2 May 2018, <<https://www.betterhealth.vic.gov.au/health/servicesandsupport/whos-who-during-pregnancy-birth-and-newborn-care>>.

²⁹⁸ Consultative Council on Obstetric and Paediatric Mortality and Morbidity (CCOPMM), Victoria's mothers, babies and children 2016, Appendix 4: Births in Victoria – table and figures, Table 4.14, Melbourne, 2017, p. 17, accessed 8 May 2018, <<https://www2.health.vic.gov.au/Api/downloadmedia/%7BC05A40BD-E3EE-4A09-8177-98E049867147%7D>>.

²⁹⁹ Ms Fiona Faulks, Deputy Director of Nursing, Women's and Children's Services, Bendigo Health, Family and Community Development Committee public hearing – Bendigo, 24 October 2017, transcript of evidence, p. 2.

³⁰⁰ Better Health Channel, 'Pregnancy and birth care options', Victorian Government, Department of Health and Human Services, accessed 28 March 2018, <<https://www.betterhealth.vic.gov.au/health/servicesandsupport/pregnancy-and-birth-care-options>>.

There are also private models of care, such as private obstetric care and private midwifery models, and a combination of both private and public, such as the arrangement between My Midwives Melbourne, a private midwifery group, and the Northern Hospital, a public hospital, discussed in section 2.3. Planned homebirths, discussed in section 2.5, can also be facilitated with a private midwife or obstetrician, or as part of two public hospital programs.

The sections below will discuss the main models of care that the Committee heard about in submissions and in public hearings: caseload midwifery (or midwifery group practice), shared care with either a GP or a midwife, private midwives, doulas, and homebirths. The Committee did not receive a lot of evidence about team midwifery care, which refers to care provided by a team of midwives or a team of midwives and doctors, despite this model of care being offered in maternity hospitals.

2.1.1 Choice of care

The Committee heard consistently that women, where possible, should be able to choose their model of care in the perinatal period, however a woman's choice is often limited by availability, finances, and the risk category of her pregnancy. The Committee also heard that the availability of particular birthing options, such as water births, were limited in Victoria.³⁰¹ In their submission to the Inquiry, Midwives and Mothers Australia (MAMA) stated:

Victorian women need to have access to all choices in pregnancy care providers, whether it be care through the public hospital, through one-to-one care programs in hospitals (such as COSMOS at the Royal Women's Hospital), through a private obstetrician, or shared care between a hospital/obstetrician and eligible midwives. At present, many women are constrained by lack of finances, and lack of availability of some models to them. Women should be able to choose private midwifery care without having to have their babies at home. ... Professional midwifery care by an eligible midwife should be an accessible, affordable choice for Victorian women.³⁰²

At a public hearing in Melbourne, Dr Michael Rasmussen, Clinical Services Director at Mercy Hospital for Women (Mercy Health), spoke about the need for women to have choices and to be informed of the available options. About the Mercy Hospital for Women, he said:

As a hospital and as a service we see it is important to offer choice in obstetric care, in the antenatal options you provide for a woman expecting a baby. Private care is there; team midwifery care; midwifery group practice, which is a dedicated one-on-one relationship between midwife and patient, taking them through the pregnancy and delivery; and shared care for some. It is important that these options are available and that they are affordable and safe, and that the public are informed of their existence.³⁰³

³⁰¹ Ms Elizabeth Murphy, Midwife, The Midwife Collective, Family and Community Development Committee public hearing – Bendigo, 24 October 2017, transcript of evidence, p. 4.

³⁰² Midwives and Mothers Australia (MAMA), submission no. 65, p. 6.

³⁰³ Dr Michael Rasmussen, Clinical Services Director, Mercy Hospital for Women (Mercy Health), Family and Community Development Committee public hearing – Melbourne, 16 October 2017, transcript of evidence, p. 4.

The Committee heard that navigating Victorian maternity systems and models of care was confusing and difficult. Some witnesses told the Committee that they found out about different models, such as private midwifery continuity of care models, by accident. At a public hearing in Melbourne, Ms Gabrielle Sammon, a mother who used a private midwifery model of care, told the Committee:

[W]hen we all started sharing our stories, we found out about My Midwives and continuity of care by accident or by referrals. I had no idea what continuity of care was. I just shopped at the shopping centre opposite My Midwives, and when I got pregnant I thought, 'The midwives will know what to do; I'll call them'. So I am extremely fortunate that I shop there.

One of our ideas was that if there is a sort of standard booklet or leaflet of information that we can give to GPs that just explains all of the different care options for pregnancy and birth in completely non-biased language — it just has statistics relating to all the different options, of what is public, what is private, what will be out-of-pocket expenses — when women first go to their GP for their pregnancy test, they could be given this information. Because the other thing I certainly came up against was that GPs were quite uncomfortable that I was just seeing a midwife and not an obstetrician, so if it is in more of a written format, they cannot put their bias on the information as well.³⁰⁴

The need for more public information about models of care was also noted in the submission of My Midwives Melbourne:

There is a need for more public information about the available options for pregnancy care. This information should explain the role of different care providers (such as public hospital, public homebirth program, private hospital, private midwife in public hospital, private midwife homebirth, private obstetrician) and include statistics regarding birthing outcomes in relation to each model of care. The information should be unbiased, easy to understand and preferably be in a written format, such as a brochure. All GPs should be obliged to provide their patients with this information so that every woman is educated as to her pregnancy care choices and is able to make an informed decision regarding her care. Additionally, the Department of Health should have clear and concise information on its website about the options for care in Victoria.³⁰⁵

In her submission, Ms Laura Stubbings, another mother who used a private midwifery model of care, wrote:

In planning my birth, there appeared to be only two options available to me: to relinquish all power and be part of a conveyor belt of births under time pressure in a hospital or to plan a homebirth: super-clinical or super-alternative with no middle ground. True continuity of care was what I had wanted, but I didn't know how to ask for that, so I planned a homebirth because it seemed the only way to be sure I would have my views and approach to birth respected. So much of the discussion in preparation for birth was about how to avoid being pushed or rushed into choices within a clinical setting, specifically unnecessary or sooner-than-needed intervention.³⁰⁶

³⁰⁴ Ms Gabrielle Sammon, My Midwives Melbourne, Family and Community Development Committee public hearing – Melbourne, 4 September 2017, transcript of evidence, p. 4.

³⁰⁵ My Midwives Melbourne, submission no. 61, p. 4.

³⁰⁶ Ms Laura Stubbings, submission no. 27, p. 2. See also: Ms Gabrielle Sammon, submission no. 38, pp. 2-3.

Another hurdle for women was that many public hospital programs were oversubscribed and women often had to wait months before finding out which program they were placed in.³⁰⁷ The Maternity Consumer Network noted that there was a lack of public midwifery group practice and that places were often given to women who were low risk, meaning that many women ‘end[ed] up with highly fragmented care, contributing to low satisfaction and sometimes more intervention’.³⁰⁸

In her submission, Ms Barbara Oh said that she did shared care with a private midwife for her pregnancy, however her sister was excluded from shared care because of her body mass index (BMI):

Caseload midwifery is the gold standard of care [sic] for a normal pregnancy and birth, however it is very difficult to access. RWH have the Cosmos ... program of one-on-one midwifery but the number of eligible spots are very limited. The MIST (midwives in small teams) program at the RWH was what my sister used – but she didn’t see the point as during her entire pregnancy she didn’t see the same midwife twice.³⁰⁹

For other women, geographical location limits the availability of certain models of care. The disparities in outcomes between rural and regional and metropolitan locations are discussed in Chapter Four, but it is worth noting that some women in rural and regional areas do not have access to the variety of models of care available to women in metropolitan areas.³¹⁰ In her submission, Ms Gabrielle Sammon wrote:

Rural and regional women have much greater restriction to continuity of care models and need to travel much greater distances to access continuity of care. That regional women do travel in order to access continuity of care and, in some circumstances, relocate their whole family for the final month in pregnancy in order to access continuity of care, as well as the fact that the limited access to such care is a consideration in whether to move from the city to the country, demonstrates the significant benefits women experience under a continuity of care model. That rural and regional Victorians have restricted choices when it comes to their antenatal and postnatal care means that a significant number of Victorian women do not have open to them the model of care that has been deemed preferred for most women given the beneficial outcomes for mothers and babies. This needs to be changed and midwife-led continuity of care needs to be made available to all Victorian families and not remain a privilege of living in a metropolitan location.³¹¹

On the other hand, the Committee also heard from Professor Euan Wallace, Chief Executive Officer of Safer Care Victoria, at a public hearing in Melbourne that women in rural areas may have greater access to continuity of carer due to smaller workforces:

I think it is probable that in a rural setting the individual woman has better continuity of carer. So she is seeing the same midwife or the same GP for all of her visits or for nearly all of her visits — or the same team of midwives and GPs for all of

³⁰⁷ My Midwives Melbourne Parents Group, submission no. 83, p. 4.

³⁰⁸ Maternity Consumer Network, submission no. 78, p. 2.

³⁰⁹ Ms Barbara Oh, submission no. 60, p. 3.

³¹⁰ For example, see Save Healesville Hospital Action Group, submission no. 43, p. 8.

³¹¹ Ms Gabrielle Sammon, submission no. 38, p. 4; My Midwives Melbourne, submission no. 61, p. 5.

her visits or nearly all of her visits — whereas in our larger, and particularly our very large, metropolitan hospitals she might see 11 or 12 different people across the course of her pregnancy.³¹²

Ms Heather Daly, a midwife in Bairnsdale, told the Committee at a public hearing in Bairnsdale that a combination of models was ideal for both women and the workforce:

I feel a combination of models, including team, outreach and continuity of care or case load is most optimal and sustainable, suiting both women and midwives. Not all midwives have the flexibility or desire to provide an on-call service, especially those with young families. Some women and their families want a closer relationship with a known midwife throughout the antenatal, intrapartum and postpartum period, whilst again others are happy with just seeing their GP obstetrician for most of their antenatal visits.³¹³

The Committee found that information about pregnancy care was readily available on Government websites.³¹⁴

2.2 Continuity of care

Throughout the Inquiry, the Committee heard of the benefits to both mothers and babies of continuity of care models. In their submission, the Australian Psychological Society recommended that ‘the Victorian Government adopt the core principle of continuity of care as fundamental to underpin effective mental health care and that this principle apply to all maternity care and service provision in the perinatal period’.³¹⁵ They noted that continuity of care is associated with better physical and emotional health outcomes for mothers, improved health outcomes for babies and higher maternal satisfaction.³¹⁶ They stated:

Continuity of care is one strategy to enhance women’s access to safe and respectful perinatal care and to minimise women’s exposure and vulnerability to health-compromising conditions, including discrimination and mistreatment by maternity service systems. Continuity of care with midwives is particularly valued by many women as it enables women to build a trusting relationship with their care provider, with greater potential to obtain holistic and individualised care...³¹⁷

Their submission noted that continuity of care or carer has been a principle underpinning the provision of effective mental health care in the inaugural Perinatal Clinical Practice Guidelines (2011) and the revised draft of the Australian Perinatal

³¹² Professor Euan Wallace, Chief Executive Officer, Safer Care Victoria, Family and Community Development Committee public hearing – Melbourne, 27 November 2017, transcript of evidence, pp. 8.

³¹³ Ms Heather Daly, Midwife, Family and Community Development Committee public hearing – Bairnsdale, 7 December 2017, transcript of evidence, p. 3.

³¹⁴ Better Health Channel, ‘Pregnancy - care choices’, Victorian Government, accessed 1 May 2018, <<https://www.betterhealth.vic.gov.au/health/healthyliving/pregnancy-care-choices>>; Health.vic, ‘Maternity and newborn care in Victoria’, Victorian Government, accessed 1 May 2018, <<https://www2.health.vic.gov.au/hospitals-and-health-services/patient-care/perinatal-reproductive/maternity-newborn-services/maternity-newborn-care>>.

³¹⁵ Australian Psychological Society, submission no. 80, p. 2.

³¹⁶ *Ibid.*, p. 10.

³¹⁷ *Ibid.*

Mental Health Guideline (2017).³¹⁸ Increasing women's access to continuity of care has also been a key priority in the National Maternal Action Plan (2002) and the Australian National Maternity Services Plan (2010) and recommended by the World Health Organization (2017).³¹⁹

Professor Euan Wallace, Chief Executive Officer of Safer Care Victoria, told the Committee at a public hearing in Melbourne that continuity of care models improved outcomes:

If you are seeing the same person, even with equal skill sets, I think you are more likely to detect a growth-restricted baby, because the same clinician could say, 'This just feels the same as it was last month; you haven't really grown very much', whereas if you saw her last month and I saw her this month, I would say, 'It's a bit small; I'll bring you back in a couple of weeks'. Then of course she sees someone else in a couple of weeks and he or she says, 'I think you're a bit small; I'll bring you back' ... There is certainly plenty of evidence worldwide, including from Australia, that improving continuity of carer, so women seeing fewer clinicians — it does not matter who the clinicians are, whether they are midwives, GPs or obstetricians — if they see fewer clinicians, their care outcomes are better.³²⁰

Ms Kate Ravenscroft told the Committee at a public hearing in Melbourne that she did not have any continuity of care and she saw a different midwife each time. She said: 'They did not know me, I did not know them, and I really think that undermines the quality of care that can be provided.'³²¹ Ms Ravenscroft said:

Not being across funding models and the complexity of how the system actually works, I think anything where there can be an investment in building a relationship with a family. I think it is also really important that we are actually thinking of families. My husband was just out there; he just seemed completely irrelevant to the process, so I think really including the whole family. If there was an opportunity to build a relationship with the whole family from the moment you found out you were pregnant through to postpartum and the fourth trimester and you were actually working with somebody who knew you and your family and knew what obstacles you faced and what your values and beliefs were and who kind of felt like a partner through the process with you.³²²

Ms Samantha Ward, a midwife at The Midwife Collective, also spoke positively about continuity of care models and told the Committee at a public hearing in Bendigo:

Continuity of care in a local setting is the model of care that provides the best outcomes for mother and baby in terms of both birthing morbidity and psychological wellbeing post-birth — keeping birth normal, keeping mothers with their babies,

³¹⁸ Ibid. See also: beyondblue. *Clinical practice guidelines for depression and related disorders – anxiety, bipolar disorder and puerperal psychosis – in the perinatal period. A guideline for primary care health professionals*, beyondblue, Melbourne, 2011; M-P Austin, N Highet and the Expert Working Group, *Mental Health Care in the Perinatal Period: Australian Clinical Practice Guideline*, Centre of Perinatal Excellence (COPE), Melbourne, 2017.

³¹⁹ Australian Psychological Society, submission no. 80, pp. 10-11. For example, see: World Health Organization, 'The case for midwifery', 2017, accessed 4 April 2018, <http://www.who.int/maternal_child_adolescent/topics/quality-of-care/midwifery/case-for-midwifery/en>.

³²⁰ Professor Euan Wallace, Chief Executive Officer, Safer Care Victoria, Family and Community Development Committee public hearing – Melbourne, 27 November 2017, transcript of evidence, pp. 8-9.

³²¹ Ms Kate Ravenscroft, Family and Community Development Committee public hearing – Melbourne, 4 September 2017, transcript of evidence, p. 5.

³²² Ibid., p. 7.

high breastfeeding rates and babies breastfeeding for longer. It is well reported that continuity of care models provide the most satisfying maternity experience with the least amount of intervention.³²³

The Committee heard that as part of regular antenatal care, seeing a consistent team of health professionals during pregnancy resulted in better outcomes for mother and baby.

2.2.1 Caseload midwifery programs

Midwifery-led continuity of care programs in hospitals, whereby a midwife is assigned to a woman to work with her throughout her pregnancy and birth, are referred to by different names, including caseload midwifery and midwifery group practice (MGP). The Committee heard about several midwifery-led continuity of care programs at Victorian public hospitals, including the COSMOS program at the Royal Women's Hospital, Mamta at Bendigo Health, and Barwon Health's midwifery group practice, which were very popular and often oversubscribed.³²⁴

At a public hearing in Bendigo, the Committee heard about the Mamta program from Ms Amanda Hewett, the Mamta Coordinator at Bendigo Health:

[T]he Mamta program is a continuity-of-care midwifery program run through Bendigo Health. We have eight midwives who work within our teams. We usually work in teams of two or three. We are a low-risk model, so we recruit women who are low risk at the beginning of their pregnancy, but we retain the women if they become high risk throughout their pregnancy. It is a very popular program within the community. Our application process is that women apply for the program and then they are recruited at about 20 weeks. Currently we are able to recruit about half of the women who apply. We see these women throughout the antenatal period, and then we are on call for their births. We see them throughout their postnatal period, and then we do their home care.³²⁵

Ms Samantha Ward, a midwife at The Midwife Collective, told the Committee at a public hearing in Bendigo that many women miss out on the Mamta program due to it being oversubscribed:

Bendigo Health offer a continuity of care model with the MAMTA program, as you have previously heard. This model has been highly successful, and, as you have heard, it gets a lot more applicants than what it is actually able to provide the care for. Many women in our area miss out on the pregnancy care model they want because it is either not available or it is cost prohibitive.

³²³ Ms Samantha Ward, Midwife, The Midwife Collective, Family and Community Development Committee public hearing – Bendigo, 24 October 2017, transcript of evidence, p. 2.

³²⁴ Ms Fiona Faulks, Deputy Director of Nursing, Women's and Children's Services, Bendigo Health, Family and Community Development Committee public hearing – Bendigo, 24 October 2017, transcript of evidence, p. 4; Ms Kylie Cole, Registered Nurse and Midwife, Family and Community Development Committee public hearing – Geelong, 11 December 2017, transcript of evidence, p. 4. Ms Samantha Ward, Midwife, The Midwife Collective, Family and Community Development Committee public hearing – Bendigo, 24 October 2017, transcript of evidence, p. 3; Ms Andrea Quanchi, Midwife and Director of Midwives, My Midwives Melbourne, Family and Community Development Committee public hearing – Melbourne, 4 September 2017, transcript of evidence, p. 2.

³²⁵ Ms Amanda Hewett, Mamta Coordinator, Bendigo Health, Family and Community Development Committee public hearing – Bendigo, 24 October 2017, transcript of evidence, p. 4.

How to futureproof maternity services? Midwives are the specialists in normal birth. There will always be more midwives than obstetricians. In our opinion the change that will futureproof maternity services is to extensively expand localised midwifery-led care to all women, enhanced by specialist care provided as clinically indicated. This is not a new concept. It is the change that many services have expanded to across the country because of the lower costs and the better outcomes.³²⁶

Ms Kylie Cole, a registered nurse and midwife in Geelong, talked about Barwon Health's midwifery group practice (MGP), which is a caseload model of care providing continuity of carer:

I would like to add that women's access to the caseload model of care is very limited. The MGP commenced in 2008, providing 25 per cent of women with midwife-led continuity of carer. Currently the numbers are at 20 to 22 per cent with no increase in numbers with the growth in numbers of women birthing at the hospital. We have a long waiting list for women requesting MGP and we know that the research has provided evidence that outcomes for women are improved and women are more satisfied with their care when they have a known carer.³²⁷

2.2.2 Research on continuity of care models

There have been several international and Victorian studies into continuity of care models which have shown benefits when compared to other models. Cochrane is regarded as a highly trustworthy 'global independent network' of 'researchers, health professionals, patients, carers, and people passionate about improving health outcomes' which aims to summarise the best evidence about healthcare.³²⁸ In 2016, a Cochrane review found that women who received midwifery-led continuity models of care experienced numerous benefits for themselves and their babies and were more likely to be satisfied with their care.³²⁹ The Cochrane review argued that most women should be offered midwifery-led continuity of care.³³⁰ Ms Andrea Quanchi, midwife and Director of Midwives, My Midwives Melbourne, told the Committee at a public hearing in Melbourne:

The Cochrane review, which was done of 17 000-plus women, has shown that this is the best way to ensure women have the best outcomes. Having that model of care, women will have less intervention, they are less likely to have caesarean sections, they are less likely to have perineal tears or episiotomies, they are more likely to have a spontaneous vaginal birth and less likely to have babies that go to a special care nursery, and the neonatal and maternal morbidity for babies is better when women have continuity of care.³³¹

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- 326 Ms Samantha Ward, Midwife, The Midwife Collective, Family and Community Development Committee public hearing – Bendigo, 24 October 2017, transcript of evidence, p. 3.
- 327 Ms Kylie Cole, Registered Nurse and Midwife, Family and Community Development Committee public hearing – Geelong, 11 December 2017, transcript of evidence, p. 4.
- 328 Cochrane, 'About us', accessed 25 May 2018, <<http://www.cochrane.org/about-us>>.
- 329 J Sandall, H Soltani, S Gates, A Shennan, and D Devane, *Midwife-led continuity models versus other models of care for childbearing women*. Cochrane Database of Systematic Reviews 2016, Issue 4. Art. No.: CD004667.
- 330 Ibid.
- 331 Ms Andrea Quanchi, Midwife and Director of Midwives, My Midwives Melbourne, Family and Community Development Committee public hearing – Melbourne, 4 September 2017, transcript of evidence, p. 2.

A Victorian study at the Royal Women's Hospital showed benefits to midwifery continuity of care models. The COMparing Standard Maternity care with One to one midwifery Support (COSMOS) trial recruited over 2,300 low risk women, half of which were randomly allocated to caseload midwifery, where they received antenatal, intrapartum and postpartum care from a primary midwife with some care provided by a 'back-up' midwife. The other half were allocated to standard care which was midwifery-led care but with varying levels of continuity, junior obstetric care or community-based medical care.³³²

The study found that women who received caseload midwifery care were less likely to have a caesarean birth, more likely to have a normal birth and less likely to have epidural pain relief during labour.³³³ The study also found that babies of women who had caseload midwifery care were less likely to be admitted to neonatal intensive care units or special care nurseries. Women who received care from a primary midwife were more positive about their overall birth experience and felt 'more in control during labour, were more proud of themselves, less anxious, and more likely to have a positive experience of pain'.³³⁴

Ms Andrea Quanchi, midwife and Director of Midwives, My Midwives Melbourne, talked about the trial at a public hearing in Melbourne and noted that public continuity of care models were limited:

The Women's did a large study of continuity of care for the COSMOS program, which has been running for over 10 years now. It has also shown better outcomes for mothers and babies. Despite that, continuity of care is not available for the majority of women in Victorian public hospitals. The programs that are run across the state are limited mostly to low-risk women. They are oversubscribed, in that many, many more women want to get into these programs than are available and the amount of continuity with the same midwife is restricted.³³⁵

Ms Elizabeth Murphy, a midwife at The Midwife Collective, also spoke about the COSMOS study at a public hearing in Bendigo:

Women want to give birth naturally with someone they know caring for them. Lots of research, including the COSMOS study at the Royal Women's Hospital, has shown that women have a much better chance of a natural birth when they are cared for by someone they know and trust.³³⁶

332 H McLachlan, D Forster, M Davey, T Farrell, M Flood, T Shafiei and U Waldenström, 'The effect of primary midwife-led care on women's experience of childbirth: results from the COSMOS randomised controlled trial', *BJOG*, 2015, vol. 123, pp. 465-474. See also: H McLachlan, D Forster, M Davey, T Farrell, J Oats, L Gold, U Waldenström, M Biro, and L Albers, 'Effects of continuity of care by a primary midwife (caseload midwifery) on caesarean section rates in women of low obstetric risk: the COSMOS randomised controlled trial', *BioMed Central Pregnancy and Childbirth*, 2008, vol. 5, iss. 35, pp. 8-35.

333 H McLachlan, D Forster, M Davey, T Farrell, L Gold, M Biro, L Albers, M Flood, J Oats, and U Waldenström, 'Effects of continuity of care by a primary midwife (caseload midwifery) on caesarean section rates in women of low obstetric risk: the COSMOS randomised controlled trial', *BJOG: An International Journal of Obstetrics & Gynaecology*, 2012, vol. 119, no. 12, pp. 1483-1492, 2012.

334 H McLachlan, D Forster, M Davey, T Farrell, M Flood, T Shafiei and U Waldenström, 'The effect of primary midwife-led care on women's experience of childbirth: results from the COSMOS randomised controlled trial', *BJOG*, 2015, vol. 123, pp. 465-474, p. 465.

335 Ms Andrea Quanchi, Midwife and Director of Midwives, My Midwives Melbourne, Family and Community Development Committee public hearing - Melbourne, 4 September 2017, transcript of evidence, p. 2.

336 Ms Elizabeth Murphy, Midwife, The Midwife Collective, Family and Community Development Committee public hearing - Bendigo, 24 October 2017, transcript of evidence, p. 3.

2.2.3 Continuity of care for vulnerable women

The Committee heard that continuity of care models were especially important to enhance perinatal outcomes for Aboriginal and Torres Strait Islander communities, culturally and linguistically diverse (CALD) communities and vulnerable groups such as young mothers.³³⁷ For more on continuity of care for CALD communities see Chapter Eight. Continuity of care is an important aspect of Koori Maternity Services, which is discussed in more detail in Chapter Seven.³³⁸

At a public hearing in Melbourne, Ms Kirstan Flannery, Chairperson and Co-Founder of Birth for HumanKIND, a group which provides continuity of care through a doula for women at risk, said that while there was minimal research around doula support, the Cochrane review supported what they found in their work about the benefits of continuity of care:

[W]e are finding through our work, that having a continuous support person who is not part of that woman's network, that has some level of training and experience is actually — well, here they say 'appears beneficial' — providing benefits to the woman in her experience. There is other research that shows the value and benefit from the presence of a support person during labour and childbirth, and that includes the emotional support and information about labour progress, because there is time to explain those things because you are there over a longer period of time, can advise about pain coping techniques and comfort measures, and also support the woman to find ways to advocate for herself when she is wanting to communicate with hospital staff.³³⁹

At a public hearing in Melbourne, Ms Jen Branscombe, Programs Manager at Birth for HumanKIND, told the Committee:

Particularly for women from [migrant, refugee and asylum seeker] backgrounds, continuity of care can enable better development of trust and rapport and better communication. It reduces the need for them to revisit traumatic memories and offers more time for them to discuss current concerns. It is not common, however, in the conventional maternal health model that many women from migrant, refugee and asylum seeker backgrounds experience. Research suggests that lists can lead to fragmented care provision, and the decrease in continuity of care can also lead to growing fear, distress and trauma in birthing women and the increased medicalisation and intervention-based management of birth.³⁴⁰

2.2.4 Doulas

A doula is a non-medical birth companion who provides emotional and physical support to a woman before, during and after childbirth. At a public hearing in Melbourne, Ms Kirstan Flannery, Chairperson and Co-Founder of Birth for HumanKIND, explained the role of a doula to the Committee:

³³⁷ Ms Mandy Miller, Midwife, Koori Maternity Service, Wathaurong Aboriginal Co-operative, Family and Community Development Committee public hearing – Geelong, 11 December 2017, transcript of evidence, p. 2.

³³⁸ *Ibid.*, p. 3. See also: Department of Health and Human Services, *Koori Maternity Service Guidelines: Delivering culturally responsive and high-quality care*, March 2017, DHHS, p. 15.

³³⁹ Ms Kirstan Flannery, Chairperson and Co-Founder, Birth for HumanKIND, Family and Community Development Committee public hearing – Melbourne, 16 October 2017, transcript of evidence, p. 3.

³⁴⁰ Ms Jen Branscombe, Programs Manager, Birth for HumanKIND, Family and Community Development Committee public hearing – Melbourne, 16 October 2017, transcript of evidence, p. 4.

We define a doula as someone who provides continuous support — non-clinical, who is professionally trained — to a mother during the antenatal period in terms of birth preparation, continuous support during the labour and the birth, and also support in that early parenting period. She does it by providing emotional support; practical physical support; and also providing information and education so the woman understands what her choices are and how to navigate the maternal health system in a way that makes sense to her and matches her needs.³⁴¹

The Committee heard that doulas are not a regulated industry like midwives and nurses and there are different kinds of training can be undertaken to become a doula, from government accredited training that runs for about 32 weeks to more informal training of about three days.³⁴²

Ms Flannery told the Committee that the support that doulas provide can benefit the medical team:

We are actually finding that clinical staff, i.e. the midwives and obstetricians, are really benefiting from the additional support of having the doula present because of what it is lending to the woman's experience of her feeling safe, calm and confident, and understanding what is happening in a way that hospital staff are maybe needing to focus on other areas. They love knowing that that is all covered for the best experience and outcomes for the mum.³⁴³

Most of what the Committee heard about doulas was in relation to culturally and linguistically diverse communities, which will be addressed in Chapter Eight.

At a public hearing in Melbourne, Ms Ofri Marton told the Committee about her decision to use a doula in order to receive continuity of care throughout her pregnancy and the birth of her son:

The reason why we wanted a doula was that we wanted continuity of care, especially from mid to late pregnancy and throughout the birth, which was not available in the public system. We did not have the same midwife, I guess, and just having the doula was invaluable — just a familiar face and someone who I was connected with, and that was extremely comforting. But again that came at a cost.³⁴⁴

Ms Marton told the Committee that the cost of having a doula was \$1,500 which was not covered by Medicare or their private insurance company. She said:

In my work I am a social worker and I work at child protection. I guess I felt sad for mothers or couples who could not afford these services that we were fortunate enough to be able to afford, but it was still challenging for us and we were on full-time salaries. With continuity of care we know that it improves outcomes for babies and for mothers and it decreases interventions, and so I guess we were maybe surprised that there was not more of that available. We feel that the public system could be more supportive of parents. It is a very challenging time of parents' lives, so there could be more room for support.³⁴⁵

³⁴¹ Ms Kirstan Flannery, Chairperson and Co-Founder, Birth for HumanKIND, Family and Community Development Committee public hearing – Melbourne, 16 October 2017, transcript of evidence, p. 3.

³⁴² *Ibid.*, p. 6.

³⁴³ *Ibid.*, p. 3.

³⁴⁴ Ms Ofri Marton, Family and Community Development Committee public hearing – Melbourne, 27 November 2017, transcript of evidence, p. 3.

³⁴⁵ *Ibid.*

The Committee notes that doulas can be formal or informal, and can benefit those without strong support networks.

2.2.5 Continuity of care and workforce issues

The Committee heard that continuity of care models were costly for public hospitals and were difficult for many midwives as they were required to be on call.³⁴⁶

Ms Hannah Quanchi, the Owner and Director of My Midwives Melbourne, explained why this is to the Committee at a public hearing in Melbourne:

[A]bout the continuity of care programs that are available in Victoria so far in public hospitals, they are funded by the state government and they are sometimes costly to the state government as well. Part of having midwives on call is that it can then become a more expensive endeavour. It is not available in all hospitals, and they have a limited amount of women that they can take in, so often the waiting lists are phenomenally bigger than the amount of women who are actually getting to the program. And then again women who are low-risk are often the only ones that are allowed in.³⁴⁷

At a public hearing in Mildura, Ms Sandra Doyle, Nurse Unit Manager of Maternity Services at Mildura Base Hospital, told the Committee that it was hard for midwives to be on call when they had young families.³⁴⁸

In their submission, the Australian Nursing and Midwifery Federation spoke of the COSMOS program, and noted that continuity of carer in the provision of maternity care has been strongly recommended and encouraged in Victoria with many hospitals responding by introducing caseload midwifery. Nonetheless, they raised concerns from a staffing perspective:

The ANMF has been a stakeholder in the development and review of midwifery continuity models of care across Victoria since 2004. Research is underway to examine the sustainability of caseload midwifery in Australia there appears little doubt that this model of care provides great benefits to most women who experience it. However there have been some real concerns from the perspective of the workforce in relation to fatigue, lack of support by employers, inadequate remuneration for hours worked and isolation from the mainstream of a health service. It is important that this model of care be reviewed carefully in the Victorian context to understand what could be done better to achieve the known improved outcome for women.³⁴⁹

At a public hearing in Bendigo, the Committee also heard from Ms Fiona Faulks, Deputy Director of Nursing, Women's and Children's Services at Bendigo Health, about the challenges for the workforce with continuity of care models, and the methods they used at Bendigo Health to prevent burnout:

In terms of being oversubscribed, I guess, one of the challenges in the continuity model is the prevention of burnout in the midwives that work in that model, because they are on call 24 hours a day. It is a hard balance to maintain, and we find that we

³⁴⁶ Ms Sandra Doyle, Nurse Unit Manager, Maternity Services, Mildura Base Hospital, Family and Community Development Committee public hearing – Mildura, 9 November 2017, transcript of evidence, p. 11.

³⁴⁷ Ms Hannah Quanchi, Owner and Director, My Midwives Melbourne, Family and Community Development Committee public hearing – Melbourne, 4 September 2017, transcript of evidence, p. 3.

³⁴⁸ Ms Sandra Doyle, Nurse Unit Manager, Maternity Services, Mildura Base Hospital, Family and Community Development Committee public hearing – Mildura, 9 November 2017, transcript of evidence, p. 11.

³⁴⁹ Australian Nursing and Midwifery Federation (Victorian Branch), submission no. 67, p. 16.

support the midwives moving in and out of the mainstream midwifery cohort to allow them to have a break from time to time from the on-call. For those who want to there is the ability to move back into our mainstream workforce, come off call for a while and kind of re-energise, if you like, and then move back into the model. Our model has been operating for 10 years now, and we have not had an issue with the recruitment or sustainability of that workforce.³⁵⁰

Due to changes in qualifications and training, Dr Will Twycross, Procedural GP in Obstetrics, Anaesthetics, and Accident and Emergency, noted that some students can choose to graduate with only midwifery qualifications rather than nursing and midwifery qualifications, and this made it difficult for smaller health services as these midwives could not be deployed to other areas in the hospital. Dr Twycross stated that a midwifery-led model of care had allowed for the retention of midwives at Mansfield:

So the way we have solved it in Mansfield is that we have a midwifery-led model of care. The midwives are involved in the antenatal care and they are involved in the postnatal care, and the midwives who work as midwives do not work in the rest of the hospital because they are not trained to do that. I am not sure how hard they thought it through when training changed to be that, but it has in a way put at risk the retention of midwives in small rural areas for obvious reasons. You need a certain number of midwives to run a service, and if they are only midwives, if they cannot also be employed as general nurses, that can be problematic. So you have to have that sort of model of care, and that model of care I think is a little bit more expensive to run than the old model of care, where you worked as a midwife and if there were not any babies in the hospital at the time, you went off into the general ward.³⁵¹

Workforce issues will be examined in more detail in Chapter Five.

The Committee heard that providing continuity of care can be disrupted by other events, such as if a mother or baby needs to be transferred to another hospital, or if a mother or baby needs treatment for another condition. Dr Wendy Pollock, an adult intensive care nurse and midwife who undertook a PhD on critical illness during pregnancy, told the Committee at a public hearing in Melbourne that it is difficult providing continuity of care for women who are very unwell:

At the moment even the big tertiary services do not cater for sick women very well. Even though Royal Women's Hospital has co-located with Royal Melbourne and Mercy has co-located with Austin, they are separate institutions. A woman gets discharged from one to go to the intensive care of the other. There is no continuity of care across the two hospitals unless you might get the obstetrician popping in. Nurses and midwives provide 24-hour surveillance and monitoring of clinical condition, and they provide support and care. The ICU nurse, for example, may have no idea what a fundus is and certainly does not understand how to establish lactation, for example. But the midwife over here cannot come across. Also, coming and going is not enough anyway because the role of a nurse and midwife is different to that of a doctor: it is 24 hours, it is hands-on all of the time. At the moment, without doubt, there is a significant service gap for caring for these women when they are in hospital.³⁵²

³⁵⁰ Ms Fiona Faulks, Deputy Director of Nursing, Women's and Children's Services, Bendigo Health, Family and Community Development Committee public hearing – Bendigo, 24 October 2017, transcript of evidence, p. 4.

³⁵¹ Dr Will Twycross, Procedural GP in Obstetrics, Anaesthetics, and Accident and Emergency, Family and Community Development Committee, public hearing – Wangaratta, 25 October 2017, transcript of evidence, p. 4. See also: Dr Will Twycross, submission no. 16, p. 2.

³⁵² Dr Wendy Pollock, Family and Community Development Committee public hearing – Melbourne, 27 November 2017, transcript of evidence, p. 2.

RECOMMENDATION 2.1: The Victorian Government, through the Department of Health and Human Services, examine the feasibility of expanding the midwifery-led continuity of care programs that are offered through the public health system.

2.3 Admitting rights for private midwives in public hospitals

At public hearings in Melbourne, the Committee heard about the Northern Hospital trial which gave admitting rights for private midwives at the Northern Hospital so that My Midwives Melbourne could provide care to women throughout their pregnancy, labour and birth, and postnatally. Ms Andrea Quanchi, midwife and Director of Midwives, My Midwives Melbourne, told the Committee about how the Northern Hospital private midwives trial began:

[T]he Andrews government made an election commitment to run a pilot program here in Victoria. Northern Health and Monash both put in to be pilot sites for that. Northern Health was selected as a pilot and they commenced with My Midwives in 2016. They chose us to be their partners in running that pilot.

Monash Health liaised with us at the time about getting going, but to date they have not yet credentialed any midwives. So the Northern remains the only hospital in Victoria that currently has credentialed private midwives.³⁵³

Ms Hannah Quanchi, the Owner and Director of My Midwives Melbourne, told the Committee at a public hearing in Melbourne about how the Northern Health trial works:

The way that we work in conjunction with Northern Health is that the midwife provides all the antenatal care and collaborates with Northern Health where appropriate. We use the midwifery guidelines for consultation and referrals, so if women need a consult with an obstetrician or a referral to an obstetrician, then we can. The premise is that all women have midwifery continuity of care and then some women will have some obstetric care along the way as needed. Intrapartum the woman is admitted under the private midwife into the Northern Hospital as a private patient. Women will either use their private health insurance or be self-funded. During intrapartum care the midwife collaborates with the obstetric team as needed. Even if there is obstetric involvement, the woman remains a private patient and uses the obstetric team of the day.³⁵⁴

Ms Hannah Quanchi noted that the women who use this model of care at the Northern Hospital are all risk, in contrast to the women who access public continuity of care models who are often low risk. She told the Committee:

After the first year of the pilot program at the Northern Hospital, the Northern reviewed the statistics of the private midwife program compared to the public sector and found that the private patients had a reduced length in hospital stay, reduction in caesarean section, reduction in the use of epidurals for pain relief in labour, reduction in the number of episiotomies and perineal tears, and reduction in

³⁵³ Ms Andrea Quanchi, Midwife and Director of Midwives, My Midwives Melbourne, Family and Community Development Committee public hearing – Melbourne, 4 September 2017, transcript of evidence, p. 2.

³⁵⁴ Ms Hannah Quanchi, Owner and Director, My Midwives Melbourne, Family and Community Development Committee public hearing – Melbourne, 4 September 2017, transcript of evidence, p. 2.

instrumental birth by forceps or ventouse. They also did a survey of public patients versus private patients in terms of satisfaction and found higher satisfaction in the private patients.³⁵⁵

Ms Jodie Ashworth, General Manager of Surgery, Women’s and Children’s, Operating Theatres and ICU and Chief Nursing Officer at Northern Health, told the Committee at a public hearing in Melbourne of the benefit of the program to women and their babies, and the health service:

The outcomes ... are: reduced length of stays, reduced caesarean section rates, reduced use of epidurals, reduced number of episiotomies and reduced number of tears pretty much across primips and multips.

The benefits to us as an organisation, again, as I said, we have been able to establish an identity and work with a new continuity of midwifery model for our region. We have got improved satisfaction from both our patients and our staff because they have helped reduce the workload of some of our employed midwives. We have been able to attract a new workforce to Northern Health. The midwives also sit on our books, so we call on them casually when we are short and things get tight. It has had a positive impact on midwifery care for all patients.³⁵⁶

In her submission, Ms Gabrielle Sammon spoke positively about her experience giving birth at the Northern Hospital with a private midwife:

For those of us that birthed in hospital, an essential element of the particular model of care we received was that our private midwife was able to admit us to the Northern Hospital, a public hospital, for the birth of our children (if we chose hospital delivery). This meant we knew that our midwife, who we had come to know and trust over nine months, would catch our baby — increasing our confidence and preparedness for birth. ‘My Midwives Melbourne’ and the Northern Hospital are the only midwives and hospital in Victoria who have such an agreement in place. There are clients of ‘My Midwives Melbourne’ who need to travel significant distances in order to birth at the Northern Hospital because they have elected the midwife-led continuity of care model. There are even extreme scenarios where clients are renting properties closer to the Northern Hospital for their last week of pregnancy because the distance from their home to the hospital is too far. In order to improve the availability, quality and safety of health services delivering services to women and their babies during the perinatal period, the private midwife visiting-access model of care should be accessible in all Victorians hospitals so that women can choose this model throughout Victoria.³⁵⁷

Ms Sammon, who is part of the My Midwives Melbourne parents group, told the Committee at a public hearing in Melbourne that having confidence in your care provider is important:

The main point that comes across in all our stories is just the importance of having confidence in your care provider when you are pregnant and going to have a baby, and especially for the first time — it is just essential. Even though a lot of us had different labour experiences and birthing experiences, we all felt empowered by

³⁵⁵ Ibid., p. 3.

³⁵⁶ Ms Jodie Ashworth, General Manager, Surgery, Women’s and Children’s, Operating Theatres and ICU and Chief Nursing Officer, Northern Health, Family and Community Development Committee public hearing – Melbourne, 5 February 2018, transcript of evidence, p. 5.

³⁵⁷ Ms Gabrielle Sammon, submission no. 38, p. 2.

them and that our care providers had made the best decisions for us and our babies, and we really believe that that is because of the continuity of care and the time that we always had with Hannah [Quanchi] or Andrea [Quanchi], knowing who our care provider was.³⁵⁸

In their submission, the Australian Nursing and Midwifery Federation state that a 12 month external review is currently underway into the arrangement with reports that outcomes have been positive thus far.³⁵⁹

The Committee heard that other private midwifery groups were hoping to gain admitting rights at public hospitals in their region. In their submission, Yarra Valley Midwives told the Committee:

Currently Yarra Valley Midwives provide maternity services with Medicare rebates, however Eastern Health will not formally acknowledge this model of care leaving local women confused and frustrated. Without formal collaboration with Eastern Health women and families receive disjointed care and have reported being judged and discriminated against for their choice in a local private maternity care provider. Eastern Health will not consider 'Admitting Rights' for midwives which the Northern Hospital in Melbourne has already implemented and have had excellent outcomes for both women and babies. If Admitting Rights were granted, families of the Yarra Ranges could have a known Midwife as their primary carer during her childbirth regardless of place of birth and would be entitled to Medicare rebates.³⁶⁰

In their submission, the Maternity Consumer Network collaborated with Victorian members of their consumer-based organisation and advocated for private midwives to have admitting rights. They stated, in their submission, that women in East Gippsland reported that 'their local private midwife was "banned" from even entering hospital grounds'.³⁶¹ They stated:

Currently, there are severe restrictions on the private midwifery profession, which ultimately affects maternity consumer access to choice in care providers. With only one private midwifery practice with visiting access to a public hospital in Victoria, it is difficult for women to access a service which is strongly supported by high quality evidence and is in demand by women. Private midwives collaborate appropriately with other care providers, as required by ACM Guidelines, to deliver safe, timely and supportive care to mothers and babies.

Many women reported traveling long distance to seek out continuity of midwifery care, with some even having to relocate their entire family for birth. For some women, this has been unachievable and they have been forced to birth with fragmented care, and report feeling unsatisfied with this model. Women enjoy building a relationship with a known midwife, without feeling rushed through appointments, uninformed and scared in traditional, fragmented maternity care models.³⁶²

³⁵⁸ Ms Gabrielle Sammon, Parents Group Representative, My Midwives Melbourne, Family and Community Development Committee public hearing - Melbourne, 4 September 2017, transcript of evidence, p. 4.

³⁵⁹ Australian Nursing and Midwifery Federation (Victorian Branch), submission no. 67, p. 16.

³⁶⁰ Yarra Valley Midwives, submission no. 39, p. 2. See also: Healesville Action Group, submission no. 63, p. 1.

³⁶¹ Maternity Consumer Network, submission no. 78, pp. 1-2.

³⁶² *Ibid.*, p. 1.

The Committee heard about the success of the Northern Hospital private midwife trial and would like to see the feasibility of other hospitals around the state exploring this option and expanding the admitting rights for private midwives. This would give women more choice in their care and could reduce the pressures on maternity hospitals. Thus, the Committee recommends that:

RECOMMENDATION 2.2: The Victorian Government, through the Department of Health and Human Services, engage with public hospitals to examine the feasibility of other hospitals around the state expanding the admitting rights for private midwives.

2.4 Shared care

Shared maternity care is an option for low risk pregnancies and describes an arrangement between a hospital and a local healthcare professional (usually a GP, a midwife, or an obstetrician) where pregnancy care is divided between the local provider and the hospital. The benefits of shared care include having one primary practitioner who can work with a woman throughout her pregnancy. It may also mean that women can see a practitioner close to their home or work and spend less time waiting for hospital appointments. A woman can also see a shared care practitioner who speaks her language and/or shares her cultural background.

A woman will still visit the hospital for specific appointments and a hospital midwife will attend the birth. The Committee heard that some women with high risk factors are ineligible for shared care, such as women with a high body mass index (BMI), gestational diabetes, high blood pressure, and thyroid issues.³⁶³

The Committee heard from many hospitals which offered shared care arrangements with some of these hospitals having extensive connections to other maternity health care providers. For example, the Royal Women's Hospital has more than 750 shared care maternity affiliates (GPs and midwives).³⁶⁴

2.4.1 General practitioner (GP) shared care

General practitioners (GPs) who provide shared care must have additional qualifications in obstetrics and an arrangement with a maternity hospital. For GP shared care arrangements, the benefits can include that a woman may be able to see her family doctor and continue to see the same doctor throughout her life and throughout her child's development.

Dr Nicola Yuen, Director of Obstetrics and Gynaecology at Bendigo Health, told the Committee at a public hearing in Bendigo about the GP shared care model in Bendigo:

³⁶³ For example, see: Ms Hannah Quanchi, Owner and Director, My Midwives Melbourne, Family and Community Development Committee public hearing – Melbourne, 4 September 2017, transcript of evidence, p. 7; Ms Barbara Oh, submission no. 60, p. 1. See also: Better Health Channel, 'GPs, shared care and pregnancy', Victorian Government, accessed 1 May 2018, <<https://www.betterhealth.vic.gov.au/health/servicesandsupport/gps-shared-care-and-pregnancy>>.

³⁶⁴ Department of Health and Human Services, Better Health Channel, 'GPs, shared care and pregnancy', 2017, accessed 7 June 2018, <<https://www.betterhealth.vic.gov.au/health/servicesandsupport/gps-shared-care-and-pregnancy>>.

The GP shared care is a model that has existed for a very long time. Its profile within Bendigo probably was not as high as it needed to be, and certainly there is a little bit of work going on around encouraging that practice of maternity shared care with their local GP. In terms of the numbers at the moment, those that engage with shared care is small. That is partly to do with the risk profile that we have just talked about — the women who are suitable for shared care are the normal-risk women, not the high-risk women. We are already identifying what is the minority in our cohort at the moment that would be eligible for shared care.

In terms of GP obstetricians, there are no GP obstetricians practising within Bendigo, but we certainly know that to sustain the rural workforce outside of Bendigo within the region GP obstetricians are incredibly important for us to support, and that is where we see our role — as really around ensuring that the training that they can receive at Bendigo with their procedural skills year is adequate to set them up for that practice.³⁶⁵

The Committee heard from Dr Will Twycross that shared care is ‘best practice’ in rural areas.³⁶⁶ However, others raised concerns about the sustainability of GP obstetrics in rural areas. At a public hearing in Bendigo, the Committee heard from Ms Samantha Ward, a midwife at The Midwife Collective, who told the Committee that shared care relying on GP obstetricians was unsustainable in many areas:

The Mount Alexander shire currently has this model with three GP obstetricians providing continuity of care in birthing through Castlemaine Health, with approximately 50 to 60 births a year. However, maternity services relying solely on GP obstetricians is unsustainable, as demonstrated by many birthing services in rural areas closing. The rural medical workforce is coming to a crisis point.³⁶⁷

Dr Joe Garra, a GP in Werribee with an RANZCOG Diploma in Obstetrics who does shared care, told the Committee that the standard of care provided by GPs doing shared care is ‘extremely variable’:

In my opinion the standard for GPs to do shared care is too low. At some hospitals attending two antenatal clinics meets the requirements. Many GPs don’t even know what the recommended antenatal tests are and both over and under order tests. After an initial assessment just after 12 weeks by hospitals, low risk women are not seen until they have 4 weeks left. Fortunately antenatal problems are quite rare so most women will be ok. The rarity of complications is also a double edged sword as this means that unless the GP has had reasonable antenatal experience then they wouldn’t be familiar with the complication. Obtaining a Diploma in Obstetrics requires working for 6 months in a women’s health position in hospitals. Maintaining a Diploma involves participating in appropriate professional development in a 3 year cycle.³⁶⁸

Dr Garra recommended that a Diploma in Obstetrics be the minimum requirement to provide antenatal shared care, noting that although this ‘will decrease the total pool of doctors doing shared care’, it ‘will enable closer links to be formed with hospitals’ giving the hospitals ‘a fighting chance of assessing competency’.³⁶⁹

³⁶⁵ Dr Nicola Yuen, Director, Obstetrics and Gynaecology, Bendigo Health, Family and Community Development Committee public hearing – Bendigo, 24 October 2017, transcript of evidence, p. 9.

³⁶⁶ Dr Will Twycross, submission no. 16, p. 2.

³⁶⁷ Ms Samantha Ward, Midwife, The Midwife Collective, Family and Community Development Committee public hearing – Bendigo, 24 October 2017, transcript of evidence, p. 2.

³⁶⁸ Dr Joe Garra, submission no. 15, p. 3.

³⁶⁹ *Ibid.*, p. 4.

Concerns about GP training were also raised in public hearings. Dr Leo Fogarty, Director of Obstetrics, Northeast Health Wangaratta told the Committee at a public hearing in Wangaratta that some GPs failed to provide appropriate antenatal care:

One of the difficulties we have with antenatal care is that some of the GPs we are sharing antenatal care with have not had sufficient training in antenatal care, and we really cannot control that. We cannot control what is happening in GP practices around the region. As a result of some GPs having insufficient training we are getting issues such as late referrals for high-risk pregnancies, failure to order appropriate routine tests and failure to offer things like Down syndrome screening in some cases. As I said, we cannot say which GPs can and cannot do antenatal care, but perhaps the health department could somehow or other just say to all hospitals, 'You can't accept patients from GPs who are not qualified to do antenatal care'. In that way if we all had the same rules, those GPs would have to have someone else in their practice doing the antenatal care.³⁷⁰

The Committee recognises that there are challenges associated with GP obstetrician shared care, such as the cost of insurance, resulting in a risk of a lack of skilled practitioners. The Committee's view is that the greater risk to mothers and babies in rural and regional Victoria is presented by losing this model of care and its associated skill set. The Committee believes this model of care and the skilled health practitioners required to provide it need to be encouraged and supported to best serve Victoria's mothers, babies and children.

The Committee addresses attracting and retaining GP obstetricians in rural and regional Victoria in Chapter Four.

2.4.2 Midwifery-led shared care

In her submission to the Inquiry, Ms Barbara Oh told the Committee about her experience with shared care at the Royal Women's Hospital and Midwives and Mothers Australia (MAMA).³⁷¹ She stated that there is a 'need to move away from the model of thinking that assumes every woman with a designated "high-risk" pregnancy will have her needs best met by the hospital instead of shared care'.³⁷² On why she chose shared care for the birth of her two children, Ms Oh said:

For the sole reason that I could choose appointment times that suited me, and I wouldn't have to sit in the waiting room at RWH for 3 hours (the sign in the waiting room says 'please allow 3 hours for your appointment'. I was working full time as a Land Development Manager and it would have been horribly inconvenient to have all my appointments at the hospital, both in terms of lost income and also just annoying!³⁷³

³⁷⁰ Dr Leo Fogarty, Director of Obstetrics, Northeast Health Wangaratta, Family and Community Development Committee public hearing – Wangaratta, 25 October 2017, transcript of evidence, p. 3.

³⁷¹ Ms Barbara Oh, submission no. 60, p. 1.

³⁷² Ibid.

³⁷³ Ibid.

Ms Oh told the Committee that she initially did shared care through her GP but switched to MAMA after hearing about its existence from one of the hospital midwives. However, she noted that for her second pregnancy, her GP was reluctant to write a referral to MAMA (which is needed to be eligible for Medicare rebates).³⁷⁴ About MAMA, she said:

My antenatal appointments were on Saturdays so didn't interfere with work, each appointment was almost an hour long, I built up a great trusting relationship with the midwives, and it was cheap. Also their level of post-natal care was exemplary, their advocacy for me during labour was welcomed, and their care of me in the immediate post-natal period was invaluable and without it I might have suffered permanent physical damage ...³⁷⁵

In their submission, Midwives and Mothers Australia (MAMA) wrote:

Midwives are affiliates, same as GPs, however unlike GPs midwives require a referral from a GP to collaborate for Medicare rebate purposes. This provides yet another barrier to accessing particular models of care for Victorian women.³⁷⁶

The Committee heard that shared care with a midwife was particularly important in rural and remote areas. At a public hearing in Bairnsdale, the Committee heard from Ms Sue Carroll, a nurse and midwife at Swifts Creek Bush Nursing Centre. Swifts Creek is 96kms north of Bairnsdale and about 374kms east of Melbourne with a population of over 400 people. There are no obstetric GPs in the area. Ms Carroll told the Committee that she offered shared care with regular communication with the obstetric GPs in Bairnsdale so that women do not have to travel to Bairnsdale for every appointment. She noted that they try to get women to Bairnsdale for deliveries, which was not always possible.³⁷⁷

The Committee heard that the shared care model works very well in some areas. However, some evidence received demonstrated the importance of appropriate training and expertise of those providing shared care to strengthen and provide consistency to achieve quality shared care.

The Committee believes there are benefits to the different shared care models that currently exist and accordingly recommends that:

RECOMMENDATION 2.3: The Victorian Government, through the Department of Health and Human Services, examine the feasibility of expanding and strengthening the current shared care models that are offered through the public health system.

2.5 Homebirths

Homebirths have usually been facilitated by a private midwife, a GP obstetrician, or an obstetrician, however, since 2009, two public hospital homebirth programs have been operating in Victoria at Sunshine Hospital (Western Health) and Casey Hospital

³⁷⁴ Ibid.

³⁷⁵ Ibid.

³⁷⁶ Midwives and Mothers Australia (MAMA), submission no. 65, p. 6.

³⁷⁷ Ms Sue Carroll, Midwife, Swifts Creek Bush Nursing Centre, Family and Community Development Committee public hearing – Bairnsdale, 7 December 2017, transcript of evidence, p. 4.

(Monash Health).³⁷⁸ In 2015, the Department of Health and Human Services published a guide to home birthing for Victorian public health services, which provides information to assist public health services with capacity and capability to establish and provide a safe, high quality and sustainable home birth program.³⁷⁹

Homebirths are less common in Australia, unlike other countries such as the United Kingdom, the Netherlands and New Zealand.³⁸⁰ Associate Professor Michael Stewart, Director of Paediatric Infant Perinatal Emergency Retrieval service (PIPER), told the Committee that homebirths in England are safe and effective:

I have friends who are midwives in England who work in homebirth scenarios which have been enormously successful and work incredibly well. We are a long way behind that in Victoria. They are well-organised homebirth programs; they are safe, they are effective. The thing about obstetrics of course — and we see this — is even in our low-level maternity services where they are really good at risk stratification and try and pick the low-risk women to birth in those services, things can go wrong very quickly. That is what makes me nervous as a neonatologist — that I am going to get landed in this. But we do have a lot of experience from other jurisdictions to say it seems to work safely.³⁸¹

During public hearings, the Committee heard different perspectives on homebirths. Professor Euan Wallace, Chief Executive Officer of Safer Care Victoria, told the Committee at a public hearing in Melbourne that he was supportive of homebirth and he thought it was ‘an unrealised opportunity for Victorian women for whom it is appropriate’:

The homebirth rate in Victoria is about half a per cent overall. As you know there are two public homebirth programs, one out of Western, Sunshine, and one out of Monash Health at Casey Hospital in Berwick. Those two programs are now probably in a steady state of looking after between 60 and 100 women a year — so very, very small numbers.

It is fair to say that Safer Care Victoria does not have an agency view on homebirth. My personal view is it is an unrealised opportunity. If you look at jurisdictions that look very like us, so England and Wales, the homebirth rate is 5 per cent — so it is 10 times higher than it is in Victoria. My college, the Royal Australian and New Zealand College of Obstetricians and Gynaecologists, have not historically been supportive of homebirth for reasons I do not really understand. The evidence says that where midwives are suitably trained and there are integrated hospital supports where there is a need, homebirthing is very safe. Indeed the National Institute for Health and Care Excellence in the UK — NICE in the UK — and the RCOG, my other college, the London college, say that homebirth should be the birth of choice for women having their second or subsequent baby who are well and healthy and whose previous pregnancy and birth was uncomplicated. The evidence shows that

³⁷⁸ Australian Nursing and Midwifery Federation (Victorian Branch), submission no. 67, p. 16. See also: Monash Health, submission no. 77, p. 2.

³⁷⁹ Department of Health and Human Services, *Implementing a public home birth program: Guidance for Victorian public health services*, Victorian Government, Melbourne, August 2015.

³⁸⁰ R Zielinski, K Ackerson and L Kane Low, ‘Planned home birth: benefits, risks, and opportunities’, *International Journal of Women’s Health*, vol. 7, 2015, pp. 361–377.

³⁸¹ Associate Professor Michael Stewart, Director, Paediatric Infant Perinatal Emergency Retrieval Service, Family and Community Development Committee public hearing – Melbourne, 5 February 2018, transcript of evidence, p. 11.

for women having their second baby, where they have had a previously healthy pregnancy and normal birth, their birth is more likely to be uncomplicated at home than it is in hospital.³⁸²

At a public hearing in Melbourne, Dr Michael Rasmussen, Clinical Services Director at Mercy Hospital for Women (Mercy Health), expressed concerns about the safety of homebirths:

If the numbers of women asking for homebirth is increasing, I think we are not giving them what they need in the hospital. That would be my view. The safety of homebirth is something we can debate. The numbers will never be enough to have an accurate assessment of maternal risk. There have been numerous reports from Europe, in particular from Holland, purporting the safety of homebirth in their circumstance. I do not know that we can transpose that here to our circumstance with distances and so forth. We do not facilitate homebirth at either site at the moment. We do not have plans to. Our door is open for women who are attempting to birth at home. Where things go wrong, our door is open and we will continue their care when they do arrive. In all honesty, I think we have tried to put our focus on providing homelier and more women and family-friendly services within the hospital than trying to introduce a homebirth service as well.

Maybe in the future circumstances will change, but as an obstetrician I have some concerns about its safety given the unpredictability of haemorrhage in particular and the unpredictability of needing help for a baby that is suddenly born flat. You are very isolated at home, and that worries me, but that there is a request out there for it means it is something we have to respond to and listen to. We have tried to do that through our MGP — midwifery group practice — programs and through our team midwifery care and through how we have set up our labour ward.³⁸³

Dr Jacqui Smith, Director Medical - Perinatal at PIPER, told the Committee:

It is quite safe for women having their second or third baby who have had a previous straightforward birth to birth at home, providing they are close to a hospital where they can be removed if there is any difficulty and they accept that it is not a zero risk situation; it is a low risk but not a zero risk situation. But it brings a whole lot of other personal benefits for them. If there was a way in which we [PIPER] could support it more, I would have no objections to it. But I think we are unnecessarily inserting ourselves into a relationship that does not really need to be disturbed.³⁸⁴

Ms Laura Stubbings said in her submission that the language needs to change around homebirths and midwifery care ‘to talk less about emotive issues and more about statistics and evidence based practice’.³⁸⁵ She noted:

Home birth lobby movement is perceived as radical and irresponsible in Australia, even though statistically homebirth is [a] safe option for low risk women. Therefore we would like to see publicly-funded homebirth programs in Victoria.³⁸⁶

³⁸² Professor Euan Wallace, Chief Executive Officer, Safer Care Victoria, Family and Community Development Committee public hearing – Melbourne, 27 November 2017, transcript of evidence, pp. 9-10.

³⁸³ Dr Michael Rasmussen, Clinical Services Director, Mercy Hospital for Women (Mercy Health), Family and Community Development Committee public hearing – Melbourne, 16 October 2017, transcript of evidence, pp. 8-9.

³⁸⁴ Dr Jacqui Smith, Director Medical - Perinatal, Paediatric Infant Perinatal Emergency Retrieval Service, Family and Community Development Committee public hearing – Melbourne, 5 February 2018, transcript of evidence, p. 11.

³⁸⁵ Ms Laura Stubbings, submission no. 27, p. 5.

³⁸⁶ Ibid.

The Committee heard that the closure of the maternity services of some hospitals, such as Healesville, led to an increase in the use of homebirths as women wanted to avoid the stress of travelling long distances to give birth.³⁸⁷

Importantly, private midwives do not have professional indemnity insurance to cover births, only antenatal and follow-up care.³⁸⁸ Ms Elizabeth Murphy told the Committee at a public hearing in Bendigo:

There is no professional indemnity insurance for homebirth, so the Australian Health Practitioner Regulation Agency — AHPRA — has given eligible midwives an exemption from requiring professional indemnity insurance for homebirth. It is actually a worldwide problem; all over the world there is no professional indemnity insurance for homebirth. We do have professional indemnity insurance for antenatal care and postnatal care, and that costs about \$3000 a year...³⁸⁹

The Committee notes this is an ongoing issue, and further notes the statement from the Commonwealth Health Minister's office of an intention to implement a long-term solution.³⁹⁰ The Committee supports a long term solution, agreeing with the Maternity Services Review 2009's statement that 'a situation where a health profession operates without appropriate professional indemnity cover is not considered acceptable'.³⁹¹

2.6 Women's birthing rights

During public hearings, the Committee heard of instances where women did not give consent or were not asked for consent for procedures. At a public hearing in Bendigo, Ms Elizabeth Murphy, a midwife at The Midwife Collective, told the Committee that vaginal examinations are often performed without proper consent and that women are coerced into having painful examinations that they do not want and do not often need.³⁹²

Furthermore, the Committee also heard that in some cases, a woman's well thought out birth plan was disregarded.³⁹³ Ms Megan Rickard told the Committee at a public hearing in Wangaratta:

I pride myself on educating myself on issues that affect me and my family. I knew every single possible complication that could have happened with me and Max, made an educated, informed decision about the birth of Max and had a comprehensive, detailed and well-developed birth plan that was completely disregarded. I knew that there would be a high chance that Max would be born with hypoglycaemia. I had

³⁸⁷ Save Healesville Hospital Action Group, submission no. 43, pp. 7-8. See also: Yarra Valley Midwives, submission no. 39, p. 2.

³⁸⁸ Department of Health and Human Services, 'Homebirth', Better Health Channel, Victorian Government, accessed 21 March 2018, <<https://www.betterhealth.vic.gov.au/health/servicesandsupport/homebirth>>.

³⁸⁹ Ms Elizabeth Murphy, Midwife, The Midwife Collective, Family and Community Development Committee public hearing – Bendigo, 24 October 2017, transcript of evidence, p. 4.

³⁹⁰ J Taylor and R Armitage, 'Homebirths: Health ministers 'working' to save practice ahead of insurance exemption deadline', ABC News online, 30 August 2017 accessed 8 May 2018, <<http://www.abc.net.au/news/2017-08-30/health-ministers-working-to-save-private-homebirths/8842348>>.

³⁹¹ Department of Health and Ageing, *Improving Maternity Services in Australia: The Report of the Maternity Services Review*, Australian Government, Canberra, 2009, p. 54.

³⁹² Ms Elizabeth Murphy, Midwife, The Midwife Collective, Family and Community Development Committee public hearing – Bendigo, 24 October 2017, transcript of evidence, p. 4.

³⁹³ Ms Megan Rickard, Family and Community Development Committee public hearing – Wangaratta, 25 October 2017, transcript of evidence.

an action plan that I developed in consultation with the wonderful women at the lactation clinic, paediatricians, obstetricians and my endocrinologist. I am appalled that such an important, well-informed document was essentially thrown to the side and all of my hard work and research did not matter to any of the staff on duty.³⁹⁴

Ms Rickard also told the Committee that her son Max was given formula against her wishes and ‘without consent’ and that he had an invasive procedure done on him without her or her husband’s consent.³⁹⁵

The Committee heard from Ms Kate Ravenscroft at a public hearing in Melbourne about her traumatic birth experience at the Mercy Hospital for Women in Heidelberg and the lack of information and choice she was given during the birth of her daughter:

Nobody told me that my daughter was posterior. At a point during the birth the midwife had called in the doctor and they were trying to turn the baby. I kind of realised that I had read about posterior labour and that must have been what was happening, but nobody explained that to me or what that meant and what was happening. I was given an episiotomy. Again nobody told me about this before it was done. I found out after it had been done that that is what had been done, so my consent was not sought for that procedure. I was not informed, consulted, given any choices; it was just done and then I was informed afterwards, as I was being stitched up, that that is why I was being stitched up.³⁹⁶

Ms Ravenscroft described not being addressed by the doctor, which she said was ‘a really dehumanising experience’ to be ‘sort of treated like I was invisible or somehow irrelevant to the process’.³⁹⁷ Ms Ravenscroft told the Committee that being informed, respected and acknowledged, having continuity of care, being able to ask questions, having consent sought for her episiotomy, and being involved in the decision-making would have made a big difference to her experience of giving birth. She told the Committee:

[T]hinking about my birth experience, it really seems to me that what would have made a difference, what would have prevented a difficult but ultimately deeply rewarding process from becoming a traumatic process, was really simple: if I had just had medical professionals who spent more time talking to me, keeping me informed, consulting me throughout the process; if I had had a midwife at the labour who had known me during the pregnancy and I had known them, so just some familiarity, some continuity of care; if there had just been time and opportunity within that experience of labouring for me to ask questions, to be informed, to be given choices and to be consulted and involved in the decision-making process; if the doctor had introduced himself, had addressed me directly, had treated me as somebody who was relevant and important and a participant in the process rather than, I guess, somebody who was just there and acted upon; if the consent had been sought for the episiotomy and if it had been explained to me why it needed to be done and I had just been consulted and involved in that process; and similarly with the posterior labour, if I had been informed and involved, if I had been able to be more active and in control and I guess respected ultimately by the people that were providing me with care.³⁹⁸

³⁹⁴ Ibid., p. 3.

³⁹⁵ Ibid., p. 2.

³⁹⁶ Ms Kate Ravenscroft, Family and Community Development Committee public hearing – Melbourne, 4 September 2017, transcript of evidence, p. 2.

³⁹⁷ Ibid., p. 3.

³⁹⁸ Ibid.

In sharp contrast to her experience in the maternity ward, Ms Ravenscroft described being informed and involved in her daughter's care in the neonatal intensive care unit at the same hospital. Each day, her daughter's doctors met with her and her husband to explain what was happening, and they took time to involve and inform Ms Ravenscroft:

We felt really respected and supported by the entire team in the neonatal intensive care unit. The nurses were available; they were really responsive. We could ask any questions at any time. We could get support if we were concerned about anything or did not understand anything... The nurses taught us how to take her temperature and involved us as much as possible in her care so we really felt part of things. At every moment it really felt like all of the medical professionals involved in her care were deeply invested in us and in ensuring the best possible outcomes for us as a family.³⁹⁹

In their submission to the Inquiry, the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) recommended that the principle of informed choice for women guide choices in maternity care.⁴⁰⁰ They stated:

Choices in maternity care have historically been made on behalf of women, rather than by women. RANZCOG believes that women should be offered information on the full range of options available to them throughout pregnancy, birth and the postnatal period. This information should include the models of care available locally, screening tests available during pregnancy, and information about birth and postnatal care.⁴⁰¹

Their submission cited an important recent judgement in the United Kingdom which upheld the principle of free choice for pregnant women in deciding what they wanted in pregnancy care and childbirth. The submission states:

The importance of providing informed care regarding mode of delivery has been highlighted in a very important recent judgement in the United Kingdom in 2015 (Montgomery v. Lanarkshire Health Board). In this case, a woman was not given an option of elective caesarean section for a macrosomic diabetic pregnancy. In summing up, the justice stated: "Whatever Dr McLellan may have had in mind, this does not look like a purely medical judgment. It looks like she judged that vaginal delivery is in some way morally preferable to a caesarean section: so much so that it justifies depriving the pregnant woman of the information needed for her to make a free choice in the matter."² It is now accepted that women show considerable diversity in their choices around childbirth³ and such diversity should be respected while providing information free of prejudice or bias.⁴⁰²

The Committee believes that it is important for women to have choice of care where possible, and the Committee heard that there were instances where women had not given informed consent for procedures. Thus, the Committee recommends that:

RECOMMENDATION 2.4: The Victorian Government, through the Department of Health and Human Services, conduct a state-wide review of public hospitals' policies and procedures with respect to the rights of birthing mothers, including the right to informed consent.

³⁹⁹ Ibid.

⁴⁰⁰ Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG), submission no. 35, p. 1.

⁴⁰¹ Ibid.

⁴⁰² Ibid.

2.7 Antenatal programs for pregnant women, fathers and families

Antenatal programs (also known as birth education, prenatal, or parenting classes) help parents prepare for labour, birth and parenthood. These programs, often run by hospitals, include information about what to expect with labour and birth, advice on relaxation techniques, and breastfeeding advice. The Australian Breastfeeding Association also holds classes for pregnant women to prepare them for breastfeeding.⁴⁰³

The Committee heard that antenatal classes at hospitals were popular and were sometimes fully booked and unavailable to new mothers. Ms Ravenscroft told the Committee at a public hearing in Melbourne:

We went to some classes through the hospital. We could not book into a number of them because they were full. They were in very high demand. I think for a lot of services through the Mercy you almost had to have booked in before you even knew you were pregnant because they were so in demand. We did go along to I think it was two sessions of an antenatal class where they did speak about birth and just different sort of pain options and ran through a whole range of things. It was, again, I just feel, a bit 'one size fits all', throwing a whole lot of information at you. I think each session was 4 hours, which is a long time, and when it is all kind of abstract — when you have not given birth before and you have not been through any of it — it is quite hard to make that a really useful experience, I think. So again, as I said, when I realised that my baby must be posterior and that was what was happening and why the doctor was doing these things, I could go back to having received that information at different points.⁴⁰⁴

The unavailability of antenatal classes meant that other pregnancy support services were providing this service. At a public hearing in Melbourne, Ms Helen Parker, Director of The Babes Project, spoke about her organisation providing antenatal education to fill gaps where hospitals were full:

[M]ost of our referrals are for labour education — antenatal and labour education — but because the hospitals are full or they are cost prohibitive and the women are just not able to access them. When we started looking at why we were getting all these hospital referrals it was because they do not have access to more antenatal education and labour education. We do function with midwives, we have a social worker — it depends on the centre; they are all different — nurses, and we do deliver an antenatal and labour education program because what we started to see when we were birthing with some women in hospital was they had been given information but they had not retained information.⁴⁰⁵

At a public hearing in Wangaratta, the Committee heard from Ms Alice Martin, who was at the hearing as a representative of the local Australian Breastfeeding Association for Wangaratta and district. She told the Committee that the ABA would

⁴⁰³ Australian Breastfeeding Association, 'Breastfeeding education classes', accessed 21 March 2018, <<https://www.breastfeeding.asn.au/classes>>.

⁴⁰⁴ Ms Kate Ravenscroft, Family and Community Development Committee public hearing – Melbourne, 4 September 2017, transcript of evidence, p. 6.

⁴⁰⁵ Ms Helen Parker, Director, The Babes Project, Family and Community Development Committee public hearing – Melbourne, 5 February 2018, transcript of evidence, pp. 3-4.

love to have ‘access to mothers before they have their babies’, noting that by the time they deliver their talk to maternal and child health groups (when those babies are between six and 12 weeks old), it is ‘too late’:

I think there is a lack of antenatal support in this region. My plan was to birth in Benalla, which went a little haywire, but there was a half-hour breastfeeding class that I elected to attend with two other women. The class itself was not particularly well run. No practical information was given. Most of the information was around what will happen when your baby comes here: ‘You will understand when your baby’s here. You won’t really get this until you actually have your baby’. There are so many incredible resources available for antenatal breastfeeding information, and those could definitely be better utilised in these contexts.

At the moment the Australian Breastfeeding Association deliver a talk to maternal and child health groups, and those babies are usually between six and 12 weeks old. What we are finding is that that is too late. By six weeks many women have encountered problems and have either stopped breastfeeding or are on the road to cease breastfeeding. That creates a difficulty for us; in particular, we have to be incredibly careful about the language that we use at those maternal and child health talks so as not to discriminate against these women and so as not to exacerbate any discomfort or pain that they are feeling around grieving that breastfeeding journey that has not met their own personal goals.⁴⁰⁶

The Committee also heard that antenatal classes often did not cover mental health issues that may arise during the perinatal period. Ms Terri Smith from Perinatal Anxiety and Depression Australia (PANDA) told the Committee of the need to incorporate mental health awareness into antenatal classes, just like other physical health issues:

No woman will get through her pregnancy without knowing about gestational diabetes; you simply will not. It is actually less common than perinatal depression and anxiety in the antenatal period, but you will not get through your pregnancy without someone having mentioned it. With the antenatal education classes, nurses commonly tell us that women do not want to hear about it. We do not want to hear about mammograms or Pap smears, but we talk about those things for really good reasons. So I think we have still got a long way to go in prioritising mental health as an issue that is at least equal to physical health issues.⁴⁰⁷

The Committee heard that Perinatal Emotional Health Program (PEHP) staff, discussed in Chapter Three, participate in a range of antenatal and postnatal education, early intervention and health promotion activities, such as new parent groups and antenatal classes.⁴⁰⁸ Ms Jenny Ahrens, Operations Director, Northeast and Border Mental Health Services, told the Committee at a public hearing in Wangaratta about the difficulty she initially had in trying to incorporate mental health education into antenatal classes. She noted that things have come a long way since those days, and credited PEHP with enhancing the working relationship between their mental health services and maternity services:

⁴⁰⁶ Ms Alice Martin, Australian Breastfeeding Association, Family and Community Development Committee, public hearing – Wangaratta, 25 October 2017, transcript of evidence, p. 2.

⁴⁰⁷ Ms Terri Smith, Chief Executive Officer, Perinatal Anxiety and Depression Australia, Family and Community Development Committee public hearing – Melbourne, 16 October 2017, transcript of evidence, p. 7.

⁴⁰⁸ South West Healthcare, submission no. 70, p. 3; Northeast Border Mental Health Service, submission no. 49, p. 2.

When I look back to my first experience of capacity building, that was attending the maternity ward at North East Health and saying, ‘Would I be able to come and talk at the antenatal classes about mental health?’. And they were going, ‘Absolutely not!’. They nearly bundled me out. They said, ‘Women aren’t interested in that. They just want to know about labour and birth’. This is even though 10 to 20 per cent of them have emotional health problems after birth.⁴⁰⁹

Ms Fiona Pilkington, Perinatal Emotional Health Clinician at Albury Wodonga Health, told the Committee at a public hearing in Wangaratta about the antenatal education they provide:

Antenatal education is our core business. We need to provide universal education as we cannot effectively predict who is going to be affected by mental health issues in the perinatal period. It is an opportunity to see the couple and have a conversation about emotional health, adjustment issues, perinatal depression and anxiety. At antenatal education we talk about the realities of parenting and try to reduce the couple’s expectations, because they are often very unrealistic. We talk about strategies to improve or maintain the couple’s relationship, including communication skills, problem solving and how they can support each other during a vulnerable time. But probably most importantly it is an opportunity again to introduce our service. We know that people are more likely to contact if they know who are they going to get on the other end of the phone, and we certainly received lots of self-referrals via the antenatal classes. It is well received by the clients, and that is indicated in the surveys that the antenatal classes send out. We also attend the new parents group and talk about the challenges of being a new parent, strategies to assist, mental health issues, and we actively encourage women, again, to self-refer to our service.⁴¹⁰

The Committee is concerned at evidence that antenatal classes are fully booked, preventing some families from accessing important antenatal education. The Committee believes all families should have access to antenatal education through Victoria’s public health system. While mental health will be discussed in more detail in Chapter Three, the Committee acknowledges the importance of mental health education and awareness given the prevalence of mental health conditions during the perinatal period. The Committee believes that antenatal classes should provide women and their partners with information and resources on mental health. Thus, the Committee recommends that:

RECOMMENDATION 2.5: The Victorian Government fund the expansion of antenatal classes across the public health system, and those classes include a focus on education on the social, physical and emotional changes that come with having a baby.

⁴⁰⁹ Ms Jenny Ahrens, Operations Director, Northeast and Border Mental Health Services, Family and Community Development Committee, public hearing – Wangaratta, 25 October 2017, transcript of evidence, p. 2.

⁴¹⁰ Ms Fiona Pilkington, Perinatal Emotional Health Clinician, Albury Wodonga Health, Family and Community Development Committee, public hearing – Wangaratta, 25 October 2017, transcript of evidence, p. 4.

2.8 Breastfeeding in Victoria

The World Health Organization (WHO) recommends exclusive breastfeeding for babies to six months of age and for breastfeeding to continue for two years and beyond to achieve optimal growth, health, and development.⁴¹¹ Similarly, the Australian National Health and Medical Research Council recommends exclusive breastfeeding for around six months and then for breastfeeding to continue until 12 months of age and beyond ‘for as long as the mother and child desire’.⁴¹²

The breastfeeding rate in Victoria at four months is 38.5 per cent, which is below the national average of 39.2 per cent.⁴¹³ The exclusive breastfeeding rates in Victoria at four months are below the World Health Organization target of 50 per cent exclusive breastfeeding at six months. The Australian Capital Territory has the highest breastfeeding rate at four months (50.7 per cent) and Western Australia has the lowest breastfeeding rate at four months (36.7 per cent).⁴¹⁴

In relation to breastfeeding outcomes reported to the Victorian Perinatal Data Collection (VPDC), the Consultative Council on Obstetric and Paediatric Mortality and Morbidity’s *Victoria’s mothers, babies and children 2016* report noted:

95 per cent of women who gave birth to term liveborn babies initiated breastfeeding. Of these babies, 25 per cent in public hospitals and 38 per cent in private hospitals were given infant formula in hospital, and 77 per cent of term breastfed babies had the last feed before they went home directly and entirely from the breast.⁴¹⁵

The report also states:

Giving infant formula in the first 48 hours of life to breastfed babies has been shown to reduce the duration of breastfeeding (Parry et al. 2013). The very high proportion of babies given formula in hospital suggests there are opportunities to reduce this risk factor for early weaning.⁴¹⁶

2.8.1 Benefits of breastfeeding

Throughout the Inquiry, the Committee heard about the nutritional, physical, social and emotional benefits of breastfeeding. At a public hearing in Warragul, Ms Marilyn Humphrey, Maternal and Child Health Coordinator with Baw Baw Shire Maternal and Child Health Services, told the Committee:

⁴¹¹ World Health Organization, Exclusive breastfeeding for six months best for babies everywhere, Geneva: World Health Organization, statement, 15 January 2011, accessed 28 March 2018, <http://www.who.int/mediacentre/news/statements/2011/breastfeeding_20110115/en>.

⁴¹² National Health and Medical Research Council, Infant Feeding Guidelines: information for health workers, National Health and Medical Research Council, Canberra, 2012, p. 1, accessed 28 March 2018, <<https://www.nhmrc.gov.au/guidelines-publications/n56>>.

⁴¹³ Australian Breastfeeding Association, correspondence, dated 8 September 2017.

⁴¹⁴ Ibid.

⁴¹⁵ Note: the report states that longer term outcomes are not reported to the VPDC as most women leave public hospitals within two days of giving birth. Consultative Council on Obstetric and Paediatric Mortality and Morbidity (CCOPMM), *Victoria’s mothers, babies and children 2016*, Melbourne, 2017, p. 44.

⁴¹⁶ Consultative Council on Obstetric and Paediatric Mortality and Morbidity (CCOPMM), *Victoria’s mothers, babies and children 2016*, Melbourne, 2017, p. 46.

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.⁴¹⁷

The Committee heard that rates of obesity in children rises with a reduction in breastfeeding.⁴¹⁸ The Committee also heard that breastfeeding has a protective effect against postnatal depression. Dr Susan Tawia, Manager of Breastfeeding Information and Research at the Australian Breastfeeding Association, told the Committee that breastfeeding provides many benefits for mothers:

Breastfeeding is also important for mothers. It benefits them, it reduces the risk of breast cancer and it is likely to reduce the risk of ovarian cancer and diabetes. Breastfeeding is protective of maternal mental health because it buffers against negative mood, decreases anxiety and downregulates the stress response. Being breastfed is important for the babies of depressed mothers because it encourages mothers to interact with their babies, which may ameliorate adverse effects on their babies.⁴¹⁹

2.8.2 Women's experiences of breastfeeding

Many women reported receiving conflicting and inconsistent advice regarding breastfeeding, this was particularly the case where there was a lack of continuity of care and women were cared for by multiple health practitioners.⁴²⁰ Ms Hilary Skelton said in her submission:

Mothers are mainly assisted with breastfeeding by multiple midwives. The problem with this is that every midwife has a different approach to breastfeeding and being given conflicting information can be very confusing.⁴²¹

Ms Skelton noted that breastfeeding advice while in hospital was confusing and frustrating and recommended that every mother be allocated several hours of funded time with an International Board Certified Lactation Consultants (IBCLC) for both pre and post-natal consultations, something Ms Skelton did privately.⁴²²

At a public hearing in Warrnambool, Ms Kerrie Donlon told the Committee about the emotional challenges she faced after the birth of her second child, and how valuable the breastfeeding experience was for her, despite being discouraged from breastfeeding:

⁴¹⁷ Ms Marilyn Humphrey, Maternal and Child Health Coordinator, Baw Baw Shire Maternal and Child Health Services, Family and Community Development Committee public hearing – Warragul, 8 December 2017, transcript of evidence, p. 4.

⁴¹⁸ Ms Helen Lees, Maternal and Child Health Clinical Coordinator, City of Greater Bendigo, Family and Community Development Committee public hearing – Bendigo, 24 October 2017, transcript of evidence, p. 5.

⁴¹⁹ Dr Susan Tawia, Manager, Breastfeeding Information and Research, Australian Breastfeeding Association, Family and Community Development Committee public hearing – Melbourne, 4 September 2017, transcript of evidence, p. 3. See also: Australian Nursing and Midwifery Federation (Victorian Branch), submission no. 67, p. 8.

⁴²⁰ Ms Hilary Skelton, submission no. 72, p. 1; Dr Joe Garra, submission no. 15, p. 4; Name withheld, submission no. 85, p. 1.

⁴²¹ Ms Hilary Skelton, submission no. 72, p. 1. See also: Dr Joe Garra, submission no. 15, p. 4.

⁴²² Ms Hilary Skelton, submission no. 72, p. 1.

The overwhelming feelings of not feeling bonded or attached to my child were frightening. I could not hear the cries. I could not settle the cries. My sense of smell was lost, and the joy had gone. My glass was empty, and I was exhausted. Breastfeeding was something that I knew I could do. It did not require any preparation, and I knew it would be a way to connect with my baby. So I persisted, trying to ignore all the advice to stop — ‘You can’t breastfeed after blood transfusions, you are too unwell, you need to rest, just give baby artificial milk during the night et cetera’. I am lucky because of that midwife and lactation consultant who visited me in the ward five weeks postpartum, who said while I was breastfeeding, ‘You need to look at your baby. Start with the eyelids. You are doing a wonderful job’.⁴²³

Ms Megan Rickard, who has type 1 diabetes, told the Committee at a public hearing in Wangaratta about her desire to breastfeed her son Max after he was born via an elective caesarean section:

Complications and incompetence first began when I was in recovery. I was teamed with a graduate midwife on her first shift at Northeast Health. She had very little knowledge of type 1 diabetes, the possible complications and risks to me, but more importantly to Max. ... Whilst recovering from major surgery I had to take the lead and ask the nurse to check Max’s blood sugar. When she finally did this, his blood sugar read low, meaning it was below 1.1 millimoles, a dangerous level for a baby who had been born less than an hour ago. I told her I needed to breastfeed Max, something I am very passionate about, to which she replied, ‘Perhaps we should give him some formula’. When I politely refused and asked her to assist me with breastfeeding, she scoffed and said, ‘You’re one of those mothers’.⁴²⁴

Her son’s health deteriorated and he was eventually taken to the special care nursery, given formula without her consent, and later flown to the Royal Women’s Hospital in Melbourne. Ms Rickard stated that this was ‘without a doubt the single most traumatic and mentally debilitating thing that has ever happened’ to her, as she was separated from her son. She said she ‘was not offered any support after giving birth’ and ‘did not get any help establishing breastfeeding from the midwives’. Ms Rickard told the Committee she had to ask multiple times to get medication and a breast pump.⁴²⁵

At a public hearing in Melbourne, Ms Elizabeth Mazeyko, a volunteer bicultural doula at Birth for HumanKIND, told the Committee about her experience as a migrant from Uruguay, South America, giving birth in Australia without support. Her baby was born with a cleft palate:

Once they had explained that the baby had a cleft palate, they sent me home four days later — and remember I had no support, I could not speak English. I did not know how to breastfeed the baby properly because every time the baby was put on the breast, the baby’s milk was coming through their nose. It was really very hard for me to deal with that situation.⁴²⁶

⁴²³ Ms Kerrie Donlon, Family and Community Development Committee public hearing – Warrnambool, 11 October 2017, transcript of evidence, p. 3.

⁴²⁴ Ms Megan Rickard, Family and Community Development Committee public hearing – Wangaratta, 25 October 2017, transcript of evidence, p. 2.

⁴²⁵ Ibid.

⁴²⁶ Ms Elizabeth Mazeyko, Volunteer Bicultural Doula, Birth for HumanKIND, Family and Community Development Committee public hearing – Melbourne, 16 October 2017, transcript of evidence, p. 5.

The Committee also heard that some GPs did not have the knowledge to assist women in continuing to breastfeed. At a public hearing in Warrnambool, Ms Jane Perry told the Committee:

It seems to be — this is anecdotally from talking to other Victorian mothers — that some mothers come across GPs who really will not encourage them to breastfeed and do not have a good knowledge and understanding of breastfeeding and how it works. I have talked to one mother, for example, whose GP told her that she did not have enough milk, based on the background of her baby being fussy and crying at two weeks old and the GP observing her baby falling asleep at the breast. This is at age two weeks old, which is biologically normal behaviour. So it is a bit worrying that the education does not seem to be there and that to get proper breastfeeding education and understanding it almost relies on a GP's own interest in breastfeeding and what continual professional development they undertake.⁴²⁷

The Committee heard that some hospitals had been proactive in supporting women to breastfeed whose babies are in neonatal intensive care (NICU) or special care nurseries. Ms Ravenscroft told the Committee about her experience when her daughter was in NICU:

One of the nurses arranged for the lactation consultant in the hospital to visit me by our daughter's bedside in the neonatal intensive care unit to support the establishment of breastfeeding, because we did not have an ordinary start to breastfeeding with her being in NICU.⁴²⁸

Likewise, Ms Suzanne Hartney told the Committee that the new nursery at Bendigo Health encouraged breastfeeding and that the lactation consultants visit the special care nursery to promote breastfeeding:

We are fortunate to have four parent zone rooms, where breastfeeding mothers can stay with their babies 24 hours a day. There is a pull-out bed for them and their meals are provided during that time. It is a fantastic service for families, allowing them to stay together and to promote breastfeeding.⁴²⁹

The health benefits of breastfeeding are well documented. Low rates of breastfeeding lead to higher rates of chronic diseases, for example diabetes, and adverse health outcomes, such as obesity, which impact directly on costs to the health system. The Committee believes that more advertising and promotion of breastfeeding in the community is required, and that it is time for a state-wide campaign to encourage breastfeeding in Victoria. Thus, the Committee recommends that:

RECOMMENDATION 2.6: The Victorian Government prioritise a public health promotion campaign to encourage breastfeeding and increase breastfeeding rates across Victoria.

⁴²⁷ Ms Jane Perry, Family and Community Development Committee public hearing – Warrnambool, 11 October 2017, transcript of evidence, p. 2. See also: Ms Ruth Berkowitz, submission no. 90, p. 2.

⁴²⁸ Ms Kate Ravenscroft, Family and Community Development Committee public hearing – Melbourne, 4 September 2017, transcript of evidence, p. 3.

⁴²⁹ Ms Suzanne Hartney, Family and Community Development Committee public hearing – Bendigo, 24 October 2017, transcript of evidence, p. 2.

2.8.3 Victorian Breastfeeding Guidelines

In 2014, a major revision of the previous Victorian Breastfeeding Guidelines (1998) was released.⁴³⁰ These guidelines for health professionals provide comprehensive information on breastfeeding, including the physiology of breastfeeding, breastfeeding advice during pregnancy, guidance for establishing breastfeeding, routine breastfeeding assessments, and breastfeeding issues. The Guidelines state:

Victorian women receive perinatal care from a range of health professionals that include midwives, general practitioners, nurses, obstetricians, paediatricians, and maternal and child health nurses. Women often describe breastfeeding information and advice as inconsistent. These guidelines are a source of evidence-based breastfeeding information for health professionals to use when working with women and their families during the continuum of breastfeeding.⁴³¹

At a public hearing in Melbourne, Dr Tawia made several recommendations to increase breastfeeding rates in Victoria, including that the Victorian Breastfeeding Guidelines be implemented.⁴³² About the Guidelines, she said:

They have been here since 2014... The guidelines state the purpose of them is to protect, promote and support breastfeeding in Victoria. They are a readily accessible, concise guide to help professionals who work with pregnant and breastfeeding women. These guidelines are a source of evidence-based breastfeeding information for health professionals to use when working with women and families during the continuum of breastfeeding. The work has been done.⁴³³

The Committee was disappointed to hear that many women were not given the information and support they needed to breastfeed by health practitioners, including midwives and GPs. This is despite the Victorian Breastfeeding Guidelines containing comprehensive information to guide practitioners. Thus, the Committee recommends that:

RECOMMENDATION 2.7: The Victorian Government develop and fund specific training for health professionals, including midwives and GP obstetricians, on supporting mothers to breastfeed.

The Committee believes lactation education and support can also be improved with an increased focus at the university level for nurses and midwives, including Maternal and Child Health nurses. Accordingly, the Committee recommends that:

RECOMMENDATION 2.8: The Victorian Government request lactation education and support be included in the core syllabus in university training for nurses and midwives, including Maternal and Child Health nurses, by making submissions to the Australian Nursing and Midwifery Education Council's reviews of nursing and midwifery education standards.

⁴³⁰ Department of Education and Early Childhood Development, *Promoting Breastfeeding: Victorian Breastfeeding Guidelines*, Victorian Government, Melbourne, June 2014.

⁴³¹ *Ibid.*, p. 1.

⁴³² Dr Susan Tawia, Manager, Breastfeeding Information and Research, Australian Breastfeeding Association, Family and Community Development Committee public hearing – Melbourne, 4 September 2017, transcript of evidence, pp. 4-5.

⁴³³ *Ibid.*

2.9 The Baby Friendly Health Initiative

The Baby Friendly Health Initiative (BFHI) was launched by the World Health Organization (WHO) and UNICEF in 1991. It aims to promote and support breastfeeding and is ‘a worldwide evidence-based project that educates and supports health professionals that work with breastfeeding mothers’.⁴³⁴ As at 18 December 2017, the following nine hospitals were BFHI accredited, with all except one hospital being public hospitals:

- Bairnsdale Regional Health Service
- Ballarat Base Hospital (Ballarat Health Services)
- Benalla and District Memorial Hospital (Benalla Health)
- Maryborough District Health Service
- Royal Women’s Hospital
- Sunshine Hospital (Western Health)
- The Bays Healthcare (formerly Hospital) – private hospital
- West Gippsland Healthcare Group
- Hamilton Hospital (Western District Health Service).

Gaining BFHI accreditation includes a framework of ten steps to successful breastfeeding.⁴³⁵ Dr Susan Tawia, Manager of Breastfeeding Information and Research at the Australian Breastfeeding Association, told the Committee at a public hearing in Melbourne:

The 10 steps to successful breastfeeding are central to and defining of the Baby Friendly Health Initiative in hospitals. Just to highlight some of the steps: health professionals should encourage breastfeeding early, within an hour of birth, step 4; they should encourage mothers to breastfeed according to their baby’s needs, step 8; health professionals should give no food or drink except breastmilk to newborn babies unless medically indicated, step 6; and hospitals should train all staff in the skills necessary to promote and support breastfeeding, step 2. The Royal Women’s Hospital has taken the lead in Victoria and has been BFHI-accredited continuously since 1994.⁴³⁶

In their submission, the Australian Breastfeeding Association stated that the Ten Steps to Successful Breastfeeding ‘which form the backbone of the BFHI initiative are not consistently followed, even in BFHI-accredited hospitals’, particularly the sixth step, concerning exclusive breastmilk unless medically indicated, and the tenth step, around fostering breastfeeding support groups.⁴³⁷

Ms Bernadette Hammond, Director of Clinical Operations/Chief Nurse and Midwife at Bairnsdale Regional Health Service (BRHS), told the Committee about BRHS’ involvement in the program:

⁴³⁴ Ms Barbara Glare, Warrnambool Breastfeeding Centre, Family and Community Development Committee public hearing – Warrnambool, 11 October 2017, transcript of evidence, p. 5.

⁴³⁵ See Appendix 4.

⁴³⁶ Dr Susan Tawia, Manager, Breastfeeding Information and Research, Australian Breastfeeding Association, Family and Community Development Committee public hearing – Melbourne, 4 September 2017, transcript of evidence, p. 4.

⁴³⁷ Australian Breastfeeding Association, submission no. 64, p. 8.

It is a national program. Not everyone is accredited. It is not mandatory; it is something we choose to do. It really assesses you against criteria that determine, I guess, whether you are providing the best nutritional start for babies. It is not just nutritional, but obviously bonding and family dynamics and things like that. We get assessed against criteria. It is not just, I guess, about breastfeeding, because if women to choose to artificially feed, then we have to demonstrate that those women have been well informed, so they are making a very informed choice about doing that. But it is predominately about encouraging breastfeeding and making sure that babies in the newborn period get the best infant nutrition they can.⁴³⁸

In their submission, the Australian Breastfeeding Association called on the Committee to make BFHI accreditation mandatory in all places that babies are born.⁴³⁹ Both Ms Barbara Glare of the Warrnambool Breastfeeding Centre⁴⁴⁰ and Dr Tawia told the Committee that BFHI has a positive impact. Dr Tawia told the Committee at a public hearing in Melbourne:

We know BFHI has a positive impact on breastfeeding rates. A large-cluster randomised control trial of a BFHI intervention showed that it significantly increased the proportion of mothers breastfeeding throughout the first year and significantly increased exclusive breastfeeding at three and six months.⁴⁴¹

The Committee heard that hospitals would need support to become BFHI accredited. Dr Tawia told the Committee:

The BFHI is a big commitment, and I know that there are hospitals — there are a few accredited facilities. It is a procedure to go through, and they have got to have a full commitment to this. It is costly. They have got to get all the staff on board. So I think in those terms the college of midwives actually administrates the process, and I think they need more support to do that. There are places in Victoria — certainly in Melbourne — that claim they are BFHI-like. So they are happy to be supporting breastfeeding but they have not gone down this process.⁴⁴²

At a public hearing in Warrnambool, the Committee heard from Ms Janene Facey, Maternity Nurse Unit Manager at South West Healthcare, that while South West Healthcare has practices in place to support breastfeeding, they were not re-funded to get BFHI accreditation.⁴⁴³

According to Dr Tawia and Ms Susan Day, President of the Australian Breastfeeding Association, nearly all the maternity hospitals in New Zealand and all of the maternity hospitals in Tasmania are BFHI accredited.⁴⁴⁴ Ms Day told the Committee:

⁴³⁸ Ms Bernadette Hammond, Director of Clinical Operations/Chief Nurse and Midwife, Bairnsdale Regional Health Service, Family and Community Development Committee public hearing – Bairnsdale, 7 December 2017, transcript of evidence, p. 7.

⁴³⁹ Australian Breastfeeding Association, submission no. 64, p. 8.

⁴⁴⁰ Ms Barbara Glare, Warrnambool Breastfeeding Centre, Family and Community Development Committee public hearing – Warrnambool, 11 October 2017, transcript of evidence, p. 5.

⁴⁴¹ Dr Susan Tawia, Manager, Breastfeeding Information and Research, Australian Breastfeeding Association, Family and Community Development Committee public hearing – Melbourne, 4 September 2017, transcript of evidence, p. 4.

⁴⁴² *Ibid.*, p. 9.

⁴⁴³ Ms Janene Facey, Maternity Nurse Unit Manager, South West Healthcare, Family and Community Development Committee public hearing – Warrnambool, 11 October 2017, transcript of evidence, p. 8.

⁴⁴⁴ Dr Susan Tawia, Manager, Breastfeeding Information and Research, Australian Breastfeeding Association, Family and Community Development Committee public hearing – Melbourne, 4 September 2017, transcript of evidence, p. 9; Ms Susan Day, President, Australian Breastfeeding Association, Family and Community Development Committee public hearing – Melbourne, 4 September 2017, transcript of evidence, p. 9.

Tasmania has all of their maternity facilities as BFHI accredited, and whilst there is a cost to become accredited through BFHI, those costs are paid back because when you increase exclusive breastfeeding rates you decrease a lot of other health and ongoing costs. So it does pay for itself, but it requires commitment, and part of BFHI includes educating staff...⁴⁴⁵

The Committee is concerned that so few maternity hospitals are BFHI accredited, and believes that the Victorian Government should support maternity hospitals to seek accreditation with the Baby Friendly Health Initiative and commit to educating staff about breastfeeding and supporting women to breastfeed. Accordingly, the Committee recommends that:

RECOMMENDATION 2.9: The Victorian Government support hospitals to become accredited with the Baby Friendly Health Initiative.

2.10 Barriers to breastfeeding

Throughout the Inquiry, the Committee heard that there are many barriers to breastfeeding, including lack of support and knowledge from health practitioners, lack of lactation consultants, early discharge from hospitals, stigma around breastfeeding, advertising of formula marketing, and mothers returning to work. These issues were raised repeatedly during the Committee's Inquiry by community groups, the Australian Breastfeeding Association, health services, local government maternal and child health service providers, and doctors.⁴⁴⁶ The Committee represents just some of that evidence here.

Ms Samantha Cooke, Community Health Coordinator at Mildura Rural City Council, told the Committee at a public hearing in Mildura:

The return to work is sooner than it used to be as well, so they are having to do other things. It is probably society and the embarrassment that they feel breastfeeding out in public. That is one of the things we hear about a lot. You will often see a poor little baby with a blanket over its head and it is breastfeeding. That is what we are dealing with: how people perceive that out in the community.⁴⁴⁷

At a public hearing in Melbourne, Ms Jodie Ashworth, General Manager of Surgery, Women's and Children's, Operating Theatres and ICU and Chief Nursing Officer at Northern Health, gave some reasons for the 'terrible' breastfeeding rate at Northern Health:

⁴⁴⁵ Ms Susan Day, President, Australian Breastfeeding Association, Family and Community Development Committee public hearing – Melbourne, 4 September 2017, transcript of evidence, p. 9.

⁴⁴⁶ Warrnambool Breastfeeding Centre, submission no. 57, p. 1; Albury Wodonga Health, submission no. 55, p. 2; Australian Nursing and Midwifery Federation (Victorian Branch), submission no. 67, pp. 13–14; Ms Susan Day, President, Australian Breastfeeding Association, Family and Community Development Committee public hearing – Melbourne, 4 September 2017, transcript of evidence, p. 12; City of Whitehorse, submission no. 46, p. 2; Dr Joe Garra, submission no. 15, pp. 1–2; Ms Marilyn Humphrey, Maternal and Child Health Coordinator, Baw Baw Shire Maternal and Child Health Services, Family and Community Development Committee public hearing – Warragul, 8 December 2017, transcript of evidence, p. 4; Save Healesville Hospital Action Group, submission no. 43, p. 6; Ms Barbara Glare, Warrnambool Breastfeeding Centre, Family and Community Development Committee public hearing – Warrnambool, 11 October 2017, transcript of evidence, p. 5.

⁴⁴⁷ Ms Samantha Cooke, Community Health Coordinator, Mildura Rural City Council, Family and Community Development Committee public hearing – Mildura, 9 November 2017, transcript of evidence, p. 7. See also: Ms Marilyn Humphrey, Maternal and Child Health Coordinator, Baw Baw Shire Maternal and Child Health Services, Family and Community Development Committee public hearing – Warragul, 8 December 2017, transcript of evidence, p. 5.

There is a cultural component to it. There is a socio-economic side to it. There is a support side to it. There is the reduced length of stay in that breastfeeding is not really even established in the 2.4 days before they leave. They then have two domiciliary visits, sometimes three if they are a really young mum, but there is very little funding opportunity or scope at the moment to provide a post-lactation service before families are handed over at the six-week mark to maternal and child health. So from day two to the six-week mark there is nothing. There is a gap. By six weeks they are done. They are tired. They are exhausted. They are looking for a perinatal emotional health bed by that stage because the sleep settle is imbalanced, and we have got a whole new problem.⁴⁴⁸

The Committee heard that many women stop breastfeeding because of difficulties that they encounter which could have been addressed with support from their hospital or a lactation consultant. At a public hearing in Wangaratta, the Committee heard from Ms Alice Martin who said that women often receive inconsistent information from health professionals:

When supply is low, for example, women are often given medication to help increase their supply as opposed to diagnosing the issue that is causing low supply. There are very few women who medically have low supply, and often low supply can be caused by a baby failing to adequately drain the breast, which could be caused by something like tongue-tie. Unless a general practitioner, which is usually the first port of call for a lot of these women, then refers onto a service like the lactation clinic or the ABA, women are not being given that information. They are being told offhandedly to just top up with formula if they are seeing something like low weight gains, which is not actually getting to the root of the problem.⁴⁴⁹

Ms Susan Day, President of the Australian Breastfeeding Association, noted that mothers can easily have their confidence eroded in those early days and cease breastfeeding prematurely:

In the first hours and the first two or three days after birth it is a new experience, it is a hazy time and there is not always a lot of knowledge to new mothers on what to actually expect, what is normal breastfed baby behaviour and what is normal behaviour after birth. Babies can be upset, fractious, all these things...

During that time they actually need really skilled, supportive people, particularly the hospital staff, around them so that in the middle of the night when the baby is crying and they are not quite sure how to attach their baby, rather than, 'Oh, it's all too hard. I don't know what to do now. I'll just put the baby on formula because I'm really tired, my baby's upset, something must be wrong', they actually have a skilled lactation support worker coming and guiding them through what needs to happen: 'Actually this is normal behaviour. Let's just calm baby down. Let me show you how to attach your baby, get baby feeding'. These are often crises at the time in the eyes of the mother, but it is, most of the time, quite normal behaviour for the babies, so it is in that time when women are vulnerable that they are not receiving the adequate information and support that they do need.⁴⁵⁰

⁴⁴⁸ Ms Jodie Ashworth, General Manager, Surgery, Women's and Children's, Operating Theatres and ICU and Chief Nursing Officer, Northern Health, Family and Community Development Committee public hearing – Melbourne, 5 February 2018, transcript of evidence, pp. 8-9.

⁴⁴⁹ Ms Alice Martin, Australian Breastfeeding Association, Family and Community Development Committee, public hearing – Wangaratta, 25 October 2017, transcript of evidence, p. 2.

⁴⁵⁰ Ms Susan Day, President, Australian Breastfeeding Association, Family and Community Development Committee public hearing – Melbourne, 4 September 2017, transcript of evidence, p. 5. See also: Australian Nursing and Midwifery Federation (Victorian Branch), submission no. 67, p. 7.

The Committee heard that lactation support for women post-birth was lacking and often inconsistent. Ms Julie Wright, Operational Director of Women’s and Children’s Services at Albury Wodonga Health, raised the issue of access to lactation services:

Breastfeeding rates continue to decline across Victoria. There needs to be more appropriate funding for lactation consultants, and they need to be accessible for all women across the state regardless of where they live. Most maternity services are not in the position due to budgetary limitations to fund full-time lactation services, and it is not unique to regional or rural areas; I have done a little bit of research around Melbourne. Where there are services, they often only run for two or three days a week. We fortunately run ours at four. So it may be of value to consider further funding of these services.⁴⁵¹

Mrs Carmel Riley, the President of Olivia’s Place, a pregnancy support organisation, told the Committee that it was important to develop ‘baby-friendly communities’ which she said ‘are evidenced in the literature to be critical to a longer duration of that breastfeeding journey’.⁴⁵²

2.11 Breastfeeding organisations

The Committee heard from breastfeeding associations and organisations, set up to support women to breastfeed, such as the Australian Breastfeeding Association and the Warrnambool Breastfeeding Centre.

2.11.1 Australian Breastfeeding Association

At a public hearing in Melbourne, the Committee heard from Ms Susan Day, President of the Australian Breastfeeding Association (ABA), and Dr Susan Tawia, Manager of Breastfeeding Information and Research at the ABA.⁴⁵³ The ABA is Australia’s largest not-for-profit breastfeeding information and support service. The ABA has 1,300 trained volunteer counsellors and educators across Australia and 230 local ABA groups which support women to breastfeed in their own communities.⁴⁵⁴ The Committee heard that the ABA receives two million hits on their website annually and receives more than 88,000 calls per year to the National Breastfeeding Helpline, which is staffed 24 hours a day, seven days a week by trained volunteer ABA counsellors.⁴⁵⁵

The ABA’s submission focused on the importance and benefits of breastfeeding for a baby’s development and a mother’s physical and emotional wellbeing. Their submission stated that Victoria falls short of the recommended breastfeeding rates of the World Health Organization (WHO) and the Australian National Health and Medical Research Council (NHMRC). The ABA expressed concern that breastfeeding

451 Ms Julie Wright, Operational Director of Women’s and Children’s Services, Albury Wodonga Health, Family and Community Development Committee public hearing – Wangaratta, 25 October 2017, transcript of evidence, pp. 4-5.

452 Mrs Carmel Riley, president, Olivia’s Place, Family and Community Development Committee public hearing – Warragul, 8 December 2017, transcript of evidence, p. 3.

453 See also Australian Breastfeeding Association, submission no. 64.

454 Dr Susan Tawia, Manager, Breastfeeding Information and Research, Australian Breastfeeding Association, Family and Community Development Committee public hearing – Melbourne, 4 September 2017, transcript of evidence, p. 2.

455 Ibid.

mothers in Victoria are not being supported in their choice to breastfeed and made several recommendations to encourage and support breastfeeding, such as having a Medicare item for lactation consultants and creating breastfeeding friendly environments.⁴⁵⁶

The Committee heard from women who had accessed the ABA's National Breastfeeding Helpline. In her submission, Ms Kate Ravenscroft told the Committee about her experience calling the helpline:

I found the advice line provided by the Australian Breastfeeding Association to be another place that provided me with an opportunity to seek support and advice, to speak frankly and to be listened to and provided with good quality care and information. I am deeply grateful to the advice line provided by the Australian Breastfeeding Association and to the wonderful volunteers who answer the calls and provide practical, compassionate and essential support to mothers navigating the postpartum period. I relied on this service frequently during the early months of my daughter's life and found it to be of much greater assistance than the Maternal and Child Health advice line, which I also called several times.⁴⁵⁷

In his submission, Dr Garra suggested that Skype may help ABA counsellors to watch a mum breastfeed and give advice.⁴⁵⁸

2.11.2 Warrnambool Breastfeeding Centre

At a public hearing in Warrnambool, the Committee heard about the Warrnambool Breastfeeding Centre and the support that it provided to women in the community.⁴⁵⁹ The Committee heard from many mothers who had used the services provided by the Warrnambool Breastfeeding Centre and described the Centre as a 'safe place'.⁴⁶⁰ Ms Jess Stretton told the Committee:

The breastfeeding centre down here is a great relief — to come down here and know that you have got a safe space to go and that it is clean, it is tidy, there is someone to talk to and Barb is there to give me a hand with trying to get her to breastfeed properly. Yes, that is pretty much our story.⁴⁶¹

The Committee heard that many women travelled vast distances to reach the Centre. Ms Alexandra Lenehan told the Committee that going to the Centre was a day trip as it was 30 to 40 minutes away.⁴⁶² Ms Jess Stretton told the Committee that she travelled four hours to get to the Centre with her nine day old baby.⁴⁶³

⁴⁵⁶ Australian Breastfeeding Association, submission no. 64.

⁴⁵⁷ Ms Kate Ravenscroft, submission no. 22, pp. 2-3.

⁴⁵⁸ Dr Joe Garra, submission no. 15, pp. 1-2.

⁴⁵⁹ Ms Alexandra Lenehan, Family and Community Development Committee public hearing – Warrnambool, 11 October 2017, transcript of evidence, p. 2.

⁴⁶⁰ Ibid.

⁴⁶¹ Ms Jess Stretton, Family and Community Development Committee public hearing – Warrnambool, 11 October 2017, transcript of evidence, p. 3.

⁴⁶² Ms Alexandra Lenehan, Family and Community Development Committee public hearing – Warrnambool, 11 October 2017, transcript of evidence, p. 2.

⁴⁶³ Ms Jess Stretton, Family and Community Development Committee public hearing – Warrnambool, 11 October 2017, transcript of evidence, p. 2.

Ms Melissa Maher told the Committee at a public hearing in Warrnambool that she found breastfeeding ‘to be incredibly challenging on both occasions’ but found support from the Warrnambool Breastfeeding Centre.⁴⁶⁴ Ms Maher said:

[T]he centre just provides a safe place to go. When you are sick of being home all day as a new mother, you can go to the centre. Somebody else is always there. There is another mum to talk to. It is a comfortable, easy place to feed your child and to get support. You can get it from maternal and child health nurses, which is just fantastic, but the opportunity to have the breastfeeding centre there, where you can pop in whenever it is convenient for you and you can feel secure in leaving the house and knowing that you do not have to be in the car or at a cafe if you are uncomfortable. For some people it is incredibly difficult, and for me it certainly was.⁴⁶⁵

This aligns with evidence the Committee heard about the personal and emotional support new mothers need, and may not be getting from either Victoria’s medical system or their personal support networks, which are not as extensive as in past generations (see Chapter Three).

Ms Barbara Glare from the Warrnambool Breastfeeding Centre told the Committee about the Centre at a public hearing in Warrnambool:

The breastfeeding centre, despite our best efforts, is completely self-funded. You might have seen in my submission that over the last three years that it has been established — really six since the fundraising began — we have raised more than \$300 000. That money, as I said, fundraised by volunteers, goes directly back to the community to provide services for breastfeeding families — well, let’s face it, for any family, because we are not checking at the door — in this area. On a practical basis the centre offers a clean and safe environment for any parent to feed their baby. We have comfortable chairs, a kitchenette, clean toilets — which can be a rarity around the place — and a warm welcome for anybody. We offer to heat bottles, heat food and just chat, really. We offer such things as discounted breast pump hire, and on Thursday we run a lactation drop-in clinic, where anybody in the community can come, and it is all free — we do not charge the parents for that; it is just part of the service we offer.⁴⁶⁶

Ms Glare told the Committee that the Centre offers ‘connection — connection between parents and the community, between family members and between parent and baby’.⁴⁶⁷

2.12 Lactation consultants

Lactation consultants are health professionals who hold an International Board Certified Lactation Consultants (IBCLC) qualification and often work either in hospitals and child health services or in private practice. Ms Susan Day, President of the Australian Breastfeeding Association, explained that IBCLCs provide specialised care and are different to breastfeeding counsellors:

⁴⁶⁴ Ms Melissa Maher, Family and Community Development Committee public hearing – Warrnambool, 11 October 2017, transcript of evidence, p. 2.

⁴⁶⁵ Ibid.

⁴⁶⁶ Ms Barbara Glare, Warrnambool Breastfeeding Centre, Family and Community Development Committee public hearing – Warrnambool, 11 October 2017, transcript of evidence, p. 2.

⁴⁶⁷ Ibid.

International board-certified lactation consultancy is a professional credential. Australian Breastfeeding Association counsellors are peer counsellors, so it is a different credential. The peer-to-peer support that our breastfeeding counsellors do provides ongoing support and information for what we consider normal, everyday things that happen, and as you see, we get a lot of phone calls. When a mother encounters something outside the scope of normal and she needs specialised care, that is when a peer-to-peer or a breastfeeding counsellor would refer that onto the IBCLC to get that next level of support and care.⁴⁶⁸

Currently, Medicare benefits are not payable for services provided by a lactation consultant. Medicare benefits can be paid for breastfeeding support provided as part of postnatal care by an eligible midwife.⁴⁶⁹ In their submission, the Australian Breastfeeding Association advocated for a Medicare item number for IBCLCs and for streamlined referral pathways for mothers from general practitioners to IBCLCs.⁴⁷⁰ They stated because the services offered by lactation consultants are not covered by Medicare ‘there is a lack of equity of access to lactation support and expertise’.⁴⁷¹

The Committee heard from witnesses who advocated for Medicare coverage to be extended to lactation consultants. At a public hearing in Warrnambool, Ms Jane Perry said to the Committee:

We are very fortunate in Warrnambool that we have a lactation consultant who gives so generously of her time to provide services for free for local mothers, which is almost entirely unheard of. But other mothers, unless they can get access through their hospitals in other areas of regional Victoria, they just say, ‘I can’t afford someone; I’ll just have to try and work it out’. And I think for people of a low socio-economic background, this is just entirely unfair — that they miss out on vital services to achieve their breastfeeding goals based on not being able to afford them. I think some of this might tie into a lack of Medicare rebate that is available for lactation consultants. Therefore lactation consultants do need to charge an appropriate amount for their fees — their professional services. Given that international board certified lactation consultants are breastfeeding experts, it should be that they are remunerated appropriately.⁴⁷²

The Committee acknowledges the importance of lactation consultants in facilitating breastfeeding in Victorian women. The Committee wants hospitals to focus on ensuring that they have sufficient lactation consultants on staff or available to provide that service to their clients. The Committee makes a recommendation on this topic later in the chapter.

⁴⁶⁸ Ms Susan Day, President, Australian Breastfeeding Association, Family and Community Development Committee public hearing – Melbourne, 4 September 2017, transcript of evidence, p. 6.

⁴⁶⁹ Australian Government, Department of Health, ‘Eligible midwives questions and answers’, accessed 7 June 2018, <<http://www.health.gov.au/internet/main/publishing.nsf/Content/midwives-nurse-pract-qanda>>.

⁴⁷⁰ Australian Breastfeeding Association, submission no. 64, p. 9.

⁴⁷¹ *Ibid.*, p. 12.

⁴⁷² Ms Jane Perry, Family and Community Development Committee public hearing – Warrnambool, 11 October 2017, transcript of evidence, p. 2.

2.12.1 Hospital lactation clinics

The Committee heard from several hospital maternity services that offered lactation clinics, such as University Hospital Geelong, Bendigo Health, and Northeast Health Wangaratta.⁴⁷³ At a public hearing in Wangaratta, the Committee heard from Ms Cate Gemmill, a lactation consultant employed by Northeast Health Wangaratta. Ms Gemmill told the Committee that the lactation clinic had been in operation for 15 years and has around 900 attended client presentations a year.⁴⁷⁴ They provide lactation and breastfeeding support to women who birth at Northeast Health as well as women who birth at smaller regional hospitals and other hospitals throughout the state. Ms Gemmill said:

We have sought to eliminate every potential barrier for attendance at the lactation clinic. The service is free. Women can self-refer or be referred by other clinicians. They can attend as many times as they need to feel that their breastfeeding is well-established, and that is very important. Some women feel that things are going very well after just a couple of visits; other women may take more. They can re-engage with the service after many months, and we provide them with lunch while they are there so that they do not have to either prepare food for the day or leave to get a meal. We do not have a waiting list; we see them on a needs basis. We triage the bookings and manage the spread of our bookings across the week.⁴⁷⁵

Ms Gemmill stated that their clinic fills a lot of gaps with early discharge from hospitals. The clinic sees a maximum of four women a day ‘to ensure an intimate environment’ and that they do not have time limited appointments.⁴⁷⁶

Quoting the WHO recommendations for exclusive breastfeeding from birth to six months, Ms Gemmill said that their service ‘must align with what we promote’, noting that: ‘You do more harm to promote something and fail to support it than you would had you never promoted it at all’.⁴⁷⁷

Ms Alice Martin, a mother and representative of the Wangaratta and district ABA, told the Committee:

I have used the lactation clinic, and they have been an incredible help. I have had two children locally and spent many a day at the lactation clinic eating sandwiches and receiving individualised, one-on-one support. It is an incredible service that we are so lucky to have.⁴⁷⁸

⁴⁷³ University Hospital Geelong, submission no. 32, p. 2; Ms Claire Geldard, Director of Operations, Women’s and Children’s Directorate, University Hospital Geelong, Family and Community Development Committee public hearing – Geelong, 11 December 2017, transcript of evidence, p. 11; Ms Fiona Faulks, Deputy Director of Nursing, Women’s and Children’s Services, Bendigo Health, Family and Community Development Committee public hearing – Bendigo, 24 October 2017, transcript of evidence, p. 10; Ms Cate Gemmill, Lactation Consultant, Northeast Health Wangaratta, Family and Community Development Committee public hearing – Wangaratta, 25 October 2017, transcript of evidence, p. 2.

⁴⁷⁴ Ms Cate Gemmill, Lactation Consultant, Northeast Health Wangaratta, Family and Community Development Committee public hearing – Wangaratta, 25 October 2017, transcript of evidence, p. 2.

⁴⁷⁵ *Ibid.*

⁴⁷⁶ *Ibid.*, p. 3.

⁴⁷⁷ *Ibid.*, p. 2.

⁴⁷⁸ Ms Alice Martin, Australian Breastfeeding Association, Family and Community Development Committee, public hearing – Wangaratta, 25 October 2017, transcript of evidence, p. 2.

At a public hearing in Bendigo, the Committee heard about the support that Bendigo Health provides mothers for free for up to six weeks after giving birth there or at a cost for those who deliver privately.⁴⁷⁹ Ms Faulks, of Bendigo Health, told the Committee:

We have a breastfeeding support service, which is a team of lactation consultants who look after women. They do classes antenatally, particularly in the gestational diabetic group, to get them expressing early so we can hopefully avoid that hypoglycaemia and admission of their babies to special care. They do general antenatal breastfeeding classes. They do inpatient breastfeeding clinics, where they are available to inpatient women to come in and spend a couple of hours with them and breastfeed in a group with the other women who are inpatients, and then they do some postnatal education as well as parenting education generally. So we rely upon them very heavily. They come into the unit for women with breastfeeding problems and write breastfeeding plans for them — lactation plans — that allow the midwives then to support those more complex breastfeeding problems.⁴⁸⁰

Regarding Bendigo Health's lactation clinic, Ms Helen Lees, Maternal and Child Health Clinical Coordinator at the City of Greater Bendigo, told the Committee that the clinic operates only as an outpatient service, which means that it is difficult for a client to access the lactation consultant clinic staff if they have been re-admitted with breastfeeding issues or if they are admitted to the parent infant unit.⁴⁸¹ Ms Lees told the Committee:

After six weeks the Australian Breastfeeding Association and private services are all that is available unless they luck an appointment with one of the MCH nurses with LC [lactation consultant] as an extra qualification in their clinic. If we are serious about improving our breastfeeding rates, which is a whole-of-community public health issue, we need to provide more services to support this, free and accessible, when clients require it.⁴⁸²

The Committee heard that some regions have excellent support for breastfeeding mothers through community organisations or hospital lactation clinics, while families living in other regions do not have access to lactation consultants. In their submission, Mount Alexander Shire stated that families located in their area have to travel to Bendigo Hospital and pay to access lactation consultants for breastfeeding support and education 'due to the birth occurring at another hospital'. They noted: 'This can be a deterrent for those needing to access the service but are unable to travel or afford the service'.⁴⁸³ They said that outreach services or the introduction of subsidies or vouchers may reduce disparity in outcomes and support those most vulnerable.⁴⁸⁴

⁴⁷⁹ Ms Helen Lees, Maternal and Child Health Clinical Coordinator, City of Greater Bendigo, Family and Community Development Committee public hearing – Bendigo, 24 October 2017, transcript of evidence, p. 5. Ms Fiona Faulks, Deputy Director of Nursing, Women's and Children's Services, Bendigo Health, Family and Community Development Committee public hearing – Bendigo, 24 October 2017, transcript of evidence, p. 10.

⁴⁸⁰ Ms Fiona Faulks, Deputy Director of Nursing, Women's and Children's Services, Bendigo Health, Family and Community Development Committee public hearing – Bendigo, 24 October 2017, transcript of evidence, p. 10.

⁴⁸¹ Ms Helen Lees, Maternal and Child Health Clinical Coordinator, City of Greater Bendigo, Family and Community Development Committee public hearing – Bendigo, 24 October 2017, transcript of evidence, p. 5.

⁴⁸² Ibid.

⁴⁸³ Mount Alexander Shire, submission no. 23, p. 2.

⁴⁸⁴ Ibid.

Similarly, the Committee heard that some services wanted to provide a lactation service but were not able to obtain funding for this service. Ms Jodie Ashworth, General Manager of Surgery, Women's and Children's, Operating Theatres and ICU and Chief Nursing Officer at Northern Health, told the Committee at a public hearing in Melbourne:

It would be remiss of me not to mention that we have one of the worst breastfeeding rates in the state. It is terrible. We are trying, and we are working really hard with that. We have our women for 2.4 days in hospital, so the establishment of a lactation service and lactation support post discharge for us is pivotal — absolutely pivotal — and at the moment we still have no funding source to provide that support, which we would actually like to give in the home.⁴⁸⁵

Many maternal and child health services raised concerns about mothers lacking support in breastfeeding, especially those who are discharged prior to breastfeeding being established. In their submission, the City of Whitehorse raised concerns about women falling through the gaps and ceasing breastfeeding before the MCH Service can engage with them, especially when there is a lack of hospital lactation support services or long waiting lists.⁴⁸⁶

Ms Maree Burgess, Maternal and Child Health Nurse and Branch President of the Australian Nursing and Midwifery Federation told the Committee that the Mercy Hospital's day-stay lactation clinic, which no longer operates due to funding pressures, provided a good service for mothers. Now mothers can only access a two-hour appointment.⁴⁸⁷

The Committee heard that some maternal and child health services were offering lactation consultants and lactation clinics to help mothers breastfeed. Ms Burgess told the Committee about the lactation services at the City of Melbourne:

As far as additional people training as lactation consultants goes, local government is actually really supportive of people who want to go on and do an additional specialty. They do support them, because some of that education is really expensive. That has seen the growth of maternal and child health nurses with that specialty, and that has leant itself to them setting up lactation clinics where parents, in addition to their drop-in visits they have with the universal service nurses, can actually drop in to, say, the City of Melbourne. They have three lactation clinics every week spread over the week that women can drop in to at no cost. They can stay there for up to 3 hours and have that additional support.⁴⁸⁸

Dr Garra said that many drop in centres to help with breastfeeding were limited to two hours, noting: 'patients have told me that the window of getting there with a hungry baby is very difficult to manage'.⁴⁸⁹

Workforce issues related to lactation consultants will be addressed in Chapter Five.

⁴⁸⁵ Ms Jodie Ashworth, General Manager, Surgery, Women's and Children's, Operating Theatres and ICU and Chief Nursing Officer, Northern Health, Family and Community Development Committee public hearing – Melbourne, 5 February 2018, transcript of evidence, p. 8.

⁴⁸⁶ City of Whitehorse, submission no. 46, p. 2.

⁴⁸⁷ Ms Maree Burgess, Maternal and Child Health Nurse, Branch President, Australian Nursing and Midwifery Federation (Victorian Branch), Family and Community Development Committee public hearing – Melbourne, 4 September 2017, transcript of evidence, p. 8.

⁴⁸⁸ *Ibid.*, pp. 7-8.

⁴⁸⁹ Dr Joe Garra, submission no. 15, p. 1.

The Committee heard of different models of lactation support, yet Victoria's breastfeeding rates are still below the national average and the World Health Organization targets. The Committee believes that additional ongoing support for women post-birth for breastfeeding can result in improved health outcomes and reduced health costs to the state. Accordingly, the Committee recommends that:

RECOMMENDATION 2.10: The Victorian Government fund and establish day stay lactation clinics across the Victorian public health system, with flexibility of delivery to best suit the needs of communities.

2.13 Formula marketing

The Committee was concerned to hear about the rate at which babies are given formula in hospitals. Dr Susan Tawia, Manager of Breastfeeding Information and Research at the Australian Breastfeeding Association, expressed concern at a public hearing in Melbourne about the rate of formula use in hospitals:

Of particular concern is the rate at which babies are being supplemented with formula in Victorian hospitals... almost all Victorian women initiate breastfeeding. They want to breastfeed. But we can also see that in Victorian public hospitals 25 per cent of what are described as 'term, breastfed' babies are given formula, and 39 per cent are supplemented in private hospitals. So even before Victorian babies leave hospital almost 30 per cent are not exclusively breastfed. The confidence of these mothers may have been undermined. They are being given the message by healthcare professionals that they are not sufficient and their bodies are not capable rather than being provided with skilled lactation support when it is needed. This, after they have just created a baby.⁴⁹⁰

Dr Tawia told the Committee that it is 'inexcusable' that so many Victorian babies 'are being supplemented with formula contrary to the best practice guidelines' developed by WHO and 'repeated in the Victorian breastfeeding guidelines'.⁴⁹¹ Dr Tawia went on to add that the guidelines:

[S]tate that supplementary feeds of infant formula, water or glucose water should only be given for medical indications or at least at the mother's informed consent. A mother's informed consent is required because she needs to be fully informed of the short-term and long-term consequences of formula use in hospital.⁴⁹²

The Committee heard that women encounter pressure to formula feed their babies. Ms Melissa Maher told the Committee at a public hearing in Warrnambool that both her children had failure to thrive and that the pressure to formula feed 'is immense from the medical community and from family and support'.⁴⁹³

⁴⁹⁰ Dr Susan Tawia, Manager, Breastfeeding Information and Research, Australian Breastfeeding Association, Family and Community Development Committee public hearing – Melbourne, 4 September 2017, transcript of evidence, p. 4. See also: Australian Breastfeeding Association, submission no. 64, p. 8.

⁴⁹¹ Dr Susan Tawia, Manager, Breastfeeding Information and Research, Australian Breastfeeding Association, Family and Community Development Committee public hearing – Melbourne, 4 September 2017, transcript of evidence, p. 4.

⁴⁹² Ibid. See also: Australian Breastfeeding Association, submission no. 64, p. 8.

⁴⁹³ Ms Melissa Maher, Family and Community Development Committee public hearing – Warrnambool, 11 October 2017, transcript of evidence, p. 2.

Ms Barbara Glare from the Warrnambool Breastfeeding Centre told the Committee at a public hearing in Warrnambool:

Mothers tell me that wherever they go, contrary to popular belief, they are pressured into stopping breastfeeding. There seems to me to be a lack of education amongst medical doctors and health professionals about how to assist breastfeeding mothers effectively. Breastfeeding is a very simple, robust system that almost always works, and yet a quick flick through Facebook would not tell you that. Mothers can be treated for almost any condition and continue to breastfeed at the same time, but I guess breastfeeding is kind of the slow food movement of health. It is an ongoing relationship that ideally, as per the World Health Organization guidelines, will last exclusively for six months and then up to two years, adding in complementary foods. A lot goes on in two years. What was happening at the start is not what is happening at the end, and people need a guide through all of that. And we believe that women have a right to that sort of help and support.⁴⁹⁴

The Committee also heard that some mothers introduce formula so that fathers can bond with the baby, however Dr Tawia said that in their breastfeeding education classes they make women aware of other options to support fathers bonding with their babies, such as skin to skin contact and cuddles.⁴⁹⁵

Ms Alexandra Lenehan told the Committee that she felt that among mothers there was 'a lot of insecurity and guilt' and that mothers who are formula feeding were sometimes defensive.⁴⁹⁶ She told the Committee:

Then we have the stigma of every time we say something good about breastfeeding we are shaming mothers who are formula feeding. From a mother's perspective I am very proud. I am still breastfeeding my two-and-half-year-old; I am quite proud of that, but I do not feel I can actually share that with people, because every time I say something positive or say, 'Look how great it is!', I get slammed, 'Oh, so I'm a bad mother because I've given them a bottle?'. 'No, this is not what I said'. So my feeling is there is a lot of insecurity and guilt, maybe because a lot of mothers do not meet their breastfeeding goals. They did not have the support, so they had to come to terms with not being able to do what they really wanted to do, and that makes everyone defensive.

I think with the stigma we really need to work on a cultural level to just make sure it is okay. If you meet your goals and you are happy with your decision, that is fantastic, but often it is actually a lack of support, not a lack of ability to breastfeed, and I think that is something that is a shame.⁴⁹⁷

The Committee was encouraged to see and hear about the Warrnambool Breastfeeding Centre's advertisement promoting the nutritional benefits of breastmilk and urges the Government to promote breastfeeding through an awareness and health

⁴⁹⁴ Ms Barbara Glare, Warrnambool Breastfeeding Centre, Family and Community Development Committee public hearing – Warrnambool, 11 October 2017, transcript of evidence, p. 3.

⁴⁹⁵ Dr Susan Tawia, Manager, Breastfeeding Information and Research, Australian Breastfeeding Association, Family and Community Development Committee public hearing – Melbourne, 4 September 2017, transcript of evidence, p. 12.

⁴⁹⁶ Ms Alexandra Lenehan, Family and Community Development Committee public hearing – Warrnambool, 11 October 2017, transcript of evidence, p. 2.

⁴⁹⁷ Ibid.

promotion campaign. This is particularly important in light of increased advertising by formula companies. Ms Glare told the Committee that she made the advertisement on a \$2,000 budget and it aired on WIN TV for one month before the money ran out.⁴⁹⁸

2.13.1 The World Health Organization (WHO) Code

In 1981, the World Health Organization (WHO) adopted the *International Code of Marketing of Breast-milk Substitutes* (the WHO Code).⁴⁹⁹ The aim of the WHO Code is to ‘contribute to the provision of safe and adequate nutrition for infants, by the protection and promotion of breast-feeding, and by ensuring the proper use of breast-milk substitutes, when these are necessary, on the basis of adequate information and through appropriate marketing and distribution’.⁵⁰⁰ The WHO Code affirmed that:

[H]ealth care systems, and the health professionals and other health workers serving in them, have an essential role to play in guiding infant feeding practices, encouraging and facilitating breast-feeding, and providing objective and consistent advice to mothers and families about the superior value of breastfeeding, or, where needed, on the proper use of infant formula, whether manufactured industrially or home-prepared...⁵⁰¹

Article 5 of the WHO Code relates to advertising, marketing and promotion of formula to the general public and mothers, stating in Article 5.1: ‘There should be no advertising or other form of promotion to the general public of products within the scope of this Code’.⁵⁰² Importantly, as noted by the Australian Breastfeeding Association, the Code ‘recognises that breastmilk substitutes have a legitimate role to play’ and that the Code aims to ‘protect the community from irresponsible and biased marketing of breastmilk substitutes’.⁵⁰³

The Marketing in Australia of Infant Formulas (MAIF) Agreement is Australia’s response to the WHO Code and is the primary means by which the Australian Government has chosen to give effect to the WHO Code.⁵⁰⁴ The MAIF Agreement has operated since 1992.⁵⁰⁵ The MAIF Agreement is a self-regulatory agreement between infant formula manufacturers and importers who are signatories to the MAIF Agreement.⁵⁰⁶

498 Ms Barbara Glare, Warrnambool Breastfeeding Centre, Family and Community Development Committee public hearing – Warrnambool, 11 October 2017, transcript of evidence, p. 3.

499 World Health Organization, *International Code of Marketing of Breast-milk Substitutes*, Geneva, WHO, 1981, accessed 3 April 2018, <http://www.who.int/nutrition/publications/code_english.pdf>.

500 *Ibid.*, p. 8.

501 *Ibid.*, pp. 6-7.

502 *Ibid.*, p. 10.

503 Australian Breastfeeding Association, ‘The WHO Code’, 2017, accessed 3 April 2018, <<https://www.breastfeeding.asn.au/who-code>>.

504 Australian Competition & Consumer Commission, ‘Agreement to restrict advertising of infant formula’, 15 July 2016, accessed 6 February 2018, <<https://www.accc.gov.au/media-release/agreement-to-restrict-advertising-of-infant-formula>>.

505 Department of Health, ‘Marketing in Australia of Infant Formulas: Manufacturers and Importers Agreement’, Department of Health, Australian Government, 16 November 2017, accessed 3 April 2018, <<http://www.health.gov.au/internet/main/publishing.nsf/Content/health-pubhlth-strateg-foodpolicy-apmaif.htm>>.

506 Australian Breastfeeding Association, ‘The WHO Code’, 2017, accessed 3 April 2018, <<https://www.breastfeeding.asn.au/who-code>>.

The MAIF Agreement is not legally binding, it is voluntary and is a code of conduct between manufacturers and importers of infant formula in Australia.⁵⁰⁷ Any sanctions can only be applied to signatories that breach the MAIF Agreement, therefore any activity by an infant manufacturer or importer that is not a signatory to the MAIF Agreement is not in breach of the MAIF Agreement.⁵⁰⁸ Breaches include the provision of free samples of infant formula (under 12 months) by manufacturers or importers to the general public, a manufacturer offering money or gifts to health care professionals, and television or print advertising for infant formula (under 12 months) which are produced and paid for by an infant formula manufacturer.⁵⁰⁹ Advertisements for infant formula by retailers, such as supermarkets and pharmacies, do not constitute a breach.⁵¹⁰

The MAIF Agreement is overseen by the MAIF Tribunal, a non-statutory dispute resolution body that handles complaints arising from the MAIF Agreement.⁵¹¹ The Tribunal reports annually to the federal Department of Health.⁵¹² In their latest report, the Tribunal Chair, Mr Graeme Innes AM, stated:

We note that some industry participants are not parties to the MAIF Agreement and that any complaints received about their conduct are rejected as beyond the scope of the Tribunal. In our opinion this reduces the effectiveness of industry self-regulation and may undermine the confidence of consumers.⁵¹³

As noted by the Australian Breastfeeding Association, the MAIF Agreement has ‘a much narrower scope’ than the WHO Code, for example, it only covers infant formula for babies under 12 months.⁵¹⁴ During a public hearing in Warrnambool, Associate Professor Alison Stuebe raised concerns over the lack of regulation of toddler formulas:

I got off the plane in Melbourne and walked out to the SkyBus and there was a giant ad for one of the follow-on formulas. That was the first thing I saw in Australia, which was a little upsetting. I think that it speaks to the fact that the brand gets out there in the name of the follow-on formulas and then mums go to the grocery store and see the infant formula and say, ‘Oh, that brand had the lovely ad that I saw on the highway. Maybe I should buy that one’. So it is a quite underhanded effort on the part of the formula companies. I think that regulation rather than trying to come up with a budget for a counter-advertising campaign is critical.

507 See: Australian Breastfeeding Association, ‘The WHO Code’, 2017, accessed 3 April 2018, <<https://www.breastfeeding.asn.au/who-code>>; Department of Health, ‘Marketing in Australia of Infant Formulas: Manufacturers and Importers Agreement’, Department of Health, Australian Government, 16 November 2017, accessed 3 April 2018, <<http://www.health.gov.au/internet/main/publishing.nsf/Content/health-pubhlth-strateg-foodpolicy-apmaif.htm>>.

508 Australian Breastfeeding Association, ‘The WHO Code’, 2017, accessed 3 April 2018, <<https://www.breastfeeding.asn.au/who-code>>.

509 Ibid.

510 Ibid.

511 The Ethics Centre, Annual report of the Marketing in Australia of Infant Formula Tribunal 2015-2016, Sydney, March 2017, accessed 17 April 2018, <[http://www.health.gov.au/internet/main/publishing.nsf/Content/175BBB2DBDB7D57CA25813900207FCF/\\$File/MAIF%20Tribunal%20Annual%20Report%202015-16.pdf](http://www.health.gov.au/internet/main/publishing.nsf/Content/175BBB2DBDB7D57CA25813900207FCF/$File/MAIF%20Tribunal%20Annual%20Report%202015-16.pdf)>.

512 The Tribunal replaced the former Advisory Panel on MAIF (APMAIF) in November 2013. See: Department of Health, ‘Annual report of the Marketing in Australia of Infant Formula Tribunal 2015-2016’, Department of Health, Australian Government, 8 June 2017, accessed 17 April 2018, <<http://www.health.gov.au/internet/main/publishing.nsf/Content/phd-brfeed-apmaif-15-16>>.

513 Department of Health, ‘Annual report of the Marketing in Australia of Infant Formula Tribunal 2015-2016’, Department of Health, Australian Government, 8 June 2017, accessed 17 April 2018, <<http://www.health.gov.au/internet/main/publishing.nsf/Content/phd-brfeed-apmaif-15-16>>.

514 Australian Breastfeeding Association, ‘The WHO Code’, 2017, accessed 3 April 2018, <<https://www.breastfeeding.asn.au/who-code>>.

...

The formula companies are in the business of selling and servicing healthcare professionals, of marketing their products, and in order to support breastfeeding we need to protect women from this insidious influence.⁵¹⁵

In their submission to the Inquiry, the Warrnambool Breastfeeding Centre said that one of the main hurdles to women breastfeeding is the formula industry, stating that the formula industry have billions of dollars of business to protect and promote and they are ‘not a benevolent society’:

In recent years with the breakdown of the MAIF committee formula companies have been able to advertise their products shamelessly. This needs to be prohibited. Supporters of breastfeeding can’t possibly compete with this kind of marketing power. Formula advertising including on social media and for toddler and follow on formula needs to be banned.⁵¹⁶

The Warrnambool Breastfeeding Centre also stated that health professionals should not receive training from formula companies ‘who have a vested interest in seeing breastfeeding fail’.⁵¹⁷

The Committee heard that many Victorian women are not given adequate support to breastfeed and that health practitioners lack an understanding and knowledge of breastfeeding. The Committee is concerned about the inappropriate use of formula in hospitals and the advertising and promotion of formula within the community. Consistent with the observations of the Marketing in Australia of Infant Formulas Tribunal in their latest annual report, the Committee believes that the Marketing in Australia of Infant Formulas Agreement could be strengthened by ensuring that all industry participants (formula companies and importers) are parties to the Agreement. Thus, the Committee recommends that:

RECOMMENDATION 2.11: The Victorian Government use its position on the Council of Australian Governments (COAG) to advocate for:

- the creation of a new Medicare item so that breastfeeding mothers can receive Medicare rebates for consultations with lactation consultants;
- a review of the Marketing in Australia of Infant Formulas: Manufacturers and Importers Agreement 1992 to expand the Agreement and ensure that all industry participants selling formula in Australia are parties to the Agreement.

⁵¹⁵ Dr Alison Stuebe, Associate Professor, Maternal-fetal Medicine, The University of North Carolina School of Medicine, Family and Community Development Committee public hearing – Warrnambool, 11 October 2017, transcript of evidence, p. 5.

⁵¹⁶ Warrnambool Breastfeeding Centre, submission no. 57, p. 2.

⁵¹⁷ Ibid.

AT A GLANCE

Background

The Committee received a substantial amount of evidence concerning mental health during the perinatal period. The Committee heard of the importance of screening for mental health during the perinatal period, and of having suitable referral pathways for women and men at risk of, or experiencing, perinatal mental illness. The Committee also heard of societal shifts in support structures and the ad hoc and unintegrated nature of perinatal mental health services affecting perinatal mental illness and its treatment. This chapter examines the prevalence of mental illness during the perinatal period and its impact on the mother, the infant, the family, and the wider community. The chapter also examines risk factors for developing perinatal mental health disorders, such as family violence and bereavement.

The chapter examines the various treatment and services available, such as mother baby Units, Early Parenting Centres, Perinatal Emotional Health Programs (PEHP), and the national perinatal mental health helpline, in addition to perinatal mental health screening and the Edinburgh Postnatal Depression Scale. This chapter also discusses perinatal depression and anxiety in fathers, and services available for men. The chapter addresses the Australian Clinical Practice Guideline, changes to Medicare items, the National Perinatal Depression Initiative (NPDI), and the impact of the withdrawal of NPDI funding on perinatal mental health.

Terms of reference addressed

This chapter addresses the following terms of reference:

2. the impact that the loss of Commonwealth funding (in particular, the National Perinatal Depression Initiative) will have on Victorian hospitals and medical facilities as well as on the health and wellbeing of Victorian families;
5. access to and provision of an appropriately qualified workforce, including midwives, paediatricians, obstetricians, general practitioners, anaesthetists, maternal and child health nurses, mental health practitioners and lactation consultants across Victoria;
6. disparity in outcomes between rural and regional and metropolitan locations; and
7. identification of best practice.

The Committee received a substantial amount of evidence concerning mental health during the perinatal period. The Committee heard of the importance of screening for mental health during the perinatal period, and of having suitable referral pathways for women and men at risk of, or experiencing, perinatal mental illness. The Committee also heard of societal shifts in support structures and the ad hoc and unintegrated nature of perinatal mental health services affecting perinatal mental illness and its treatment. This chapter examines the prevalence of mental illness during the perinatal period and its impact on the mother, the infant, the family, and the wider community. The chapter also examines risk factors for developing perinatal mental health disorders, such as family violence and bereavement.

The chapter examines the various treatment and services available, such as mother baby Units, Early Parenting Centres, Perinatal Emotional Health Programs (PEHP), and the national perinatal mental health helpline, in addition to perinatal mental health screening and the Edinburgh Postnatal Depression Scale. This chapter also discusses perinatal depression and anxiety in fathers, and services available for men. The chapter addresses the Australian Clinical Practice Guideline, changes to Medicare items, the National Perinatal Depression Initiative (NPDI), and the impact of the withdrawal of NPDI funding on perinatal mental health.

The mental health of women from culturally and linguistically diverse communities and from Aboriginal and Torres Strait Islander communities will be addressed in more detail in Chapters Seven and Eight.

3.1 Societal shift in perinatal support

The experience of mothers in the perinatal period in recent years is different to that of previous generations. As a society we have moved toward families with different dynamics, with less support from relatives, neighbours, friends, and the community. The Committee heard from many sources that parents are experiencing social isolation.⁵¹⁸ The Warrnambool Breastfeeding Centre expressed the situation as:

More than ever families are isolated and alone in bringing up their children. Mothers, in particular [have a] burden to shoulder, when economic circumstances necessitate them working outside the home, but yet still manage the family and home and all the crises families have to negotiate.⁵¹⁹

The Australian Psychological Society (APS) in their submission told the Committee:

⁵¹⁸ Ms Patti Reilly, Acting Family Health Coordinator, City of Melbourne, Family and Community Development Committee public hearing – Melbourne, 18 September 2017, transcript of evidence, p. 3; Ms Barbara Glare, President and Lactation Consultant, Warrnambool Breastfeeding Centre, Family and Community Development Committee public hearing – Warrnambool, 11 October 2017, transcript of evidence, p. 5; Ms Maryanne Purcell, Maternal and Child Health Nurse Coordinator, Warrnambool City Council, Family and Community Development Committee public hearing – Warrnambool, 11 October 2017, transcript of evidence, p. 3; Ms Sue Carroll, Midwife, Swifts Creek Bush Nursing Centre, Family and Community Development Committee public hearing – Bairnsdale, 7 December 2017, transcript of evidence, p. 5; Mrs Kirsten Finger, Co-Founder of Olivia's Place, Family and Community Development Committee public hearing – Warragul, 8 December 2017, transcript of evidence, p. 2; Ms Suzanne Higgins, Midwife and Credentialed Mental Health Nurse, Family and Community Development Committee public hearing – Geelong, 11 December 2017, transcript of evidence, p. 4.

⁵¹⁹ Warrnambool Breastfeeding Centre, submission no. 57, p 2.

The social context of parenting also means that women are increasingly required to navigate this important life transition in isolation. Extended families are increasingly not close by or available to assist, workplace flexibility and conditions are often inadequate to support parents during this period, and childcare is often limited in terms of accessibility, affordability and quality.

While there is arguably more information to support mothers during this period, it is difficult for parents to navigate this material and find quality, accurate resources. There are also increasing and unrealistic social expectations of mothers which add to an already stressful period.⁵²⁰

The APS recommended adopting a ‘*social determinants of health*’ approach which considers the influence that broader societal, economic and political factors, including the way perinatal health services are structured and organised, and how women experience these services’, citing research by the World Health Organization and Sutherland, Yelland, and Brown in the *Maternal and Child Health Journal*.⁵²¹

The culturally and linguistically diverse (CALD) members of our community are at particular risk of experiencing social isolation.⁵²² Migrants can lack the support networks of family and friends they might otherwise have relied on.⁵²³ This can be further compounded by geographical factors such as lack of access to transport and infrastructure.⁵²⁴

The Multicultural Centre for Women’s Health, in their submission, told the Committee:

[T]he post-childbirth experiences of Australian born and immigrant mothers from non-English speaking backgrounds found that compared with Australian born women, immigrant mothers less proficient in English had a higher prevalence of depression (28.8% vs 15%) and were more likely to report wanting more practical (65.2% vs 55.4%) and emotional (65.2% vs 44.1%) support. They were also more likely to have no ‘time out’ from baby care (47% vs 28%) and to report feeling lonely and isolated (39% vs 17%).⁵²⁵

Families living in rural and regional Victoria are particularly vulnerable to social isolation and a lack of emotional support, as well as geographical isolation from formal support services:

In many instances, isolated rural women in particular do not routinely have access to high quality support services.⁵²⁶

Ms Tania Maxwell described her experience as a mother in a rural community:

⁵²⁰ Australian Psychological Society, submission no. 80, p. 5.

⁵²¹ Emphasis in original. Ibid.; Commission on Social Determinants of Health, *Closing the gap in a generation: health equity through action on the social determinants of health, Final Report of the Commission on Social Determinants of Health*, World Health Organization, Geneva, 2008; G Sutherland, J Yelland and S Brown, ‘Social inequalities in the organization of pregnancy care in a universally funded public health care system’, *Maternal and Child Health Journal*, vol. 16, no. 2, 2012, pp. 288-96.

⁵²² Dr Adele Murolo, Executive Director, Multicultural Centre for Women’s Health, Family and Community Development Committee public hearing – Melbourne, 27 November 2017, transcript of evidence, pp. 3-6; City of Melbourne, submission no. 21, p. 3.

⁵²³ Birth for HumanKIND, submission no. 59, p. 3.

⁵²⁴ IPC Health, submission no. 19, p. 2.

⁵²⁵ Multicultural Centre for Women’s Health, submission no. 88, p. 2.

⁵²⁶ South West Healthcare, submission no. 70, p. 3.

The importance of having support to bond with your newborn, experience positive moments, reading, laughing and generally enjoying the experience of motherhood requires greater support in the early days after giving birth. we [sic] have lost the days when the neighbour knocked on the door and nursed the baby for a few hours whilst you had a rest, or brought food over etc. That sense of community is slowly diminishing.⁵²⁷

The Committee heard that social isolation is a risk factor for developing a mental illness in the perinatal period⁵²⁸ and the Australian Clinical Practice Guideline for Mental Health Care in the Perinatal Period cites research that women who feel isolated are more likely to develop a mental health condition.⁵²⁹

The Committee heard of community organisations that have developed to address the social isolation new mothers in particular are experiencing. Organisations such as The Babes Project,⁵³⁰ Olivia's Place,⁵³¹ the Gianna Centre in Bendigo,⁵³² and the Sunraysia Postnatal Depression Support Network⁵³³ are working to give women and families the personal, emotional support they need in the perinatal period.

Based on the evidence the Committee heard and the very existence of organisations such as those listed above, the Committee wishes to emphasise that there is a need and desire for mothers and families in the perinatal period to have access to the kind of personal, emotional support that is less prevalent now than it was in generations past.

Ms Anne O'Brien, of The Gianna Centre in Bendigo, a volunteer organisation 'offering assistance to families and individuals of Central Victoria for in excess of 13 years', put this desire in words that reflect well what the Committee heard:

Much of our service revolves around supporting families during and after pregnancy. This service encompasses planned and unplanned pregnancy support and post-birth parenting assistance. Client evaluations indicate one of the most valued services offered by the Gianna Centre is an opportunity to speak one-on-one with our volunteers. Clients are clearly advised the centre is not a counselling, medical or legal identity. However, the opportunity of the proverbial cup-of-tea-service, where thoughts, emotions, opportunities and options can be discussed in a warm and welcoming confidential setting, is highly sought after.⁵³⁴

It is in this context that the Committee presents the information below about perinatal mental services in Victoria.

⁵²⁷ Ms Tania Maxwell, submission no. 91, pp. 1-2.

⁵²⁸ Royal Australian and New Zealand College of Obstetricians and Gynaecologists, submission no. 35, p. 4.

⁵²⁹ M-P Austin, N Hight and the Expert Working Group, *Mental Health Care in the Perinatal Period: Australian Clinical Practice Guideline*, Centre of Perinatal Excellence (COPE), Melbourne, 2017, p. 16.

⁵³⁰ See: Ms Andreeza Rodriguez, and Ms Helen Parker, Director, The Babes Project, Family and Community Development Committee public hearing - Melbourne, 5 February 2018, transcript of evidence.

⁵³¹ See: Mrs Kirsten Finger, Co-Founder, and Mrs Carmel Riley, President, Olivia's Place, Family and Community Development Committee public hearing - Warragul, 8 December 2017, transcript of evidence.

⁵³² See: Ms Anne Maree O'Brien, The Gianna Centre, Family and Community Development Committee public hearing - Bendigo, 24 October 2017, transcript of evidence.

⁵³³ See: Ms Kassie Hocking, Family and Community Development Committee public hearing - Mildura, 9 November 2017, transcript of evidence.

⁵³⁴ Ms Anne O'Brien, The Gianna Centre, Family and Community Development Committee public hearing - Bendigo, 24 October 2017, transcript of evidence, p. 2.

3.2 The ad hoc and unintegrated nature of perinatal mental health services

The Committee notes that the evidence it heard indicated that perinatal mental health services in Victoria are somewhat ad hoc in nature, and need to be better integrated into general perinatal health services. The Royal Women's Hospital in their submission called a model for integrating mental health care into maternity services 'the missing element':

Best practice in perinatal care responds to the physical and mental health needs of women and newborns. In Victoria's service system, the missing element is a comprehensive model for integrating mental health care into maternity services.⁵³⁵

Professor Louise Newman AM, Past President of the Royal Australian and New Zealand College of Psychiatrists, Director of the Royal Women's Hospital Centre for Women's Mental Health, and Professor of Psychiatry at The University of Melbourne expanded on this at two separate public hearings in Melbourne:

The points I would like to highlight are firstly that those of us who are working in clinical settings are certainly aware of the need to have a better integrated approach to perinatal and infant mental health services. By that I mean that we need better integration between maternity services and women's health but also the mental health responses that can support women, families and partners and also infant and child development. Our current service setting is maybe one that is best described, at least in some parts, as patchy in terms of access, with significant access difficulties, but also poorly integrated. I think some of the issues are not necessarily purely about resourcing but are about ways of working more effectively and actually introducing a model of care that is much better able to do that risk identification and to provide appropriate services and interventions as early as possible.⁵³⁶

...

We are very much of the opinion that there is no health without mental health and that a prevailing problem has been, if you like, the isolation or seclusion of mental health from general health services, particularly when we are thinking about women, infants and families at these crucial times. I think it is actually very important that we move beyond that and look at health in a much more holistic way. Our model is very much about integrating health into the range of medical and maternity services that we offer.⁵³⁷

While the Parent-Infant Research Institute urged the Committee 'to include a specific focus on improving perinatal mental health services, and integrated identification and intervention programs in this most crucial of areas',⁵³⁸

⁵³⁵ The Royal Women's Hospital, submission no. 75, p. 2.

⁵³⁶ Professor Louise Newman AM, Past President, Royal Australian and New Zealand College of Psychiatrists (Victorian Branch), Family and Community Development Committee public hearing – Melbourne, 18 September 2017, transcript of evidence, p. 2.

⁵³⁷ Professor Louise Newman AM, Director, Royal Women's Hospital Centre for Women's Mental Health, Family and Community Development Committee public hearing – Melbourne, 16 October 2017, transcript of evidence, p. 2.

⁵³⁸ Parent-Infant Research Institute, submission no. 79, p. 5.

Mr Simon Troeth, Board Director of the Centre of Perinatal Excellence (COPE), told the Committee at a public hearing in Melbourne that the Australian Clinical Practice Guideline for Mental Health Care in the Perinatal Period would inform an integrated perinatal mental health system in Australia:

[I]n the future Australia's world-leading perinatal mental health support system will be based on an integrated, innovative, sustainable and data-driven approach which is informed by the national guidelines.⁵³⁹

Mr Troeth was not alone. Many witnesses told the Committee of the value of an integrated approach to perinatal mental health.⁵⁴⁰ Mr Troeth also noted that the ad hoc nature of services makes referrals to a perinatal mental health provider difficult:

Services are currently using pen and paper-listed preferred providers, which is clearly unsatisfactory and very ad hoc. In many areas we do not know where perinatal expertise exists or even what constitutes having expertise in perinatal mental health.⁵⁴¹

Ms Lynne Smith, acting team leader, family services, from the City of Melbourne, agreed:

[W]e acknowledge that Victoria has a world-class child and family service. Nevertheless, our mothers and babies deserve and require a better coordinated service that is less reliant on ad hoc goodwill. There needs to be a systemic change across the multijurisdictional service platform, including stronger interface collaboration, improved communication and robust early identification and assessment of vulnerabilities and risks. It needs to involve acute allied health and community-based support services across the public and private health systems. We need a shared platform.⁵⁴²

The Committee heard that there are success stories in delivering perinatal mental health services, whether through state services such as the Agnes Parent and Infant Unit at Latrobe Regional Hospital,⁵⁴³ community services such as Olivia's Place⁵⁴⁴

⁵³⁹ Mr Simon Troeth, Board Director, Centre of Perinatal Excellence (COPE), Family and Community Development Committee public hearing – Melbourne, 4 September 2017, transcript of evidence, p. 4.

⁵⁴⁰ Professor Jane Fisher, Director, Jean Hailes Research Unit, Family and Community Development Committee public hearing – Melbourne, 4 September 2017, transcript of evidence, p. 7; Ms Lisa Fitzpatrick, Branch Secretary, Australian Nursing and Midwifery Federation (Victorian Branch), Family and Community Development Committee public hearing – Melbourne, 18 September 2017, transcript of evidence, p. 2; Ms Lois O'Callaghan, Chief Executive Officer, Mallee Track Health and Community Service, Family and Community Development Committee public hearing – Mildura, 9 November 2017, transcript of evidence, p. 5;

⁵⁴¹ Mr Simon Troeth, Board Director, Centre of Perinatal Excellence (COPE), Family and Community Development Committee public hearing – Melbourne, 4 September 2017, transcript of evidence, p. 4.

⁵⁴² Ms Lynne Smith, Acting Team Leader, Family Services, City of Melbourne, Family and Community Development Committee public hearing – Melbourne, 18 September 2017, transcript of evidence, p. 4.

⁵⁴³ For more see Dr Simon Fraser, Chief Medical Officer and Paediatrician, Ms Christine Hoyne, Nurse Unit Manager, Parent and Infant Unit, and Dr Stuart Thomas, Psychiatrist, Latrobe Regional Hospital, Family and Community Development Committee public hearing – Warragul, 8 December 2017, transcript of evidence, pp. 3-12; Ms Marilyn Humphrey, Maternal and Child Health Coordinator, Baw Baw Shire maternal and child health services, Family and Community Development Committee public hearing – Warragul, 8 December 2017, transcript of evidence, p. 4.

⁵⁴⁴ For more see Mrs Kirsten Finger, Co-Founder, and Mrs Carmel Riley, president, Olivia's Place, Family and Community Development Committee public hearing – Warragul, 8 December 2017, transcript of evidence.

and Zoe Support (which focuses on young mothers),⁵⁴⁵ staff accessing training from international programs such as Circle of Security,⁵⁴⁶ or programs for families such as MumMoodBooster⁵⁴⁷ and What Were We Thinking!.⁵⁴⁸

However, what is lacking is an overarching, state-wide plan to integrate perinatal mental health services into broader perinatal health services. It is in this setting that the Committee now turns to a discussion of mental health in the perinatal period, and the way it is detected and treated in Victoria, particularly the Australian Clinical Practice Guideline for Mental Health Care in the Perinatal Period and the need for a Victorian Perinatal Mental Health Plan.

3.3 Australian Clinical Practice Guideline for Mental Health Care in the Perinatal Period

In October 2017, the Australian Clinical Practice Guideline for Mental Health Care in the Perinatal Period was launched following approval from the National Health and Medical Research Council (NHMRC) under section 14A of the *National Health and Medical Research Council Act 1992* (Cth).⁵⁴⁹ The Guideline was commissioned by the Commonwealth Government and updates the first Australian perinatal mental health guideline developed by beyondblue in 2011.⁵⁵⁰

The Guideline is designed to support health professionals in providing evidence-based mental health care during the perinatal period. The Guideline includes the assessment of high prevalence disorders (depression, anxiety, bipolar disorder, puerperal psychosis) and in 2017, new disorders were added (schizophrenia and borderline personality disorder). They also detail the safe use of medication during pregnancy and other evidence-based treatments.

The Guideline recommends that every woman is routinely screened to identify her risk and the presence of depression and anxiety during pregnancy and in the postnatal period. COPE has also developed a free, accredited online training program for health professionals to support the implementation of the Guideline across healthcare settings.⁵⁵¹ The Committee discusses screening during the perinatal period at section 3.7.

⁵⁴⁵ For more see Ms Anne Webster, Executive Director, Zoe Support Australia, Family and Community Development Committee public hearing – Mildura, 9 November 2017, transcript of evidence.

⁵⁴⁶ For more see Mr Nicholas Place, Manager, Primary Mental Health Team, South West Healthcare, Family and Community Development Committee public hearing – Warrnambool, 11 October 2017, transcript of evidence, p. 5; Ms Ursula Kiel, Senior Clinician, St John of God Raphael Services, Family and Community Development Committee public hearing – Bendigo, 24 October 2017, transcript of evidence, p. 3; Ms Marilyn Humphrey, Maternal and Child Health Coordinator, Baw Baw Shire Maternal and Child Health Services, Family and Community Development Committee public hearing – Warragul, 8 December 2017, transcript of evidence, p. 2.

⁵⁴⁷ Developed by the Parent-Infant Research Institute and the Oregon Research Institute in the United States, for more see Parent-Infant Research Institute, submission no. 79, and Mum Mood Booster, 'Homepage', accessed 27 March 2018, <<https://www.mummoodbooster.com/public>>.

⁵⁴⁸ Jean Hailes Research Unit, submission no. 14, p. 3.

⁵⁴⁹ M-P Austin, N Hight and the Expert Working Group, *Mental Health Care in the Perinatal Period: Australian Clinical Practice Guideline*, Centre of Perinatal Excellence (COPE), Melbourne, 2017.

⁵⁵⁰ Centre of Perinatal Excellence (COPE), 'NEW National Perinatal Mental Health Guideline', accessed 30 October 2017, <<http://cope.org.au/about/review-of-new-perinatal-mental-health-guidelines>>.

⁵⁵¹ Centre of Perinatal Excellence (COPE), 'Welcome to COPE', accessed 12 April 2018, <<http://training.cope.org.au>>.

The Committee welcomes the updated Guideline and the positive impact it should have in delivering perinatal mental health services.

3.4 Victorian Perinatal Mental Health Plan

Victoria's 10-year Mental Health Plan states that:

Gender can uniquely affect the way people experience mental health and mental illness. Women experience disproportionate rates of domestic violence and sexual abuse and this significantly impacts mental health. Women are at higher risk of particular mental illnesses. Women have increased risk to their mental health during pregnancy and following child birth.⁵⁵²

The Mental Health Plan commits the Victorian Government to 'improving prevention, early intervention and treatment for vulnerable mothers from pregnancy through the post-partum and early infancy period'.⁵⁵³ The Committee supports the objectives of the 10-year Mental Health Plan. The Mental Health Plan is global in its ambitions, with its intended positive outcomes to apply across the community, and thus, specific references to perinatal mental health in the Mental Health Plan are essentially limited to those quoted here.

The Committee has received a large body of evidence across this Inquiry in relation to the mental health of women in the perinatal period. The critical nature of this period to the development of the health and future health of the child, combined with the various risk factors faced by women in the perinatal period, makes perinatal mental health a key area for the attention of public policy makers. The Committee has heard and agrees that a Perinatal Mental Health Plan is needed to prioritise the mental health of mothers and their babies, fathers, and families.⁵⁵⁴ A Perinatal Mental Health Plan will build on, and be an adjunct to, the 10-year Mental Health Plan, and provide a set of goals, focus areas, and outcomes for governments, policy makers, and the sector. A Perinatal Mental Health Plan will also be informed by relevant sections of the Australian Clinical Practice Guideline for Mental Health Care in the Perinatal Period, described above. The Government will need to collaborate with key stakeholders, such as COPE, who developed the new national guideline, to develop such a plan.

Throughout this chapter, the Committee will outline specific areas which need to be addressed to improve access to, and the availability of, perinatal mental health services. These include: universal mental health screening for women during the perinatal period; universal screening for family violence; ensuring health professionals have clear pathways for treatment of women and families; training of health professionals in mental health screening and bereavement care; and the funding and expansion of a state-wide PEHP program. These are all areas that can be articulated in a Perinatal Mental Health Plan for Victoria.

The Committee believes that there is a real need for greater awareness of the perinatal mental health services that currently do exist, so that early interventions can be achieved for women and families at risk of mental illness, particularly in the antenatal

⁵⁵² Victorian Government, Department of Health and Human Services (DHHS), *Victoria's 10-year Mental Health Plan*, DHHS, 2015, p. 22.

⁵⁵³ *Ibid.*, p. 18.

⁵⁵⁴ The Royal Women's Hospital, submission no. 75, p. 3.

period. The Committee recognises the important contribution of organisations, such as PANDA and COPE, in supporting the mental health needs of women in the perinatal period. A government funded and supported public health education campaign should be based on collaboration with groups, such as PANDA and COPE, who are expert in public communication in this area.

Accordingly, the Committee recommends:

RECOMMENDATION 3.1: The Victorian Government create a Perinatal Mental Health Plan, as an adjunct to the 10-year Mental Health Plan, as a matter of priority to address the perinatal mental health needs of mothers, fathers and families.

- The Perinatal Mental Health Plan will include as a key element a public awareness campaign, created in collaboration with key stakeholders, to promote perinatal mental health, and services.
- The Plan will include specific goals and outcomes for Aboriginal and Torres Strait Islander communities and culturally and linguistically diverse communities.

3.5 Prevalence of mental health disorders in the perinatal period

The Committee heard that women are at greater risk of developing a mental illness during the perinatal period than at any other time,⁵⁵⁵ and that the emergence or relapse of mental illness during the perinatal period can follow a history of mental illness.⁵⁵⁶ According to the DSM-5, women with prior postpartum mood episodes, a prior history of a depressive or bipolar disorder (especially bipolar I disorder), and those with a family history of bipolar disorders are at increased risk of postpartum episodes with psychotic features.⁵⁵⁷

Mental illnesses ‘related to childbearing’ can occur during pregnancy (antenatal depression) and after birth (postnatal depression).⁵⁵⁸

The Diagnostic and Statistical Manual of Mental Disorders 5th edition (DSM-5) does not recognise perinatal depression as separate from depressive disorders apart from as an onset criteria.⁵⁵⁹ Regarding depressive disorders with peripartum onset, the DSM-5 states:

Mood episodes can have their onset either during pregnancy or postpartum. Although the estimates differ according to the period of follow-up after delivery, between 3% and 6% of women will experience the onset of a major depressive episode

⁵⁵⁵ Royal Australian and New Zealand College of Psychiatrists (Victorian Branch), submission no. 25, p. 3; Centre of Perinatal Excellence (COPE), submission no. 4, p. 4.

⁵⁵⁶ Ms Patti Reilly, Acting Family Health Coordinator, City of Melbourne, Family and Community Development Committee public hearing – Melbourne, 18 September 2017, transcript of evidence, p. 3; Royal Women’s Hospital, submission no. 75, pp. 6–7.

⁵⁵⁷ American Psychological Association, *Diagnostic and statistical manual of mental disorders* (5th ed.), Arlington, VA, American Psychiatric Publishing, 2013, p. 187. See also: Royal Australian and New Zealand College of Psychiatrists (Victorian Branch), submission no. 25, p. 4; and P Boyce and A Buist, ‘Management of bipolar disorder over the perinatal period’, *Australian Family Physician*, vol. 45, no. 12, December 2016, p. 890 which noted that women with bipolar disorder have a high risk of relapse following childbirth.

⁵⁵⁸ Royal Australian and New Zealand College of Psychiatrists (Victorian Branch), submission no. 25, p. 3.

⁵⁵⁹ American Psychological Association, *Diagnostic and statistical manual of mental disorders* (5th ed.), American Psychiatric Publishing, Arlington, VA, 2013.

during pregnancy or in the weeks or months following delivery (Gaynes et al. 2005). Fifty percent of “postpartum” major depressive episodes actually begin prior to delivery (Yonkers et al. 2001). Thus, these episodes are referred to collectively as peripartum episodes. Women with peripartum major depressive episodes often have severe anxiety and even panic attacks (Miller et al. 2006). Prospective studies have demonstrated that mood and anxiety symptoms during pregnancy, as well as the “baby blues,” increase the risk for a postpartum major depressive episode (O’Hara et al. 1991).⁵⁶⁰

This section will briefly outline mental illnesses that can occur during the perinatal period before describing how depression and anxiety are currently screened in Australia using the Edinburgh Postnatal Depression Scale.

3.5.1 Depression

One of the most common psychiatric disorders associated with pregnancy is depression.⁵⁶¹ It is estimated that depression affects one in ten women in pregnancy and that following birth, postnatal depression affects one in seven Australian women, with symptoms often presenting between one month and twelve months postpartum.⁵⁶²

There can be an overlap between the symptoms of depression and the reality of becoming a new parent, such as sleep deprivation and increased stress.⁵⁶³ These can also be risk factors which can lead to depression.⁵⁶⁴ Furthermore, it is estimated that up to 80 per cent of new mothers will experience ‘baby blues’, which describes mood swings, and feeling overwhelmed, teary, and/or anxious in the three to five days after the birth of a baby.⁵⁶⁵ These symptoms, which usually go away after a few days without any treatment, are often related to ‘rapidly changing hormone levels’ after birth.⁵⁶⁶

The Committee heard that depression can also present later than the first year after childbirth. As noted by the Australian Nursing and Midwifery Federation (Victorian Branch) in their submission:

Currently the emphasis of maternal health surveillance is predominantly on women’s health in pregnancy and the immediate postpartum period. The Maternal Health Study showed that the prevalence of maternal depression was higher when the first child was 4 years of age than at any point in the first 18 months postpartum.⁵⁶⁷

⁵⁶⁰ Ibid., pp. 186-187.

⁵⁶¹ D Carter and X Kostaras, ‘Psychiatric disorders in pregnancy’, *British Columbia Medical Journal*, vol. 47, no. 2, March 2005.

⁵⁶² M-P Austin, N Hight and the Expert Working Group, *Mental Health Care in the Perinatal Period: Australian Clinical Practice Guideline*, Centre of Perinatal Excellence (COPE), Melbourne, 2017, p. 6.

⁵⁶³ beyondblue, ‘Perinatal depression’, accessed 16 November 2017, <<https://healthyfamilies.beyondblue.org.au/pregnancy-and-new-parents/maternal-mental-health-and-wellbeing/depression>>.

⁵⁶⁴ Ibid.

⁵⁶⁵ The Royal Women’s Hospital, ‘Baby blues’, accessed 16 November 2017, <<https://www.thewomens.org.au/health-information/pregnancy-and-birth/mental-health-pregnancy/baby-blues>>.

⁵⁶⁶ Ibid.

⁵⁶⁷ Australian Nursing and Midwifery Federation (Victorian Branch), submission no. 67, p. 3.

3.5.2 Anxiety

Anxiety disorders are the most common type of mental health problem. It is estimated that one in five women experience anxiety when they are pregnant.⁵⁶⁸ Despite being common, the Centre of Perinatal Excellence (COPE) notes that symptoms of anxiety are often overlooked, interpreted as part of the general symptoms of pregnancy, or just considered part of someone's 'organised personality'.⁵⁶⁹

Women who have symptoms of an anxiety disorder may experience anxiety or fear that interrupts thoughts and interferes with daily tasks, panic attacks, a constant feeling of irritability or restlessness, heart palpitations, difficulty sleeping, and anxiety or fear that prevents the woman going out with her baby or leads her to check on her baby constantly.⁵⁷⁰

The Edinburgh Postnatal Depression Scale, discussed below, was specifically developed to detect symptoms of depression, however scores on certain questions may help health professionals detect symptoms of anxiety.⁵⁷¹

The Committee heard that there was a lack of an understanding in the community and among health professionals about anxiety. Ms Terri Smith from Perinatal Anxiety & Depression Australia (PANDA) told the Committee about community research that PANDA undertook in 2016 about community understanding of perinatal mental illness. She noted that anxiety was not readily understood and recognised, including by those who experienced anxiety during the perinatal period:

[T]he broad community are not talking about anxiety at all, whether it is during the pregnancy or after the birth of the baby. It is not on the agenda. The problem with that is that the symptoms are so different to depression, so we will often have callers saying, 'Well, I knew something was wrong, but I clearly wasn't depressed because I was having palpitations. I just had a heightened mood, not the depressed mood that we commonly talk about'.⁵⁷²

3.5.3 Post-traumatic stress disorder

Some women can develop post-traumatic stress disorder (PTSD) following childbirth, which can include reliving the birth, being overly alert or wound up, avoiding reminders of the event, and feeling emotionally numb. PTSD following birth can happen to anyone, particularly those who have experienced a previous traumatic event or difficult birth, rape or sexual assault in the past, and intimate partner violence.⁵⁷³

⁵⁶⁸ Centre of Perinatal Excellence (COPE), 'Antenatal anxiety: A guide for women and their families', factsheet, accessed 15 November 2017, <http://cope.org.au/wp-content/uploads/2017/11/Antenatal-Anxiety_Consumer-Fact-Sheet.pdf>.

⁵⁶⁹ Centre of Perinatal Excellence (COPE), 'Antenatal anxiety', <<http://cope.org.au/pregnancy/mental-health-conditions-pregnancy/antenatal-anxiety>>, accessed 13 February 2018.

⁵⁷⁰ Centre of Perinatal Excellence (COPE), 'Symptoms of perinatal anxiety', accessed 15 November 2017, <<http://cope.org.au/health-professionals-3/perinatal-mental-health-disorders/perinatal-anxiety/signs-symptoms-perinatal-anxiety>>.

⁵⁷¹ Centre of Perinatal Excellence (COPE), 'Things to remember about perinatal anxiety', accessed 16 November 2017, <<http://cope.org.au/health-professionals-3/perinatal-mental-health-disorders/perinatal-anxiety/things-remember-perinatal-anxiety>>.

⁵⁷² Ms Terri Smith, Chief Executive Officer, Perinatal Anxiety and Depression Australia, Family and Community Development Committee public hearing – Melbourne, 16 October 2017, transcript of evidence, p. 3.

⁵⁷³ Centre of Perinatal Excellence (COPE), 'Post traumatic stress disorder (PTSD)', accessed 16 November 2017, <<http://cope.org.au/birth/post-traumatic-stress-disorder-ptsd-2>>.

3.5.4 Bipolar disorder

The rate of bipolar disorder and psychotic disorders (schizophrenia and postpartum psychosis) is less common than depressive and anxiety disorders with a prevalence rate of around one in 100 in the general population for bipolar disorder.⁵⁷⁴ The prevalence of both major depression and bipolar disorder peaks during the childbearing years.⁵⁷⁵

A factsheet developed by COPE to support the Australian Clinical Practice Guideline states that women with bipolar disorder may find the early postnatal period distressing and struggle bonding with their baby.⁵⁷⁶ The factsheet also notes that it is important to seek help for women with bipolar disorder as the disorder 'significantly impacts on a woman's ability to care for her baby' and the woman may be at risk of suicide or of harming herself or the baby:

Whether a woman is experiencing the symptoms of depression or mania, it is very important to seek help as early as possible. Often the women will not recognise the symptoms in herself, so partners and family members play a critical role in observing changes in character and taking the lead to ensure she gets help early.⁵⁷⁷

3.5.5 Schizophrenia

The prevalence rate of schizophrenia is around one in 100 in the general population.⁵⁷⁸ Signs and symptoms of schizophrenia include delusions, hallucinations, and thought disorder. COPE notes that antenatal care is important for women with schizophrenia as relapse is common during pregnancy.⁵⁷⁹

3.5.6 Borderline personality disorder

The estimated prevalence rate of borderline personality disorder ranges from one per cent among all Australian adults to 3.5 per cent among Australians aged 24-25 years.⁵⁸⁰ According to the Australian Clinical Practice Guideline, borderline personality disorder is 'characterised by a pervasive pattern of instability of emotions,

⁵⁷⁴ Bipolar disorder is a condition characterised by intense and sustained mood shifts usually between episodes of depression and mania: M-P Austin, N Highet and the Expert Working Group, *Mental Health Care in the Perinatal Period: Australian Clinical Practice Guideline*, Centre of Perinatal Excellence (COPE), Melbourne, 2017, p. 17.

⁵⁷⁵ Royal Australian and New Zealand College of Psychiatrists (Victorian Branch), submission no. 25, p. 4.

⁵⁷⁶ Centre of Perinatal Excellence (COPE), 'Bipolar disorder in the postnatal period', accessed 16 November 2017, <http://cope.org.au/wp-content/uploads/2017/11/Bipolar-Disorder-in-Postnatal-Period_Consumer-Fact-Sheet.pdf>.

⁵⁷⁷ Centre of Perinatal Excellence (COPE), 'Bipolar disorder in the postnatal period', accessed 13 February 2018, <<http://cope.org.au/first-year/postnatal-mental-health-conditions/bipolar-disorder>>.

⁵⁷⁸ M-P Austin, N Highet and the Expert Working Group, *Mental Health Care in the Perinatal Period: Australian Clinical Practice Guideline*, Centre of Perinatal Excellence (COPE), Melbourne, 2017, p. 17.

⁵⁷⁹ Centre of Perinatal Excellence (COPE), 'Schizophrenia in pregnancy: A guide for women and their families', factsheet, accessed 16 November 2017, <http://cope.org.au/wp-content/uploads/2017/11/Schizophrenia-in-Pregnancy_Consumer-Fact-Sheet.pdf>; The Royal Women's Hospital also noted the prevalence of relapse in those with pre-existing mental disorders including schizophrenia: Royal Women's Hospital, submission no. 75, pp. 6-7.

⁵⁸⁰ M-P Austin, N Highet and the Expert Working Group, *Mental Health Care in the Perinatal Period: Australian Clinical Practice Guideline*, Centre of Perinatal Excellence (COPE), Melbourne, 2017, p. 17; National Health and Medical Research Council, *Clinical Practice Guideline for the Management of Borderline Personality Disorder*, National Health and Medical Research Council, Melbourne, 2012, p. 21.

relationships, sense of identity and poor impulse control and is consistently associated with severe functional impairment'.⁵⁸¹ Borderline personality disorder is also associated with a higher risk of suicide.

A factsheet developed by COPE to support the Australian Clinical Practice Guideline explains the way borderline personality disorder can impact parenting:

A mother with borderline personality disorder may struggle with her relationship with her baby. She may not feel the way she thinks that she should feel about the baby. She may also find caring for the baby difficult. It can be very hard to cope when the baby is crying or distressed when you have trouble managing your own distress.⁵⁸²

The factsheet also draws attention to the impact of a mother's borderline personality disorder on the infant:

Having a mother with borderline personality disorder affects infants in different ways. If the mother's behaviour is 'frightening' for the infant or she has trouble responding to the infant's emotional needs, it is more likely that the infant will develop problems with emotions and relationships. Having other people take care of the baby sometimes can reduce these effects on the baby.⁵⁸³

3.5.7 Postnatal psychosis

Postpartum or puerperal psychosis affects around one to two women in 1,000 women giving birth, often affecting women who are pregnant for the first time (primiparous women).⁵⁸⁴ Women with bipolar disorder are at increased risk, but postpartum psychosis can occur in women with no previous psychiatric history.⁵⁸⁵ The early postnatal period is when symptoms of postpartum psychosis emerge.⁵⁸⁶ Postpartum psychoses, as noted by the Jean Hailes Research Unit in their submission to the Inquiry, are 'psychiatric emergencies and require hospital admission and specialist in-patient treatment'.⁵⁸⁷ This is because postnatal psychosis puts both the infant and mother at risk of harm.

581 M-P Austin, N Highet and the Expert Working Group, *Mental Health Care in the Perinatal Period: Australian Clinical Practice Guideline*, Centre of Perinatal Excellence (COPE), Melbourne, 2017, p. 17; National Health and Medical Research Council, *Clinical Practice Guideline for the Management of Borderline Personality Disorder*, National Health and Medical Research Council, Melbourne, 2012, p. 44.

582 Centre of Perinatal Excellence (COPE), 'Borderline personality disorder in pregnancy and the postnatal period: A guide for women and their families', factsheet, 2017, accessed 16 November 2017, <http://cope.org.au/wp-content/uploads/2017/11/BPD-in-Perinatal-Period_Consumer-Fact-Sheet.pdf>.

583 Ibid.

584 American Psychological Association, *Diagnostic and statistical manual of mental disorders* (5th ed.), American Psychiatric Publishing, Arlington, VA, 2013, p. 187; I M Terp and P B Mortensen, 'Post-partum psychoses: clinical diagnoses and relative risk of admission after parturition', *British Journal of Psychiatry*, vol. 172, pp. 521-526, 1998; M-P Austin, N Highet and the Expert Working Group, *Mental Health Care in the Perinatal Period: Australian Clinical Practice Guideline*, Centre of Perinatal Excellence (COPE), Melbourne, 2017, p. 6; National Health and Medical Research Council, *Clinical Practice Guideline for the Management of Borderline Personality Disorder*, National Health and Medical Research Council, Melbourne, 2012.

585 American Psychological Association, *Diagnostic and statistical manual of mental disorders* (5th ed.), American Psychiatric Publishing, Arlington, VA, 2013, p. 187.

586 M-P Austin, N Highet and the Expert Working Group, *Mental Health Care in the Perinatal Period: Australian Clinical Practice Guideline*, Centre of Perinatal Excellence (COPE), Melbourne, 2017, p. 47.

587 Jean Hailes Research Unit, submission no. 14, p. 1.

As noted in the DSM-5, once a woman has had a postpartum episode with psychotic features, the risk of recurrence with each subsequent delivery is between 30-50 per cent.⁵⁸⁸

Peripartum-onset mood episodes can present either with or without psychotic features. Infanticide is most often associated with postpartum psychotic episodes that are characterized by command hallucinations to kill the infant or delusions that the infant is possessed, but psychotic symptoms can also occur in severe postpartum mood episodes without such specific delusions or hallucinations.⁵⁸⁹

At a public hearing in Melbourne, Associate Professor Phil Maude, Executive Member of the Council of Deans of Nursing and Midwifery (Australian & New Zealand) said:

A woman can deteriorate into depression and then into postnatal psychosis within eight to 12 days of the birth, and the services do not always necessarily have the appropriate follow-up for that woman.⁵⁹⁰

Signs of postnatal psychosis can include confusion and disorientation, severe physical anxiety or agitation, variable mood, insomnia, delusions or paranoia, hallucinations or impaired sensations, feeling that the mind is overloaded with too many thoughts, and thoughts of and/or plans to harm yourself or your baby.⁵⁹¹ Women with postnatal psychosis would usually be admitted to a mother baby unit (with their baby) or a general adult psychiatric unit (without their baby).⁵⁹² Treatment usually involves medication and sometimes electroconvulsive therapy (ECT).⁵⁹³

3.5.8 Maternal suicide

In a study of maternal deaths in Australia in 2008-2012, the Australian Institute for Health and Welfare noted that 16 deaths were due to psychosocial causes.⁵⁹⁴ Of the 16 women who died, 12 committed suicide, two were murdered, one was a known substance user who overdosed on illicit drugs, and one had an adverse reaction to psychotropic medication.⁵⁹⁵ Of the 12 women who committed suicide, three died while they were pregnant, six died in the postnatal period, and two died after a termination of pregnancy.⁵⁹⁶ As noted in their report:

588 American Psychological Association, *Diagnostic and statistical manual of mental disorders* (5th ed.), American Psychiatric Publishing, Arlington, VA, 2013, p. 187; T Munk-Olsen, T M Laursen, T Mendelson, C B Pedersen, O Mors and P B Mortensen, 'Risks and predictors of readmission for a mental disorder during the postpartum period', *Archives of General Psychiatry*, vol. 66, no. 2, February 2009.

589 American Psychological Association, *Diagnostic and statistical manual of mental disorders* (5th ed.), American Psychiatric Publishing, Arlington, VA, 2013, p. 187.

590 Associate Professor Phil Maude, Council Executive Member, Council of Deans of Nursing and Midwifery (Australia & New Zealand), Family and Community Development Committee public hearing – Melbourne, 27 November 2017, transcript of evidence, p. 3.

591 The Royal Women's Hospital, 'Post-partum psychosis', accessed 16 November 2017, <<https://www.thewomens.org.au/health-information/pregnancy-and-birth/mental-health-pregnancy/post-partum-psychosis>>.

592 Ibid.

593 Ibid.

594 Australian Government, *Australian Institute for Health and Welfare, Maternal deaths in Australia 2008-2012*, maternal death series, no. 5, Canberra, Cat. No. PER 70, accessed 17 May 2018, <<https://www.aihw.gov.au/getmedia/07bba8de-0413-4980-b553-7592089c4c8c/18796.pdf.aspx?inline=true>>, p. 13.

595 Ibid., p. 32.

596 Ibid.

Psychosocial morbidity is a leading cause of maternal death in Australia. ... The high proportion of deaths occurring in women with a known psychiatric history highlights the importance of antenatal and postnatal mental health screening. The adoption of antenatal psychosocial screening and guidelines for the management of psychiatric illnesses in the perinatal period are timely initiatives in preventing maternal deaths related to psychosocial morbidity.⁵⁹⁷

Certain populations are more vulnerable. The report states:

Antenatal care early in pregnancy is particularly important for Aboriginal and Torres Strait Islander women to ensure that there is provision to detect and appropriately manage chronic disease, and services need to be aware of the higher rates of depression and suicide risk in Aboriginal and Torres Strait Islander women compared with non-Indigenous women.⁵⁹⁸

In 2016, Victoria 'reported an unprecedented number of maternal deaths from psychosocial causes', comprising 47 per cent with five deaths from completed suicides and three deaths from intentional self-harm (suspected suicide).⁵⁹⁹ The latest report from the Consultative Council on Obstetric and Paediatric Mortality and Morbidity (CCOPMM) identified maternal mental health as a key priority area, stating that in 2016, 'the leading cause of direct and indirect maternal deaths (including late maternal deaths) in Victoria was completed suicide or intentional self-harm (suspected suicide)'.⁶⁰⁰ Seventy-five per cent of these women had pre-existing mental health disorders, one had no documented mental health problems, and one had a newly diagnosed mental health disorder related to pregnancy.⁶⁰¹

The report stated that substance dependence was a known contributing factor in three maternal deaths, social isolation was identified as a known contributing factor in one maternal death, and domestic violence was a known contributing factor in two maternal deaths:

Maternal mental illness is often undiagnosed and hence remains untreated and underreported. The *National maternity clinical practice guidelines* and the *Effective mental health care in the perinatal period Australian clinical practice guidelines* recommend that all pregnant women be assessed for psychosocial factors including previous or current mental illness as early as practical in pregnancy and after giving birth. It is nonetheless apparent that not all women are accordingly assessed. Even for the women in whom mental illness is diagnosed, they may not have timely access to appropriate health services, appropriate treatment and ongoing psychosocial support. Cultural, socioeconomic and language barriers can also make mental health assessment and follow-up challenging. Psychosocial support is often not tailored to the context, impeding women and their families from engaging with the appropriate mental health service providers. This is particularly true for Aboriginal mothers demonstrating the need for culturally safe healthcare in the maternity setting.⁶⁰²

597 Ibid., p. 34.

598 Ibid., p. 75.

599 Consultative Council on Obstetric and Paediatric Mortality and Morbidity (CCOPMM), *Victoria's mothers, babies and children 2016*, Melbourne, 2017, p. 15.

600 Ibid., p. 14.

601 Ibid., p. 15.

602 Ibid., p. 14.

CCOPMM made several recommendations, including that all clinicians be familiar with the Australian Clinical Practice Guideline, and that health services screen all pregnant women for anxiety and depression early in pregnancy and at least once during the pregnancy, and that all women be screened 6-12 weeks after birth.⁶⁰³

At a public hearing in Melbourne, Professor Euan Wallace, the Chief Executive Officer of Safer Care Victoria, told the Committee that maternal mental health needs to be a priority for Victoria 'in terms of system improvement and care improvement':

[Maternal suicides] are not all happening in pregnancy; some of them happen months later. Given that they now account for almost half of all maternal deaths, I do think we need a state-coordinated approach to improve detection of depression and other mental health issues and to put in place supports. Again, we are not a policy-commissioning agent, but we do have a role to say, 'We have a problem, and here's a pathway forward'.⁶⁰⁴

In their submission, the Loddon Mallee Aboriginal Reference Group noted that it was the suicide of a 19-year-old heavily pregnant Aboriginal woman that drew attention to her unmet needs and contributed to the subsequent development of the Mallee District Aboriginal Service (MDAS) Early Years model.⁶⁰⁵

3.6 Impact of mental illness during the perinatal period

The Committee heard that the impact of maternal mental illness during the perinatal period can be far reaching, not only for the mother, but also the child. Studies have shown that increased cortisol (stress hormone) levels can have significant and long lasting impact on the developing brain of the baby. In their submission, the Royal Australian and New Zealand College of Obstetricians and Gynaecologists wrote:

The importance of perinatal mental health and well-being cannot be underestimated in ensuring the future health of the next generation ... The presence of maternal mental health conditions can also have an adverse impact on the growth and development of the fetus/infant, and the wellbeing of other family members. The psychological wellbeing of pregnant women and new mothers should therefore be considered as important as their physical health and considered as part of routine antenatal and postnatal care. Recognition and management of postnatal depression requires a comprehensive plan to address the complete spectrum of maternal social and psychological health, which would include not only depression but also other key issues such as domestic violence, drug & alcohol dependence and economic disadvantage.⁶⁰⁶

In their submission, Tweddle Child and Family Health Service cited several studies illustrating how exposure of maternal depression and 'toxic stress' impact the developing brain of babies and toddlers.⁶⁰⁷ These studies emphasise that maternal

⁶⁰³ Ibid., p. 16.

⁶⁰⁴ Professor Euan Wallace, Chief Executive Officer, Safer Care Victoria, Family and Community Development Committee public hearing – Melbourne, 27 November 2017, transcript of evidence, p. 7.

⁶⁰⁵ Loddon Mallee Aboriginal Reference Group, submission no. 66, p. 2 and attachment: Mallee District Aboriginal Service, *Early Years Service: Evaluation of Aboriginal Health Case Management and Care Coordination Models in Victoria*, September 2016, p. 5.

⁶⁰⁶ Royal Australian and New Zealand College of Obstetricians and Gynaecologists, submission no. 35, p. 4.

⁶⁰⁷ Tweddle Child and Family Health Service, submission no. 45, pp. 11-12.

depression can compromise the mother-infant relationship and induce biological changes, which may increase the risk that the child will be hypersensitive to stress and may develop mental health problems later in life. They state:

As such there is a significant need for a reinvestment into early intervention in the very early years as this delivers benefits not only to individuals, families and communities but also economic benefits to the state.⁶⁰⁸

The impacts of perinatal mental health also affect others in the family, such as fathers, siblings, and extended family. The submission from the Royal Australian and New Zealand College of Psychiatrists (RANZCP) noted that maternal mental health problems ‘can have very disruptive effects on families’, contributing to relationship breakdowns and increasing the risk of concurrent paternal depression.⁶⁰⁹ Furthermore, early disruption of mother-infant interactions can have a long-term adverse effect on developmental milestones, cognition, and behavioural outcomes.⁶¹⁰

The Committee received a submission from the Families where a Parent has a Mental Illness (FaPMI) program.⁶¹¹ The objectives of the FaPMI program are to increase the capacity of adult area mental health services (AMHS), to provide a family-inclusive response, increase the capacity of adult AMHS network partners to recognise and respond appropriately to parental mental illness, and establish and strengthen service networks to provide a coordinated and collaborative response to the needs of families where a parent has a mental illness.⁶¹² At a public hearing, Ms Rose Cuff, State-wide FaPMI Coordinator, told the Committee about the value of their work with adult mental illnesses for families:

[V]ulnerable parents across the life span accessing a range of adult focused services present us with an opportunity to intervene and indeed to prevent the onset of inter-generational challenges.⁶¹³

Perinatal mental illness also has economic costs for the individual, the family, and the wider community. It has been estimated, in a report by PricewaterhouseCoopers (PwC) for the Centre of Perinatal Excellence (COPE), that the cost of not treating perinatal depression and anxiety resulting from births in 2013 is up to \$538 million by the time the children turn one, which includes healthcare costs and loss of productivity for parents.⁶¹⁴ The report stated:

A particular feature of perinatal depression and anxiety is that, if not treated, the impacts are lasting. This can be to the extent that they affect a child far into their adult years.⁶¹⁵

At a public hearing in Melbourne, Mr Simon Troeth, Board Director at the Centre of Perinatal Excellence, told the Committee that:

⁶⁰⁸ Ibid., p. 11.

⁶⁰⁹ Royal Australian and New Zealand College of Psychiatrists (Victorian Branch), submission no. 25, p. 4.

⁶¹⁰ Ibid.

⁶¹¹ Families where a Parent has a Mental Illness (FaPMI), submission no. 28.

⁶¹² Ibid., p. 1.

⁶¹³ Ms Rose Cuff, State-wide Coordinator, Families where a Parent has a Mental Illness (FaPMI), Family and Community Development Committee public hearing – Geelong, 11 December 2017, transcript of evidence, p. 2.

⁶¹⁴ PricewaterhouseCoopers, *Valuing Perinatal Health: The consequences of not treating perinatal depression and anxiety*. PricewaterhouseCoopers Australia for the Centre for Perinatal Excellence (COPE), 2014, accessed 17 May 2018, <http://cope.org.au/wp-content/uploads/2013/12/PWC-2013_Final3.pdf>.

⁶¹⁵ Ibid.

Perinatal mental health problems take a huge toll on women and families in Victoria. There are very significant personal, social and economic costs to the community. The perinatal period of pregnancy and the 12 months following birth is the greatest mental illness risk period for women. Mental illness is also the leading cause of maternal death and disability. The cost to the community is very significant. If left untreated, research shows that it would cost at least \$538 million nationally and the cost in Victoria, not including higher risk refugee populations, would be around \$116 million. If we reduce the national incidence of perinatal mental health conditions by just 5 per cent, we would save \$147 million. So identifying and preventing these conditions where possible means that we can reduce this terrible toll on women, families and the community.⁶¹⁶

3.6.1 Risk factors

The Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) noted in their submission that perinatal anxiety and depression ‘arises from a complex interplay of biological, sociological and psychological factors’.⁶¹⁷ Risk factors include a history of mental health problems, lack of social supports, isolation (physical, mental, cultural), stressful life events, a history of drug or alcohol abuse, and previous trauma, including physical, emotional or sexual abuse.⁶¹⁸ Other risk factors include intimate partner violence, low education/low socioeconomic status, and a perfectionistic personality style.⁶¹⁹

There are a number of factors that can contribute to perinatal anxiety and depression, such as previous reproductive loss (infertility, IVF, miscarriage, termination, stillbirth, death of baby), a difficult or complex pregnancy, birth trauma, a premature or sick baby, challenges with feeding or settling, financial stress, relationship stress, pre-existing physical illnesses, and sleep deprivation.⁶²⁰

The Royal Australian and New Zealand College of Psychiatrists (RANZCP) noted in their submission that particular populations are at increased risk for developing perinatal mental disorders, such as adolescent parents, and women with a history or current experiences of domestic violence.⁶²¹ Nonetheless, despite these risk factors, as noted by Ms Terri Smith from PANDA at a public hearing in Melbourne, any expecting and new parents can experience a perinatal mental illness:

[T]his illness really does not discriminate. It will be important for us to talk about social risk factors, because they all play a role as well, but in fact I swear there is no profession that we have not spoken to on our helpline, and I include obstetricians in that, I include maternal and child health nurses, I include those professional

⁶¹⁶ Mr Simon Troeth, Board Director, Centre of Perinatal Excellence (COPE). Family and Community Development Committee public hearing – Melbourne, 4 September 2017, transcript of evidence, p. 2.

⁶¹⁷ Royal Australian and New Zealand College of Obstetricians and Gynaecologists, submission no. 35, p. 4.

⁶¹⁸ Ibid.

⁶¹⁹ A Buist, ‘Perinatal mental health: Identifying problems and managing medications’, *Australian Family Physician*, vol. 43, no. 4, April 2014, pp. 182-185, p. 183.

⁶²⁰ Perinatal Anxiety and Depression Australia (PANDA), ‘Anxiety & depression in pregnancy & early parenthood’, factsheet, accessed 16 November 2017, <<https://www.panda.org.au/images/resources/Resources-Factsheets/Anxiety-And-Depression-In-Early-Parenthood-And-Pregnancy.pdf>>.

⁶²¹ Royal Australian and New Zealand College of Psychiatrists (Victorian Branch), submission no. 25, p. 3.

women who say, ‘You’d think I would have known’. It is a very, very difficult illness to understand and to come to terms with, not least of all because there is an enormous shame and stigma still attached to it.⁶²²

3.6.2 Family violence

The Committee recognises that the Royal Commission into Family Violence Report, including its 227 recommendations, tabled in Parliament in April 2016, represents the deep and considered work of the Royal Commission, and serves as the starting point for addressing family violence in Victoria. The Committee does not wish to re-prosecute the findings and recommendations of the Royal Commission. Rather the Committee notes that it supports the Royal Commission’s recommendations, particularly in the context of the perinatal period.

As such, the Committee will not make specific recommendations in relation to family violence in the perinatal period. Rather, the Committee wishes to acknowledge and represent the contributions made by witnesses and submitters to the Inquiry in relation to family violence in the perinatal period, and briefly outline Government funding announced in January 2018 to help address this issue.

In their report, the Royal Commission into Family Violence noted that pregnancy is a time of heightened risk for intimate partner violence, especially if the pregnancy is unplanned or unwanted.⁶²³ They note that pregnancy and the early postnatal period are times of adjustment and change, and that:

Family violence in this context has been linked to the perpetrator feeling that his primacy in the relationship is being undermined.⁶²⁴

The Commission also referred to an analysis of hospital data showing that at least 11 per cent of the women admitted to hospital for intimate partner violence-related assaults were pregnant, ‘with some evidence suggesting that the abdomen-pelvic area of pregnant women was over-involved in these assaults compared with women who were not pregnant’.⁶²⁵ The Commission noted that it is likely that the hospital data significantly under-reports family violence in this and other contexts. A recommendation of the Royal Commission into Family Violence was that the Department of Health and Human Services (DHHS) require routine screening for family violence in all public antenatal settings.⁶²⁶

The Committee is pleased to hear that the Victorian Government recently committed an additional \$11 million to provide up to 12,000 hours of additional Maternal and Child Health (MCH) Service consultations and outreach visits to those at risk of family violence.⁶²⁷ As stated in the Victorian Government media release:

⁶²² Ms Terri Smith, Chief Executive Officer, Perinatal Anxiety and Depression Australia, Family and Community Development Committee public hearing – Melbourne, 16 October 2017, transcript of evidence, p. 2.

⁶²³ State of Victoria, *Royal Commission into Family Violence: Report and Recommendations*, Vol. 1, Parliamentary Paper No. 132, Victorian Government Printer, Melbourne, p. 20.

⁶²⁴ Ibid.

⁶²⁵ Ibid. See also: E Cassell and A Clapperton, ‘Hospital-treated assault injury among Victorian women aged 15 years and over due to intimate partner violence (IPV), Victoria 2009–10 to 2013–14’, *Hazard*, vol. 79, no. 24, p. 2, 2015.

⁶²⁶ See Recommendation 96: State of Victoria, *Royal Commission into Family Violence: Report and Recommendations*, Vol. 3, Parliamentary Paper No. 132, Victorian Government Printer, Melbourne.

⁶²⁷ Hon. Jenny Mikakos, Minister for Families and Children, ‘Supporting mums and bubs affected by family violence’, media release, 3 January 2018.

Given discussing family violence can be difficult due to the presence of a partner, or insufficient time, the additional consultations will allow discussions to take place at a time and place that suits the mother and her kids.

MCH nurses will be provided with professional development and support so they can confidently discuss family violence with parents, assess the risk, and respond in a timely and meaningful way.⁶²⁸

The funding is part of the \$202.1 million Education State Early Childhood Reform Plan, which provided \$81.1 million to expand the MCH phone line, the Enhanced MCH Service, and supported playgroups.⁶²⁹

The Committee heard that in the perinatal period, women are more at risk of family violence than at any other time.⁶³⁰ An Australian longitudinal study of over 1,500 first time mothers and their firstborn children found that one in five mothers experienced emotional and/or physical abuse by an intimate partner in the year after having a baby.⁶³¹ As noted in the study's policy brief, 'This translates to 14,000 Victorian families a year affected by family violence in the course of a child's first year of life'.⁶³² The study, conducted by the Murdoch Children's Research Institute, found that family violence is 'at least as common as maternal depression and in many cases more devastating, with potentially grave consequences for maternal and child health'.⁶³³ The Committee also heard from Ms Cheree Jukes, who practised as a midwife in Mildura, that family violence can be related to teenage pregnancy.⁶³⁴

The Australian Psychological Society cited research in their submission that family violence is associated with adverse obstetric outcomes and negatively affects infants.⁶³⁵ They also stated that violence may occur for the first time in pregnancy or pregnancy may trigger exacerbation of violence.⁶³⁶

Exposure to family violence significantly impacts women's mental health, as well as the infant. In their submission, the Royal Australian and New Zealand College of Psychiatrists (RANZCP) stated:

The high levels of maternal stress and anxiety usually seen in women experiencing domestic violence are associated with poor infant development and outcomes including premature delivery, infants who are small for gestational age, birth complications, and poor infant developmental outcomes.

⁶²⁸ Ibid.

⁶²⁹ Ibid. See also: Department of Education and Training (DET), *Victorian Government Early Childhood Reform Plan*, DET, Melbourne, May 2017.

⁶³⁰ Ms Emma Sampson, Research and Policy Officer, Public Interest, Australian Psychological Society, Family and Community Development Committee public hearing – Melbourne, 5 February 2018, transcript of evidence, p. 3; Ms Patti Reilly, Acting Family Health Coordinator, City of Melbourne, Family and Community Development Committee public hearing – Melbourne, 18 September 2017, transcript of evidence, p. 3. Hume City Council, submission no. 69, p. 13.

⁶³¹ S Brown, D Gartland, H Woolhouse, R Giallo, *Maternal Health Study Policy Brief No. 2: Health consequences of family violence*. Murdoch Children's Research Institute, Melbourne, 2015.

⁶³² Ibid.

⁶³³ Ibid.

⁶³⁴ Ms Cheree Jukes, Family and Community Development Committee public hearing – Mildura, 9 November 2017, transcript of evidence, p. 2.

⁶³⁵ Australian Psychological Society, submission no. 80, p. 7. See also: L M Howard, S Oram, H Galley, K Trevillion, and G Feder, 'Domestic Violence and perinatal mental disorders: a systematic review and meta-analysis', *PLoS Med*, vol. 10, no. 5, 2013.

⁶³⁶ Australian Psychological Society, submission no. 80, pp. 6-7.

...

Parenting of infants can be adversely affected when a wom[a]n is experiencing violence. The impact on the infant of having a highly stressed and vulnerable parent is significant, with infants often experiencing anxiety, developmental impacts and poor quality attachment and interaction. Infants and young children who are exposed in a family situation to ongoing violence and stress are extremely likely to have attachment difficulties and have high rates of behavioural and developmental problems.⁶³⁷

In their submission, RANZCP advocated for better early detection of those experiencing or at risk of experiencing violence in the perinatal maternity care system, including improved systems of screening and identification of women at risk and the establishment of specific and targeted mental health services.⁶³⁸

The Committee heard about the importance of screening for family violence in the perinatal period in addition to mental health screening. In their submission, Albury Wodonga Health pointed toward the need for better staff training for domestic violence screening:

Domestic violence prevention, screening and intervention, and child safety is of paramount importance in ensuring a responsive and responsible Maternity service. Training programs for domestic violence screening and child protection/safety education needs to be ongoing and sustainable.⁶³⁹

The Committee heard that family violence also impacted health professionals, and that some women experiencing family violence were further isolated as hospitals decided not to send domiciliary staff out to the home to protect the safety of their staff, requiring women to travel to hospital for their first postnatal visit.⁶⁴⁰ In their submission, the City of Melbourne stated:

Most importantly it is the woman and child who remain the most vulnerable. They have fewer people watching out for them, isolating them further at a universally identified period of extreme risk in a context of family violence, not to mention health and wellbeing.⁶⁴¹

The Committee heard similarly from the Australian Nursing and Midwifery Federation's (ANMF) submission, quoting the Victorian Midwifery Homecare Group (a special interest group of the ANMF):

Many vulnerable women are not visited at home due to safety concerns for midwives and other staff. For example, women who have been assessed as having a history of drug use, or an abusive partner/ family members, will be asked to return to hospital for a check-up. These women are arguably more in need of a home visiting service than many others due to their inability to leave home.⁶⁴²

⁶³⁷ Royal Australian and New Zealand College of Psychiatrists (Victorian Branch), submission no. 25, p. 5.

⁶³⁸ Ibid.

⁶³⁹ Albury Wodonga Health, submission no. 55, p. 2.

⁶⁴⁰ City of Melbourne, submission no. 21, p. 2.

⁶⁴¹ Ibid., p. 3.

⁶⁴² Australian Nursing and Midwifery Federation (Victorian Branch), submission no. 67, p. 9.

The Committee heard that many municipal councils struggled with the impact of family violence in their region.⁶⁴³ The City of Melbourne stated that this decision not to send domiciliary staff on the basis of the threat of violence was often not communicated to maternal and child health nurses, increasing the risk carried by these nurses.⁶⁴⁴

In her submission, Ms Cassie Austin, the Immunisation and Maternal and Child Health Coordinator at the Corangamite Shire, stated that despite high and increasing levels of family violence incidents in the Corangamite Shire, they had no locally based support services to target the prevention, identification, and treatment of family violence.⁶⁴⁵ Ms Austin stated that family violence 'has a significant impact on the way a woman raises their child, ultimately affecting the development of that child'.⁶⁴⁶

Regarding workforce issues, Ms Austin cites a literature review which found that governments often implement family violence screening policies in healthcare settings without addressing key barriers reported by primary care professionals, such as the need for ongoing training, managing workloads, and the lack of effective collaboration between agencies.⁶⁴⁷ The study noted: 'Without addressing such barriers, there is doubt about the sustainability or effectiveness of screening'.⁶⁴⁸

In their submission, the Caroline Chisholm Society (CCS) referred to a Victorian State Government funded family violence early intervention pilot called *Children and Mothers in Mind* which is a program delivered in partnership with CCS, McAuley Community Services for Women, and VincentCare.⁶⁴⁹ According to their submission, the program 'provides therapeutic interventions to support young women and children under the age of four, who are victim survivors of family violence and are no longer living with the perpetrator of the abuse'.⁶⁵⁰

The program is designed to increase parenting competency, support mothers and young children early to overcome the impact of trauma, improve developmental outcomes for children, improve and repair the mother-child bond, and decrease mother and child isolation.⁶⁵¹ They state that the program recognises 'that women who have experienced family violence often lose confidence in their ability to parent effectively, particularly if their parenting is or has been undermined or criticised by an abusive partner, leading to isolation and unhealthy coping mechanisms'.⁶⁵² The program runs at Goulburn Valley, Western Melbourne, Barwon, Gippsland, and North East Melbourne.⁶⁵³

⁶⁴³ Hume City Council, submission no. 69, p. 13.

⁶⁴⁴ City of Melbourne, submission no. 21, p. 2.

⁶⁴⁵ Ms Cassie Austin, submission no. 24, p. 2.

⁶⁴⁶ Ibid.

⁶⁴⁷ Ibid., citing C D Stayton and M M Duncan, 'Mutable influences on intimate partner abuse screening in health care settings: A synthesis of the literature', *Trauma Violence Abuse*, vol. 6, no. 4, 2005.

⁶⁴⁸ C D Stayton and M M Duncan, 'Mutable influences on intimate partner abuse screening in health care settings: A synthesis of the literature', *Trauma Violence Abuse*, vol. 6, no. 4, 2005.

⁶⁴⁹ Caroline Chisholm Society, submission no. 29, p. 19.

⁶⁵⁰ Ibid., p. 42.

⁶⁵¹ Ibid.

⁶⁵² Ibid.

⁶⁵³ Caroline Chisholm Society (CCS), 'Children and mothers in mind', CCS website, accessed 16 November 2017, <<http://caroline.org.au/cmim>>.

In their most recent review of all cases of maternal, perinatal, and paediatric deaths, the Consultative Council on Obstetric and Paediatric Mortality and Morbidity (CCOPMM) identified that in 2016, domestic violence was a known contributing factor in two maternal deaths.⁶⁵⁴ In the years 2011-2016, CCOPMM note that family violence was identified as being the principal cause in one maternal death, but noted that deaths related to domestic violence may be underestimated due to ‘inadequate ascertainment’ of domestic violence.⁶⁵⁵

As explained below in section 3.7, recent changes to Medicare were made regarding screening for family violence during the perinatal period. Changes were made to existing items to put a greater emphasis on managing and screening for domestic violence during pregnancy, and a new item (16407) was introduced to include a mental health assessment, including screening for domestic violence.⁶⁵⁶

The Committee welcomes the recent changes to Medicare that allow for greater screening for the presence of domestic violence in the lives of perinatal women, and the Victorian Government’s extra support for Maternal and Child Health services provided to those at risk of family violence. The Committee believes that screening for domestic violence does, however, need to be available and accessible across the perinatal period. The Committee concurs with and supports the Royal Commission into Family Violence recommendation, mentioned above, that routine screening for family violence occur in all public antenatal settings.⁶⁵⁷

3.7 Screening during the perinatal period

The Australian Clinical Practice Guideline for Mental Health Care in the Perinatal Period recommends routine and universal screening to identify the risk and the presence of depression and anxiety during pregnancy and in the postnatal period.⁶⁵⁸ Regarding the rates of screening, at a public hearing in Melbourne, Dr Nicole Highet, Founder and Executive Director of COPE, told the Committee:

Currently we do not really know what the screening rates are, despite the significant Commonwealth and state investments to date, and we also know that screening is rarely occurring in the private sector at all.⁶⁵⁹

Dr Highet referred to the new Medicare items, discussed below, which enable GPs and obstetricians to receive Medicare rebates to undertake screening, which, she noted, ‘should really increase the rates of screening in the private sector’.⁶⁶⁰

⁶⁵⁴ Consultative Council on Obstetric and Paediatric Mortality and Morbidity (CCOPMM), *Victoria’s mothers, babies and children 2016*, Melbourne, 2017, p. 15.

⁶⁵⁵ *Ibid.*, p. 52.

⁶⁵⁶ Department of Health, ‘Changes to MBS items for obstetrics services’, Australian Government, accessed 17 May 2018, <<http://www.mbsonline.gov.au/internet/mbsonline/publishing.nsf/Content/Factsheet-ObstetricsServices>>.

⁶⁵⁷ See Recommendation 96: State of Victoria, *Royal Commission into Family Violence: Report and Recommendations*, Vol. 3, Parliamentary Paper No. 132, Victorian Government Printer, Melbourne.

⁶⁵⁸ M-P Austin, N Highet and the Expert Working Group, *Mental Health Care in the Perinatal Period: Australian Clinical Practice Guideline*, Centre of Perinatal Excellence (COPE), Melbourne, 2017.

⁶⁵⁹ Dr Nicole Highet, Founder and Executive Director, Centre of Perinatal Excellence (COPE), Family and Community Development Committee public hearing – Melbourne, 4 September 2017, transcript of evidence, p. 3.

⁶⁶⁰ *Ibid.*

Ms Suzanne Higgins, a midwife and credentialed mental health nurse who represented the Australian College of Mental Health Nurses in reviewing the Australian Clinical Practice Guideline for Mental Health Care in the Perinatal Period, also told the Committee that screening rates at private hospitals have lagged behind public hospitals:

In Geelong up until about four years ago, screening only happened in the public hospital but now I'm proud to say Raphael was involved in introducing antenatal screening at St John of God through their maternity booking in process ...

Around Australia, the private hospitals have been very slow to take up screening. There are some interesting relationships between who manages the care of pregnant women and with obstetricians in the private sector. It has been a little tricky getting screening in the private sector but I'm pleased to say it's on the agenda and it's certainly strongly advocated in the Clinical Practice Guidelines for Perinatal Mental Health.⁶⁶¹

Ms Terri Smith from PANDA told the Committee, at a public hearing in Melbourne, that screening is not universally undertaken despite the fact that screening has been in place for some time, the importance of screening is known, and screening is encapsulated in the Guideline.⁶⁶² She said:

Sometimes what happens with screening is that the health professionals start it, but they actually fade off by the time you get to the pointy questions, which are at the end because they think, 'Mum looks okay'. In the Edinburgh score the pointy questions at the bottom are, 'Have you thought about hurting your child?', 'Have you thought about hurting yourself?'. It is not uncommon for professionals to think, 'No, you're looking fine, you're doing okay, you've answered the other questions well, we'll close that off'.⁶⁶³

Ms Cheree Cosgriff, Grampians FaPMI Coordinator, also told the Committee of the fear maternity staff who are not mental health trained may have in putting the more confronting questions proposed by screening tools to their patients:

Question 10 in the Edinburgh [Postnatal Depression Scale] talks about self-harm and it's always the scary thing for anyone who is not familiar with mental health and having those conversations about I don't want to ask that question, what do I do if I get a response where they say yes?⁶⁶⁴

The Committee also heard about the trial of new digital screening technology, which would enable screening to be conducted on an iPad, and facilitate screening to be conducted more effectively in other languages.⁶⁶⁵

⁶⁶¹ Ms Suzanne Higgins, Midwife and Credentialed Mental Health Nurse, Family and Community Development Committee public hearing – Geelong, 11 December 2017, transcript of evidence, p. 4.

⁶⁶² Ms Terri Smith, Chief Executive Officer, Perinatal Anxiety and Depression Australia, Family and Community Development Committee public hearing – Melbourne, 16 October 2017, transcript of evidence, pp. 3-4.

⁶⁶³ *Ibid.*, p. 4.

⁶⁶⁴ Ms Cheree Cosgriff, Grampians Coordinator, Families where a Parent has a Mental Illness, Family and Community Development Committee public hearing – Geelong, 11 December 2017, transcript of evidence, p. 11.

⁶⁶⁵ Centre of Perinatal Excellence (COPE), submission no. 4, p. 1.

As noted in COPE's submission and evidence at the public hearing, current screening practices use pen and paper to complete questionnaires and are prone to scorer error.⁶⁶⁶ They state that current screening practices also rely on trained health professionals to provide timely information relevant to the individual's score, they do not cater for the needs of non-English speaking patients, and they do not enable the automated collection and collation of data, preventing the evaluation of screening outcomes or the ability to inform policy and service provision.⁶⁶⁷

The Parent-Infant Research Institute (PIRI), who were part of the development of COPE's digital screening platform pilot, stated in their submission that many professionals lack 'on-the-spot access to gold-standard guidance for interpreting, and acting on, women's screening results'.⁶⁶⁸ They stated:

This is a major gap that could be addressed by the introduction of digital systems to guide professionals with on-screen prompts for interpretation of screening results and psychosocial information adhering to national guidelines. This would allow the user to develop a structured management plan tailored to each client's needs and have an electronically produced onward referral form.⁶⁶⁹

The Committee heard overwhelming support for universal screening, although some stakeholders raised concerns about workplace barriers to screening, such as time limitations, workforce competence in asking sensitive questions, and the need for suitable referral pathways. In her submission, Ms Suzanne Higgins, a midwife and credentialed mental health nurse who represented the Australian College of Mental Health Nurses in reviewing the Australian Clinical Practice Guideline for Mental Health Care in the Perinatal Period, said:

Midwives in particular need to be skilled up to conduct screening and psychosocial assessment in the area of mental health and have confidence about care pathways for referral. Their workload needs to facilitate time to conduct necessary depression screening and psycho-social assessment with options for clinical supervision for capacity building, debriefing and maintain well-being to ensure professional longevity.⁶⁷⁰

The Australian Nursing and Midwifery Federation (Victorian Branch) stated:

Most health service antenatal clinic templates provide insufficient time to enable midwives to provide all pregnancy care required. In relation to mental health screening, midwives need appropriate education and training to perform this screening and an increase in consultation time.⁶⁷¹

Ms Terri Smith from PANDA told the Committee at a public hearing in Melbourne that accurate screening depends on the skill of the workforce:

You have heard, I know, about electronic screening and the opportunities to use a different tool. We think that is a great step forward, but it is not the answer in itself, because what button you press might not be what you are feeling, so there is an

⁶⁶⁶ Centre of Perinatal Excellence (COPE), submission no. 4, attachment p. 6; Dr Nicole Highet, Founder and Executive Director, Centre of Perinatal Excellence (COPE). Family and Community Development Committee public hearing – Melbourne, 4 September 2017, transcript of evidence, p. 4.

⁶⁶⁷ Centre of Perinatal Excellence (COPE), submission no. 4, attachment p. 6.

⁶⁶⁸ Parent-Infant Research Institute (PIRI), submission no. 79, p. 3.

⁶⁶⁹ Ibid.

⁶⁷⁰ Ms Suzanne Higgins, submission no. 30, p. 2.

⁶⁷¹ Australian Nursing and Midwifery Federation (Victorian Branch), submission no. 67, p. 5.

important message there about the skill of the health workforce. We think that the midwives out there, the maternal child health nurses out there, are all there to do a great job. They are good people, mostly women, getting on every day dealing with a busy life and a busy job, but they are not always doing the best work they can do because of, in our view, a lack of skill around having conversations around mental illness and perhaps making some judgements around things that might not be quite true up-front.⁶⁷²

The Jean Hailes Research Unit noted in their submission that screening programs ‘are difficult to implement systematically because of health system constraints and staff perceptions that appropriate referral services are not available’.⁶⁷³ Likewise, the submission from the Families where a Parent has a Mental Illness (FaPMI) Program stated: ‘Without the appropriate resources to support a suitable referral pathway, screening itself is rendered redundant’.⁶⁷⁴ Professor Jeannette Milgrom, Executive Director of the Parent-Infant Research Institute, supported this point, telling the Committee that ‘[t]he best research that we know shows that screening is only effective if it is integrated with something further down the line’.⁶⁷⁵

3.7.1 Edinburgh Postnatal Depression Scale

The Edinburgh Postnatal Depression Scale (EPDS) is a widely used assessment tool for postnatal depression by health professionals and consists of a set of ten questions.⁶⁷⁶ The Committee heard and the Guideline notes that despite its name, the EPDS is also used in prenatal care.⁶⁷⁷ The Committee also heard that the EPDS measures anxiety symptoms, as well as depression symptoms.⁶⁷⁸ It is not a diagnostic tool, but aims to identify women who may benefit from follow-up care, such as a mental health assessment, which may then, in turn, lead to a diagnosis based on the ‘accepted diagnostic criteria’ set out in the DSM-5 or the International Classification of Disease (ICD-10).⁶⁷⁹

⁶⁷² Ms Terri Smith, Chief Executive Officer, Perinatal Anxiety and Depression Australia, Family and Community Development Committee public hearing – Melbourne, 16 October 2017, transcript of evidence, p. 4.

⁶⁷³ Jean Hailes Research Unit, submission no. 14, p. 2. See also: J Fisher, E Chatham, S Haseler et al., ‘Uneven implementation of the National Perinatal Depression Initiative: Findings from a survey of Australian women’s hospitals’, *Australian and New Zealand Journal of Obstetric Gynaecology*, vol. 52, pp. 559-564, 2012.

⁶⁷⁴ Families where a Parent has a Mental Illness (FaPMI), submission no. 28, p. 2.

⁶⁷⁵ Professor Jeannette Milgrom, Executive Director, Parent-Infant Research Institute, Family and Community Development Committee public hearing – Melbourne, 27 November 2017, transcript of evidence, p. 4.

⁶⁷⁶ The Committee also heard of other tools, including the K10 anxiety and depression checklist, and psychosocial assessment tools, which focus more on risk, rather than an assessment of current anxiety/depression symptoms. For more see: M-P Austin, N Highet and the Expert Working Group, *Mental Health Care in the Perinatal Period: Australian Clinical Practice Guideline*, Centre of Perinatal Excellence (COPE), Melbourne, 2017, pp. 31-33.

⁶⁷⁷ *Ibid.*, p. 27; Mr Nicholas Place, Manager, Primary Mental Health Team, South West Healthcare, Family and Community Development Committee public hearing – Warrnambool, 11 October 2017, transcript of evidence, p. 4.

⁶⁷⁸ Ms Suzanne Higgins, Midwife and Credentialed Mental Health Nurse, Family and Community Development Committee public hearing – Geelong, 11 December 2017, transcript of evidence, p. 6.

⁶⁷⁹ Centre of Perinatal Excellence (COPE), ‘Assessing women for perinatal anxiety’, accessed 16 November 2017, <<http://cope.org.au/health-professionals-3/perinatal-mental-health-disorders/perinatal-anxiety/assessing-women-perinatal-anxiety>>.

It is recommended that all women should complete the EPDS at least once, but preferably twice in both the antenatal and postnatal period.⁶⁸⁰ The Guideline recommends further assessment of women with an EPDS score of 13 or more.⁶⁸¹ Nonetheless, it is important to note that Aboriginal and Torres Strait Islander women may score lower on the EPDS but still have depression. As noted on the COPE website:

For Aboriginal and Torres Strait Islander women, the score may be influenced by the woman's understanding of the language used, mistrust of mainstream services or fear of consequences of depression being identified.

Translations of the EPDS developed in consultation with women from Aboriginal communities have been found to identify a slightly higher number of women experiencing symptoms of depression.⁶⁸²

Furthermore, cultural considerations also need to be made when testing women from culturally and linguistically diverse backgrounds:

Cultural practices (such as attending the consultation with a family member) and differences in emotional reserve and the perceived degree of stigma associated with depression may also influence the performance of the EPDS in women from culturally and linguistically diverse backgrounds.⁶⁸³

The Committee heard of the importance of screening for mental illness during the perinatal period and the need for suitable referral pathways. The Committee understands that while some antenatal screening does now occur, it is by no means universal. There is support for digital screening technology. Depending on what model of antenatal care a woman is receiving, screening for anxiety and depression is best conducted by the person primarily responsible for the woman's care, whether that be by a GP or midwife under a 'shared care' arrangement, an obstetrician, a private midwife, or a public midwife in a hospital.

In their most recent report, the Consultative Council on Obstetric and Paediatric Mortality and Morbidity (CCOPMM), recommended that in improving the provision of maternal mental health services, health services should implement the Australian Clinical Practice Guideline for Mental Health in the Perinatal Period, 'to screen all pregnant women for anxiety and depression early in pregnancy, and repeated at least once during the pregnancy'.⁶⁸⁴

The Committee is also cognisant of the fact that, without appropriate pathways to treatment being available, screening for mental health is, as Families where a Parent has a Mental Illness (FaPMI) and Professor Jeannette Milgrom, Executive Director of the Parent-Infant Research Institute have recognised in their statements above, in itself redundant. The Committee is of the view that pathways to treatment for perinatal mental health illnesses are not consistently available or accessible. Health

⁶⁸⁰ Ibid.

⁶⁸¹ M-P Austin, N Highet and the Expert Working Group, *Mental Health Care in the Perinatal Period: Australian Clinical Practice Guideline*, Centre of Perinatal Excellence (COPE), Melbourne, 2017, p. 7.

⁶⁸² Centre of Perinatal Excellence (COPE), 'Using the EPDS as a screening tool', accessed 16 November 2017, <<http://cope.org.au/health-professionals-3/perinatal-mental-health-disorders/calculating-score-epds>>.

⁶⁸³ Ibid.

⁶⁸⁴ Consultative Council on Obstetric and Paediatric Mortality and Morbidity (CCOPMM), *Victoria's Mothers, Babies and Children 2016*, 2017, p. 3. See: Centre of Perinatal Excellence (COPE), 'NEW National Perinatal Mental Health Guideline', October 2017, accessed 30 October 2017, <<http://cope.org.au/about/review-of-new-perinatal-mental-health-guidelines>>.

professionals need clear pathways to refer women identified as being at risk of or experiencing mental illnesses during the perinatal period. It is also important that these pathways be available for the referral of family members.

Consistent with the recommendations made by CCOPMM and in the Guideline, and based on all the evidence the Committee heard, the Committee therefore recommends that:

RECOMMENDATION 3.2: The Victorian Government establish a taskforce of key stakeholders to consult with relevant health professionals and implement a state-wide program that ensures that all pregnant women will be screened for anxiety and depression by a health professional throughout pregnancy, as envisioned in the Australian Clinical Practice Guideline for Mental Health Care in the Perinatal Period.

- Screening to be conducted using a standard assessment tool.
- Screening to be repeated throughout the pregnancy.
- The taskforce to investigate and recommend action to ensure that all health professionals have available clear referral pathways and services for treatment for women and families who are identified as having, or at risk of having, perinatal mental health issues.
- The program include a state level accountability process.

The Committee appreciates that not all front-line health professionals are currently trained, or sufficiently trained, to conduct perinatal mental health screening. The Committee believes that the Victorian Government needs to work with key stakeholders to ensure that the perinatal health workforce has the training and tools to conduct perinatal mental health screening during pregnancy. Accordingly, the Committee recommends that:

RECOMMENDATION 3.3: The Victorian Government work with key stakeholders to ensure that the perinatal health workforce has the training and assessment tools to conduct perinatal mental health screening during pregnancy.

The Committee further discusses referral pathways to treatment later in this Chapter. Referral pathways are also discussed in relation to rural and regional perinatal services in Chapter Four, and with regard to Maternal and Child Health services in Chapter Six.

3.8 Bereavement

Approximately one in four pregnancies end in miscarriage and one baby in every 120 births will be stillborn or die within the first 28 days of life.⁶⁸⁵ The submission of Sands Australia stated that bereaved mothers have a four-fold increased risk for depression and a seven-fold risk of screening positive for post-traumatic stress disorder.⁶⁸⁶ The risk of experiencing postnatal depression and anxiety is also

⁶⁸⁵ Sands Australia, submission no. 86, p. 2.

⁶⁸⁶ Ibid., pp. 9, 7.

increased following the birth of a subsequent healthy baby.⁶⁸⁷ Furthermore, research indicates that rates of anxiety in women during a subsequent pregnancy are likely to be higher if she falls pregnant within 12 months of a stillbirth.⁶⁸⁸

At a public hearing in Melbourne, the Committee heard from Sands Australia and Red Nose about the services they provide to bereaved parents. Sands Australia's model of support is a peer-to-peer support model and they provide a 24/7 support line staffed by trained volunteers who are bereaved parents themselves, and they provide a men's support line provided by a trained male bereaved parent supporter. They also provide a low-cost e-learning course to train health professionals in bereavement care.⁶⁸⁹

Ms Anita Guyett, General Manager Improving Bereavement Care of Sands Australia, told the Committee at a public hearing in Melbourne that there is a lack of grief education in maternity services:

Some examples of inconsistency or lack of grief education are: it is not uncommon for bereaved parents to be placed in maternity wards with crying babies in the background, and we are so sure that every attempt is made for that not to happen but it still occurs and it is quite distressing for bereaved parents; differences in changes of shifts, so the mother having to re-explain that she has lost her baby to midwives, nurses and not necessarily just the clinical staff but the tea lady that comes in; nurses not knowing what support the patient might have already received or not received; and the really important one is the language used, which I touched on before.⁶⁹⁰

At a public hearing in Melbourne, Ms Petra den Hartog, a bereavement care specialist at Red Nose, told the Committee about the support provided by Red Nose for families, such as one-on-one support through a trained bereavement counsellor, memorial services, support for men, and workshops for bereaved siblings, grandparents, and for people having a subsequent pregnancy. They also have a group for people who have had to terminate a much-wanted pregnancy for abnormality and provide workshops for health professionals.⁶⁹¹

Red Nose also outreaches to parents following a referral from a health professional. Ms den Hartog stated:

We do not wait for them to make the phone call to us. We know many bereaved parents just cannot make that first call, so we outreach to parents and we ensure support for them immediately we get that referral.⁶⁹²

The Committee heard about the importance of peer-to-peer support. The Compassionate Friend Victoria also provides support for parents and siblings after a child dies and has a 24-hour support line, staffed by members who have been trained as peer-support volunteers.⁶⁹³

⁶⁸⁷ Centre of Perinatal Excellence (COPE), 'Coping after a stillbirth', accessed 16 November 2017, <<http://cope.org.au/coping-stillbirth>>.

⁶⁸⁸ Ibid.

⁶⁸⁹ Ms Anita Guyett, General Manager Improving Bereavement Care, Sands Australia, Family and Community Development Committee public hearing – Melbourne, 27 November 2017, transcript of evidence, p. 2.

⁶⁹⁰ Ibid., p. 5.

⁶⁹¹ Ms Petra den Hartog, Bereavement Care Specialist, Red Nose, Family and Community Development Committee public hearing – Melbourne, 27 November 2017, transcript of evidence, p. 2.

⁶⁹² Ibid.

⁶⁹³ The Compassionate Friends, 'Our services', accessed 30 November 2017, <<https://www.compassionatefriendsvictoria.org.au/about-us/our-services>>.

Mr Graham Fountain, the Chief Executive Officer of Remembrance Parks – Central Victoria, told the Committee at a public hearing in Bendigo that parents are left in ‘a state of isolation’ following the death of a baby because people do not know how to speak to them or how to confront the situation. He stated:

We would strongly encourage the committee, within its terms of reference and particularly those terms of reference that go to the quality, the type of care and the identification of best practice, to not stop its considerations at the hospital door, so to speak... It is really about a whole-of-government system and a continuum of care that needs to occur in the space in the unfortunate circumstance of the loss of a loved one, which is particularly traumatic with the loss of a baby or a stillborn death. We experience this every day. What our change of strategic direction has identified is an increased demand for someone to provide that support to the families and particularly the parents of the loved ones so they are not isolated and so they have a continuum of support during what is a very fragile time in their life.⁶⁹⁴

The Committee heard that it was important for parents who had lost a child to receive additional support and follow up, to have their loss acknowledged, and to have time to grieve the loss. One mother, whose son was stillborn at 35 weeks, told the Committee that parents do not always have a supported experience immediately following a stillbirth and during the follow up of a stillbirth.⁶⁹⁵ She wrote in her submission:

The care we received immediately after Luca’s birth was great. We spent time with him and were assisted in bathing and dressing him. We were not pressured to leave, although I didn’t realise we could stay the night and we left at the end of the day which I regret having since heard other parent’s experiences. The hospital arranged a photographer and created a memories folder.

Unfortunately this level of care is not experienced by all parents following a stillbirth. Often the loss is minimised. Parents are not always made aware that they can bath and dress their baby or that they can spend time with their baby. Some hardly have any photos and don’t have the experience of friends and family visiting. I’ve come across lots of parents who have desperately regretted not doing these things. This makes grieving so much harder, adding extra losses to grieve.⁶⁹⁶

She also stated that hospitals lack appropriate facilities for parents to wait for follow up appointments as parents often wait in the antenatal waiting area.⁶⁹⁷ She noted that governments could purchase cuddle cots for maternity hospitals, which is a cooling system designed to fit in a small cot allowing a family to spend more time with their baby. She also noted:

I would like to see bereavement rooms as standard in public maternity hospitals. Parents often find themselves in the maternity ward if they want to stay – listening to the happy sounds of parents cherishing their newborns.⁶⁹⁸

The Committee also heard this from Ms Kirrily Tibb, who told the Committee of her experience of miscarriage, and the lack of an appropriate space for her to grieve and receive care:

⁶⁹⁴ Mr Graham Fountain, Chief Executive Officer, Remembrance Parks Central Victoria, Family and Community Development Committee public hearing – Bendigo, 24 October 2017, transcript of evidence, p. 2.

⁶⁹⁵ Ms Rebecca Gelsi, submission no. 37, pp. 2-3.

⁶⁹⁶ Ibid.

⁶⁹⁷ Ibid., p. 3.

⁶⁹⁸ Ibid.

I spent 5 hours waiting in tears in the emergency waiting room, watching as people came in celebrating the births of babies, coming in in labour and others also facing miscarriage, I was given a brochure titled 'Miscarriage'; and told to read it in the very public waiting room, still very emotional over the news I would no longer be pregnant and no longer be welcoming a baby in 2017...⁶⁹⁹

Ms Gabrielle Gamble, speaking as a member of the Aboriginal community at a public hearing in Bendigo, told the Committee of the particular need to enable Aboriginal families to deal with loss in a manner that is culturally appropriate:

We really do need to take in the cultural aspect so the sorry business is dealt with, and it is not going to be dealt with 40 years down the track when mum realises, 'I did have choices, but nobody told me'.

I am harping on the negative outcomes, but once an infant dies and is still in the care of the hospital, that is a moment in time when, once that baby is removed, you have lost the opportunity to give that mum and her partner and extended family the ability to culturally deal with this sorry business and to give the options. As hard as that may seem, I believe there should be counselling offered with the options, particularly for the Aboriginal women.⁷⁰⁰

The Committee received a submission from the Australasian Sonographers Association outlining the negative impact of a poorly handled delivery of bad news as part of an ultrasound on mothers and families, and noting a need for sonographers to be trained in how to best help families when delivering such news:

Although the benefits of medical diagnostic ultrasound during pregnancy are well known there is also evidence linking the benefits of ultrasound and the relationship between maternal anxiety during pregnancy, poor perinatal history, prenatal diagnosis and maternal bonding. The patient's experience during an ultrasound scan, especially in the event of a lethal fetal diagnosis, is greatly affected by the sonographer providing the medical diagnostic ultrasound.

There is a genuine need to improved [sic] ultrasound training for the sonographers to deal with miscarriage, perinatal loss, maternal anxiety and delivering bad news. There is significant evidence of the negative impact of poor handling of communicating medical diagnostic ultrasound results has on expectant mothers and families, especially where there are fetal anomalies. Without this there is a risk that Victorian expectant mothers' health, care and wellbeing cannot be assured. This need to provide training in looking after patients after adverse ultrasound findings extends to all health professionals involved in the provision of perinatal services.⁷⁰¹

The Australasian Society for Ultrasound in Medicine similarly told the Committee in their submission:

Specific training on handling bereavement or difficult discussions with patients is limited and dependent on the clinical practice. Discussions as to clinical findings is also site dependent as a number of practices have protocols in place to ensure the sonographer does not communicate any findings, but instead the doctor delivers this news or discusses this with the referring doctor.⁷⁰²

⁶⁹⁹ Ms Kirrily Tibb, submission no. 58, p. 1.

⁷⁰⁰ Ms Gabrielle Gamble, Family and Community Development Committee public hearing – Bendigo, 24 October 2017, transcript of evidence, p. 2.

⁷⁰¹ Australasian Sonographers Association, submission no. 100, p. 5.

⁷⁰² Australasian Society for Ultrasound in Medicine, submission no. 101, p. 4.

The Committee heard about the importance of bereavement care for families who experience loss during the perinatal period. The Committee believes that training in bereavement care should be provided to all health professionals working in maternity services, including nurses, midwives, obstetricians, sonographers and GPs. Accordingly, the Committee recommends that:

RECOMMENDATION 3.4: The Victorian Government engage with Victorian hospitals, key providers and stakeholders to develop a training package on bereavement care for health practitioners.

The Committee heard about the important assistance provided to grieving families by organisations such as Sands Australia and Red Nose. Accordingly, the Committee recommends that:

RECOMMENDATION 3.5: The Victorian Government work with and support the organisations that support families grieving pregnancy loss or newborn death, including creating linkages between health services and those organisations.

3.9 Treatments and services for women

There are various treatments and services available for women experiencing mental health illnesses in the perinatal period. This section describes services such as mother baby units, Early Parenting Centres, and the national perinatal mental health helpline. The section following discusses the National Perinatal Depression Initiative (NPDI), the Perinatal Emotional Health Programs (PEHP), and the impact of the loss of the NPDI funding.

3.9.1 Early Parenting Centres (EPC)

Victoria has three publicly funded Early Parenting Centres (EPC): Tweddle Child and Family Health in Footscray, the O'Connell Family Centre (part of Mercy Health) in Canterbury, and the Queen Elizabeth Centre in Noble Park. These EPCs offer residential, day and community programs for families with children from birth up to before the child's fourth birthday, such as day stay programs, residential programs, and parenting education workshops. They offer 4-5 night admissions and programs to assist with mild to moderate maternal mental health problems and the management of unsettled infant behaviours.

The Committee heard that there were not enough Early Parenting Centres and that consumers often faced long waiting lists.⁷⁰³ In their submission to the Inquiry, the Jean Hailes Research Unit stated that Early Parenting Centres are associated with sustained improvements in maternal mood and infant manageability, yet long waiting lists and high occupancy rates 'suggest an unmet need for these services'.⁷⁰⁴ The submission noted that around six per cent of women in Victoria who have recently given birth are admitted to early parenting centres annually, and relatively few

⁷⁰³ Hobson Bay City Council, submission no. 26, p. 2; The Australian College of Mental Health Nurses, submission no. 48; Tweddle Child and Family Health Service, submission no. 45; Jean Hailes Research Unit, submission no. 14.

⁷⁰⁴ Jean Hailes Research Unit, submission no. 14, p. 1.

women (less than one per cent) are admitted to specialist psychiatric mother baby units, and the low occupancy rates of these units, they add, suggests that Victoria has 'sufficient beds to meet community needs'.⁷⁰⁵

In their submission, the Caroline Chisholm Society recommended the establishment of a service akin to an Early Parenting Centre in Shepparton, with links to existing services such as the Shepparton Hospital and supported by community-based perinatal services working in partnership:

The demand in the region is high with a high-level of family complexity and regional disadvantage most notably long-term unemployment and poverty.⁷⁰⁶

The Committee heard about the value of Early Parenting Centres, but that consumers faced long waiting lists for admission to an Early Parenting Centre. On this issue, the Committee recommends that:

RECOMMENDATION 3.6: The Victorian Government evaluate the demand for Early Parenting Centres across the state with a view to expanding this service to provide effective coverage for mothers, babies and families.

3.9.2 Mother baby units

Several hospitals in Victoria have tertiary level psychiatric mother baby units, which provide for the admission of mothers with a mental illness along with their baby when inpatient psychiatric treatment is required. These facilities allow for the baby to stay with the mother in her room, thereby assisting in the development of parenting skills and a positive relationship with the baby. As noted in the Guideline, this approach may not be appropriate for women who are severely ill and incapable of caring for the baby, or where the safety of the baby is compromised.⁷⁰⁷

There are six public mother baby units in Victoria: Austin Health (Austin Hospital), Monash Medical Centre, Werribee Mercy Hospital, Latrobe Regional Hospital, Ballarat Health Service (from late 2015) and Bendigo Health (from February 2018). There are also private mother baby units in Victoria, including at Mitcham Private Hospital, Northpark Private Hospital, Waverley Private Hospital, and Masada Private Hospital.

Both the Parent Infant Inpatient Program at the Austin Hospital and the Mother and Baby Unit at the Monash Medical Centre consist of six psychiatric beds and cots. The Mother Baby Unit at Werribee Mercy Hospital is an eight bed, eight cot inpatient unit, and the Mother and Family Unit in Ballarat is a five bed (Monday to Friday) service. Latrobe Regional Hospital offers a five bed unit (Monday to Friday). Bendigo Health offers a five bed Parent and Infant Unit which is the only unit of its kind in regional Australia which offers a 24-hour service.⁷⁰⁸

⁷⁰⁵ Ibid.

⁷⁰⁶ Caroline Chisholm Society, submission no. 29, p. 30.

⁷⁰⁷ M-P Austin, N Highet and the Expert Working Group, *Mental Health Care in the Perinatal Period: Australian Clinical Practice Guideline*, Centre of Perinatal Excellence (COPE), Melbourne, 2017, p. 48; National Health and Medical Research Council, *Clinical Practice Guideline for the Management of Borderline Personality Disorder*, National Health and Medical Research Council, Melbourne, 2012, p. 48.

⁷⁰⁸ Mark Kearney, 'Bendigo mental health unit to treat mothers and babies side by side', *Bendigo Advertiser*, 5 September 2016, accessed 17 May 2018, <<http://www.bendigoadvertiser.com.au/story/4143215/parents-and-children-get-care-together>>. See also: Bendigo Health, 'Parent Infant Unit', accessed 20 February 2018, <http://www.bendigohealth.org.au/search_detail.asp?PageID=179>.

The Committee heard from Ms Christine Hoyne, the nurse unit manager of the Agnes Parent and Infant Unit (Latrobe Regional Hospital) at a public hearing in Warragul. Ms Hoyne told the Committee that the Agnes unit had had 486 admissions since opening three years ago:

We are open from Monday to Friday. The parent is the admitted client, although baby obviously comes in with them. Both parents are welcome to stay, and we do have lots of couples that do stay. Since June 2015 we have been full, now we have a bit of a waitlist which fluctuates between two weeks and about four to five weeks.

It has been really well received. Initially there was a bit of a stigma that it was seen as a mental health unit, that only really sick and crazy people go to that, but we changed a few processes and now it has been embraced by the community. Certainly many of the women that come to it talk about it with other mothers and tell them and recommend that they go in, and there is also the fact that women can self-refer, ring the unit directly, refer themselves in, discuss it with a clinician. They can even come and have a walk around the unit — anything that they want — so that they feel comfortable and they can see how normal it is.⁷⁰⁹

In October 2016, Uniting Care ReGen opened a state-wide voluntary mother and baby drug and alcohol withdrawal service, funded by DHHS.⁷¹⁰ This service, the first of its kind in Victoria, accommodates up to four mothers and their babies at Curran Place in Ivanhoe.⁷¹¹

In their submission, Tweddle stated that they were particularly concerned by the long waiting lists for mother baby unit beds and the decreasing services to support families experiencing postnatal depression:

This reduction in specialist services delays clinical interventions that may prevent the incidence of suicide ... The decreasing number of support services available to mothers, fathers and families (due to the NPDI cuts) may contribute to a rise in maternal suicide rates as access to specialist clinical interventions becomes more difficult and harder to navigate to find the most appropriate help.⁷¹²

In their submission to the Inquiry, RANZCP advocated for further research into a model of care in mother baby units that best supports maternal mental health, infant development, and improved parenting, including research into the stepped-care model and how follow up treatments can support the infant-parent relationship.⁷¹³

709 Ms Christine Hoyne, Nurse Unit Manager, Parent and Infant Unit, Latrobe Regional Hospital, Family and Community Development Committee public hearing – Warragul, 8 December 2017, transcript of evidence, p. 5.

710 Uniting Care ReGen, 'Mother and baby unit', accessed 17 May 2018, <<http://www.regen.org.au/treatment-support/withdrawal/mother-and-baby>>.

711 Hon. Martin Foley, Minister for Mental Health, 'New service to put mothers on the right path', media release, 21 November 2016.

712 Tweddle Child and Family Health Service, submission no. 45, p. 12.

713 Royal Australian and New Zealand College of Psychiatrists (Victorian Branch), submission no. 25, p. 7 (recommendation 13). Stepped care refers to an 'evidence-based, staged system comprising a hierarchy of interventions, from the least to the most intensive, matched to the individual's needs. Within a stepped care approach, an individual will be supported to transition up to higher intensity services or transition down to lower intensity services as their needs change': Department of Health, 'PHN Primary mental health care flexible funding pool implementation guidance', Australian Government, accessed 1 December 2017, <<http://www.health.gov.au/internet/main/publishing.nsf/content/2126B045A8DA90FDCA257F6500018260/%24File/1PHN%20Guidance%20-%20Stepped%20Care.PDF>>, p. 13.

Ms Kassie Hocking spoke to the Committee in Mildura about her experience as a mother going into a mother baby unit, and the financial burden that this imposed on her family:

To give you some context of my experience, when I had my first child I had quite severe PND and anxiety. I ended up having to leave Mildura to go to Bundoora for a mother and baby unit.

...

I had to hop on a plane with a new baby, fly to Bundoora in Melbourne, pay for all of that myself, get myself to a private hospital and pay for that ourselves as well. Luckily we had private health insurance.⁷¹⁴

The Committee recognises the importance of mother baby units and heard that there could be long waiting lists for admission. Accordingly, the Committee recommends that:

RECOMMENDATION 3.7: The Victorian Government evaluate the demand for mother baby units across the state with a view to expanding this service to meet the current level of unmet demand.

3.9.3

National helpline: Perinatal Anxiety and Depression Australia (PANDA)

At a public hearing in Melbourne, the Committee heard from PANDA, a not-for-profit organisation established 30 years ago. PANDA provides the only national helpline dedicated to perinatal mental health. PANDA's national helpline is staffed by professional counsellors and around 25 peer support volunteers.⁷¹⁵ At a public hearing in Melbourne, Ms Terri Smith from PANDA explained the staffing arrangement and the roles provided by professionals and volunteers:

We have both a professional staff — professional counsellors, and that is funded through the national helpline, so it is the federal government — but we also have a peer support team, and they are half-funded through state government funding ... One of the beautiful things that the peer support volunteers can do is a lot of follow-up calls. The professional counsellors take all the incoming calls to the service now. That is not the model we used to have, but basically as we became more competent, the nature of the calls just started to move up the risk scale. But there is still a large group of women who, once we sort out the key issues for them, can really benefit from the peer support volunteers, who are able to say, 'It happened to me, and I'm fine' — that message of recovery.⁷¹⁶

⁷¹⁴ Ms Kassie Hocking, Family and Community Development Committee public hearing – Mildura, 9 November 2017, transcript of evidence, p. 2.

⁷¹⁵ Ms Terri Smith, Chief Executive Officer, Perinatal Anxiety and Depression Australia, Family and Community Development Committee public hearing – Melbourne, 16 October 2017, transcript of evidence, p. 6. See also: PANDA, 'National Helpline Programs', accessed 3 April 2018, <<https://www.panda.org.au/about/panda-programs/national-helpline-programs>>.

⁷¹⁶ Ms Terri Smith, Chief Executive Officer, Perinatal Anxiety and Depression Australia, Family and Community Development Committee public hearing – Melbourne, 16 October 2017, transcript of evidence, p. 6.

Ms Smith noted that 53 per cent of callers to the PANDA national helpline have had symptoms for more than four weeks and 25 per cent had symptoms for six months or more, and in some cases more than one year.⁷¹⁷ The Committee heard that more than 50 per cent of calls are in the moderate-to-severe range.⁷¹⁸ Furthermore, 84 per cent of callers from Victoria had not told their midwife or maternal and child health nurse about their symptoms of perinatal depression or anxiety, and around 72 per cent had not told their GP.⁷¹⁹

Ms Smith told the Committee about the importance of early intervention at a public hearing in Melbourne:

Early identification is something that is really so crucial for us to talk about, and managing best practice in this illness begins with early identification. We can deal with it at the extreme end in the acute setting, but it is a much better idea to be able to identify it very quickly and avoid escalation of the illness. In simple terms, very often new parents do not understand what is happening to them, and if you do not understand what is happening right now, it is very difficult to get help, particularly at this time. It is an extraordinary time of transition, so what is normal is really difficult to measure. We know the perinatal period is the period in a woman's life when she is most likely to have her first episode of mental illness. Understand that the thing we hear day in and day out through PANDA's helpline is, 'I was blindsided. I just didn't know what was happening', so you cannot get help. For us there is a message that says, 'Let's get in early'. I do not think I need to tell you about the benefits of early intervention, not just for the benefit of those families but at a cost level. It makes much more sense to be intervening early.⁷²⁰

In addition to the National Helpline, PANDA runs other programs, such as a community education program and training for health professionals. They also have a community champions program, which is a national network of volunteers who have lived experience of perinatal mental health illnesses who raise community awareness about perinatal anxiety and depression, including with first-time-mum groups, in maternal and child health settings, and in the media. PANDA also provides an Intensive Care Coordination Program, whereby they provide advocacy and care coordination, including ongoing counselling, through working with local health professionals and services in Victoria and Adelaide.⁷²¹

3.9.4 Other programs

The Committee heard about many other programs designed to improve mental health during the perinatal period, including MumMoodBooster and What Were We Thinking! (WWWT). MumMoodBooster was developed by the Parent-Infant Research Institute and the Oregon Research Institute in the United States. The Committee heard about the online program with its six session interactive online treatment designed to help women recover from postnatal depression at a public hearing in

⁷¹⁷ Ibid., p. 3.

⁷¹⁸ Ibid., p. 6.

⁷¹⁹ Ibid.

⁷²⁰ Ibid., p. 2.

⁷²¹ See Perinatal Anxiety and Depression Australia, 'PANDA Programs', accessed 3 April 2018, <<https://www.panda.org.au/about/panda-programs>>.

Melbourne. Professor Jeannette Milgrom, the Executive Director of the Parent-Infant Research Institute, told the Committee that there was a four-fold increase in remission after treatment with the MumMoodBooster.⁷²²

The WWWT program received support from the Victorian Government Department of Education and Training and six local government areas. It is a program designed to prevent postnatal mental disorders in women who have given birth to a first baby. The program is offered by trained maternal and child health nurses as part of first time parents' groups and aims to 'give participants the understanding, language and skills to adapt to changed roles and responsibilities, resolve conflict respectfully, provide competent effective infant care and reduce fatigue'.⁷²³

3.10 National Perinatal Depression Initiative

The National Perinatal Depression Initiative (NPDI) was a Commonwealth-led, jointly funded initiative aimed at improving the prevention and early detection of antenatal and postnatal depression and providing support and treatment for new and expectant mothers experiencing depression. Eighty-five million dollars was jointly allocated to the initiative for five years from 2008 to June 2013.⁷²⁴

The NPDI was designed to enable the provision of routine and universal screening for depression for women during the perinatal period using the Edinburgh Postnatal Depression Scale, and provide follow up treatment, support and care for women at risk of or experiencing perinatal depression. The NPDI also enabled the provision of training and development for health professionals to help them screen expectant and new mothers and make appropriate referrals, and to provide for research and data collection.⁷²⁵

Thirty million dollars of the Commonwealth funding was distributed to state and territory governments to contribute to the roll out of routine and universal screening, support and treatment services, and training of health professionals. State and territory governments matched Commonwealth funding, contributing to a total of \$60 million.⁷²⁶ The Committee heard about programs such as the Perinatal Emotional Health Program (PEHP) in Warrnambool, Wangaratta, and Traralgon, discussed below, which were developed with that funding.

Funding of \$20 million was distributed to the Access to Allied Psychological Services (ATAPS) component of the Better Health Outcomes in Mental Health Care Program to 'build the capacity of divisions of general practice to better support women with perinatal depression'.⁷²⁷

⁷²² Professor Jeannette Milgrom, Executive Director, Parent-Infant Research Institute, Family and Community Development Committee public hearing – Melbourne, 27 November 2017, transcript of evidence, p. 3.

⁷²³ Jean Hailes Research Unit, submission no. 14, p. 3.

⁷²⁴ Department of Health, 'National Perinatal Depression Initiative', Australian Government, accessed 16 November 2017, <<http://www.health.gov.au/internet/main/publishing.nsf/content/mental-perinat>>.

⁷²⁵ Ibid.

⁷²⁶ N Hight and C Purtell, *The National Perinatal Depression Initiative: A synopsis of progress to date and recommendations for beyond 2013*, beyondblue, the national depression and anxiety initiative, Melbourne, August 2012, p. 6.

⁷²⁷ Department of Health, 'National Perinatal Depression Initiative', Australian Government, accessed 16 November 2017, <<http://www.health.gov.au/internet/main/publishing.nsf/content/mental-perinat>>.

Funding of \$5 million also went to beyondblue to raise community awareness about perinatal depression and develop information and training materials for health professionals who screen and treat new and expectant mothers for perinatal depression.⁷²⁸ COPE was established out of the growth and success of the perinatal program at beyondblue.

A progress review of the NPDI stated that 'Australia has become a world leader in perinatal mental health with significant advances made over the past decade'.⁷²⁹ The review found that significant progress had been made under each of the NPDI objectives, including the development of the first Clinical Practice Guideline (approved by NHMRC) to inform and promote best practice.⁷³⁰ However, the review highlighted the need to continue to fund the NPDI beyond 2013.⁷³¹

3.10.1 Perinatal Emotional Health Program (PEHP)

The Perinatal Emotional Health Program (PEHP) was a key treatment component of the Victorian NPDI response.⁷³² The Committee heard evidence about the success of PEHP, particularly at the Inquiry's public hearings in Warrnambool and Wangaratta. PEHP provides early intervention for women at risk of, or experiencing, perinatal mental health problems. The program includes free assessment, screening, referral, outreach or clinic based appointments, in addition to education of families and healthcare workers about perinatal mental health.⁷³³

In 2010, the Victorian Government allocated funding for the Perinatal Emotional Health Program (PEHP) to regional Victorian area mental health services (AMHS) on the basis of one FTE per 1,000 births. The program was developed for rural Victorian area mental health services.⁷³⁴ As noted in the submission from Albury Wodonga Health:

Rural and regional areas lack access to specialist perinatal psychiatry assessment and consultation. These services are crucial to ensuring appropriate response and development of effective care provision for women experiencing more acute mental health conditions in the perinatal period. Rather than fly in-fly out, which is impacted on a practical level by weather conditions impacting travel, is costly and infrequent access, telehealth initiatives could be considered to provide timely access to psychiatric expertise for both women and the local clinicians providing their care.⁷³⁵

728 Ibid.; N Highet and C Purtell, *The National Perinatal Depression Initiative: A synopsis of progress to date and recommendations for beyond 2013*, beyondblue, the national depression and anxiety initiative, Melbourne, August 2012, p. 6.

729 N Highet and C Purtell, *The National Perinatal Depression Initiative: A synopsis of progress to date and recommendations for beyond 2013*, beyondblue, the national depression and anxiety initiative, Melbourne, August 2012, p. 3.

730 Ibid.

731 Ibid., p. 14.

732 Department of Health, Mental Health, Drugs and Regions Division, *Implementation of the Perinatal Emotional Health Program*, Victorian Government, March 2010.

733 Ibid.

734 Mr Nicholas Place, Manager of Primary Mental Health Team, South West Healthcare, Family and Community Development Committee public hearing - Warrnambool, 11 October 2017, transcript of evidence, p. 2.

735 Albury Wodonga Health, submission no. 55, p. 1.

The Committee heard that an important feature of the PEHP program in Wangaratta is that it was co-located with generic maternity services, such as the lactation clinic, the community midwife program, the home visiting midwife, and the antenatal clinic coordinator. Ms Fiona Pilkington, a perinatal emotional health clinician at Albury Wodonga Health, said at a public hearing in Wangaratta:

Being co-located with generic maternity services reduces the stigma and normalises that we are incorporating mental health into routine maternity care.⁷³⁶

Ms Pilkington said that the early motherhood service, which is the local name of the perinatal emotional health program, is a free, home-based service which is well received by clients and referrers, and ‘prides itself on being accessible, evidence-based and flexible’. She stated that clients do not require referrals and that they provide Cognitive Behavioural Therapy, supportive counselling, mindfulness, and behavioural interventions. The program also encourages women to be socially connected to other mothers. She also said:

In the past with the looming funding woes it has been very, very stressful for our clients and for the services that refer to the early motherhood service ... So we thank the state government for the continuing support and ongoing funding of the perinatal emotional health program. It really does make a difference to the women and their families. We would maintain that prenatal mental health is truly early intervention ... The perinatal emotional health program is a cost-effective, lifesaving model.⁷³⁷

The Committee also heard that it was difficult for women to access psychologists in regional areas due to a lack of psychologists in the area.⁷³⁸ The Committee heard from mothers who had accessed this program. Ms Megan Rickard told the Committee that after having a traumatic birth experience and having her son Max transferred to a Melbourne hospital she struggled for a long time:

When he was five months old, with the help of my husband and my mother, I accessed the wonderful services at the early motherhood service, where an incredible woman ensured that my mental health was put first. She developed a plan with my GP, who then diagnosed me with PTSD. With a lot of love, care and hard work, and a few meds along the way, I am proud to say that I am better. I am dealing with what happened to me and my son Max. I am enjoying my kids, and I am grateful that Max is still here.⁷³⁹

Another mother who had not accessed the service expressed gratitude at knowing the service was available should she need it. She told the Committee:

Shortly after my daughter was born in 2015 I heard the news that perinatal services, in particular the early motherhood service run from the community midwife centre, would potentially cease due to federal funding cuts. In our newly formed mothers group of 18 mums close to half of the women had made use of this service within the

⁷³⁶ Ms Fiona Pilkington, Perinatal Emotional Health Clinician, Albury Wodonga Health, Family and Community Development Committee public hearing – Wangaratta, 25 October 2017, transcript of evidence, p. 3.

⁷³⁷ *Ibid.*, pp. 4-5.

⁷³⁸ Dr Sarah Hancock, GP, Benalla Carrier Street Clinic, Family and Community Development Committee public hearing – Wangaratta, 25 October 2017, transcript of evidence, p. 5.

⁷³⁹ Ms Megan Rickard, Family and Community Development Committee public hearing – Wangaratta, 25 October 2017, transcript of evidence, p. 3.

first two months of their babies' lives. We were shocked to hear that this service may not continue and collectively wrote a letter to our federal member, Cathy McGowan, at the time ...

Whilst I have never had to make use of the early motherhood service myself, it is something that could be a possibility. Many in this room would know that postnatal depression and other postnatal issues can strike anyone without warning following the birth of a baby. It could even potentially happen to me. I would describe myself as a generally happy and well person, but postnatal depression is something that is not predetermined, so it could happen to anyone in the community, and we do not know, so it is so important to have this service there.⁷⁴⁰

Ms Jane Perry, who spoke to the Committee in Warrnambool, explained how PEHP helped her:

The last item that I wanted to address is the perinatal emotional health support program that is here in Warrnambool. This seems to be a really important program. I have also had personal experience with this when my youngest daughter was five months old. I recognised that I was not coping. I was not being my normal self, and my behaviour had changed. I was extremely lucky to have already heard of this program when the nurse came and talked at an Australian Breastfeeding Association discussion meeting. Without that, I was not aware of the program. So I was in a position where I finally gathered the confidence to make a self-referral. The empathy that was provided by this nurse was incredible. The strategies that she provided got me back on the right track, and after a follow-up visit I was feeling better and better all the time.

I think that this early intervention prevents the deterioration of many mothers' mental health. From an economic viewpoint, it prevents further strains on the healthcare system and more cost to the healthcare system, because mothers' mental health can be possibly improved with this early intervention, instead of deteriorating to a point where it requires much more intensive strategies. The perinatal emotional health program is one that I think should be continued, if possible, with funding. These nurses and counsellors have a good understanding of the particular situations that mothers face with their families.⁷⁴¹

According to their submission, Northeast Border Mental Health Services' mental health service won several awards and became the template for the state-wide Victorian PEHP.⁷⁴² They stated in their submission that there are more than 2,500 births in this region, with close to 20 per cent of these mothers requiring perinatal mental health care. There are currently 150 women and families receiving PEHP services at the Northeast Border Mental Health Service, with more than 400 referrals in the past 12 months.⁷⁴³

Their submission noted that after the Commonwealth ceased funding abruptly, Albury Wodonga Health committed to continuing PEHP without an identified funding stream.⁷⁴⁴ In their submission, they recommended recurrent funding for state-wide PEHP programs, with support for all rural health services to reinstate this

⁷⁴⁰ Ms Emma Avery, Family and Community Development Committee public hearing – Wangaratta, 25 October 2017, transcript of evidence, p. 2.

⁷⁴¹ Ms Jane Perry, Family and Community Development Committee public hearing – Warrnambool, 11 October 2017, transcript of evidence, p. 2.

⁷⁴² Northeast Border Mental Health Services, submission no. 49, p. 1.

⁷⁴³ Ibid.

⁷⁴⁴ Ibid., p. 2.

service. They also stated that upskilling and building on the PEHP workforce to foster expertise in providing specialist infant mental health care is an essential element of future mental health care planning.⁷⁴⁵

The Committee also heard about the success of the PEHP program in Warrnambool. South West Healthcare has a staff profile of two 0.5 FTE PEHP clinicians who are midwives with additional training in perinatal mental health.⁷⁴⁶ Referrals come predominately from antenatal support services, but women can and do also self-refer.⁷⁴⁷ South West Healthcare's PEHP has received an average of over ten referrals per month since its inception, which equates to 12 per cent of all births in the catchment's birthing hospitals.⁷⁴⁸

The submission from South West Healthcare states that the PEHP program provides invaluable services to women in need of perinatal mental health support and that there is significant demand for PEHP services. The submission states that PEHP has been disadvantaged by the withdrawal of the NPDI.⁷⁴⁹ Following the cut of NPDI funding, South West Healthcare's Mental Health Service Division committed to continuing PEHP without confirmation of ongoing government funding, and has remained one of the few PEHP programs to continue running a substantive PEHP program.⁷⁵⁰

At a public hearing in Warrnambool, the Committee heard from Mr Nicholas Place, the Manager of the Primary Mental Health Team at South West Healthcare. Mr Place told the Committee that the program was cost-effective, led to significant capacity building among staff and stakeholders, and that the program was valued by consumers and stakeholders alike.⁷⁵¹ The program entailed one full time equivalent (FTE) staff member working across five municipalities and four birthing hospitals, taking in 140 referrals. A FTE of one person was a challenge, Mr Place stated, when it came to covering leave and absences. Mr Place also noted that the acuity of presentations has increased in the last few years.⁷⁵²

The Committee also heard about the Gippsland Perinatal Emotional Health Program, run out of Latrobe Regional Hospital, at a public hearing in Warragul, which had received 601 referrals in the last three years. The Committee heard from Ms Hoyne about the funding instability and regions missing out on PEHP coverage:

The difficulty PEHP has had, which you are probably also aware of, was that initially they were funded for 3 EFT to cover the whole Gippsland area, and then when funding was reduced, somehow the hospital did not completely cut it to half and it stayed at 1.6, but really those clinicians were just in the east and south-east of Gippsland and supposedly covered the whole of Gippsland, but realistically that was not able to happen. That was around the time that the Agnes unit opened up, but it left Latrobe Valley uncovered as far as a PEHP outreach clinician was concerned, and also Warragul was not covered.

745 Ibid., p. 7.

746 South West Healthcare, submission no. 70, p. 2.

747 Ibid.

748 Ibid.

749 Ibid., p. 5.

750 Ibid., p. 1.

751 Mr Nicholas Place, Manager of Primary Mental Health Team, South West Healthcare, Family and Community Development Committee public hearing – Warrnambool, 11 October 2017, transcript of evidence, pp. 3-4.

752 Ibid.

Then in February funding was reintroduced, but it was not at the time ongoing. It was still on a yearly basis, and they were able to recruit to 2.5 EFT. The funding has since been made ongoing, but it is only to 2.5. It has never been returned to the 3 EFT. The problem with it is that they have lost valuable staff. It made the community a little bit wary that you build up with people and then you lose that service, so the new clinician has had to do a bit of work getting back into the services. It is still not fully recruited. There is no backfill for PEHP clinicians; if they go on annual leave or if there is any sick leave, no-one covers them. Then it is just there. Also when it was first started, there was initial seed funding for those initial clinicians to have some training, which is not ongoing, so clinicians have to really fund anything they want to do themselves.⁷⁵³

3.10.2 Withdrawal of NPDI funding

Responding to Inquiry term of reference 2, many stakeholders expressed concern about the loss of NPDI funding and the gap in services as a result. As the NPDI focused primarily on early intervention, the Committee received many submissions detailing how the loss of the NPDI had led to increased acuity in presentations.

Regarding the impact of the withdrawal of the NPDI, Tweddle Child and Family Health Service's submission referred to how Tweddle has had to reshape its mental health support services despite the increased acuity of clients presenting in Early Parenting Centres.⁷⁵⁴ This has included the cessation of the perinatal psychology clinic, the redundancy of four specialist perinatal psychologists, and the restructure of available mental health support staff.⁷⁵⁵

In their submission, the Caroline Chisholm Society stated that the loss of the NPDI had a significant impact on services for women at risk of, or experiencing, depression during pregnancy or in the first year following childbirth. They mentioned that Early Parenting Centres such as Tweddle reduced the long-term costs of mother baby unit bed days by 'providing a community based pathway to care and support', as well as provide mental health assessments of infants and fathers.⁷⁵⁶ They stated:

There is no question that there is a need to invest immediately in perinatal services and once the critical shortage is addressed, reform and further increase funds for perinatal mental health services to meet the needs of expectant and new mothers and their babies. In the experience of CCS, families without suitable support for their mental health are at greater risk of engagement with tertiary services such as the emergency departments of hospitals, family violence services and child protection.⁷⁵⁷

Hobsons Bay City Council stated that the loss of the NPDI led to a healthcare system that was reactive rather than proactive:

[T]he perinatal period is a time when parents are most vulnerable to experiencing mental health/depression. Further reduction in funding in this vital area only increases the complexities and takes away vigorous support, it adds further to the

753 Ms Christine Hoyne, Nurse Unit Manager, Parent and Infant Unit, Latrobe Regional Hospital, Family and Community Development Committee public hearing – Warragul, 8 December 2017, transcript of evidence, pp. 4-5.

754 Tweddle Child and Family Health Service, submission no. 45, pp. 9-10.

755 Ibid.

756 Caroline Chisholm Society, submission no. 29, p. 23.

757 Ibid.

vicious cycle of being reactive in health care rather than proactive and providing early, practical support to reduce the incidence and severity of a number of health and wellbeing concerns.⁷⁵⁸

A key criticism of the withdrawal of NPDI funding was the effect on workplace training and development. The Victorian Branch of the Australian Nursing and Midwifery Federation (ANMF) stated in their submission:

Midwives and nurses were actively engaged in the National Perinatal Depression Initiative, and welcomed the program because it filled a gaping hole in service provision for vulnerable women. Some midwives were provided with education and training to perform screening of depressive disorders associated with the National Perinatal Depression Initiative and incorporated this screening into their routine antenatal care.

The loss of this Commonwealth funding stream has impacted on the ongoing education for nurses and midwives within Victoria. The initial ongoing support by the Victorian Government was welcomed, and gave services time to make other arrangements or in many cases plan to cut the service. This has once again left a significant gap in services for women. It is ironic that as we increase risk assessment, we see a decrease in the options for referral and treatment. Midwives report that this is a very challenging ethical and clinical scenario which is regularly experienced in some antenatal clinics.⁷⁵⁹

Similarly, in their submission, the RANZCP stated that they had previously advocated against the loss of the NPDI:

The NPDI enabled provision of screening for depression during the perinatal period, treatment and support for women at risk of experiencing postnatal depression, and training for a range of front line health professionals in screening and supporting the mental health needs of new mothers. The RANZCP maintains that loss of this funding increases service gaps, and decreases opportunities for workforce capacity building.⁷⁶⁰

The Australian Psychological Society stated in their submission that the withdrawal of NPDI funding led to the cessation or reduction of mental health services provided by psychologists including in maternity hospitals, Early Parenting Centres, community health, outreach and home visiting services, and tertiary and secondary consultations.⁷⁶¹ This has led to increased privatisation of the service sector, which disadvantages those who cannot afford these services.⁷⁶² They noted:

Where psychologists and mental health services remain, there is less capacity for multidisciplinary and coordinated care resulting in a lower quality of care for women. For example, the lack of psychologists now employed at maternity hospitals has impacted on the capacity to identify, refer and support women with mental health concerns during pregnancy, which means women with mental health difficulties that could have been treated antenatally are missed, or these women present with great symptom acuity and higher levels of distress postnatally. It is also more likely that they are experiencing difficulties with the mother-infant relationship.⁷⁶³

⁷⁵⁸ Hobsons Bay City Council, submission no. 26, p. 2.

⁷⁵⁹ Australian Nursing and Midwifery Federation (Victorian Branch), submission no. 67, p. 11.

⁷⁶⁰ Royal Australian and New Zealand College of Psychiatrists (Victorian Branch), submission no. 25, p. 8.

⁷⁶¹ Australian Psychological Society, submission no. 80, p. 13.

⁷⁶² Ibid.

⁷⁶³ Ibid.

Several submissions argued that the loss of NPDI funding has disproportionately impacted rural and regional communities. In his submission, Dr Will Twycross said that the loss of the NPDI ‘has led to significant disadvantage for rural women’ with postnatal depression, ‘where isolation is a very significant issue’.⁷⁶⁴

The Caroline Chisholm Society noted that the NPDI supported training for maternal and child health nurses to provide a universal postnatal depression screening through the Edinburgh Postnatal Depression Scale, and funded community-based professionals to coordinate support for women.⁷⁶⁵ This was particularly important in regional areas:

Regionally these professionals had significant issues because of the large areas that they were responsible for but the service in rural Victoria was embraced. It was achieving positive outcomes helping to address factors in small communities that exacerbated PND. Social isolation, financial pressures and community stigma most notably. Without the NPDI funding it is feared that rates of perinatal depression screening will fall and ill women and children will not receive the early intervention treatment and support that they need. Trusted psychologists and counselling support will be less accessible.⁷⁶⁶

Many submissions also drew attention to the impact on state funded services. For example, IPC Health noted that the loss of the NPDI put an additional burden on state funded services.⁷⁶⁷

At a public hearing in Melbourne, the Department of Health and Human Services noted that when the NPDI was withdrawn, the state had to fill the gap, which came at the expense of other programs the state could fund.⁷⁶⁸ Ms Kym Peake, Secretary of the Department of Health and Human Services, stated:

The commonwealth withdrew its funding for perinatal emotional health programs in 2015, but we have stepped in to address the gap through a \$1.6 million commitment in 2016–17. But it goes to some of the earlier questions — whenever we step in it is a trade-off with other things that we could otherwise have invested in. So in addition to that filling of that gap of \$1.6 million we have also grown our investment on top of that, so we are providing an additional \$2.8 million recurrently from 2017–18. So in short, in terms of services for people on the ground, we have filled the gap, but that creates a flow-on consequence for what else we can do.⁷⁶⁹

Many hospitals, such as South West Healthcare, also contributed their own funds to keep the Perinatal Emotional Health Programs going.⁷⁷⁰

The Committee appreciates the work done by PEHPs in regional areas and heard about their impact and value to women with perinatal mental health illnesses. The Committee understands that some PEHPs have continued to be funded through the Victorian Government and regional hospitals and believes that, in the absence

⁷⁶⁴ Dr W Twycross, submission no. 16, p. 2.

⁷⁶⁵ Caroline Chisholm Society, submission no. 29, p. 23.

⁷⁶⁶ Ibid.

⁷⁶⁷ IPC Health, submission no. 19, p. 1.

⁷⁶⁸ Ms Kym Peake, Secretary, Department of Health and Human Services, Family and Community Development Committee public hearing – Melbourne, 27 November 2017, transcript of evidence, p. 13.

⁷⁶⁹ Ibid.

⁷⁷⁰ South West Healthcare, submission no. 70, p. 1.

of Commonwealth funding, PEHPs should receive ongoing Victorian Government funding. The Committee also believes that there is significant value in expanding and funding a state-wide Perinatal Emotional Health Program.

Accordingly, the Committee recommends that:

RECOMMENDATION 3.8: The Victorian Government provide ongoing funding for the existing Perinatal Emotional Health Programs (PEHP), and fund the expansion of the program state-wide to be delivered as a key element of supporting women at risk of, or experiencing, mental health illness in the perinatal period.

The Committee notes that the loss of Commonwealth funding for the NPDI has left many Victorian mothers and families without appropriate emotional and mental health support. This includes the loss of funding to PEHPs in regional areas. The Committee believes perinatal mental health is a vital aspect of perinatal health, for which the Commonwealth Government must reinstate its funding. Accordingly, the Committee recommends that:

RECOMMENDATION 3.9: The Victorian Government use its position on the Council of Australian Governments (COAG) to continue to advocate for the reestablishment of Commonwealth National Perinatal Depression Initiative (NPDI) funding.

3.11 Medicare items

On 1 November 2017, several changes were made to Medicare Benefits Schedule (MBS) items related to obstetric services, and new items were introduced, based on recommendations of the Medicare Benefits Schedule Review Taskforce.⁷⁷¹ The changes to the following items put a greater emphasis on managing and screening for mental health concerns, domestic violence, and drug and alcohol use during pregnancy:

- Item 16522 Complex birth item;
- Item 16590 Planning and management of a pregnancy where the doctor intends to attend the birth;
- Item 16591 Planning and management of a pregnancy where the doctor does not intend to attend the birth.⁷⁷²

Item 16522 now includes having a mental health disorder prior to pregnancy, during pregnancy or postpartum, disclosure or evidence of domestic violence and/or illicit drug use as denoting a 'complex birth' in addition to a range of physical conditions, such as gestational diabetes, cardiac disease, or a body mass index of 40 or above. This change acknowledges that patients with a mental health disorder, drug use, or domestic violence experiences may require more comprehensive care and thus attracts a higher MBS fee.⁷⁷³

⁷⁷¹ Department of Health, 'Changes to MBS items for obstetrics services', Australian Government, accessed 17 May 2018, <<http://www.mbsonline.gov.au/internet/mbsonline/publishing.nsf/Content/Factsheet-ObstetricsServices>>.

⁷⁷² Ibid.

⁷⁷³ Ibid.

Items 16590 and 16591 require that a mental health assessment is undertaken, consistent with the clinical practice guideline.⁷⁷⁴ A new item 16407 (Postnatal consultation) was also introduced to include a mental health assessment, including screening for drug and alcohol use and domestic violence, in a postnatal attendance lasting at least 20 minutes between four and eight weeks after birth. While these mental health services are to be offered to all patients, patients who choose not to undertake the assessment are not to be disadvantaged in their care.⁷⁷⁵ These changes have been positively received by stakeholders, including the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG).⁷⁷⁶

While the above screening measures are now in place, there is no specific perinatal Medicare referral pathway for women diagnosed with a mental illness. Women experiencing perinatal mental illnesses have access to generic Medicare items, such as the Better Access to Psychiatrists, Psychologists and General Practitioners through the Medicare Benefits Schedule (MBS) (Better Access) initiative. This initiative provides Medicare rebates for up to ten individual and ten group allied mental health services per calendar year to patients with an assessed mental health disorder.⁷⁷⁷ Women can access services provided by psychiatrists and psychologists, however the Committee heard that there are few psychiatrists and psychologists specialising in perinatal mental health.

3.12 Depression and anxiety in fathers

The Committee heard that fathers are at increased risk of experiencing mental health problems during the perinatal period and need also to be supported during this time.⁷⁷⁸ Approximately one in ten men experience depression during the pregnancy or after his baby is born.⁷⁷⁹ The Australian Clinical Practice Guideline for Mental Health Care in the Perinatal Period states:

Mood disorders among fathers have not been well studied but the emerging evidence suggests that the individual and social costs of paternal perinatal depression and anxiety are significant.⁷⁸⁰

A factsheet from PANDA states the following in relation to perinatal anxiety and depression in men:

⁷⁷⁴ Medicare Benefits Schedule Review Taskforce, *Report from the Obstetrics Clinical Committee*, 2016, p. 6, accessed 17 May 2018, <[http://www.health.gov.au/internet/main/publishing.nsf/content/24913E0474E75768CA2580180016A033/\\$File/MBS-Obstetrics.pdf](http://www.health.gov.au/internet/main/publishing.nsf/content/24913E0474E75768CA2580180016A033/$File/MBS-Obstetrics.pdf)>.

⁷⁷⁵ Department of Health, 'Changes to MBS items for obstetrics services', Australian Government, accessed 17 May 2018, <<http://www.mbsonline.gov.au/internet/mbsonline/publishing.nsf/Content/Factsheet-ObstetricsServices>>.

⁷⁷⁶ Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) 'RANZCOG welcomes Medicare-funded mental health support for pregnant women', media release, November 2017, RANZCOG website, accessed 17 May 2018, <<https://www.ranzcog.edu.au/news/RANZCOG-welcomes-Medicare-funded-mental-health-sup>>.

⁷⁷⁷ Department of Health, Better access to mental health care: fact sheet for patients, Australian Government, accessed 8 January 2018, <<http://www.health.gov.au/internet/main/publishing.nsf/Content/mental-ba-fact-pat>>.

⁷⁷⁸ Royal Australian and New Zealand College of Psychiatrists (Victorian Branch), submission no. 25, p. 3.

⁷⁷⁹ J F Paulson and S D Bazemore, 'Prenatal and postpartum depression in fathers and its association with maternal depression: A meta-analysis', *JAMA*, vol. 303, iss. 19, 2010, pp. 1961-1969.

⁷⁸⁰ M-P Austin, N Highet and the Expert Working Group, *Mental Health Care in the Perinatal Period: Australian Clinical Practice Guideline*, Centre of Perinatal Excellence (COPE), Melbourne, 2017, p. 18.

People often think that depression is a form of extreme sadness, characterised by a low mood or constant crying. In fact, anxiety or depression can lead to a very agitated state of mind in some people. Men with depression may feel wound up, frustrated, or unable to relax – a feeling sometimes described as ‘like being trapped’, or ‘pacing in a cage’. They can have outbursts of anger or rage that are ‘not in character’, leading to feelings of shame or guilt. It is important to recognise these symptoms as signs it may be time to get some help, and not let them simmer away or keep them bottled up.⁷⁸¹

Factors that contribute to the risk of developing perinatal anxiety and depression include a previous history of anxiety or depression, a history of childhood trauma or family conflict, sleep deprivation, relationship stress, lack of available support networks, and supporting a partner with perinatal anxiety or depression.⁷⁸² Men are more likely to develop perinatal anxiety or depression if their partner is also suffering from perinatal anxiety or depression.⁷⁸³

The Australian Clinical Practice Guideline cites research from the US that depressed fathers are four times more likely to spank their infants and less than half as likely to read to them as non-depressed fathers.⁷⁸⁴ As noted by the Australian Institute of Family Studies, much of the research on fathers’ mental health has focused on the effects of paternal mental illness on children and child development, with children of men with a mental illness being more likely than other children to experience emotional and behavioural problems, as well as to be diagnosed with a mental illness themselves.⁷⁸⁵

The Guideline cites studies showing evidence that fathers want to be included in perinatal health care and engaged by health professionals about their health and wellbeing. Regarding screening, the Guideline states:

The Edinburgh Postnatal Depression Scale has been validated for fathers with a lower cut-off of 5/6 recommended (Cox et al 1987; Matthey et al 2001). However, as fathers may express their low mood in behaviours, such as anger and irritation, that may differ from those for women, alternative scales have been introduced to some settings to better identify distress (Fletcher et al 2015).⁷⁸⁶

The Guideline notes that despite a few mental health programs attempting to tailor their content and delivery to better engage men, there have been no evaluations of these programs and adaptations. The Guideline states:

The widespread adoption of mobile technology may present an alternative route for assessing and supporting new fathers. The provision of timely, relevant information for fathers throughout the antenatal and postnatal period can be effectively achieved through the use of technology (beyondblue 2016; Fletcher et al 2016). The costs of

781 PANDA, ‘Perinatal anxiety and depression in men’, factsheet, accessed 16 November 2017, <<https://www.panda.org.au/images/resources/Resources-Factsheets/Perinatal-Anxiety-and-Depression-in-Men.pdf>>.

782 Ibid.

783 Royal Australian and New Zealand College of Psychiatrists (Victorian Branch), submission no. 25, p. 4.

784 See: M-P Austin, N Highet and the Expert Working Group, *Mental Health Care in the Perinatal Period: Australian Clinical Practice Guideline*, Centre of Perinatal Excellence (COPE), Melbourne, 2017, p. 18.

785 Australian Government, Australian Institute of Family Studies, ‘Fatherhood and mental illness: A review of key issues’, Children Family Community Australia, paper no. 30, February 2015. See also: M-P Austin, N Highet and the Expert Working Group, *Mental Health Care in the Perinatal Period: Australian Clinical Practice Guideline*, Centre of Perinatal Excellence (COPE), Melbourne, 2017, p. 18.

786 M-P Austin, N Highet and the Expert Working Group, *Mental Health Care in the Perinatal Period: Australian Clinical Practice Guideline*, Centre of Perinatal Excellence (COPE), Melbourne, 2017, p. 19.

failing to assess and address paternal perinatal depression and anxiety are high. Developing effective support for new fathers will require innovative solutions to the design and delivery of information, assessment and treatment options.⁷⁸⁷

Ms Fiona Pilkington, a perinatal emotional health clinician at Albury Wodonga Health, said at a public hearing in Wangaratta:

We mainly see women, but we will also see fathers. This is not something we advertise due to staff and funding limitations. With additional funding this is an area we would definitely consider expanding on. Women have contacted our service worried about their partner, and we have organised a home visit to see the couple together. This has allowed us to engage the dad, offer support and further assessment. When women have contacted us, it is not because their partners are just struggling. Historically the men we have seen have been acutely unwell, extremely high risk, unlikely to ever access help, and our interventions, I believe, absolutely have been lifesaving.⁷⁸⁸

The Committee heard that fathers can be looking for emotional support during the perinatal period. Mr Steven Kennedy told the Committee of his experience when his newborn son was in special care:

It would have been really nice for someone just to come along and say, 'Hey, we realise that you're looking after two of your dearest right now. How are you doing?'. I was a little fortunate that I am able to process these things, but I think that maybe that would cause some problems down the line for people who want to kind of —

I mean, I broke down when he was in care and I really lost it in the room, but all they said was, 'Oh, dad's losing it. Do you want a cup of tea?'.⁷⁸⁹

Mr Kennedy went on to say that he saw a role for government:

[T]here is trauma for the male, and he has to look after the baby — well, he has got those emotional kinds of challenges going on, not only with the mother but also with the child — so it is just a bit of background support. I think it is the role of government to kind of drive this change, and the only way that men will be respected in this world is if it comes from some kind of government process where we see a future with a feeling, kind of forward thinking kind of attitude towards dads being more involved in not only childbirth but also in parenting.⁷⁹⁰

3.12.1 Services and programs for fathers

Sms4dads is a University of Newcastle project, with funding support from beyondblue and Movember, which provides new fathers with information and connections to online services through their mobile phones.⁷⁹¹ A father registers his mobile and the expected due date of his baby's birth and then receives periodic support, information, and advice messages linked to the developmental stage of the baby. Many of the texts use the 'voice' of the baby to help the father engage.

⁷⁸⁷ Ibid.

⁷⁸⁸ Ms Fiona Pilkington, Perinatal Emotional Health Clinician, Albury Wodonga Health, Family and Community Development Committee public hearing – Wangaratta, 25 October 2017, transcript of evidence, p. 4.

⁷⁸⁹ Mr Steven Kennedy, Family and Community Development Committee public hearing – Melbourne, 27 November 2017, transcript of evidence, p. 3.

⁷⁹⁰ Ibid., pp. 3-4.

⁷⁹¹ Sms4dads, 'About the project', accessed 16 November 2017, <<https://www.sms4dads.com/About/Project>>.

Dadvice is an online resource from beyondblue, which includes a four-part web series which follows a group of new dads on their journey into fatherhood. It also has a 'dad stress test' and includes advice on becoming a dad, working on relationships, supporting your partner, juggling work and family, and resources on anxiety and depression.⁷⁹²

Other online resources include Raising Children Network's Dads Toolkit, Gay Dads Australia, How Is Dad Going? (PANDA), and the UK Fatherhood Institute. Stayin' On Track is an online resource developed by Aboriginal men for Aboriginal dads, which also offers personal mentoring.⁷⁹³ The project is an initiative of the Young and Well Cooperative Research Centre at the University of Newcastle, New South Wales.

Another program the Committee heard about which aimed to challenge gender stereotypes, roles and responsibilities was the What Were We Thinking? (WWWT) program, mentioned above. In their submission, the Jean Hailes Research Unit stated the WWWT program:

[P]ositions mothering and fathering as of equal importance, promotes respect for the unpaid workload and improves emotional literacy without the use of psychiatric labelling. The program comprises a highly-interactive, structured face-to-face small group seminar for couples and their babies, take-home materials for ongoing reference, and routine primary care from a WWWT-trained MCH nurse.⁷⁹⁴

They noted that WWWT differs from other programs 'by including the father and the baby' and is consistent with the Department of Education's Respectful Relationships program.⁷⁹⁵

Regarding domestic violence, the Department of Health and Human Services and Gandel Philanthropy have funded a three year trial of the Caring Dads program, which is being run across three sites: North East Melbourne, Inner West Melbourne, and Inner Gippsland. The program is delivered through the Children's Protection Society, Anglicare Victoria, IPC Health, and UnitingCare ReGen.⁷⁹⁶ The program is a 17 session group work program which aims to improve the parenting behaviour of fathers who have exposed their children to family violence.⁷⁹⁷

The Committee heard evidence that fathers can experience depression and anxiety during the perinatal period and need to be supported during this time. The Committee appreciates that a number of programs aimed at supporting the mental health of fathers during the perinatal period have been initiated, some of which have been listed above. However, from the evidence received by the Committee, it is clear that at present there is a lack of such programs for fathers overall, and too often men's mental health appears to be treated as an afterthought.

The Committee believes that supporting the mental health of fathers is critical, not just to fathers, but to the health and wellbeing of mothers and their babies. This is particularly the case in the context of the rise in reported levels of family violence.

⁷⁹² Dadvice, 'Get some Dadvice', accessed 16 November 2017, <<https://healthyfamilies.beyondblue.org.au/pregnancy-and-new-parents/dadvice-for-new-dads>>.

⁷⁹³ Stayin' On Track, 'About', accessed 13 November 2017, <<https://stayinontrack.com/About.aspx>>.

⁷⁹⁴ Jean Hailes Research Unit, submission no. 14, p. 3.

⁷⁹⁵ Ibid.

⁷⁹⁶ Caring Dads, 'About Caring Dads', accessed 16 November 2017, <<http://caringdads.org.au/about-us>>.

⁷⁹⁷ Caring Dads, 'Helping fathers value their children', accessed 16 November 2017, <<http://caringdads.org.au>>.

Accordingly, the Committee recommends that:

RECOMMENDATION 3.10: The Victorian Government fund the expansion of perinatal mental health programs for fathers.

- The Department of Health and Human Services collaborate with key stakeholders and service providers to identify and develop best practice programs to support the mental health of fathers in the perinatal period.

4 Perinatal services in rural and regional Victoria

AT A GLANCE

Background

The Committee consistently heard that women in rural and regional areas had a higher risk profile in the perinatal period, due to factors such as high rates of obesity and smoking. Women in these areas are also more likely to face barriers of distance, higher travel costs to services, and disadvantage. In addition, the Committee heard there are difficulties attracting and retaining a perinatal workforce in rural and regional Victoria, with workforce shortages being a significant issue for rural and regional health services. The presence of higher risk factors among women and rural population growth also present additional challenges for the rural and regional perinatal workforce. Whilst the Committee heard a lot of the challenges, it also heard of the levels of competence that should give confidence to any person accessing perinatal care in rural and regional Victoria. There are strengths in rural and regional areas, such as continuity of care models.

This chapter discusses rural and regional women's experiences of accessing perinatal health and mental health services, pressures on deliveries in line with the Capability Framework, pressures on the rural and regional workforce, the closure of smaller birthing services in the regions, access to perinatal mental health services, strategies to attract and retain staff, the potential to further develop telehealth, and the work of one of Victoria's bush nurses.

Terms of reference addressed

This chapter addresses the following terms of reference:

1. the availability, quality and safety of health services delivering services to women and their babies during the perinatal period;
2. the impact that the loss of Commonwealth funding (in particular, the National Perinatal Depression Initiative) will have on Victorian hospitals and medical facilities as well as on the health and wellbeing of Victorian families;
3. the adequacy of the number, location, distribution, quality and safety of health services capable of dealing with high risk and premature births in Victoria;
4. the quality, safety and effectiveness of current methods to reduce the incidence of maternal and infant mortality and premature births;
5. access to and provision of an appropriately qualified workforce, including midwives, paediatricians, obstetricians, general practitioners, anaesthetists, maternal and child health nurses, mental health practitioners and lactation consultants across Victoria; and
6. disparity in outcomes between rural and regional and metropolitan locations.

The Committee consistently heard that women in rural and regional areas had a higher risk profile in the perinatal period, due to factors such as high rates of obesity and smoking. Women in these areas are also more likely to face barriers of distance, higher travel costs to services, and disadvantage. In addition, the Committee heard there are difficulties attracting and retaining a perinatal workforce in rural and regional Victoria, with workforce shortages being a significant issue for rural and regional health services. The presence of higher risk factors among women and rural population growth also present additional challenges for the rural and regional perinatal workforce. Whilst the Committee heard a lot of the challenges, it also heard of the levels of competence that should give confidence to any person accessing perinatal care in rural and regional Victoria. There are strengths in rural and regional areas, such as continuity of care models.

This chapter discusses rural and regional women's experiences of accessing perinatal health and mental health services, pressures on deliveries in line with the Capability Framework, pressures on the rural and regional workforce, the closure of smaller birthing services in the regions, access to perinatal mental health services, strategies to attract and retain staff, the potential to further develop telehealth, and the work of one of Victoria's bush nurses.

The Committee is aware of the higher numbers of Aboriginal and Torres Strait Islander people residing in rural and regional locations and the presence of small, recently-settled, refugee communities. The challenges identified in this chapter also apply to Aboriginal and Torres Strait Islander women and women of culturally and linguistically diverse (CALD) backgrounds in rural and regional Victoria. For more, see Chapter Seven and Chapter Eight, respectively.

4.1 The disparity in perinatal outcomes between rural and regional and metropolitan Victoria

The Committee recognises that there are a range of factors that have increased the risk profile of rural and regional women. Chapters One to Three examined perinatal services and outcomes across Victoria, including evidence the Committee heard of the disparity between rural and regional communities and metropolitan areas. These disparities are discussed in more detail in previous chapters and include:

Chapter One: The Quality and Safety of Perinatal Services in Victoria:

- women living in rural and regional areas were more likely to be obese or smoke during pregnancy;⁷⁹⁸
- rural and regional areas had higher rates of teenage pregnancies;⁷⁹⁹

⁷⁹⁸ Professor Euan Wallace, Chief Executive Officer, Safer Care Victoria, Family and Community Development Committee public hearing – Melbourne, 27 November 2017, transcript of evidence, p. 6. See also: Figure 4.1; Australian Nursing and Midwifery Federation (Victorian Branch), submission no. 67, p. 17; Ms Meryn Pease, Chief Executive Officer, Orbst Regional Health, Family and Community Development Committee public hearing – Bairnsdale, 7 December 2017, transcript of evidence, p. 4; Mr Wale Oladimeji, submission no. 1, p. 4.

⁷⁹⁹ Professor Euan Wallace, Chief Executive Officer, Safer Care Victoria, Family and Community Development Committee public hearing – Melbourne, 27 November 2017, transcript of evidence, p. 6.

- there are higher rates of alcohol and drug use during pregnancy in rural and regional areas.⁸⁰⁰ Furthermore, that rural and regional areas lacked sufficient support services to care for pregnant women with drug and alcohol issues;⁸⁰¹
- premature births are more common in rural and regional areas than in metropolitan areas.⁸⁰² See also Figure 4.1; and
- there is a need for more parenting and family support groups in rural and regional areas.⁸⁰³

Chapter Two: Models of Care for Mothers and their Babies:

- rural and regional communities have less access to diverse models of care;⁸⁰⁴
- some women living in small rural communities are receiving continuity of care due to the small workforce in these locations;⁸⁰⁵ and
- access to lactation consultants and breastfeeding guidance for mothers in the antenatal and postnatal period needs to be improved across Victoria and in rural and regional areas.⁸⁰⁶

Chapter Three: Perinatal Mental Health Services:

- families living in rural and regional Victoria are particularly vulnerable to social isolation and a lack of emotional support, as well as geographical isolation from formal support services;⁸⁰⁷ and
- rural and regional areas lack access to specialist services including psychiatry assessment and consultation.⁸⁰⁸

At a public hearing in Melbourne, Professor Euan Wallace, Chief Executive Officer of Safer Care Victoria, summarised the overall disparity in perinatal outcomes between rural and regional and metropolitan areas (see Figure 4.1). According to Professor Wallace, the rate of low birth weights among newborn infants and preterm births have been 'broadly the same' for rural and regional populations and the metropolitan area. However, Professor Wallace explained to the Committee:

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- 800** For example, Ms Raylene Harradine, Chief Executive Officer, Bendigo and District Aboriginal Co-operative, and chair, Loddon Mallee Aboriginal Reference Group, Family and Community Development Committee public hearing – Bendigo, 24 October 2017, transcript of evidence, p. 2; Ms Julie Wright, Operational Director of Women's and Children's Services, Albury Wodonga Health, Family and Community Development Committee public hearing – Wangaratta, 25 October 2017, transcript of evidence, p. 7.
- 801** Albury Wodonga Health, submission no. 55, p. 1; Dr Liz Uren, Obstetrics and Gynaecology, South West Healthcare, Family and Community Development Committee public hearing – Warrnambool, 11 October 2017, transcript of evidence, p. 10.
- 802** Mr Wale Oladimeji, submission no. 1, p. 3.
- 803** Ms Anne O'Brien, Volunteer, Gianna Centre, Family and Community Development Committee public hearing – Bendigo, 24 October 2017, transcript of evidence, p. 3.
- 804** For example, Save Healesville Hospital Action Group, submission no. 43, p. 8.
- 805** Professor Euan Wallace, Chief Executive Officer, Safer Care Victoria, Family and Community Development Committee public hearing – Melbourne, 27 November 2017, transcript of evidence, pp. 8-9; Ms Meryn Pease, Chief Executive Officer, Orbost Regional Health, Family and Community Development Committee public hearing – Bairnsdale, 7 December 2017, transcript of evidence, p. 2.
- 806** Ms Susan Day, President, Australian Breastfeeding Association, Family and Community Development Committee public hearing – Melbourne, 4 September 2017, transcript of evidence, p. 12; Ms Julie Wright, Operational Director of Women's and Children's Services, Albury Wodonga Health, Family and Community Development Committee public hearing – Wangaratta, 25 October 2017, transcript of evidence, pp. 4-5.
- 807** South West Healthcare, submission no. 70, p. 3; Ms Tania Maxwell, submission no. 91, pp. 1-2.
- 808** Albury Wodonga Health, submission no. 55, p. 1.

You can see — and you are already aware of this from your trips around the state — smoking is twice as common in the country as it is in the city. Smoking in the second half of pregnancy is three times as common. Then some outcomes are the same: postpartum haemorrhage, severe perineal tears — very similar, if anything slightly better ... obesity is much more common in the country. Indigenous women are more likely to live in the country and be looked after by country services than the city and teenage pregnancies are more common in the country. That is important because Aboriginality, teenage status — so young mothers — smoking and obesity all contribute to poorer outcomes.⁸⁰⁹

Table 4.1 Disparity between rural and metropolitan outcomes in Victoria

2016	Metropolitan	Rural
Perinatal outcomes		
Low birth weight	6.8%	6.8%
Preterm births	8.0%	8.9%
Undetected severe fetal growth restriction	32.7%	23.3%
Perinatal death rate	9.0 per 1,000 births	10.3 per 1,000 births
Stillbirth rate	6.3 per 1,000 births	7.7 per 1,000 births
Neonatal death rate	2.6 per 1000 births	2.6 per 1000 births
Maternal demographics and outcomes		
Smoking first half of pregnancy	7%	14.2%
Smoking second half of pregnancy	3.7%	10.4%
Postpartum haemorrhage (blood loss \geq 500mls)	24.1%	24.6%
Severe perineal tears	2.1%	1.9%
Obesity (BMI \geq 30)	16.9%	26.3%
Mother being Aboriginal	0.9%	2.9%
Teenage mother	1%	2.8%

Source: Compiled by the Consultative Councils Unit, Safer Care Victoria with data from the Victorian Perinatal Data Collection 2016, approved for use by the Consultative Council on Obstetric and Paediatric Mortality and Morbidity (CCOPMM).⁸¹⁰

The Australian Institute of Health and Welfare (AIHW) publishes information indicating the state of child and maternal health nation-wide. The latest AIHW report on Child and Maternal Health includes local-level information across Australia's 31 Primary Health Network (PHN) areas on four indicators of child and maternal health: infant and young child mortality, low birthweight babies, smoking during

⁸⁰⁹ Professor Euan Wallace, Chief Executive Officer, Safer Care Victoria, Family and Community Development Committee public hearing – Melbourne, 27 November 2017, transcript of evidence, p. 6.

⁸¹⁰ Professor Wallace presented this information from the Victorian Perinatal Data Collection 2016, for which the Consultative Council on Obstetric and Paediatric Mortality and Morbidity is the data custodian. Professor Euan Wallace, Chief Executive Officer, Safer Care Victoria, Family and Community Development Committee public hearing – Melbourne, 27 November 2017. The Committee is grateful to the Consultative Council on Obstetric and Paediatric Mortality and Morbidity for providing access to the de-identified data used for this report and for the assistance of the staff at the Consultative Councils Unit, Safer Care Victoria. The conclusions, findings, opinions and views or recommendations expressed in this report are strictly those of the Committee. They do not necessarily reflect those of the Consultative Council on Obstetric and Paediatric Mortality and Morbidity.

pregnancy, and antenatal visits in the first trimester of pregnancy.⁸¹¹ The AIHW report is a national overview of child and maternal health for PHNs across Australia in 2013-15 and reflected some of the disparities highlighted by Safer Care Victoria in their evidence to the Committee. For example, the higher rate of smoking during pregnancy among rural Victorian mothers (see Figure 4.1) was reflected in the AIHW report, which showed a higher proportion of women in regional areas smoked during pregnancy (17 per cent) than in metropolitan areas (7.9 per cent) across Australia.⁸¹²

The AIHW data on child and maternal health across the PHNs also measured the rate of mothers who had attended at least one antenatal visit in the first trimester of their pregnancy. According to the AIHW, on this indicator there were slightly better results for mothers in rural areas (65 per cent) compared to metropolitan areas (61.5 per cent).⁸¹³

At its rural and regional public hearings, witnesses told the Committee that their communities tend to experience a level of socioeconomic disadvantage, and health and community workers also noted an increasing profile of higher risk pregnancies due to obesity, diabetes, smoking and teenage pregnancy (see Chapter One).⁸¹⁴ In some places, the Committee heard that drug and alcohol issues and family violence were also identified as issues.⁸¹⁵

In their submission, the Victorian Branch of the Australian Nursing and Midwifery Federation (ANMF) stated that rural and remote communities tend to have poorer health outcomes in general. They cited another recent report on rural and remote health outcomes by the AIHW, which stated:

Australians living in rural and remote areas tend to have shorter lives, higher levels of disease and injury and poorer access to and use of health services compared to people living in metropolitan areas. Poorer health outcomes in rural and remote areas may be due to a range of factors, including a level of disadvantage related to education and employment opportunities, income and access to health services.⁸¹⁶

⁸¹¹ Australian Institute of Health and Welfare (AIHW), 'Child and Maternal Health in 2013-2015 - Summary Findings', published April 2018, Australian Government, accessed 30 April 2018, <https://www.myhealthycommunities.gov.au/Content/publications/downloads/AIHW_HC_Report_Child_and_maternal_health_April_2018.pdf?t=1525738844250>.

⁸¹² Australian Institute of Health and Welfare (AIHW), 'Healthy Communities: Child and maternal health in 2013-2015 - Overview', p. 3, Australian Government, accessed 30 April 2018, <<https://www.myhealthycommunities.gov.au/our-reports/child-and-maternal-health/april-2018/report/overview>>.

⁸¹³ Australian Institute of Health and Welfare (AIHW), 'Healthy Communities: Child and maternal health in 2013-2015 - Antenatal visits in the first trimester of pregnancy', Australian Government, accessed 22 May 2018, <<https://www.myhealthycommunities.gov.au/our-reports/child-and-maternal-health/april-2018/report/antenatal-visits-in-the-first-trimester-of-pregnancy>>.

⁸¹⁴ For example see, Dr Nikhil Patravali, Director, Obstetrics and Gynaecology, Mildura Base Hospital, Family and Community Development Committee public hearing - Mildura, 9 November 2017, p. 8; Ms Claire Geldard, Director of Operations, Women's and Children's Directorate, University Hospital Geelong, Family and Community Development Committee public hearing - Geelong, 11 December 2017, transcript of evidence, p. 10.

⁸¹⁵ For example see, Ms Ailsa Carr, Executive Manager, Family, Youth and Children's Services, Gippsland Lakes Community Health, Family and Community Development Committee public hearing - Bairnsdale, 7 December 2017, transcript of evidence, p. 2; Ms Marilyn Humphrey, Maternal and Child Health Coordinator, Baw Baw Shire Maternal and Child Health Services, Family and Community Development Committee public hearing - Warragul, 8 December 2017, transcript of evidence, p. 5; Ms Maryanne Purcell, Maternal and Child Health Nurse Coordinator, Warrnambool City Council, Family and Community Development Committee public hearing - Warrnambool, 11 October 2017, transcript of evidence, p. 8; Ms Samantha Cooke, Community Health Coordinator, Mildura Rural City Council, Family and Community Development Committee public hearing - Mildura, p. 5.

⁸¹⁶ Australian Nursing and Midwifery Federation (Victorian Branch), submission no. 67, p. 16; Australian Institute of Health and Welfare (AIHW), 'Rural and Remote Health, (web report)', updated 29 May 2017, accessed 10 April 2018, <<https://www.aihw.gov.au/reports/rural-health/rural-remote-health/contents/rural-health>>.

The ANMF also highlighted the benefits of living in rural and regional areas, drawing attention to the Household, Income and Labour Dynamics in Australia survey, which found that Australians living in small towns of fewer than 1,000 people and in non-urban areas ‘generally experienced higher levels of satisfaction compared to those living in Major cities’.⁸¹⁷

Throughout the Inquiry, the Committee received evidence illustrating some of the extensive efforts among health and community workers, rural and regional women, and their families to address disadvantage in their communities, and establish quality perinatal services locally. Examples of this include Hands Up Mallee, the Warrnambool Breastfeeding Centre, Zoe Support Australia, and Olivia’s Place. However, gaps in perinatal services remain for rural and regional communities and there is evidence that health and community workers in these areas require more support to provide care for women in high risk categories and their babies (see section 4.4). These issues are discussed throughout this chapter.

4.2 The experiences of rural and regional women

During the Inquiry, the Committee heard from rural and regional women at public hearings. These women highlighted experiences of social isolation and the financial and emotional costs for themselves and their families when they have travelled long distances to access services.⁸¹⁸ This section describes some of those experiences.

The Committee wishes to note it also heard of positive experiences for women in rural and regional Victoria, however the nature of the Inquiry highlighted limitations in these areas. The Committee was impressed by innovative programs developed locally and tailored to the circumstances of the rural and regional setting. At a public hearing in Warragul, the Committee heard about Olivia’s Place, a registered charity which provides pregnancy support to families. They offer material support, emotional support, social support, parenting sessions, and financial support.⁸¹⁹ Mrs Carmel Riley, President of Olivia’s Place, described the role of the organisation in providing support to mothers and families in the region:

[T]here are currently no other services that provide a holistic social, educational and peer support service to families through that perinatal period. I often picture it like a fence. You have got different bricks, which you can describe as different funding silos and different organisations. Unfortunately a family’s journey does not quite segment like that. Olivia’s Place continually endeavours to almost be that mortar between the bricks to bring those agencies together and smooth that individual’s journey through the system for the best outcomes for their family.⁸²⁰

⁸¹⁷ Australian Nursing and Midwifery Federation (Victorian Branch), submission no. 67, p. 17.

⁸¹⁸ Ms Jess Stretton, Family and Community Development Committee public hearing – Warrnambool, 11 October 2017, transcript of evidence, pp. 2-3; Ms Alexandra Lenehan, Family and Community Development Committee public hearing – Warrnambool, 11 October 2017, transcript of evidence, p. 2; Ms Kassie Hocking, Family and Community Development Committee public hearing – Mildura, 9 November 2017, transcript of evidence, pp. 2-3; Ms Tania Maxwell, submission no. 91, pp. 1-2.

⁸¹⁹ Mrs Kirsten Finger, Co-Founder, Olivia’s Place, Family and Community Development Committee public hearing – Warragul, 8 December 2017, transcript of evidence, pp. 2, 3, 7.

⁸²⁰ Mrs Carmel Riley, President, Olivia’s Place, Family and Community Development Committee public hearing – Warragul, 8 December 2017, transcript of evidence, p. 4. For more see: Chapter One.

Ms Bernadette Hammond, Director of Clinical Operations and Chief Nurse and Midwife at Bairnsdale Regional Health Service, told the Committee at a public hearing in Bairnsdale of their efforts to improve services and continuity of care for women in the region. Ms Hammond stated that their new model of care:

[T]ook eight months in the planning, and we had consumers, midwives, GP obstetricians, consultants and executive on the steering committee. The vision for the new model was that it would be collaborative, woman-centred care that provided more choice. We wanted safe care as close to home as possible and a flexible and sustainable workforce providing care when the women needed it.⁸²¹

At a public hearing in Warrnambool, the Committee heard about the Warrnambool Breastfeeding Centre, which has provided support to women in the community.⁸²² The Committee heard from mothers who described the Warrnambool Breastfeeding Centre as a great service and a ‘safe place’ for mothers and children (see also Chapter Two). At the public hearing, Ms Jess Stretton, a local mother, told the Committee of the benefits of the Centre, including its President and lactation consultant Ms Barbara Glare:

The breastfeeding centre down here is a great relief — to come down here and know that you have got a safe space to go and that it is clean, it is tidy, there is someone to talk to and Barb [Ms Barbara Glare] is there to give me a hand with trying to get her to breastfeed properly.⁸²³

The Committee also heard from those working in perinatal health of the challenges facing women in rural and regional Victoria. The Committee recognises that evidence describing the experiences of Victoria’s most vulnerable rural and regional women often came from health and community service staff.

Bendigo Health operates Level 5 maternity and Level 4 neonatal care services. At a public hearing in Bendigo, the Committee heard that women with gestational diabetes, diabetes, and high body mass index (BMI) are comprising a larger percentage of the total number of perinatal women seen at Bendigo Health.⁸²⁴ The Committee heard that the profile of normal risk to high risk perinatal women seen at Bendigo Health is 30-70, with high risk women being their predominant cohort, and high BMI and diabetes the main contributor to the high risk number.⁸²⁵ These women have often had to travel from long distances to access services at Bendigo Health. Ms Fiona Faulks, Deputy Director of Nursing, Women’s and Children’s Services at Bendigo Health, explained:

⁸²¹ Ms Bernadette Hammond, Director of Clinical Operations/Chief Nurse and Midwife, Bairnsdale Regional Health Service, Family and Community Development committee, public hearing – Bairnsdale, 7 December 2017, transcript of evidence, p. 3.

⁸²² Ms Alexandra Lenehan, Family and Community Development Committee public hearing – Warrnambool, 11 October 2017, transcript of evidence, p. 2; Ms Jess Stretton, Family and Community Development Committee public hearing – Warrnambool, 11 October 2017, transcript of evidence, p. 2.

⁸²³ Ms Jess Stretton, Family and Community Development Committee public hearing – Warrnambool, 11 October 2017, transcript of evidence, p. 3.

⁸²⁴ Ms Fiona Faulks, Deputy Director of Nursing, Women’s and Children’s Services, Bendigo Health, Family and Community Development Committee public hearing – Bendigo, 24 October 2017, transcript of evidence, p. 2; Dr Nicola Yuen, Director, Obstetrics and Gynaecology, Bendigo Health, Family and Community Development Committee public hearing – Bendigo, 24 October 2017, transcript of evidence, p. 7.

⁸²⁵ Dr Nicola Yuen, Director, Obstetrics and Gynaecology, Bendigo Health, Family and Community Development Committee public hearing – Bendigo, 24 October 2017, transcript of evidence, p. 7.

We have a lot of women coming from Kerang, and that is an hour and a half for them to travel. We have high-risk women coming from Swan Hill, which is over 2 hours, and then we have women coming from Mildura, which is over four... You can imagine how challenging it is for them. The higher risk women will be transferred from Mildura down to one of the metro centres. In some ways they are displaced at a very critical time of their lives when they are at extremely high risk of social and emotional disadvantage, and being removed from their social networks and their support networks is challenging for them.⁸²⁶

Mildura is more than 500kms away from Melbourne (six hour drive) and more than 400kms away (four hours) from Bendigo. At a public hearing in Mildura, the Committee heard from health workers that even with existing government subsidies, the need to travel such long distances represented significant challenges for women in the region.⁸²⁷

As noted above, witnesses and submissions that focused on rural and regional perinatal services often drew attention to a level of socioeconomic disadvantage that exists in these areas. In Mildura, witnesses stated that women in the region are at higher risk of becoming 'disengaged' from services, due to complex social and economic factors.⁸²⁸ Ms Cheree Jukes worked as a midwife in Mildura for many years. At the public hearing in Mildura, Ms Jukes provided further insight into women's experiences in the region:

When there is so much household financial pressure and a woman has to choose between an ultrasound and putting food on the table for her children, she chooses food. It is not that women do not want to access antenatal care; it is that there are significant social barriers.⁸²⁹

Ms Jukes further stated that when a woman must leave her home and community to access services, there is a 'flow-on effect for that woman and her family ... who takes care of her children at home?'⁸³⁰ Ms Samantha Cooke, Community Health Coordinator at Mildura Rural City Council, similarly told the Committee that some families in Mildura experience significant financial barriers to accessing the recommended antenatal care.⁸³¹

The Committee heard that these issues continue to place pressure on the workforce. At a public hearing in Mildura, Dr Kimberley Sleeman, a specialist in obstetrics and gynaecology at a private Mildura clinic, which has provided an ongoing service to women in the region for the past five years, told the Committee:

⁸²⁶ Ms Fiona Faulks, Deputy Director of Nursing, Women's and Children's Services, Bendigo Health, Family and Community Development Committee public hearing – Bendigo, 24 October 2017, transcript of evidence, p. 4.

⁸²⁷ Dr Nikhil Patravali, Director, Obstetrics and Gynaecology, Mildura Base Hospital, Family and Community Development Committee public hearing – Mildura, 9 November 2017, pp. 4-5.

⁸²⁸ *Ibid.*, p. 4.

⁸²⁹ Ms Cheree Jukes, Family and Community Development Committee public hearing – Mildura, 9 November 2017, transcript of evidence, p. 2.

⁸³⁰ *Ibid.*, p. 3.

⁸³¹ Ms Samantha Cooke, Community Health Coordinator, Mildura Rural City Council, Family and Community Development Committee public hearing – Mildura, 9 November 2017, p. 3.

[T]here has been a very concerning number of patients who present to the hospital in labour with minimal or no antenatal care. This group often has complex social issues, particularly drug and alcohol, domestic violence and mental health issues or issues related to being a refugee — non-English speaking and no Medicare cover. These patients place a very great strain on the already limited resources in our unit.⁸³²

The Committee received similar evidence of complex social issues and disadvantage affecting women in other rural and regional locations.⁸³³

For women and infants living in remote and isolated areas there are even greater challenges in terms of time, cost, and logistics to access services. At a public hearing in Bairnsdale, the Committee heard from one of Victoria's bush nurses. Ms Sue Carroll is the remote nurse and midwife at Swifts Creek Bush Nursing Centre in East Gippsland. Swifts Creek is 96kms (about one and a half hour drive) to Bairnsdale and about 374kms east (six hours) to Melbourne. Ms Carroll told the Committee:

The issues in rural areas are that there is that isolation and quite often they have moved to the area with no family support. There can be that mental health issue, so we do have to really keep a close eye on that. Quite often it is a lower socio-economic area and a large amount of families are on healthcare cards or sole parent pensions. So you are dealing with that and quite often with poor literacy, so you are really assisting there with a lot of their issues. And a lack of transport — there is one lady that is up there who does not have a car so relies on everybody else to drive her and children around. The only public transport is the Dyson's bus line that leaves at 7:30 Monday morning and arrives back at 3:30 in the afternoon and for the rest of the week it is 8:30 in the morning. So there is not much available, and they have got to get in somewhere to be able to actually catch that bus. Sometimes there are washouts on the side of the road from floods, so it makes that drive even worse.⁸³⁴

4.2.1 Separation of mothers and babies and women birthing away from home

The Committee heard evidence of the issues faced by mothers and babies who experienced separation soon after birth, and the challenges faced as a consequence. These situations are distressing and can have long-term implications for the future wellbeing of the mother, baby and family, which may require ongoing treatment that has a potentially significant impact on the health system.

At a public hearing in Wangaratta, the Committee heard from two mothers who had newborn babies transferred to tertiary facilities in Melbourne, and the impact of the separation of mother and baby for these women and their families. Ms Lauren Bowie gave birth by caesarean section at Northeast Health Wangaratta. Ms Bowie's baby was then transferred to the Royal Children's Hospital to receive critical care. Ms Bowie told the Committee:

⁸³² Dr Kimberley Sleeman, Obstetrics and Gynaecology Specialist, Mildura O&G Clinic, Family and Community Development Committee public hearing – Mildura, 9 November 2017, transcript of evidence, p. 3.

⁸³³ For example see, Ms Ailsa Carr, Executive Manager, Family, Youth and Children's Services, Gippsland Lakes Community Health, Family and Community Development Committee public hearing – Bairnsdale, 7 December 2017, transcript of evidence, pp. 2-3; Ms Meryn Pease, Chief Executive Officer, Orbost Regional Health, Family and Community Development Committee public hearing – Bairnsdale, 7 December 2017, transcript of evidence, p. 2.

⁸³⁴ Ms Sue Carroll, Midwife, Swifts Creek Bush Nursing Centre, Family and Community Development Committee public hearing – Bairnsdale, 7 December 2017, transcript of evidence, p. 5.

Being separated from your child less than 24 hours after they are born, I think there needs to be better support and the availability of transfers for mothers to be with their children. I found out after I arrived at the Royal Children's Hospital in Melbourne, nearly a week after my baby was born, that there were services and support at the hospital, but due to having a caesarean I was not confident in travelling to Melbourne from Wangaratta to get to the hospital. But if I had had some sort of patient transport or some sort of medical assistance in getting to the children's hospital, I could have been there a lot sooner.⁸³⁵

Ms Bowie emphasised the need for patient transport support for mothers who are not strong enough to travel to Melbourne to be with their babies shortly after a birth.⁸³⁶

The Committee also heard from Ms Megan Rickard, a mother of two children. Ms Rickard spoke about complications after the birth of her son Max at Northeast Health Wangaratta. Ms Rickard has type 1 diabetes and she was aware that her son Max could suffer from hypoglycaemia as a result of her diabetes. Ms Rickard also told the Committee that midwives at the hospital ignored a care plan that she had carefully created to ensure her and her son's wellbeing.⁸³⁷ Max was flown to the Royal Women's Hospital after his blood sugar levels did not rise with medical assistance. Ms Rickard stated that:

This was without a doubt the single most traumatic and mentally debilitating thing that has ever happened to me...⁸³⁸

Ms Rickard spoke about arranging her own transport and assistance to travel to Melbourne shortly after having had a caesarean section to deliver her baby. Ms Rickard also recommended investment into transportation to and from major hospitals for mothers from outside of Melbourne in the event that a mother and child have to be separated.⁸³⁹ Ms Rickard further told the Committee that she 'struggled for a long time after Max' and was 'diagnosed with PTSD' as a result of what had happened to her and her son.⁸⁴⁰

The Victorian Patient Transport Assistance Scheme

The Victorian Patient Transport Assistance Scheme (VPTAS) covers travel and accommodation costs incurred by rural Victorians when they travel more than 100kms one way for specialist treatment. Travel is subsidised to the nearest specialist. The current travel subsidy reimburses:

- \$0.21 per kilometre if a private car is used;
- full economy class fare reimbursements for public transport;
- air travel reimbursement if the journey exceeds 350kms one way on a commercial flight;

⁸³⁵ Ms Lauren Bowie, Family and Community Development Committee public hearing – Wangaratta, 25 October 2017, transcript of evidence, p. 2.

⁸³⁶ Ibid., p. 2.

⁸³⁷ Ms Megan Rickard, Family and Community Development Committee public hearing – Wangaratta, 25 October 2017, transcript of evidence, p. 2.

⁸³⁸ Ibid., p. 2.

⁸³⁹ Ibid., p. 2.

⁸⁴⁰ Ibid., p. 3.

- taxi travel reimbursement only to or from the nearest public transport when there are no other transport options.⁸⁴¹

Ms Suzanne Hartney, a neonatal nurse and midwife in Bendigo, told the Committee that Bendigo Health ‘see a lot of women from Echuca, but unfortunately they are 10 kilometres short of the VPTAS requirements’ compounding the challenges these women face.⁸⁴² In addition, Ms Hartney explained that women who are transferred to Bendigo Health from other areas and are eligible for VPTAS, need to outlay their costs first and then submit applications for reimbursement, which can be difficult for some women in the region.⁸⁴³

In a submission, Dr Antoinette Mowbray, a GP obstetrician practicing in Bairnsdale, highlighted the issue of pregnant women coming from 200kms away who receive reimbursement from VPTAS for ultrasound and midwife visits, but are declined when it comes to visiting GP obstetricians for antenatal care. Dr Mowbray told the Committee:

I find it counterintuitive that the government would pour millions of dollars into upskilling GPs in rural areas to provide anaesthetic and obstetric services in areas that otherwise would not have these skills, and on the other hand also provide rural people with travel support, and yet deny them travel support to see the very GPs who have been upskilled by government funding to provide an essential service for these people.⁸⁴⁴

According to Dr Mowbray, as the guidelines currently stand, these women would receive the travel assistance if they saw a specialist obstetrician. However, Dr Mowbray told the Committee that there are no specialist obstetricians who provide ongoing antenatal care in Bairnsdale, with GP obstetricians filling the gap for women in this area.⁸⁴⁵ Dr Mowbray recommended the guidelines be updated to ensure visits to GP obstetricians are on the list for reimbursed travel.⁸⁴⁶

At a public hearing in Bendigo, Ms Christine Gibbins, Health Services Coordinator with the Bendigo and District Aboriginal Co-operative (BDAC), told the Committee:

[W]e could do a lot better on the coordination of transport across the region so that it is not just about an infant but it is also about the adult and the family.⁸⁴⁷

Ms Raylene Harradine, Chief Executive Officer BDAC and Chair of the Loddon Mallee Aboriginal Reference Group, told the Committee that BDAC receives ‘a lot of phone calls’ from Aboriginal and Torres Strait Islander women and their families who have had to travel from Swan Hill and ‘even as far as Robinvale and sometimes Mildura’

⁸⁴¹ Department of Health and Human Services, ‘Victorian Patient Transport Assistance Scheme (VPTAS)’, accessed 24 April 2018, <<https://www2.health.vic.gov.au/hospitals-and-health-services/rural-health/vptas-how-to-apply>>.

⁸⁴² Ms Suzanne Hartney, Neonatal Nurse and Midwife, Family and Community Development Committee public hearing – Bendigo, 24 October 2017, transcript of evidence, p. 4.

⁸⁴³ Ibid.

⁸⁴⁴ Dr Antoinette Mowbray, submission no. 99, p. 1.

⁸⁴⁵ Ibid.

⁸⁴⁶ Ibid.

⁸⁴⁷ Ms Christine Gibbins, Health Services Coordinator, Bendigo and District Aboriginal Co-operative, Family and Community Development Committee public hearing – Bendigo, 24 October 2017, transcript of evidence, p. 5.

to Bendigo because of an emergency caesarean or other service that can only be delivered at the higher capability hospital in Bendigo.⁸⁴⁸ Ms Harradine stated that these families have contacted BDAC to see if they can 'get them back home'.⁸⁴⁹

The Committee is concerned that women in rural and regional communities are not being adequately supported when they are required to travel long distances to access perinatal services, including real-time support when discharged from hospital. Accordingly, the Committee recommends that:

RECOMMENDATION 4.1: The Victorian Government review the Victorian Patient Transport Assistance Scheme to provide greater support to rural and regional women who need to travel long distances to access maternity services including on their discharge from hospital.

The Committee recognises that it is challenging when mothers and families are separated from babies that are receiving care in tertiary facilities far from home. Women who are required to leave their communities to birth are also best supported when their family members are nearby. Accordingly, the Committee recommends that:

RECOMMENDATION 4.2: The Victorian Government work with public health services including social workers to provide expanded travel and accommodation support for rural and regional families when mothers and babies are receiving care away from home.

4.3 Closure of birthing services

In recent decades, many smaller rural hospitals have ceased birthing services.⁸⁵⁰ For many women this means that they have to travel distances to give birth. Issues such as workforce capability, attraction and retention of staff, risk, and insurance place pressure on rural birthing services.

During the Inquiry, the Committee heard that birthing services had ceased at Orbost, Kerang, and Healesville.⁸⁵¹ Myrtleford and Bright had recently ceased birthing services and were operating at Level 1 in the state-wide Capability Framework.⁸⁵² This has reduced birthing options for women in these areas and increased their need

⁸⁴⁸ Ms Raylene Harradine, Chief Executive Officer, Bendigo and District Aboriginal Co-operative, and Chair, Loddon Mallee Aboriginal Reference Group, Family and Community Development Committee public hearing – Bendigo, 24 October 2017, transcript of evidence, p. 5.

⁸⁴⁹ Ibid.

⁸⁵⁰ Dr Will Twycross, Procedural GP in Obstetrics, Anaesthetics and Accident and Emergency, Family and Community Development Committee public hearing – Wangaratta, 25 October 2017, p. 3; A reduction in maternity services in Australia over the last 20 years in rural and remote areas is noted in S Kruske, S Kildea, B Jenkinson, J Pilcher, S Robin, M Rolfe, J Kornelsen, L Barclay, 'Primary Maternity Units in Rural and Remote Australia: results of a national survey', *Midwifery*, author's accepted manuscript, 17 December 2015, p. 3, accessed 21 May 2018, <<https://espace.library.uq.edu.au/view/UQ:406299>>.

⁸⁵¹ Ms Meryn Pease, Chief Executive Officer, Orbost Regional Health, Family and Community Development Committee public hearing – Bairnsdale, 7 December 2017, transcript of evidence; Save Healesville Action Group, submission no. 43, p. 1; Dr Nicola Yuen, Director, Obstetrics and Gynaecology, Bendigo Health, Family and Community Development Committee public hearing – Bendigo, 24 October 2017, transcript of evidence, p. 4.

⁸⁵² Dr Leo Fogarty, Director of Obstetrics, Northeast Health Wangaratta, Family and Community Development Committee public hearing – Wangaratta, 25 October 2017, transcript of evidence, p. 5.

to travel. The Committee heard that the loss of these services has also had a flow-on effect for the local perinatal workforce. This section discusses these issues with a focus on Orbost Regional Health and the Healesville Hospital.

Rural and regional witnesses and submissions recognised that women in higher risk categories will need to receive care at higher capability hospitals.⁸⁵³ However, the Committee also heard that women would prefer to birth in their own communities or as close to their homes as possible.⁸⁵⁴ Some submitters told the Committee that this reduces risks to women and their babies, as well as travel costs.⁸⁵⁵

At a public hearing in Wangaratta, the Committee heard from Dr Will Twycross, Procedural GP in Obstetrics, Anaesthetics, and Accident and Emergency in Mansfield, who stated that an hour, or an hour and a half, can be just 'a little bit too long' if a pregnant woman is 'really in trouble'.⁸⁵⁶ Dr Twycross also stated that for small rural communities it is vital to their future that birthing services continue:

[P]eople have confidence in their communities if they have good education and if they have good health, and the ability to deliver your baby locally or at least approximate to where you live ...⁸⁵⁷

According to Dr Twycross, best practice across Victoria is to deliver locally in rural communities with good secondary regional services and tertiary Melbourne support when necessary.⁸⁵⁸

In their submission, the Victorian Branch of the Australian Nursing and Midwifery Federation (ANMF) stated that there has been a trend towards the closure of birthing services in rural and remote areas across Australia:

The rationales behind these closures are often concerns about safety, economic resources, and professional indemnity. Many developed nations have experienced similar trends in closure of rural birthing services. These closures have considerable implications for patients, communities, clinical workforce and health services in rural areas. Many non-metropolitan community members continue to lobby for the reinstatement of local birthing care as they seek safe, equitable service access and high quality care. After many years of closures, the state of Queensland in Australia has seen increased interest and success in restarting remote birthing services.⁸⁵⁹

The ANMF also stated that, in areas where it is no longer possible to ensure a low risk birthing service, it is important that pregnancy care and postnatal services should be made available for women locally.⁸⁶⁰

The Committee highlights evidence it heard regarding the closure of birthing services at Orbost Regional Health and Healesville Hospital below.

⁸⁵³ For example see, Save Healesville Hospital Action Group, submission no. 43, p. 2.

⁸⁵⁴ For example see, East Grampians Health Service, submission no. 11, p. 1; Save Healesville Hospital Action Group, submission no. 43.

⁸⁵⁵ For example see, East Grampians Health Service, submission no. 11, p. 1; Save Healesville Hospital Action Group, submission no. 43.

⁸⁵⁶ Dr Will Twycross, Procedural GP in Obstetrics, Anaesthetics, and Accident and Emergency, Family and Community Development Committee, public hearing – Wangaratta, 25 October 2017, transcript of evidence, p. 3.

⁸⁵⁷ *Ibid.*, p. 4.

⁸⁵⁸ *Ibid.*, pp. 4-5.

⁸⁵⁹ Australian Nursing and Midwifery Federation (Victorian Branch), submission no. 67, p. 17.

⁸⁶⁰ *Ibid.*

Orbost Regional Health

At a public hearing in Bairnsdale, Ms Meryn Pease, Chief Executive Officer of Orbost Regional Health, told the Committee that Orbost operated a maternity service at Level 2 capability before April 2017. Ms Pease told the Committee:

[W]e operated a maternity service at level 2 capability, providing a low-risk maternity service, an antepartum service, a birthing service, postpartum services and neonatal care, with excellent outcomes for mothers and babies. The service was staffed by a sole GP with a specialty in obstetrics and five qualified competent and highly experienced midwives. The team provided 24/7, on-call service for birthing women.⁸⁶¹

Orbost Regional Health supports a catchment area of about a million hectares, containing small and isolated communities along the Snowy River. With the closure of Orbost's birthing service, some women in this catchment travel between two and two and a half hours to birth.⁸⁶²

According to Ms Pease, the service ceased due to low birth numbers, with Orbost having had an average of 22 to 24 births a year.⁸⁶³ Ms Pease explained that their GP obstetrician had an existing arrangement to work at other hospitals, for a part of his time, in order to maintain his skills, including a longstanding partnership with Western Health:

[B]ut when Djerriwarrh emerged, Western Health withdrew their support for him to continue to do extra cases and gain experience with birthing at Western.⁸⁶⁴

The GP obstetrician left Orbost in April 2017 to go to another rural health service with a higher number of births.⁸⁶⁵ Ms Pease noted Orbost's present inability to recommence the birthing service has meant that their midwives 'could leave to practice midwifery elsewhere', which would leave their large catchment area with less maternity care.⁸⁶⁶

Ms Pease stated that since April, they have had 'one unplanned birth'.⁸⁶⁷ The midwives did the delivery and then the support services came from Bairnsdale. Ms Pease recognised that the support is good, however, she noted that if Orbost were to reinstate its birthing service, this would reduce the travel for women, and ensure they can deal with emergency births.⁸⁶⁸ These views were reiterated in evidence from other rural and regional communities regarding their birthing services.⁸⁶⁹

⁸⁶¹ Ms Meryn Pease, Chief Executive Officer, Orbost Regional Health, Family and Community Development Committee public hearing – Bairnsdale, 7 December 2017, transcript of evidence, p. 2.

⁸⁶² Ibid.

⁸⁶³ Ibid., p. 3.

⁸⁶⁴ Ibid., p. 2.

⁸⁶⁵ Ibid.

⁸⁶⁶ Ibid., p. 3.

⁸⁶⁷ Ibid.

⁸⁶⁸ Ibid.

⁸⁶⁹ For example see, Dr Will Twycross, Procedural GP in Obstetrics, Anaesthetics, and Accident and Emergency, Family and Community Development Committee, public hearing – Wangaratta, 25 October 2017, transcript of evidence; Yarra Valley Midwives, submission no. 39.

Healesville Hospital

In 2012, Healesville Hospital, which is part of Eastern Health, ceased its birthing service, which it had operated for over 30 years. In their submission, Yarra Valley Midwives supported the reinstatement of the birthing service, noting that since the closure, women in the Shire of Yarra Ranges had to travel to the Angliss or Box Hill hospitals to birth.⁸⁷⁰ Yarra Valley Midwives, in their submission, told the Committee:

Women in the Yarra Ranges wanting a hospital birth are forced to attend antenatal clinics over an hour away from their community. Women all over the Yarra Ranges approach us for continuity of carer, some are disappointed with the care they are receiving at the available hospitals, they report the wait times, the commute times, parking, access to transport, cost, exhaustion in later pregnancy/weather conditions and the level of care they are offered is unacceptable. Women also report experiencing high levels of anxiety about the distance they must travel in labour. Some women are forced to have unplanned home births, birth in ambulances or in cars en-route to hospital because of the travel times due to the distance to the available Maternity Hospitals.⁸⁷¹

The Committee recognises the desire of many rural and regional women to have the option to birth locally. While rural women in high risk categories will need to access birthing services in the higher capability hospitals, the availability of low risk birthing services and antenatal and postnatal care in rural communities are important for all women in these communities. Accordingly, the Committee recommends that:

RECOMMENDATION 4.3: The Victorian Government support rural and regional maternity services through increased funding and staffing, to allow women in rural and regional areas the choice of giving birth in their own community, taking into account the safety of mothers and babies, and the Capability Framework for Victorian maternity and newborn services in that region.

RECOMMENDATION 4.4: The Victorian Government put systems in place to facilitate maintenance of skill sets of rural and regional obstetricians and GP obstetricians through enabling them to do short-term placements at higher capability hospitals.

4.4 Pressures on the Capability Framework in rural and regional Victoria

The Committee heard that rural and regional health services are operating under the aims of the *Capability framework for Victorian maternity and newborn services* and *Defining levels of care for Victorian newborn services, 2015*.⁸⁷² However, some of the health services in these areas are under pressure due to factors such as their distance from the higher capability hospitals, longer wait-times to transfer patients out, workforce issues including staff shortages, and ageing and inadequate facilities.

⁸⁷⁰ Yarra Valley Midwives, submission no. 39.

⁸⁷¹ Ibid., p. 2.

⁸⁷² Department of Health, *Capability framework for Victorian maternity and newborn services*, Victorian Government, Melbourne, 2010; Department of Health and Human Services, *Defining levels of care for Victorian newborn services, 2015*, Victorian Government, Melbourne, November 2015.

Along with the challenges above, this section also discusses actions that can strengthen the capacity of rural and regional health services to deal with high risk and premature births. These include addressing workforce issues and resource needs, investing in workforce education and training, improving timely transferral of acute patients, adopting a consistent neonatal pack to enable emergency care, similar to New South Wales' (NSW) Good Egg Packs, continued support for intraregional collaboration and cooperation through the perinatal mortality and morbidity committees, and better communication across health services.

4.4.1 Distance to higher capability health services

The Committee heard that health workers in rural and regional areas need to be prepared to assist women and babies outside of their capability level and in emergency situations. Some rural and regional health services are seeing higher numbers of women in risk categories.⁸⁷³ They require more staff and resources to extend their capability level.

At a public hearing in Mildura, Dr Nikhil Patravali, Director of Obstetrics and Gynaecology at Mildura Base Hospital (a Level 4 maternity service and Level 3 neonatal care service), told the Committee that there are times when they have had to 'accept level 5 work'.⁸⁷⁴ At the public hearing, Ms Janet Hicks, Director of Nursing at Mildura Base Hospital, explained:

I think that is really one of our key challenges — our geographical location. Ultimately if a woman walks in the door in labour, she is staying with us; we do not have an opportunity to actually transfer her. If she has threatened labour we may have a window of time when we call PIPER for a retrieval. It is going to be a minimum of 4 hours for them to get a plane in the air, come up here, stabilise someone and actually transfer them. We will call PIPER. We will have that conversation. They may often just fly up here and support us and be here for those very high-risk women, but that is a really key challenge for us in ensuring that our staff are well-trained to be able to actually deal with whatever walks in the door. We can be classed as a level 4 maternity service, but we actually have to have the capability to respond to whatever walks in the door, because we are not a 20-minute ambulance ride up the road to the next level 5 facility.⁸⁷⁵

Dr Patravali added that 'there is very limited financial support for these women who would be deemed medically not safe to deliver here', which has meant some women cannot travel out to access appropriate services.⁸⁷⁶ In response to a question about what types of Level 5 cases they have had to deal with, Dr Patravali stated:

⁸⁷³ Ms Fiona Faulks, Deputy Director of Nursing, Women's and Children's Services, Bendigo Health, Family and Community Development Committee public hearing – Bendigo, 24 October 2017, transcript of evidence, p. 2; Dr Nikhil Patravali, Director, Obstetrics and Gynaecology, Mildura Base Hospital, Family and Community Development Committee public hearing – Mildura, 9 November 2017, transcript of evidence, p. 4; Ms Julianne Clift, Director of Nursing, South West Healthcare, Family and Community Development Committee public hearing – Warrnambool, 11 October 2017, transcript of evidence, p. 2; Dr Leo Fogarty, Director of Obstetrics, Northeast Health Wangaratta, Family and Community Development Committee public hearing – Wangaratta, 25 October 2017, transcript of evidence, p. 6; Dr Simon Fraser, Chief Medical Officer and Paediatrician, Latrobe Regional Hospital, Family and Community Development Committee public hearing – Warragul, 8 December 2017, transcript of evidence, p. 3.

⁸⁷⁴ Dr Nikhil Patravali, Director, Obstetrics and Gynaecology, Mildura Base Hospital, Family and Community Development Committee public hearing – Mildura, 9 November 2017, transcript of evidence, p. 3.

⁸⁷⁵ Ms Janet Hicks, Director of Nursing, Mildura Base Hospital, Family and Community Development Committee public hearing – Mildura, 9 November 2017, transcript of evidence, p. 9.

⁸⁷⁶ Dr Nikhil Patravali, Director, Obstetrics and Gynaecology, Mildura Base Hospital, Family and Community Development Committee public hearing – Mildura, 9 November 2017, transcript of evidence, pp. 4-5.

The ones which perhaps we are unable to transfer, the extreme premature births who are imminently delivering and we do not have the time, or a few months ago, the airport was shut at night and we just could not transfer people out.⁸⁷⁷

Dr Patravali added that Mildura Base Hospital has an Intensive Care Unit and the neonatologists are ‘very experienced’ but the hospital is not adequately staffed to deliver next level services.⁸⁷⁸ He stated:

We are endeavouring, by increasing consulting numbers and registrar numbers. I had a meeting with the clinical director for paediatrics and neonatology. They are certainly endeavouring to improve their own service so that we can then take more high-risk people. But again it boils down to midwifery staff.⁸⁷⁹

At a public hearing in Warrnambool, Dr Liz Uren, Specialist in Obstetrics and Gynaecology at South West Healthcare (Level 4 maternity service and Level 3 neonatal service), similarly stated that they have seen cases where women deemed high risk have returned to the region:

The other thing I think is that there may need to be more accommodation options for women who are required to wait for delivery in Melbourne or the bigger centres. We have got a problem there where we will not deliver women with a BMI over 50. We have had a couple of occasions where women have been sent down and they were supposed to stay in Melbourne or wherever to deliver their baby and they have just said, ‘No, I can’t do it. I can’t afford it. I’m just going to go home’. So we end up with them anyway, and it sort of defeats the purpose of referring them.⁸⁸⁰

4.4.2 Transfer of mothers and babies to higher capability services

The Committee heard that the Paediatric Infant Perinatal Emergency Retrieval Service (PIPER) has greatly improved the process of transferring rural and regional women and children to higher capability hospitals. However, the long distances and the availability of beds at tertiary facilities can hinder the timely transferral of women and children. At a public hearing in Wangaratta, Dr Leo Fogarty, Director of Obstetrics at Northeast Health Wangaratta (Level 4 maternity and Level 3 neonatal services), told the Committee:

I would, firstly, have to say that having PIPER organising transfers for us is a vast improvement on the previous situation we had of having to ring around three different tertiary hospitals, which is something I remember from 10 or 15 years ago. Most of the problems we have with PIPER and with transfers are, I am sure, due to the unavailability of sufficient neonatal intensive care beds in Melbourne. But we also do have some PIPER clinicians on the other end of the phone in Melbourne who do seem to have very little understanding of our situation and our staffing and our capabilities. As a result of difficulties with transferring patients, we are now fairly regularly left to deal with situations which are outside our capability framework, such as holding on to very premature babies because there is nowhere for them to go in Melbourne.⁸⁸¹

⁸⁷⁷ Ibid., p. 9.

⁸⁷⁸ Ibid.

⁸⁷⁹ Ibid.

⁸⁸⁰ Dr Liz Uren, Obstetrics and Gynaecology, South West Healthcare, Family and Community Development Committee public hearing – Warrnambool, 11 October 2017, transcript of evidence, p. 3.

⁸⁸¹ Dr Leo Fogarty, Director of Obstetrics, Northeast Health Wangaratta, Family and Community Development Committee public hearing – Wangaratta, 25 October 2017, transcript of evidence, p. 3.

At a public hearing in Warragul, Dr Simon Fraser, Chief Medical Officer and Paediatrician at Latrobe Regional Hospital (Level 5 maternity and Level 4 neonatal services), told the Committee that PIPER has found it easier to bypass Latrobe Regional Hospital when they are collecting a baby or mother from Bairnsdale or Sale, which means that their special care nursery at Level 4 capability is bypassed and there are then separation issues for families and their children:

They are concerned about double transfers, where they take a sick baby to the Latrobe Regional Hospital and then they might have to come back and take them a day or two later. I have certainly raised this on behalf of the region and the regional M and M [mortality and morbidity] committee with PIPER. We have a strong commitment in the region, including our referral pathways, to where we can, within the capability of the health services, to try and keep mums and babies together and in the region, rather than having them travelling long distances.⁸⁸²

Dr Fraser added that while there is a strong commitment to transferring babies, 'there can be a little bit of *Ring a Ring o' Rosie* with antenatal transfers, which is very frustrating'.⁸⁸³

At a public hearing in Mildura, Dr Kimberley Sleeman, Specialist Obstetrician and Gynaecologist at the private Mildura O&G Clinic, which sees many antenatal and postnatal women in the region and has seen the majority of women birthing in Mildura, described the cross-border issues and concerns about cost, which can leave high risk women in the region with little choice regarding which tertiary facility they go to:

Transfers result in significant stresses for families, physically, emotionally and financially. It is also increasingly difficult to arrange said transfers to other locations because of resource limitations across the state. The PIPER system is not really well-equipped to deal with these situations, and bed shortages are a problem everywhere. Cross-border issues are also a problem. Ideally in the past we always transferred patients to Adelaide because it was closer, but due to higher transport costs we are now directed to transfer patients to Melbourne, which is physically further, and a lot of patients from this area find that to be a much more intimidating situation.⁸⁸⁴

The Committee makes recommendations in Chapter One regarding PIPER and Neonatal Intensive Care Units. Recommendation 1.4 in Chapter One recommends a review of PIPER. Recommendation 1.1 in Chapter One recommends a review of Neonatal Intensive Care Units in Victoria.

At its public hearings in rural and regional Victoria, the Committee also heard that rural and regional health services will use ambulances for transfers within their region. The Committee heard that ambulance access and wait times can be particularly challenging in rural and regional areas.⁸⁸⁵ In these cases, the Committee

⁸⁸² Dr Simon Fraser, Chief Medical Officer and Paediatrician, Latrobe Regional Hospital, Family and Community Development Committee public hearing – Warragul, 8 December 2017, transcript of evidence, p. 3.

⁸⁸³ *Ibid.*, p. 11.

⁸⁸⁴ Dr Kimberley Sleeman, Obstetrics and Gynaecology Specialist, Mildura O&G Clinic, Family and Community Development Committee public hearing – Mildura, 9 November 2017, transcript of evidence, p. 2.

⁸⁸⁵ Ms Janene Facey, Maternity Nurse Unit Manager, South West Healthcare, Family and Community Development Committee public hearing – Warrnambool, 11 October 2017, transcript of evidence, p. 5; Dr Liz Uren, Obstetrics and Gynaecology, South West Healthcare, Family and Community Development Committee public hearing – Warrnambool, 11 October 2017, transcript of evidence, p. 5; Dr Antoinette Mowbray, GP Obstetrician, Family and Community Development Committee public hearing – Bairnsdale, 7 December 2017, transcript of evidence, p. 4.

heard that staff need to be prepared and supported by higher capability services in their region to stabilise a woman and/or infant before ambulance services arrive.⁸⁸⁶ According to Dr Fraser of Latrobe Regional Hospital, ‘there needs to be a better commitment to facilitating or coordinating intra-regional transfers’.⁸⁸⁷ For more see section 4.4.5.

Good Egg Packs

Albury Wodonga Health provides perinatal services in north-east Victoria and across the border in southern NSW. At a public hearing in Wangaratta, Ms Julie Wright, Operational Director of Women’s and Children’s Services at Albury Wodonga Health, told the Committee that navigating cross-border issues can be challenging but it occasionally has some real benefit.⁸⁸⁸ Ms Wright stated:

Another very basic thing — it would be a wonderful thing to see — is what in New South Wales is called the Good Egg Pack. We were very lucky to receive a Good Egg Pack about three or four years ago, but they were rolled out across New South Wales about 10 years ago and funded by the Humpty Dumpty Foundation. Essentially it is like a big backpack and it has got everything you would need for a neonatal resuscitation, should you need it, including an oximeter and a Neopuff to help breathing support.⁸⁸⁹

The Committee heard that these packs could be introduced across rural and regional Victoria for medical staff to stabilise an infant and provide some immediate care while waiting for the PIPER team to arrive.⁸⁹⁰

Adequate training of health workers who are first-responders in rural and regional locations is also critical. Section 4.7.5 discusses two current emergency care training programs available for the rural and regional perinatal workforce.

4.4.3 Rural and regional workforce issues

The Committee consistently heard that one of the most important issues affecting the quality and safety of rural and regional perinatal health services is the adequacy of the workforce, both in terms of numbers and skills. The Committee heard some rural and regional communities in Victoria are facing greater workforce and resource shortages than others. For more on workforce challenges in rural and regional Victoria, see Chapter Five.

⁸⁸⁶ For example see, Ms Julie Wright, Operational Director of Women’s and Children’s Services, Albury Wodonga Health, Family and Community Development Committee public hearing – Wangaratta, 25 October 2017, transcript of evidence, pp. 5-6; Ms Julianne Barclay, Maternity Services Officer, Australian Nursing and Midwifery Federation (Victorian Branch), Family and Community Development Committee public hearing – Melbourne, 18 September 2017, transcript of evidence, p. 6; Ms Sue Carroll, Midwife, Swifts Creek Bush Nursing Centre, Family and Community Development Committee public hearing – Bairnsdale, 7 December 2017, transcript of evidence, pp. 7-8.

⁸⁸⁷ Dr Simon Fraser, Chief Medical Officer and Paediatrician, Latrobe Regional Hospital, Family and Community Development Committee public hearing – Warragul, 8 December 2017, transcript of evidence, p. 11.

⁸⁸⁸ Ms Julie Wright, Operational Director of Women’s and children’s Services, Albury Wodonga Health, Family and Community Development Committee public hearing – Wangaratta, 25 October 2017, transcript of evidence, p. 2.

⁸⁸⁹ *Ibid.*, p. 5.

⁸⁹⁰ *Ibid.*, p. 6.

At a public hearing in Wangaratta, Ms Julie Wright, of Albury Wodonga Health, told the Committee that they 'are very lucky at this point in time to have a full complement of midwives'.⁸⁹¹ However, she explained that this took 'a lot of work' and that nine years ago when she first came into the role of nurse unit manager, there was a significant shortfall of ten equivalent full time (EFT).⁸⁹² Ms Wright described Albury Wodonga Health's 'grow your own' approach for building up the rural and regional workforce, which has helped them fill roles in their service. For more see section 4.7.3.

The Committee heard that workforce shortages are significant in other areas. At a public hearing in Mildura, Dr Nikhil Patravali, Director of Obstetrics and Gynaecology at Mildura Base Hospital, said that their 'biggest challenge' is recruitment and retention of staff. Dr Patravali told the Committee:

I have, time and again every other day, seen midwives working over and above the time that they are contracted for just to mind the floor, so there is a lot of hard work, although there is a lot of camaraderie going on. We are a beautiful team. It only takes you so far when you are flogged time and again.⁸⁹³

At the public hearing in Mildura, Ms Janet Hicks, Director of Nursing at Mildura Base Hospital, further explained to the Committee that the hospital has a 'very junior workforce compared to most hospitals that have an ageing workforce' which further affects their capacity to deliver their services.⁸⁹⁴ The Committee heard that the stress and strain on the workforce has led to staff departures in Mildura.⁸⁹⁵

At a public hearing in Mildura, Dr Kimberley Sleeman of the private Mildura O&G Clinic, which offers a range of services to women including antenatal care, stated that the workforce shortage at Mildura Base Hospital has been 'an evolving crisis for about two years' and regularly impacts on patient care.⁸⁹⁶

Workforce issues place significant stress on staff and affect the quality and accessibility of services in rural and regional areas. While not all rural and regional health services are suffering shortages, the Committee heard that constant management is required to ensure staffing levels are adequate.⁸⁹⁷ In Warrnambool, the Committee heard that South West Healthcare's staffing levels are 'satisfactory' and they are reliant on regional Deakin University to continue offering its courses in the region and supplying graduate midwives and nurses to South West Healthcare.⁸⁹⁸

⁸⁹¹ Ibid., p. 3.

⁸⁹² Ibid.

⁸⁹³ Dr Nikhil Patravali, Director, Obstetrics and Gynaecology, Mildura Base Hospital, Family and Community Development Committee public hearing – Mildura, 9 November 2017, transcript of evidence, p. 5.

⁸⁹⁴ Ms Janet Hicks, Director of Nursing, Mildura Base Hospital, Family and Community Development Committee public hearing – Mildura, 9 November 2017, transcript of evidence, p. 6.

⁸⁹⁵ Dr Kimberley Sleeman, Obstetrics and Gynaecology Specialist, Mildura O&G Clinic, Family and Community Development Committee public hearing – Mildura, 9 November 2017, transcript of evidence, p. 3.

⁸⁹⁶ Ibid., p. 2.

⁸⁹⁷ Ms Julie Wright, Operational Director of Women's and Children's Services, Albury Wodonga Health, Family and Community Development Committee public hearing – Wangaratta, 25 October 2017, transcript of evidence, p. 3; Ms Julianne Clift, Director of Nursing, South West Healthcare, Family and Community Development Committee public hearing – Warrnambool, 11 October 2017, transcript of evidence, pp. 3, 6; Dr Nicola Yuen, Director, Obstetrics and Gynaecology, Bendigo Health, Family and Community Development Committee public hearing – Bendigo, 24 October 2017, transcript of evidence, p. 11.

⁸⁹⁸ Ms Julianne Clift, Director of Nursing, South West Healthcare, Family and Community Development Committee public hearing – Warrnambool, 11 October 2017, transcript of evidence, pp. 6-7.

In Wangaratta, the Committee heard that Northeast Health Wangaratta struggles with their medical workforce, including a lack of registrars to cover out of hours and weekend shifts.⁸⁹⁹ Bendigo Health identified midwifery, obstetric and GP obstetrician workforce issues.⁹⁰⁰ For more on Victoria's perinatal workforce see Chapter Five.

4.4.4 Facilities to meet demand

The Committee heard that some rural and regional services are under significant pressure due to ageing facilities and growing demands on their services. At a public hearing in Warragul, Ms Kathy Kinrade, Director of Clinical Operations at the West Gippsland Healthcare Group, told the Committee:

Our biggest issue at the moment is our population growth in the Baw Baw shire is increasing all the time, and we have an [Emergency Department] ED presentation rising at around 9 per cent per year and an ageing and inadequate infrastructure, which prohibits us from having any temporary care models. We have a huge number of young families moving into our area as well.⁹⁰¹

The Committee heard the West Gippsland Healthcare Group delivers the highest number of babies of any health service in Gippsland. In 2012-13, they delivered over 1,000 babies, which Ms Kinrade stated was 'a pressure point for the organisation not only in the safety of the service ... but being faced with an ongoing increasing demand and no formal ability to contain that'.⁹⁰² Ms Kinrade further stated:

So when we hit over 1000 births, we looked at converting what was currently the high dependency unit into a postnatal area to try and increase our bed numbers and meet demand. That only potentially gave us two extra postnatal beds, and it has meant that we have had a decrease in our ability to look after high-dependency patients.

We also had a really serious issue in our ability to meet secondary referral patterns across Gippsland. We have a very strong relationship with South Gippsland, so Bass Coast, Leongatha and Foster really are supported by our organisation for their complex births, but we also had a huge problem with people coming from Casey shire and also Latrobe shire to West Gippsland, for birthing in particular.⁹⁰³

Further, Ms Kinrade told the Committee that having only two operating theatres at their hospital led to one mother who required a caesarean section birthing in a recovery room:

Only three weeks ago we had an unfortunate incident where we had an emergency caesar happen in our recovery room area because both theatres were occupied at that time. Fortunately, due to good planning, we have a live mother and baby but also a very anxious workforce looking at the future.⁹⁰⁴

⁸⁹⁹ Dr Leo Fogarty, Director of Obstetrics, Northeast Health Wangaratta, Family and Community Development Committee public hearing – Wangaratta, 25 October 2017, transcript of evidence, p. 2.

⁹⁰⁰ Dr Nicola Yuen, Director, Obstetrics and Gynaecology, Bendigo Health, Family and Community Development Committee public hearing – Bendigo, 24 October 2017, transcript of evidence, p. 11.

⁹⁰¹ Ms Kathy Kinrade, Director, Clinical Operations, Nursing and Midwifery, West Gippsland Healthcare Group, Family and Community Development Committee public hearing – Warragul, 8 December 2017, transcript of evidence, p. 3.

⁹⁰² Ibid.

⁹⁰³ Ibid.

⁹⁰⁴ Ibid.

Ms Kinrade also stated that there are plans to expand to a third operating theatre and build a short-stay unit for their emergency department. However, she told the Committee that a ‘totally new designed hospital’ is needed.⁹⁰⁵ The Committee heard that the hospital was built in the 1940s.⁹⁰⁶

The Committee received similar evidence of rural and regional health services requiring new facilities to meet the demand at its other rural and regional public hearings. The Committee heard that the Northeast Health Wangaratta hospital runs ‘a very busy antenatal clinic’ that deals with normal and complex, high risk pregnancies for Wangaratta and the wider region. At a public hearing in Wangaratta, Dr Leo Fogarty, Director of Obstetrics at Northeast Health Wangaratta, told the Committee:

We manage all this with six post and antenatal beds – six in total – four delivery rooms and six neonatal beds. We have no assessment room, so that pregnant women who come in off the street or are referred to us with problems during pregnancy need to be seen in one of the delivery rooms, which puts quite a bit of pressure on us geographically or with rooms.⁹⁰⁷

In Warrnambool, the Committee heard that South West Healthcare requires more theatre availability and after-hours staff to reduce the waiting times for women requiring emergency caesarean sections.⁹⁰⁸

At a public hearing in Warragul, the Committee heard that Latrobe Regional Hospital is receiving government support to increase the capacity of its special care nursery in the next 12 to 18 months, which will enable more babies requiring special care to be kept in the region closer to their families.⁹⁰⁹

4.4.5 Intraregional referral pathways and support for smaller health services

The Committee heard that the perinatal mortality and morbidity regional committees have facilitated sharing of information and advice between health services across Victoria. Chapter One discusses the work of these committees and recommends extending their funding. At a public hearing in Geelong, the Committee also heard of the need for more coordination within the regions to ensure there are clear referral pathways and policies, which support the Capability Framework in the regions.

At a public hearing in Geelong, Dr David Fuller, Clinical Director of University Hospital (Barwon Health), which operates a Level 5 maternity service and a Level 5 special care nursery, told the Committee:

Lastly in terms of safe and effective care, there’s been a lot of work done at defining levels of capability so we’ve got level 6 services, level 5 and level 4 and so on all the way down. What we don’t have so much at the moment is such a good coordination

⁹⁰⁵ Ibid.

⁹⁰⁶ Ibid., p. 6.

⁹⁰⁷ Dr Leo Fogarty, Director of Obstetrics, Northeast Health Wangaratta, Family and Community Development Committee public hearing – Wangaratta, 25 October 2017, transcript of evidence, p. 2.

⁹⁰⁸ Ms Julianne Clift, Director of Nursing, South West Healthcare, Family and Community Development Committee public hearing – Warrnambool, 11 October 2017, transcript of evidence, p. 4.

⁹⁰⁹ Dr Simon Fraser, Chief Medical Officer and Paediatrician, Latrobe Regional Hospital, Family and Community Development Committee public hearing – Warragul, 8 December 2017, transcript of evidence, p. 3.

between those different levels, so pathways of care and working out when someone should go from level 3 to level 4, or level 4 to level 5. So, there are some general principles but not such well-defined pathways worked out across a range of criteria.⁹¹⁰

Dr Fuller commented favourably on the services ‘east of the state’ where he stated, ‘they have actually taken a significant lead with and doing much better coordinated care between services’.⁹¹¹

At a public hearing in Warragul, the Committee heard from Dr Simon Fraser, Chief Medical Officer and Paediatrician at Latrobe Regional Hospital (Level 5 maternity and Level 4 neonatal care services). Dr Fraser stated that Latrobe Regional Hospital offers the highest capability maternity and neonatal care in the region and is ‘heavily involved in clinical governance’.⁹¹² It coordinates the Gippsland regional perinatal mortality and morbidity committee.⁹¹³

In addition, the Committee heard that in Gippsland there has been ‘for a number of years a well-coordinated and collaborative maternity services group which meets every two months’.⁹¹⁴ Dr Fraser told the Committee this group includes ‘representatives of all eight of the Gippsland health services providing perinatal care’.⁹¹⁵ Dr Fraser stated that through the Gippsland maternity services group:

We have developed a regional policy for BMI in terms of levels at which women can be safely delivered and where they might need to be escalated up to higher levels, including to Monash as the tertiary referral centre.⁹¹⁶

The Committee is aware that transport incubators were rolled out across Victoria in 2014 to 16 health services in rural and regional Victoria.⁹¹⁷ Dr Fraser stated they have a protocol for the use of their inter-hospital incubator and ‘are just in the final throes of working on agreed referral pathways in the region for women before, during and after delivery, and for their babies’.⁹¹⁸

At a public hearing in Bairnsdale, the Committee heard of the benefits for smaller health services when there are shared policies and good coordination between health services in a region. Ms Bernadette Hammond, Director of Clinical Operations, Chief Nurse and Midwife at Bairnsdale Health Service (Level 3 maternity and Level 2 neonatal services), told the Committee that their service is staffed by GP obstetricians and midwives, and that being a low risk service for mothers and babies there are

⁹¹⁰ Dr David Fuller, Clinical Director, University Hospital Geelong, Family and Community Development Committee public hearing – Geelong, 11 December 2017, transcript of evidence, p. 4.

⁹¹¹ Ibid.

⁹¹² Dr Simon Fraser, Chief Medical Officer and Paediatrician, Latrobe Regional Hospital, Family and Community Development Committee public hearing – Warragul, 8 December 2017, transcript of evidence, p. 3.

⁹¹³ Ibid.

⁹¹⁴ Ibid.

⁹¹⁵ Ibid.

⁹¹⁶ Ibid.

⁹¹⁷ Ms Julie Wright, Operational Director of Women’s and Children’s Services, Albury Wodonga Health, Family and Community Development Committee public hearing – Wangaratta, 25 October 2017, transcript of evidence, p. 6; The Royal Children’s Hospital Melbourne, ‘Statewide incubator documents’, accessed 11 May 2018, <https://www.rch.org.au/piper/guidelines/Statewide_incubator_documents>.

⁹¹⁸ Dr Simon Fraser, Chief Medical Officer and Paediatrician, Latrobe Regional Hospital, Family and Community Development Committee public hearing – Warragul, 8 December 2017, transcript of evidence, p. 3.

policies in place for the emergency management of pregnancies and neonatal care that are above their capability level.⁹¹⁹ Ms Hammond explained how sharing policies benefits the care provided:

We are beginning to share a lot more policies and to work together on escalation of care to prevent any delays in transfer of care or escalation of care if someone presents to us and things are starting to not head in the right direction. We are looking at ways that we can streamline transfer more promptly.⁹²⁰

Further, Ms Hammond told the Committee this has included developing clear regional referral pathways:

Sometimes if we have someone present who is outside our capability, we might ring two, three or four places before we can find a bed. We are working on pathways across the region, so then the escalation of care will be that the level 4 has to take them, then the level 5, which is Sale and LRH [Latrobe Regional Hospital]. There are no questions asked. If they do not have a bed, then they will have to sort something out at their end — transfer someone out or move someone, which generally can be done. So it is a more timely response, I suppose, from them. In the past we might have had delays of 4 hours sometimes. We might have been making multiple phone calls. The clinicians will be able to probably better explain the impact of that than I, but that is generally it. So the regional pathway is about developing or streamlining those transfers and making them more timely.⁹²¹

Ms Hammond was similarly positive about the regional policy for pregnant women with higher BMIs, and she told the Committee that the policy has helped them to secure faster transfers of women with BMIs over their capability level to higher capability services in the region.⁹²²

The Committee recognises the great innovative practices in place in different parts of the state, which should be encouraged and provide a model for DHHS to consider implementing state-wide.

The work of advising smaller health services in the regions

The Committee heard that since the creation of the perinatal mortality and morbidity committees, there have been ‘great opportunities for learning in all directions’ for health services across rural and regional Victoria.⁹²³ The Committee also heard that some of the higher capability hospitals are providing more advice and support to the smaller hospitals in the regions. Dr Nicola Yuen, Director of Obstetrics and Gynaecology at Bendigo Health, told the Committee at a public hearing in Bendigo:

⁹¹⁹ Ms Bernadette Hammond, Director of Clinical Operations/Chief Nurse and Midwife, Bairnsdale Regional Health Service, Family and Community Development Committee public hearing – Bairnsdale, 7 December 2017, transcript of evidence, pp. 3-4.

⁹²⁰ Ibid.

⁹²¹ Ibid., p. 4.

⁹²² Ibid. See also: Ms Kathy Kinrade, Director, Clinical Operations, Nursing and Midwifery, West Gippsland Healthcare Group, Family and Community Development Committee public hearing – Warragul, 8 December 2017, transcript of evidence, p. 10.

⁹²³ Dr Leo Fogarty, Director of Obstetrics, Northeast Health Wangaratta, Family and Community Development Committee public hearing – Wangaratta, 25 October 2017, transcript of evidence, p. 3.

[T]he impact of the maternity capability framework has had quite a significant effect on the services that we deliver. The capability framework has had an effect on the smaller hospitals, meaning that they are seeking advice and support from the regional referral centre — this being Bendigo — around patients that exceed their capability. We are collaborating quite extensively with the smaller referral centres to ensure that we are supporting them to meet their capability, therefore ensuring that women receive at least some of their care closer to home, reducing the travel for some of them.⁹²⁴

The Committee recognises that there are new opportunities through the perinatal mortality and morbidity committees in the regions to develop stronger intraregional referral pathways and policies, and support smaller health services. This has meant that the higher capability health services have taken on an advisory role to the smaller health services, which can improve services within regions.

While the Committee generally heard positive feedback about the supportive networks that are formalised through the Capability Framework and the perinatal mortality and morbidity committees, some witnesses expressed concern about what this might mean for clinical governance of health services in a region. At a public hearing in Warrnambool, Ms Julianne Clift, Director of Nursing at South West Healthcare, asked:

In relation to support to smaller services ... that is difficult when actually our governance is South West Healthcare with our board. It does not extend to the other hospitals. We have a governance responsibility, but I suppose it is the legal side of those ramifications. If we provide advice to them and something goes wrong, how does that literally work?⁹²⁵

At a public hearing in Wangaratta, the Committee heard that Dr Leo Fogarty, Director of Obstetrics at Northeast Health Wangaratta, is also the Subregional Director of Clinical Governance in Obstetrics for the Central Hume area, and has been since the position was instituted about five years ago.⁹²⁶ According to Dr John Elcock, Director of Medical Services at Northeast Health Wangaratta, what is needed is more formal support for the smaller rural health services:

The ability of the small rural health services to support safe obstetric delivery is really dependent on them having the right workforce and the right structure process and the right clinical governance to support that ... such as Leo's role as a subregional director for clinical governance in obstetrics, so that we can support the small rural health services to have the right processes, the right policies and the right set-up to provide safe care delivery. This includes things like shared protocols for treatment, agreed transfer criteria et cetera. It also provides for continuing professional development and education. It provides for audit and review of cases.⁹²⁷

⁹²⁴ Dr Nicola Yuen, Director, Obstetrics and Gynaecology, Bendigo Health, Family and Community Development Committee public hearing – Bendigo, 24 October 2017, transcript of evidence, p. 3.

⁹²⁵ Ms Julianne Clift, Director of Nursing, South West Healthcare, Family and Community Development Committee public hearing – Warrnambool, 11 October 2017, transcript of evidence, p. 4; See also: Dr David Fuller, Clinical Director, University Hospital Geelong, Family and Community Development Committee public hearing – Geelong, 11 December 2017, transcript of evidence, p. 4.

⁹²⁶ Dr Leo Fogarty, Director of Obstetrics, Northeast Health Wangaratta, Family and Community Development Committee public hearing – Wangaratta, 25 October 2017, transcript of evidence, p. 2.

⁹²⁷ Dr John Elcock, Director of Medical Services, Northeast Health Wangaratta, Family and Community Development Committee public hearing – Wangaratta, 25 October 2017, transcript of evidence, p. 5.

Communication across services and shared protocols

During the Inquiry, the Committee heard that the Victorian Maternity Record provides a consistent means to record information for women that can be accessed across health services and that this is important when women in higher risk categories are likely to be accessing more than one service.⁹²⁸ However, the Committee heard more could be done to improve communication and timely access to these records in Victoria.⁹²⁹ In addition, the Committee heard that shared protocols, such as obstetric care protocols and drug protocols, could be developed to assist health services across Victoria.⁹³⁰

At a public hearing in Wangaratta, Ms Julie Wright, Operational Director of Women's and Children's Services at Albury Wodonga Health, which operates a Level 4 special care nursery, described taking the initiative to adopt neonatal drug protocols based on information from PIPER:

But then in the case of a neonatal resuscitation we use the PIPER neonatal drug calculator worksheet, because we know if PIPER come and retrieve the babies they will want to know that we have used similar protocols to what they would do. However, they do not have a range of detailed protocols. So you do the worksheet — it will give you a formula about the amount of drugs and the certain drugs to deliver, and we do it that way. So they are some of the issues that we have to deal with.⁹³¹

The Committee heard that rural and regional health services are under pressure due to factors such as their distance from the higher capability hospitals, longer wait-times to transfer patients out, workforce issues including staff shortages, and ageing and inadequate facilities. The Committee recognises that rural and regional health services require more support in the delivery of maternity and neonatal care services in their regions. As discussed in section 4.1, the higher number of rural and regional women in high risk categories will also mean that rural and regional health services require timely access to patient information and shared guidelines on the management of high risk pregnancies and neonatal care while waiting for patient transfers. Thus, the Committee makes several recommendations to support rural and regional health services:

RECOMMENDATION 4.5: The Victorian Government review how the Capability Framework for Victorian maternity and newborn services impacts maternity and neonatal services in regional Victoria.

⁹²⁸ Dr Nicola Yuen, Director, Obstetrics and Gynaecology, Bendigo Health, Family and Community Development Committee public hearing – Bendigo, 24 October 2017, transcript of evidence, p. 7.

⁹²⁹ Dr Liz Uren, Obstetrics and Gynaecology, South West Healthcare, Family and Community Development Committee public hearing – Warrnambool, 11 October 2017, transcript of evidence, p. 2; Ms Julianne Clift, Director of Nursing, South West Healthcare, Family and Community Development Committee public hearing – Warrnambool, 11 October 2017, transcript of evidence, p. 4; Dr Erin Kelly, GP Obstetrician, Mildura O&G Clinic, Family and Community Development Committee public hearing – Mildura, 9 November 2017, transcript of evidence, p. 6.

⁹³⁰ Dr John Elcock, Director of Medical Services, Northeast Health Wangaratta, Family and Community Development Committee public hearing – Wangaratta, 25 October 2017, transcript of evidence, p. 5; Ms Rachel Lee, Practice Coordinator, South West Healthcare, Family and Community Development Committee public hearing – Warrnambool, 11 October 2017, transcript of evidence, p. 8.

⁹³¹ Ms Julie Wright, Operational Director of Women's and Children's Services, Albury Wodonga Health, Family and Community Development Committee public hearing – Wangaratta, 25 October 2017, transcript of evidence, p. 5.

The Committee also heard that New South Wales' Good Egg Packs have been found to be effective for rural and regional workers in the work of stabilising an infant and providing immediate care while waiting for emergency services to arrive. Accordingly, the Committee recommends that:

RECOMMENDATION 4.6: The Victorian Government consider adopting a consistent neonatal pack to enable emergency care, including neonatal resuscitation, to be administered to newborn infants in rural and regional health services, such as the New South Wales' Good Egg Packs.

Rural and regional health services would also benefit from a consistent set of obstetric and neonatal care policies and protocols across Victoria for medical workers, which will benefit women and infants who are waiting for emergency services or PIPER to arrive, and the Committee recommends that:

RECOMMENDATION 4.7: The Victorian Government facilitate the development of shared policies and protocols in obstetric and neonatal care for health services across Victoria.

4.5 Access to models of care and continuity of care

During the Inquiry, the Committee heard consistently that pregnant women, where possible, should be able to choose a model of care that suits their needs. However, as the evidence in Chapter Two outlined, a woman's choice is often limited by availability, finances, and the risk category of her pregnancy.⁹³² While the Committee heard of some exemplary programs available in the regions (for example, Mamta, the midwifery-led program at Bendigo Health), there is limited access to more than one model of care in many parts of rural and regional Victoria.

At public hearings in rural and regional Victoria, the Committee heard that some areas further away from regional centres focus on providing shared care led by GPs and midwives, given the small workforce in these locations.⁹³³ In regional centres, in addition to obstetrician-led care, some of the major hospitals have developed midwife-led continuity of care programs. However, these are generally only available to low risk women and are not extensively available.⁹³⁴

At a public hearing in Bendigo, Ms Amanda Hewett, the Mamta Coordinator at Bendigo Health, told the Committee their program has been in high demand and some women have been missing out:

[T]he Mamta program is a continuity-of-care midwifery program run through Bendigo Health. We have eight midwives who work within our teams. We usually work in teams of two or three. We are a low-risk model, so we recruit women who are low risk at the beginning of their pregnancy, but we retain the women if they become high risk throughout their pregnancy. It is a very popular program within the

⁹³² Ms Gabrielle Sammon, submission no. 38, p. 4; My Midwives Melbourne, submission no. 61, p. 5; Ms Julianne Clift, Director of Nursing, South West Healthcare, Family and Community Development Committee public hearing – Warrnambool, 11 October 2017, transcript of evidence, p. 2.

⁹³³ Dr Will Twycross, submission no. 16, p. 2; Ms Sue Carroll, Midwife, Swifts Creek Bush Nursing Centre, Family and Community Development Committee public hearing – Bairnsdale, 7 December 2017, transcript of evidence, p. 4.

⁹³⁴ Ms Julianne Clift, Director of Nursing, South West Healthcare, Family and Community Development Committee public hearing – Warrnambool, 11 October 2017, transcript of evidence, p. 2.

community. Our application process is that women apply for the program and then they are recruited at about 20 weeks. Currently we are able to recruit about half of the women who apply. We see these women throughout the antenatal period, and then we are on call for their births. We see them throughout their postnatal period, and then we do their home care.⁹³⁵

As discussed in Chapter Two, one of the barriers to offering midwife-led continuity of care in rural and regional areas is the shortage of staff. At a public hearing in Mildura, Dr Nikhil Patravali, Director of Obstetrics and Gynaecology at Mildura Base Hospital, told the Committee that the shortage of experienced midwives was the reason behind the closure of the midwifery-led program:

We had a very beautiful, midwifery-led pregnancy and partnership program where all the low-risk women with no risk factors could just see a midwife in their antenatal care and on two occasions be referred to a consultant just to make sure the whole plan was in order. We had to suspend that program almost forcefully in May of this year because of an inability to staff the main birth suite, so these midwives got pulled from antenatal clinics to be on birth suites helping their colleagues, which definitely then has had an impact on all the services, including the antenatal clinics.⁹³⁶

The Committee heard that the program if it had run at full capacity would have provided care to about 20 per cent of the mothers who delivered at Mildura Base Hospital.⁹³⁷

At a public hearing in Warragul, Dr Simon Fraser, Chief Medical Officer and Paediatrician, stated that Latrobe Regional Hospital predominately offers a specialist-obstetrician-run service. They also have shared care clinics between midwives and specialist obstetricians on site. In addition, Dr Fraser told the Committee that they offer:

[T]he midwife day assessment clinic, which runs three days a week. We have been doing this for about two or three years. We have an outreach clinic which we run in Moe, which includes a morning clinic once a week shared by two obstetricians and a midwife specifically for vulnerable women and women who may have difficulty getting to the hospital for antenatal appointments. This certainly appears to have improved access to a better antenatal care.

We have an outreach service where a midwife visits vulnerable women, and these would be defined as women with teenage pregnancy and women with mental health issues and child protection concerns ... We have recently, in the last 12 months, developed a multidisciplinary enhanced maternity clinic for women with high BMI, which is a major problem in pregnancy in Gippsland, women with diabetes and women who smoke. This involves a midwife, dietitian, diabetes educator and HARP nurse.⁹³⁸

⁹³⁵ Ms Amanda Hewett, Mamta Coordinator, Bendigo Health, Family and Community Development Committee public hearing – Bendigo, 24 October 2017, transcript of evidence, p. 4.

⁹³⁶ Dr Nikhil Patravali, Director, Obstetrics and Gynaecology, Mildura Base Hospital, Family and Community Development Committee public hearing – Mildura, 9 November 2017, transcript of evidence, p. 5.

⁹³⁷ Ms Sandra Doyle, Nurse Unit Manager, Maternity Services, Mildura Base Hospital, Family and Community Development Committee public hearing – Mildura, 9 November 2017, transcript of evidence, p. 10; Dr Nikhil Patravali, Director, Obstetrics and Gynaecology, Mildura Base Hospital, Family and Community Development Committee public hearing – Mildura, 9 November 2017, transcript of evidence, p. 10.

⁹³⁸ Dr Simon Fraser, Chief Medical Officer and Paediatrician, Latrobe Regional Hospital, Family and Community Development Committee public hearing – Warragul, 8 December 2017, transcript of evidence, p. 2.

In Chapter Two, the Committee makes recommendations to increase women's knowledge about the different models of care available. The Committee also makes recommendations to increase access to models of care and continuity of care for pregnant women across Victoria.

4.6 Access to perinatal mental health services in rural and regional Victoria

Chapter Three discusses the availability of perinatal mental health services across Victoria and the importance of the Perinatal Emotional Health Programs (PEHP) in Victoria's rural and regional areas. PEHP was funded and supported by the National Perinatal Depression Initiative (NPDI) from 2008 to 2013. PEHP enabled rural and regional health services to employ one FTE worker per 1,000 births in each region. This worker was dedicated to providing perinatal women's mental health services and improving the capability of other staff in the regions to support perinatal women's mental health.

4.6.1 Impact of the loss of National Perinatal Depression Initiative funding on rural and regional perinatal mental health services

The Committee heard that PEHP has been invaluable for rural and regional women and their families who are particularly vulnerable to experiences of social isolation and a lack of emotional support, as well as geographical isolation from formal support services.⁹³⁹

Despite the success of PEHP services, the Committee heard that the withdrawal of the National Perinatal Depression Initiative (NPDI) funding resulted in the loss of a number of PEHP services in rural and regional areas. At a public hearing in Geelong, Dr David Fuller, Clinical Director of University Hospital Geelong (Barwon Health), told the Committee that 'unfortunately' the loss of Commonwealth funding and uncertainty at the time led to most PEHP services around the state being closed, including University Hospital Geelong's PEHP.⁹⁴⁰ Dr Fuller stated that after 12 months without the service, the PEHP at University Hospital Geelong 'is just in the process of starting again'.⁹⁴¹ However, the Committee heard, it will not operate at the same capacity as before.⁹⁴² The Committee received similar evidence in other parts of rural and regional Victoria.⁹⁴³

⁹³⁹ For example see, Ms Jenny Ahrens, Operations Director, Northeast and Border Mental Health Services, Family and Community Development Committee public hearing – Wangaratta, 25 October 2017, transcript of evidence, p. 2; Ms Kassie Hocking, Family and Community Development Committee public hearing – Mildura, 9 November 2017, transcript of evidence, p. 2; Ms Emma Avery, Family and Community Development Committee public hearing – Wangaratta, 25 October 2017, transcript of evidence, p. 2.

⁹⁴⁰ Dr David Fuller, Clinical Director, University Hospital Geelong, Family and Community Development Committee public hearing – Geelong, 11 December 2017, transcript of evidence, p. 4. See also: Mr Nicholas Place, Manager, Primary Mental Health Team, South West Healthcare, Family and Community Development Committee public hearing – Warrnambool, 11 October 2017, transcript of evidence, pp. 4-5.

⁹⁴¹ Dr David Fuller, Clinical Director, University Hospital Geelong, Family and Community Development Committee public hearing – Geelong, 11 December 2017, transcript of evidence, p. 4.

⁹⁴² Ms Claire Geldard, Director of Operations, Women's and Children's Directorate, University Hospital Geelong, Family and Community Development Committee public hearing – Geelong, 11 December 2017, transcript of evidence, p. 8.

⁹⁴³ Dr Nikhil Patravali, Director, Obstetrics and Gynaecology, Mildura Base Hospital, Family and Community Development Committee public hearing – Mildura, 9 November 2017, transcript of evidence, p. 13.

Women in rural and regional communities experience risk factors that increase their vulnerability to poorer health outcomes including social isolation and higher levels of socioeconomic disadvantage (see section 4.1). For example, at a public hearing in Warrnambool, Mr Nicholas Place, Manager of the Primary Mental Health Team at South West Healthcare, told the Committee that in the past couple of years they have witnessed an ‘increased acuity of presentations’ of women with major mental illnesses in the region, due to a range of factors that can affect women in the perinatal period.⁹⁴⁴ According to Mr Place, it would be beneficial to see PEHP funding for an additional FTE worker to ensure that their service can meet the demand in their region and cover times when they have a staff member on leave.⁹⁴⁵ Recommendation 3.8 in Chapter Three recommends maintaining and extending PEHP across Victoria.

4.6.2 Gaps in referral pathways

The Committee heard that there are gaps in the availability of public and private mental health services in rural and regional Victoria.⁹⁴⁶ This limits the ability of perinatal health workers to effectively refer patients in Victoria’s regions. At a public hearing in Bendigo, the Committee heard from Ms Ursula Kiel of the St John of God Raphael Services. Ms Kiel told the Committee their service is free of charge to women and their partners, and focuses on perinatal mental health, including postnatal depression. However, she told the Committee:

[T]here is a gap between what we can offer and what the public mental health system can offer. We are a Monday to Friday, 9 to 5 service, and we have a small EFT. We cannot provide that crisis care that some people need for at least short periods of time, so we facilitate referrals through to Bendigo Health psychiatric services if needed ...⁹⁴⁷

Ms Kiel stated that the public mental health system will not accept a referral unless it is someone who has an urgent and acute need for care, leaving limited options for women in the region.⁹⁴⁸

Private clinicians are also not extensively available outside of Melbourne. At a public hearing in Warragul, Dr Stuart Thomas, a psychiatrist who provides supervision to PEHP staff and staff of the Agnes Parent and Infant Unit at Latrobe Regional Hospital, told the Committee that private psychiatrists are ‘few and far between’ in their region, and more are needed.⁹⁴⁹ Dr Thomas stated:

[S]ometimes a patient could do well with a private psychiatrist and does not necessarily need a public service, which of course has a team and a structure. Sometimes a person could do well with a private psychiatrist, not needing a case

⁹⁴⁴ Mr Nicholas Place, Manager, Primary Mental Health Team, South West Healthcare, Family and Community Development Committee public hearing – Warrnambool, 11 October 2017, transcript of evidence, pp. 3-4.

⁹⁴⁵ Ibid., p. 8.

⁹⁴⁶ For example see, Ms Helen Lees, Maternal and Child Health Clinical Coordinator, City of Greater Bendigo, Family and Community Development Committee public hearing – Bendigo, 24 October 2017, transcript of evidence, p. 8; Ms Alisa Carr, Executive Manager, Family, Youth and Children’s Services, Gippsland Lakes Community Health, Family and Community Development Committee public hearing – Bairnsdale, 7 December 2017, transcript of evidence, p. 6.

⁹⁴⁷ Ms Ursula Kiel, Senior Clinician, St John of God Raphael Services, Family and Community Development Committee public hearing – Bendigo, 24 October 2017, transcript of evidence, p. 4.

⁹⁴⁸ Ibid., p. 6.

⁹⁴⁹ Dr Stuart Thomas, Psychiatrist, Latrobe Regional Hospital, Family and Community Development Committee public hearing – Warragul, 8 December 2017, transcript of evidence, p. 10.

manager, not needing assertive follow-up. And it is disappointing when we have to recommend that they try to get in with a local psychiatrist whose space is very limited, or that they have to travel to Melbourne. So, yes, some more need is there; there is more need.⁹⁵⁰

The Committee also heard of limited access to mental health practitioners with expertise in perinatal mental health services in the regions. At a public hearing in Warragul, Ms Christine Hoyne, Nurse Unit Manager of the Parent and Infant Unit at Latrobe Regional Hospital, told the Committee of the positive work of the Agnes Parent and Infant Unit at Latrobe Regional Hospital.⁹⁵¹ Ms Hoyne stated, however, that there are limited perinatal specialists who can provide follow-up support for women after their stay at the unit, and she advocated for more PEHP clinicians in the region.⁹⁵²

At a public hearing in Warrnambool, the Committee heard that pregnant women are screened for mental health issues at South West Healthcare and they can receive services through PEHP.⁹⁵³ The Committee also heard that higher acuity women in Warrnambool and surrounding towns are referred to the mother baby units at Werribee or at Ballarat.⁹⁵⁴ The Committee heard, however, that the Werribee Mother Baby Unit is some distance for mothers in the region and that ‘the benefits sometimes are outweighed by the women being dislocated from their community’.⁹⁵⁵

The lack of local perinatal mental health services is more acute in isolated parts of Victoria. At a public hearing in Bairnsdale, Ms Sue Carroll, Midwife at Swifts Creek Nursing Centre, which serves small communities in outer East Gippsland, described the lack of mental health referral pathways:

And a lack of mental health pathways and care is a major problem. We did have a social worker that was employed by Omeo health that would come down once a week and I could refer patients, but we do not have anyone employed there at the moment. They were trying to recruit somebody. There was a psychologist who came across from Orbost once a fortnight, so I could refer across to him. He finished in about July, so there is nobody.⁹⁵⁶

Ms Carroll told the Committee that she is in the process of renegotiating with the Royal Flying Doctor Service to see if they can access mental health services via videoconferencing with the Royal Flying Doctor Service. Ms Carroll told the Committee that without this service, women and families will need to travel to Bairnsdale, which is over one and a half hours’ drive for women in that part of East Gippsland, or even further away to Traralgon to access the Parent and Infant Unit at Latrobe Regional Hospital.⁹⁵⁷

950 Ibid.

951 Ms Christine Hoyne, Nurse Unit Manager, Parent and Infant Unit, Latrobe Regional Hospital, Family and Community Development Committee public hearing – Warragul, 8 December 2017, transcript of evidence, pp. 4-6.

952 Ibid., p. 8.

953 Mr Nicholas Place, Manager, Primary Mental Health Team, South West Healthcare, Family and Community Development Committee public hearing – Warrnambool, 11 October 2017, transcript of evidence, p. 7.

954 Ibid., pp. 7-8.

955 Ibid.

956 Ms Sue Carroll, Midwife, Swifts Creek Bush Nursing Centre, Family and Community Development Committee public hearing – Bairnsdale, 7 December 2017, transcript of evidence, p. 5.

957 Ibid.

Services for fathers are also limited. At a public hearing in Wangaratta, Ms Jenny Ahrens, Operations Director of Northeast and Border Mental Health Services, told the Committee that they also see fathers, but that this service is subject to staff and funding limitations.⁹⁵⁸ Ms Ahrens told the Committee that when they have seen fathers they have presented with high need:

Historically the men we have seen have been acutely unwell, extremely high risk, unlikely to ever access help, and our interviews, I believe absolutely have been lifesaving.⁹⁵⁹

In Chapter Three, the Committee recommends that the Victorian Government provide ongoing funding for the existing PEHP services and provide more mental health support to perinatal women and fathers in Victoria.

4.7 Attracting and retaining staff in rural and regional areas

As discussed in section 4.4.3, one of the most important issues for rural and regional perinatal services is to ensure that there is access to sufficient numbers of qualified health practitioners to maintain health service capability levels, as well as deal with emergencies. While rural and regional employment incentives and other similar support for the workforce and those studying in key areas (such as nursing, midwifery, obstetrics and gynaecology, and psychiatry and psychology) can attract appropriate staff to rural and regional areas, witnesses and submissions also discussed other strategies to support staff retention in these areas.

As discussed in detail in Chapter Five on workforce issues, during the Inquiry the Committee heard that people who have lived in rural and regional areas or have family members in these areas are more likely to stay and build a life in these communities. Witnesses also told the Committee of the need to invest in a 'grow your own approach' by maintaining the availability of university degrees in fields such as nursing and midwifery in rural and regional locations.⁹⁶⁰

The Committee heard that in rural and regional areas it is often necessary to recruit people who are skilled across several areas (for example, people trained in nursing and midwifery, and GPs with additional obstetrics training).⁹⁶¹ Providing clinical training and locum work in rural and regional services also supports the retention of graduates

⁹⁵⁸ Ms Jenny Ahrens, Operations Director, Northeast and Border Mental Health Services, Family and Community Development Committee public hearing – Wangaratta, 25 October 2017, transcript of evidence, p. 4.

⁹⁵⁹ Ibid.

⁹⁶⁰ Ms Julie Wright, Operational Director of Women's and Children's Services, Albury Wodonga Health, Family and Community Development Committee public hearing – Wangaratta, 25 October 2017, transcript of evidence, p. 6; Ms Fiona Faulks, Deputy Director of Nursing, Women's and Children's Services, Bendigo Health, Family and Community Development Committee public hearing – Bendigo, 24 October 2017, transcript of evidence, p. 10; Ms Julianne Clift, Director of Nursing, South West Healthcare, Family and Community Development Committee public hearing – Warrnambool, 11 October 2017, transcript of evidence, p. 6.

⁹⁶¹ Ms Fiona Faulks, Deputy Director of Nursing, Women's and Children's Services, Bendigo Health, Family and Community Development Committee public hearing – Bendigo, 24 October 2017, transcript of evidence, p. 3; Ms Julianne Clift, Director of Nursing, South West Healthcare, Family and Community Development Committee public hearing – Warrnambool, 11 October 2017, transcript of evidence, p. 3; Dr Liz Uren, Obstetrics and Gynaecology, South West Healthcare, Family and Community Development Committee public hearing – Warrnambool, 11 October 2017, transcript of evidence, pp. 3-4.

and staff in these areas.⁹⁶² In addition, regular and ongoing training programs can ensure that the rural and regional workforce are confident to deal with emergency situations, particularly in locations where specialist back-up is further away.⁹⁶³ The smaller workforce in rural areas also needs access to regular training programs and placements at the larger health services so they can maintain their skills.⁹⁶⁴

The Committee heard that these strategies go some way to addressing current gaps in perinatal services in rural and regional Victoria. This section considers some of the evidence related to key perinatal health workers and mental health practitioners (obstetricians and gynaecologists, GP obstetricians, midwives and nurses, psychologists and psychiatrists) and the strategies that could support this workforce to stay and work in rural and regional areas. Workforce issues are also considered at length in Chapter Five.

4.7.1 Obstetricians and gynaecologists

Each year, the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) receives more than 200 applicants for the 80 places it offers to medical graduates to specialise in obstetrics and gynaecology.⁹⁶⁵ At a public hearing in Melbourne, Professor Michael Permezel, Immediate Past-President of RANZCOG, told the Committee that there are enough obstetricians and gynaecologists in Australia and New Zealand, ‘but the distribution is all wrong’ with gaps in the rural and regional workforce.⁹⁶⁶

According to Professor Permezel, RANZCOG has strategies to encourage obstetricians and gynaecologists into rural and regional practice. For example, during their selection process, RANZCOG will award extra ‘points’ to trainees from an Aboriginal or Torres Strait Islander background and to trainees from rural backgrounds.⁹⁶⁷ In addition, the six years of training that obstetricians and gynaecologists will undertake includes a mandatory rural placement.⁹⁶⁸ RANZCOG has found that trainees who spend their last two years in a rural centre are also more likely to stay in these places, as they will have settled their families in the area.⁹⁶⁹ Rural locum places are

⁹⁶² Professor Michael Permezel, Immediate Past-President, Royal Australian and New Zealand College of Obstetricians and Gynaecologists, Family and Community Development Committee public hearing – Melbourne, 4 September 2017, transcript of evidence, pp. 5-6; Dr Leo Fogarty, Director of Obstetrics, Northeast Health Wangaratta, Family and Community Development Committee public hearing – Wangaratta, 25 October 2017, transcript of evidence, p. 9.

⁹⁶³ Ms Julianne Clift, Director of Nursing, South West Healthcare, Family and Community Development Committee public hearing – Warrnambool, 11 October 2017, transcript of evidence, p. 3; Dr Nikhil Patravali, Director, Obstetrics and Gynaecology, Mildura Base Hospital, Family and Community Development Committee public hearing – Mildura, 9 November 2017, transcript of evidence, p. 11; Ms Meryn Pease, Chief Executive Officer, Orbest Regional Health, Family and Community Development Committee public hearing – Bairnsdale, 7 December 2017, transcript of evidence, pp. 2-3.

⁹⁶⁴ Ms Meryn Pease, Chief Executive Officer, Orbest Regional Health, Family and Community Development Committee public hearing – Bairnsdale, 7 December 2017, transcript of evidence, p. 6.

⁹⁶⁵ Professor Michael Permezel, Immediate Past-President, Royal Australian and New Zealand College of Obstetricians and Gynaecologists, Family and Community Development Committee public hearing – Melbourne, 4 September 2017, transcript of evidence, p. 9.

⁹⁶⁶ *Ibid.*, p. 3.

⁹⁶⁷ *Ibid.*, p. 5. Medical doctors wanting to specialise in obstetrics and gynaecology are prioritised during the selection process according to a ‘point’ system, by which medical doctors who are Aboriginal and Torres Strait Islander or come from a rural background or have other qualifications, such as a PhD, can score higher points than medical doctors without those attributes, enhancing their chances of being selected.

⁹⁶⁸ *Ibid.*

⁹⁶⁹ *Ibid.*, pp. 5-6.

also important.⁹⁷⁰ However, Professor Permezel stated that more needs to be done at universities and by the specialist training colleges to address the shortages of specialists for perinatal services in rural and regional areas.⁹⁷¹ In their submission, RANZCOG recommended that all relevant universities increase their number of medical students from rural backgrounds.⁹⁷²

The Committee also heard that all of the specialist medical training colleges need consistent policies and strategies to address the shortage of rural and regional specialists. Professor Permezel stated:

[W]e can put everything we would like in place to get a rural obstetrician but unless the anaesthetist, the paediatrician, the surgeon and all the supports are around them, it is not going to last. So everybody needs to be doing similar stuff.⁹⁷³

The Australian Medical Council oversees the development of national standards for medical education and training.⁹⁷⁴ RANZCOG advocated that the Victorian Government, through the Australian Health Ministers' Advisory Council (AHMAC), direct the Australian Medical Council to introduce a standard that will ensure that all medical colleges and allied health colleges have in place strategies to 'enhance an appropriate distribution of specialists.'⁹⁷⁵ The Committee makes a recommendation on this topic in Chapter Five, see Recommendation 5.1.

4.7.2 GP obstetricians

The Committee recognises that there are challenges associated with ensuring there are sufficient GP obstetricians in rural and regional areas. As discussed in Chapter Two, the cost of insurance contributes to a risk of a lack of skilled practitioners. The Committee heard that developing collaborative relationships with specialists in the higher capability hospitals will support the maintenance of a rural and regional GP obstetrician workforce.⁹⁷⁶ The Committee's view is that the greater risk to mothers and babies in rural and regional areas is presented by losing GP obstetricians who can facilitate shared care in rural and regional areas, provide birthing services to low risk women, and deliver in emergency situations with follow-up support from the higher capability hospitals.

⁹⁷⁰ Ibid., p. 6.

⁹⁷¹ Ibid., pp. 4, 9-10.

⁹⁷² Royal Australian and New Zealand College of Obstetricians and Gynaecologists, submission no. 35, p. 6.

⁹⁷³ Professor Michael Permezel, Immediate Past-President, Royal Australian and New Zealand College of Obstetricians and Gynaecologists, Family and Community Development Committee public hearing – Melbourne, 4 September 2017, transcript of evidence, p. 6.

⁹⁷⁴ Australian Medical Council, 'About', accessed 13 April 2018, <<https://www.amc.org.au/about>>.

⁹⁷⁵ Royal Australian and New Zealand College of Obstetricians and Gynaecologists, submission no. 35, p. 6.

⁹⁷⁶ Dr Erin Kelly, GP Obstetrician, Mildura O&G Clinic, Family and Community Development Committee public hearing – Mildura, 9 November 2017, transcript of evidence, pp. 5-6; Dr Elizabeth Boyd, GP Obstetrician, Family and Community Development Committee public hearing – Bairnsdale, 7 December 2017, p. 2.

The Committee heard from GP obstetricians in rural areas who have delivered babies in emergency situations.⁹⁷⁷ At a public hearing in Wangaratta, Dr Will Twycross, Procedural GP in Obstetrics, Anaesthetics and Accident and Emergency, described several situations when GP obstetricians had to deliver emergency births in Mansfield.⁹⁷⁸ In his submission, Dr Twycross stated:

We would also be able to demonstrate the lives of a number of babies, sometimes of women not resident here, have been saved because the hospital, which is one and a half hours from the nearest regional hospital, has an obstetrics service.⁹⁷⁹

According to Dr Twycross, the record of small rural hospitals has been excellent.⁹⁸⁰ At a public hearing in Bairnsdale, Dr Elizabeth Boyd, a GP obstetrician similarly stated that the GP obstetrician led service at Bairnsdale Regional Health Service has ‘a good track record’ and is working to ensure it is as ‘woman-centred as possible’ in its model of care.⁹⁸¹

At its rural and regional public hearings, the Committee heard that GP obstetricians are able to provide a level of maternity care and birthing services in rural communities where there are often no specialist obstetricians available locally. In Australia, the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) offers a diploma and an advanced diploma in obstetrics and gynaecology.⁹⁸²

During the Inquiry, the Committee heard that GP obstetricians can help to maintain birthing and maternity services in rural areas. However, their role is challenging and the Committee heard of some concerns about the sustainability of GP obstetrics in rural areas as birthing services cease.⁹⁸³

The Committee received evidence that GP obstetricians are critical in locations where there are no specialists. At a public hearing in Bendigo, Dr Nicola Yuen, Director of Obstetrics and Gynaecology at Bendigo Health, told the Committee that as part of Bendigo Health’s commitment to supporting the wider Loddon Mallee region, it provides training each year to GP registrars to specialise in obstetrics, before they move out to practice in the region.⁹⁸⁴ Dr Yuen explained:

⁹⁷⁷ Dr Will Twycross, Procedural GP in Obstetrics, Anaesthetics and Accident and Emergency, Family and Community Development Committee public hearing – Wangaratta, 25 October 2017, pp. 3-4. See also: Dr Elizabeth Boyd, GP Obstetrician, Family and Community Development Committee public hearing – Bairnsdale, 7 December 2017, p. 2.

⁹⁷⁸ Dr Will Twycross, Procedural GP in Obstetrics, Anaesthetics and Accident and Emergency, Family and Community Development Committee public hearing – Wangaratta, 25 October 2017, pp. 3-4.

⁹⁷⁹ Dr W Twycross, submission no. 16, pp. 2-3.

⁹⁸⁰ Dr Will Twycross, Procedural GP in Obstetrics, Anaesthetics and Accident and Emergency, Family and Community Development Committee public hearing – Wangaratta, 25 October 2017, p. 5.

⁹⁸¹ Dr Elizabeth Boyd, GP Obstetrician, Family and Community Development Committee public hearing – Bairnsdale, 7 December 2017, p. 2.

⁹⁸² Royal Australian and New Zealand College of Obstetricians and Gynaecologists, ‘About the diploma’, accessed 17 April 2018, <<https://www.ranzcog.edu.au/members/Member-categories/Diplomates/about>>.

⁹⁸³ Dr Will Twycross, Procedural GP in Obstetrics, Anaesthetics and Accident and Emergency, Family and Community Development Committee public hearing – Wangaratta, 25 October 2017, p. 6; Dr Elizabeth Boyd, GP Obstetrician, Family and Community Development Committee public hearing – Bairnsdale, 7 December 2017, pp. 3-4; Ms Samantha Ward, Midwife, The Midwife Collective, Family and Community Development Committee public hearing – Bendigo, 24 October 2017, transcript of evidence, p. 2.

⁹⁸⁴ Dr Nicola Yuen, Director, Obstetrics and Gynaecology, Bendigo Health, Family and Community Development Committee public hearing – Bendigo, 24 October 2017, transcript of evidence, p. 3.

[W]e are not going to be able to provide obstetricians to every rural hospital within the region, and therefore GP obstetricians are absolutely critical to us supporting maternity care at the smaller hospitals.⁹⁸⁵

At a public hearing in Bairnsdale, the Committee heard from two rural GP obstetricians, Dr Elizabeth Boyd and Dr Antoinette Mowbray. Dr Boyd has practiced in the area for over 30 years. Dr Boyd told the Committee that in rural areas:

[T]hese days people are not going to do 24/7, so you are probably looking for two GP Obstetricians, and I think that is where the real problem lies – attracting two people.⁹⁸⁶

The Committee heard that GP obstetricians require support from specialist obstetricians in order to work efficiently and safely.⁹⁸⁷ Dr Boyd told the Committee this support is not always available, particularly when the nearest higher capability hospital has trouble attracting obstetricians who understand the work of the rural GP obstetrician:

People at places like Sale have quite a lot of difficulty in attracting obstetricians, so often they are extremely busy or they are short term or they are a locum. Short term and locum often have little idea of what GP obstetrics is about. They have often come from countries where GP obstetrics is not existent, and that can be quite a difficulty where you are speaking to people.⁹⁸⁸

The Committee also heard that training for new GP obstetricians and succession planning to ensure the continuity of rural GP obstetrics is important in rural and regional areas. At a public hearing in Bairnsdale, Dr Antoinette Mowbray spoke about the importance of having received support and training from experienced GP obstetricians in the region:

[T]he crucial part of maintaining a GP obstetric workforce here is the good training that we were given in that Gippsland hub, and I think it is really crucial that that continue. Also, the opportunity for maintenance of skills, conferences and opportunities for upskilling, the government grants that are given, the \$2000 a day procedural grant, which helps to make up for the loss of income from leaving the clinic ... as well as pay for conference costs as well as go to a hospital and spend a day with a consultant to make sure you are not learning any bad new tricks, I think is really crucial. I benefited from the HECS reimbursement scheme as well as the RAMUS [Rural Australia Medical Undergraduate Scholarship], and I think all of those things are critical for maintaining the workforce.⁹⁸⁹

Dr Boyd and Dr Mowbray also told the Committee that Gippsland has had bridging posts to enable GPs to train half-time in obstetrics and in general practice for a year before moving out to a place where they are less supported.⁹⁹⁰

985 Ibid., p. 9.

986 Dr Elizabeth Boyd, GP Obstetrician, Family and Community Development Committee public hearing - Bairnsdale, 7 December 2017, transcript of evidence, p. 2.

987 Dr Erin Kelly, GP Obstetrician, Mildura O&G Clinic, Family and Community Development Committee public hearing - Mildura, 9 November 2017, transcript of evidence, pp. 5-6.

988 Dr Elizabeth Boyd, GP Obstetrician, Family and Community Development Committee public hearing - Bairnsdale, 7 December 2017, transcript of evidence, p. 2.

989 Dr Antoinette Mowbray, GP Obstetrician, Family and Community Development Committee public hearing - Bairnsdale, 7 December 2017, transcript of evidence, pp. 3-4.

990 Dr Elizabeth Boyd, GP Obstetrician, Family and Community Development Committee public hearing - Bairnsdale, 7 December 2017, transcript of evidence, p. 2; Dr Antoinette Mowbray, GP Obstetrician, Family and Community Development Committee public hearing - Bairnsdale, 7 December 2017, transcript of evidence, p. 2.

A study jointly conducted by the School of Rural Health at Monash University, Flinders University, Southern General Practice Training, and West Gippsland Hospital identified the challenges for GP obstetricians practicing in rural areas. The study found that rural GP obstetricians are challenged by isolation, the impact of the job on work-life balance, and safety. According to the study, the theme of safety was mentioned often by doctors who were at an early point in their career and included subthemes of patient safety, which was related to having backup, and practitioner safety was about feeling supported and having confidence to deal with the unknown. The study also described a forecasted ‘deficit’ in GP obstetricians in rural areas, due to factors such as:

[A] rise in specialisation, centralisation of services, concerns regarding indemnity and litigation, rural workload and difficulty maintaining competence.⁹⁹¹

The study concluded that the support, training, and leadership provided to GP obstetricians through programs such as the ‘Gippsland expanded obstetric training program’ in Victoria had helped GPs training in obstetrics manage the challenges of practicing in rural areas.⁹⁹² One of the GP obstetricians interviewed for the study stated the Gippsland program was seen to have contributed to improving safety for junior doctors, “[b]ecause (obstetrics) is a high-risk area and people burn out”.⁹⁹³

4.7.3 Midwives and nurses

Midwives and nurses play an important role in the rural and regional perinatal workforce. The Victorian Healthcare Association expressed concern, in their submission, about the shortage of midwives now and into the future, particularly given the aging workforce.⁹⁹⁴

The Committee heard that the continued offering of relevant nursing and midwifery courses in rural and regional universities is important to maintain and grow the number of nurses and midwives in rural and regional communities.⁹⁹⁵ At a public hearing in Melbourne, Ms Lisa Fitzpatrick, Victorian Branch Secretary of the Australian Nursing and Midwifery Federation (ANMF), told the Committee:

One of the things that we are adamant about and really work hard on doing is ensuring that our regional campuses of universities remain open, so the threat of Deakin University in Warrnambool closing its midwifery and nursing programs was really significant because we do rely on those regional campuses, being Bendigo, Warrnambool and other places, around ensuring that we actually do have a regional workforce.⁹⁹⁶

⁹⁹¹ A M Campbell, J Brown, D R Simon, S Young, L Kinsman, ‘Leading the rebirth of the rural obstetrician’, *Medical Journal of Australia*, vol. 201, no. 11, 2014, p. 667.

⁹⁹² Ibid.

⁹⁹³ Ibid., p. 668.

⁹⁹⁴ Victorian Healthcare Association, submission no. 53, p. 5.

⁹⁹⁵ Ms Lisa Fitzpatrick, Branch Secretary, Australian Nursing and Midwifery Federation (Victorian Branch), Family and Community Development Committee public hearing – Melbourne, 18 September 2017, transcript of evidence, p. 5; East Grampians Health Service, submission no. 11.

⁹⁹⁶ Ms Lisa Fitzpatrick, Branch Secretary, Australian Nursing and Midwifery Federation (Victorian Branch), Family and Community Development Committee public hearing – Melbourne, 18 September 2017, transcript of evidence, p. 5.

Federation University Australia has campuses at Ballarat, Berwick, Gippsland, and the Wimmera.⁹⁹⁷ At a public hearing in Warragul, Ms Jan Jones, Coordinator of Nursing and Midwifery courses at Federation University, told the Committee that rural and regional health services ‘prefer to use local students because they figure in the end those students might stay’.⁹⁹⁸ Ms Jones further stated:

I can say with absolute confidence that in many of the health services in Western Victoria and here in Gippsland we have actually produced the bulk of the staff who are currently practicing ... every time we do a site visit a good half of the staff on the shift are previous students.⁹⁹⁹

In addition, the Committee heard that the ongoing provision of midwifery postgraduate degrees and double degrees will help ensure that there is a pool of available nurses and midwives skilled in both areas for rural and regional health services.¹⁰⁰⁰

Rural and regional health services also stated that they have sought to ‘grow their own’ staff, by providing paid-employment placements to midwifery students. These placements have supported students to undertake additional study and gain the skills to work in maternity services in the region.¹⁰⁰¹

At a public hearing in Wangaratta, Ms Julie Wright, Operational Director of Women’s and Children’s Services at Albury Wodonga Health, spoke about their ‘graduate diploma in midwifery grow your own program’ which provides an ‘employment model’ for midwifery students in partnership with La Trobe University.¹⁰⁰² The model enables their students to work three days a week in the health service, to do their birth suite day non-paid as a placement day and attend university. Ms Wright told the Committee:

So over the past 20 years we have had in excess of 100 midwives graduating as a registered midwife through our graduate diploma in midwifery grow your own program. A number of the midwives who move on often go for career things. The Royal Flying Doctor Service in rural and remote Australia seems to be very attractive to some.¹⁰⁰³

Ms Wright stated that of the 113 midwives currently employed by Albury Wodonga Health, 50 per cent were graduates who had trained with Albury Wodonga Health.¹⁰⁰⁴

⁹⁹⁷ Federation University Australia, ‘Our Campuses’, accessed 11 May 2018, <<https://federation.edu.au/about-us/our-campuses>>.

⁹⁹⁸ Ms Jan Jones, Coordinator, Graduate Diploma of Midwifery Program and Bachelor of Nursing Practice and Bachelor of Midwifery Program, School of Nursing, Midwifery and Healthcare, Federation University, Family and Community Development Committee public hearing – Warragul, 8 December 2017, transcript of evidence, p. 5.

⁹⁹⁹ Ibid.

¹⁰⁰⁰ Associate Professor Phil Maude, Council Executive Member, Council of Deans of Nursing and Midwifery (Australia & New Zealand), Family and Community Development Committee public hearing – Melbourne, 27 November 2017, transcript of evidence, p. 4.

¹⁰⁰¹ For example see, Ms Julie Wright, Operational Director of Women’s and Children’s Services, Albury Wodonga Health, Family and Community Development Committee public hearing – Wangaratta, 25 October 2017, transcript of evidence, p. 6; Ms Fiona Faulks, Deputy Director of Nursing, Women’s and Children’s Services, Bendigo Health, Family and Community Development Committee public hearing – Bendigo, 24 October 2017, transcript of evidence, p. 10.

¹⁰⁰² Ms Julie Wright, Operational Director of Women’s and Children’s Services, Albury Wodonga Health, Family and Community Development Committee public hearing – Wangaratta, 25 October 2017, transcript of evidence, p. 6.

¹⁰⁰³ Ibid.

¹⁰⁰⁴ Ibid.

At a public hearing in Bendigo, Ms Fiona Faulks, Deputy Director of Nursing, Women's and Children's Services at Bendigo Health, also told the Committee that they have been investing in the employment model in order to 'grow their own' midwives, who will have 'a vested interest in our community and the health service and will stay with us'.¹⁰⁰⁵ For more on models of postgraduate midwifery training, see Chapter Five.

Similarly, students at rural universities require access to placements in higher capability health services. At a public hearing in Warragul, Ms Jan Jones, of Federation University, described some of the present difficulties in securing placements for their students in the major Melbourne hospitals:

The Royal Women's and the Mercy have agreements with another university, and they will not place any students, which we think is really unfair because when referrals are made, the women and babies usually go to the Mercy or the Women's. We have had some placements available at Monash Medical Centre, which has been fantastic, but they are very limited and basically we get what is left over that no-one else wants.¹⁰⁰⁶

The Committee recognises the importance of maintaining rural and regional university offerings, as well as providing training and funding to support student placements in rural and regional health services. This also supports the retention and required expansion of the maternity services workforce in rural and regional health services. The Committee makes recommendations on these topics in Chapter Five.

Special care nurseries and nursing

At a public hearing in Wangaratta, Ms Julie Wright, Operational Director of Women's and Children's Services at Albury Wodonga Health, which operates a Level 4 special care nursery, described the need to provide training and support for nurses in neonatal care, particularly given the increased numbers of women in high risk categories. Ms Wright told the Committee:

The other component of the workforce, particularly for us at Albury Wodonga Health — and I would imagine Wangaratta may have similar concerns, although I did not hear them mentioned today — is ensuring our special care nursery nurses and midwives have adequate skills and training. As we see more complex babies come through our nurseries, we are struggling to ensure that we have got the right skill mix of nurses and midwives in there.¹⁰⁰⁷

Ms Wright told the Committee that the need to travel to Melbourne for training is an obstacle to training rural and regional neonatal nurses:

Again, cost is prohibitive. Them needing to go to Melbourne to do a 12-month program is often out of the picture, because they have got families or they are established, and merely just because of the cost of going down. Funding and support or a course that would be developed in line with level 4 nurseries or special care nurseries that are not metro and that are not neonatal intensive care would be

¹⁰⁰⁵ Ms Fiona Faulks, Deputy Director of Nursing, Women's and Children's Services, Bendigo Health, Family and Community Development Committee public hearing – Bendigo, 24 October 2017, transcript of evidence, p. 10.

¹⁰⁰⁶ Ms Jan Jones, Coordinator, Graduate Diploma of Midwifery Program and Bachelor of Nursing Practice and Bachelor of Midwifery Program, School of Nursing, Midwifery and Healthcare, Federation University, Family and Community Development Committee public hearing – Warragul, 8 December 2017, transcript of evidence, p. 6.

¹⁰⁰⁷ Ms Julie Wright, Operational Director of Women's and Children's Services, Albury Wodonga Health, Family and Community Development Committee public hearing – Wangaratta, 25 October 2017, transcript of evidence, p. 6.

fabulous. Some years ago there was what they called a level 2 program: they went down, did three months in Melbourne, came back and continued to work and do some study within their local service, and we had a number of staff that did that. But that program has actually dropped off. That is the one thing that we are struggling with at the moment, because it does require another level of expertise as well as a level of confidence.¹⁰⁰⁸

For more on the neonatal nursing workforce, see Chapter Five, section 5.4.2.

4.7.4 Psychologists and psychiatrists

The Committee heard of the need for more psychologists and psychiatrists in rural and regional areas who can provide services to women during the perinatal period. At a public hearing in Warragul, Ms Christine Hoyne, Nurse Unit Manager of the Agnes Parent and Infant Unit at Latrobe Regional Hospital, spoke about the lack of psychiatrists in the region and the lack of specialist psychiatrists in perinatal mental health.¹⁰⁰⁹ Similarly, Dr Simon Fraser, Chief Medical Officer and Paediatrician at Latrobe Regional Hospital, told the Committee:

Just in terms of workforce, I have worked at Latrobe Regional Hospital for nearly eight years, and prior to that, was the medical director in Warragul for five, and certainly my observation is psychiatry is probably the last craft group where we continue to have trouble recruiting not just into private areas ... but into the public domain.¹⁰¹⁰

Dr Fraser stated that it is a complex area and that rural and regional areas remain reliant on international graduates.¹⁰¹¹ The Committee also heard from mothers in rural and regional areas of the need for perinatal mental health services to continue being funded, and in some cases, expanded (see section 4.6). Women in rural and regional areas who have accessed PEHP services also highlighted the greater availability and diversity of services in the metropolitan area compared to rural and regional areas.¹⁰¹²

In their submission, the Victorian branch of the Royal Australian and New Zealand College of Psychiatrists (RANZCP) stated that there is a 'maldistribution' of the psychiatry workforce away from rural, regional and outer metropolitan Victoria.¹⁰¹³

The Committee also consistently heard of the need to increase the availability of perinatal mental health services and support for rural and regional women. At a public hearing in Melbourne, Ms Emma Sampson, Research and Policy Officer, Public Interest, at the Australian Psychological Society (APS), the peak body representing psychologists, told the Committee:

¹⁰⁰⁸ Ibid.

¹⁰⁰⁹ Ms Christine Hoyne, Nurse Unit Manager, Parent and Infant Unit, Latrobe Regional Hospital, Family and Community Development Committee public hearing – Warragul, 8 December 2017, transcript of evidence, p. 8; Albury Wodonga Health, submission no. 55.

¹⁰¹⁰ Dr Simon Fraser, Chief Medical Officer and Paediatrician, Latrobe Regional Hospital, Family and Community Development Committee public hearing – Warragul, 8 December 2017, transcript of evidence, p. 13.

¹⁰¹¹ Ibid.

¹⁰¹² Ms Kassie Hocking, Family and Community Development committee public hearing – Mildura, 9 November 2017, transcript of evidence, p. 3.

¹⁰¹³ Royal Australian and New Zealand College of Psychiatrists (Victorian Branch), submission no. 25, p. 6.

I suppose just to sum up, screening alone is possibly unethical without increasing services, because we are identifying more women, but if there is nowhere for them to go, particularly in rural areas, then we are leaving them on their own at a really vulnerable time ... I suppose that would be our key message. It needs to be done concurrently with an increase in service capacity.¹⁰¹⁴

In their submission, the APS wrote that there is especially a need for more support for women in higher risk groups and for families dealing with high risk and premature birth.¹⁰¹⁵

At a public hearing in Melbourne, Dr Virginia Loftus, Committee Member of the Faculty of Child and Adolescent Psychiatry at RANZCP and Clinical Director of Raphael Services, Bendigo, stated:

In terms of the number of psychiatrists in the Loddon Mallee region, I do not know the exact number of EFT, but certainly our region is under resourced in terms of psychiatry overall. There are no private child and adolescent psychiatrists working in Bendigo. I have a very small private practice in the region, but there is no other private psychiatrist specialising in perinatal and infant mental health in the Bendigo region, so we are very underresourced from that perspective.¹⁰¹⁶

At a public hearing in Melbourne, Ms Viviane Lebnan, Convenor, Perinatal Interest Group of the Australian Psychological Society and Senior Psychologist at the Mercy Hospital for Women, recommended that more student placements for postgraduate students in maternity hospitals and perinatal mental health services are needed to improve the psychology workforce in the perinatal mental health sector in Victoria:

[T]he opportunity for more student placements from postgraduate students in maternity hospitals and in public perinatal mental health services. That is one way of encouraging new graduates to get into this area and develop the specialist skills required. Unfortunately because of the lack of psychologists within the services the capacity to provide student placements and supervise them is already limited.¹⁰¹⁷

The Committee makes a recommendation to support clinical placements for psychologists in Chapter Five.

The Committee heard access to supervision, training, and support is also important. At a public hearing in Melbourne, Professor Louise Newman AM, of RANZCP and Director of the Centre for Women's Mental Health at the Royal Women's Hospital, described the present situation in Victoria:

We have places — at some of the major hospitals and the Women's [Royal Women's Hospital] — where you would have a handful of specialists, a lot of specialist expertise, in metropolitan areas who do not necessarily do much outreach and very limited formal arrangements for anyone to do consulting to outlying areas.¹⁰¹⁸

¹⁰¹⁴ Ms Emma Sampson, Research and Policy Officer, Public Interest, Australian Psychological Society, Family and Community Development Committee public hearing – Melbourne, 5 February 2018, transcript of evidence, p. 7.

¹⁰¹⁵ Australian Psychological Society, submission no. 80, p. 14.

¹⁰¹⁶ Dr Virginia Loftus, Committee Member, Faculty of Child and Adolescent Psychiatry, Royal Australian and New Zealand College of Psychiatrists (Victorian Branch), Family and Community Development Committee public hearing – Melbourne, 18 September 2017, transcript of evidence, p. 9.

¹⁰¹⁷ Ms Viviane Lebnan, Convenor, Perinatal Interest Group, Australian Psychological Society, Family and Community Development Committee public hearing – Melbourne, 18 September 2017, transcript of evidence, pp. 9-10.

¹⁰¹⁸ Professor Louise Newman AM, Past President, Royal Australian and New Zealand College of Psychiatrists (Victorian Branch), Family and Community Development Committee public hearing – Melbourne, 16 October 2017, transcript of evidence, p. 5.

The Committee heard that similar strategies are needed to grow the number of mental health practitioners in rural and regional areas, with investment into strategies that support more psychologists and psychiatrists in public sector health required.¹⁰¹⁹

4.7.5 Training in emergency obstetrics

During the Inquiry, the Committee heard of some programs that have provided the rural and regional medical workforce with emergency training in obstetrics and neonatal care. These include the Practical Obstetric Multi-Professional Training (PROMPT) and the Royal Women's Hospital's Maternity and Newborn Emergencies program (MANE). This training is important to address the need presented by babies being delivered in emergency wards.

Practical Obstetric Multi-Professional Training (PROMPT)

PROMPT is an evidence-based multi-professional training package for obstetric emergencies that was developed in the UK and has been trialled in Australia and New Zealand.¹⁰²⁰ PROMPT has been found to reduce adverse neonatal and perinatal outcomes.¹⁰²¹ The Committee heard that some rural and regional health services (including Mildura Base Hospital, South West Healthcare, Bairnsdale Regional Health, and the West Gippsland Healthcare Group) had invested in PROMPT training for their staff.¹⁰²² At a public hearing in Warrnambool, Ms Julianne Clift, Director of Nursing at South West Healthcare, stated that they are 'keen to look at that program as a regional program'.¹⁰²³

The Royal Women's Hospital Maternity Services Education Program (MSEP)

The Royal Women's Hospital's Maternity Services Education Program (MSEP) provides training to support the delivery of best-practice birthing services for health services across Victoria. In its submission, the Royal Women's Hospital stated that MSEP has:

[P]rovided multidisciplinary education on site through workshops to clinicians in Victoria's maternity services. MSEP is a mobile program strongly committed to providing high quality education that is clinically focused, relevant, accessible and tailored to meet site-specific needs. Using patient simulation, structured reflection

¹⁰¹⁹ Dr Simon Fraser, Chief Medical Officer and Paediatrician, Latrobe Regional Hospital, Family and Community Development Committee public hearing - Warragul, 8 December 2017, transcript of evidence, p. 13.

¹⁰²⁰ PROMPT, 'Brief History', accessed 7 May 2018, <<http://www.promptmaternity.org/au/about/brief-history>>.

¹⁰²¹ SA Health, 'Perinatal Emergency Education Strategy', Government of South Australia, accessed 7 May 2018, <<http://www.sahealth.sa.gov.au/wps/wcm/connect/public+content/sa+health+internet/clinical+resources/clinical+topics/perinatal/perinatal+emergency+education+strategy>>.

¹⁰²² Dr Nikhil Patravali, Director, Obstetrics and Gynaecology, Mildura Base Hospital, Family and Community Development Committee public hearing - Mildura, 9 November 2017, transcript of evidence, p. 11; Ms Julianne Clift, Director of Nursing, South West Healthcare, Family and Community Development Committee public hearing - Warrnambool, 11 October 2017, transcript of evidence, p. 3; Ms Bernadette Hammond, Director of Clinical Operations/Chief Nurse and Midwife, Bairnsdale Regional Health Service, Family and Community Development Committee public hearing - Bairnsdale, 7 December 2017, transcript of evidence p. 9; Ms Kathy Kinrade, Director, Clinical Operations, Nursing and Midwifery, West Gippsland Healthcare Group, Family and Community Development Committee public hearing - Warragul, 8 December 2017, transcript of evidence, p. 5.

¹⁰²³ Ms Julianne Clift, Director of Nursing, South West Healthcare, Family and Community Development Committee public hearing - Warrnambool, 11 October 2017, transcript of evidence, p. 3.

and clinical discussion, these interactive hands-on workshops aim to reinforce evidence based practice and assist individual levels of confidence, competence, knowledge and skills. Each workshop is based on principles for care that is woman-centred, high quality, evidence-based and culturally safe.¹⁰²⁴

MSEP includes the following programs:

- The Maternity and Newborn Emergencies (MANE) program;
- Maternity Update program;
- Emergency Birthing for non-birthing and Level 1 Services Program;
- Maternity Skills Program;
- Workshops on culturally safe maternity care for Aboriginal and Torres Strait Islander women; and
- Koori Maternity Services Pregnancy Care Program.¹⁰²⁵

MANE was launched in early 2017 in partnership with the Royal Children's Hospital. Under the program, specialist 'staff from both hospitals provide training to interdisciplinary teams in order to improve capability to manage maternal and newborn emergencies'.¹⁰²⁶ Associate Professor Michael Stewart, Director of PIPER, described the MANE program to the Committee at a public hearing in Melbourne:

[T]he maternity and newborn joint education program that has been in operation for the last couple of years, called the MANE program, where we go out with our maternity educators is based at the Royal Women's Hospital and funded by DHHS. Its mandate is to visit every level 2 to 4 maternity service in the state at least once every three years. We deliver a two-day program on obstetric emergencies and neonatal emergencies.¹⁰²⁷

The MANE program is open to doctors, midwives, nurses, paramedics and students. The Committee supports the MANE program, and other MSEP programs aimed at improving and maintaining perinatal skills in rural and regional Victoria. The Committee recognises the need to provide regular training opportunities in emergency obstetrics to rural and regional doctors, nurses, and midwives. Accordingly, the Committee recommends that:

RECOMMENDATION 4.8: The Victorian Government enable and ensure ongoing training opportunities to health practitioners in rural and regional areas to be sufficiently skilled to provide emergency perinatal care.

¹⁰²⁴ The Royal Women's Hospital, submission no. 75, p. 4.

¹⁰²⁵ The Royal Women's Hospital, 'The Women's Maternity Services Education Program (MSEP)', accessed 19 April 2018, <<https://www.thewomens.org.au/health-professionals/clinical-education-training/the-womens-maternity-services-education-program-msep>>.

¹⁰²⁶ The Royal Women's Hospital, submission no. 75, p. 5.

¹⁰²⁷ Associate Professor Michael Stewart, Director, Paediatric Infant Perinatal Emergency Retrieval Service, Family and Community Development Committee public hearing – Melbourne, 5 February 2018, transcript of evidence, p. 9.

4.8 Telehealth

Telehealth enables clients and patients to access health services from distant providers. Witnesses and submissions also used the terms telemedicine and teleconferencing. Telemedicine refers to medical practitioners using telecommunication for diagnosis and medical care, which in some cases involves the use of high-technology practices to support remote surgery.¹⁰²⁸ During the Inquiry, the Committee heard of the benefits and the limitations of telehealth, telemedicine, and teleconferencing for the delivery of perinatal services in rural and regional areas.

4.8.1 The potential benefits of telehealth

The Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) submission to the Inquiry stated:

The interaction between specialists at tertiary centres and those delivering rural maternity services is critical to the provision of best practice care to rural women with often complex pregnancies and genetic or structural fetal abnormalities. It is impractical to expect these women to regularly travel to Melbourne for face to face consultations.¹⁰²⁹

The Committee heard that telehealth and telemedicine can reduce the need for women to travel to access some perinatal services. At a public hearing in Bairnsdale, Ms Heather Daly, a registered nurse and midwife who has worked in maternity services in Gippsland for 25 years, told the Committee that:

Telemedicine, if offered by tertiary centres, could also prevent women having to travel long distances to access specialist antenatal care for complex conditions. It might not replace it 100 per cent but just reduce the times they have to travel.¹⁰³⁰

At a public hearing in Melbourne, the Committee heard from the Australian Nursing and Midwifery Federation (ANMF) about the benefits of telehealth to ensure women in rural and regional locations can access specialist perinatal services. Ms Lisa Fitzpatrick, Victorian Branch Secretary at the ANMF, told the Committee the use of telehealth for maternity services would be 'a very positive step forward' for rural and regional communities to gain better access to maternity services.¹⁰³¹

At a public hearing in Melbourne, Ms Julianne Barclay, Maternity Services Officer at the ANMF, stated that a criticism of telehealth is when it is used in situations when a woman does not have an existing relationship with the service provider.¹⁰³² In 2011, the ANMF was a member of a consortia which developed guidelines on telehealth standards for registered midwives and telehealth guidelines for online

¹⁰²⁸ Terminology explained in: Australian Nursing Federation, *Telehealth Standards: Registered Midwives*, Australian Nursing Federation, April 2013, accessed 30 May 2018, <http://anf.org.au/documents/reports/Telehealth_Standards_Registered_Midwives.pdf>, p. 8. The Australian Nursing Federation is now known as the Australian Nursing and Midwifery Federation.

¹⁰²⁹ Royal Australian and New Zealand College of Obstetricians and Gynaecologists, submission no. 35, p. 7.

¹⁰³⁰ Ms Heather Daly, Midwife and Community Health Nurse, Family and Community Development Committee public hearing – Bairnsdale, 7 December 2017, transcript of evidence, p. 3.

¹⁰³¹ Ms Lisa Fitzpatrick, Branch Secretary, Australian Nursing and Midwifery Federation (Victorian Branch), Family and Community Development Committee public hearing – Melbourne, 18 September 2017, p. 6.

¹⁰³² Ms Julianne Barclay, Maternity Services Officer, Australian Nursing and Midwifery Federation (Victorian Branch), Family and Community Development Committee public hearing – Melbourne, 18 September 2017, transcript of evidence, p. 6.

video consultation for nurses and midwives.¹⁰³³ According to Ms Barclay, best practice telehealth is set up so a woman has a known health practitioner with her during her consultation with a remotely located specialist:

The woman sees the midwife, the midwife is with the woman and they have a consultation with an obstetrician who is at the Royal Women's Hospital. So the woman does have a known professional with her and that person can actually have further conversations after the consultation, but we also have the opportunity to have that expert advice from the Women's hospital about some complicated matter.¹⁰³⁴

Ms Barclay further stated that there could be improvements made to expand and formalise telehealth services between the major hospitals in Melbourne and regional and rural health services:

What I think needs to occur is that those big level 6 hospitals would have, for example, a clinic that ran and women would make appointments with their GP or with their local midwife and would have their appointments via telehealth. It is funded by Medicare; there is a Medicare item number for telehealth. It is not the woman sitting at home having a consultation with a health professional who is somewhere else ... I think it is a real benefit in terms of improving access.¹⁰³⁵

The Committee also heard of the potential to use telehealth to support rural and regional staff waiting on retrieval services. Ms Barclay of the ANMF stated:

I just want to raise that as a concern because if a midwife and a GP, for example, are in a small facility with a sick baby, it is incredibly stressful and it is quite worrying to be having to wait a considerable amount of time before the retrieval service can arrive. But once again, with really good telehealth facilities people can be looking at what is happening with the baby from a more acute facility and can be providing advice. All of those things provide great reassurance, I think, in case they cannot be physically present.¹⁰³⁶

At a public hearing in Melbourne, Associate Professor Michael Stewart, Director of the Paediatric Infant Perinatal Emergency Retrieval Service (PIPER), spoke of the benefits of installing a televideoconferencing system to enhance perinatal retrieval and transferral services. Associate Professor Stewart told the Committee that New South Wales has introduced televideoconferencing into their special care nurseries and emergency departments at a cost of about \$8 million, of which half was funded by philanthropy.¹⁰³⁷

Telehealth for training and collaboration among health practitioners

The Committee heard that telehealth could also facilitate additional support and training needs to the rural and regional perinatal workforce. Some witnesses stated that telehealth facilitated collaborative networks can be beneficial for trainees in rural

¹⁰³³ Australian Nursing and Midwifery Federation, 'Telehealth', accessed 19 April 2018, <<http://anmf.org.au/pages/telehealth>>.

¹⁰³⁴ Ms Julianne Barclay, Maternity Services Officer, Australian Nursing and Midwifery Federation (Victorian Branch), Family and Community Development Committee public hearing – Melbourne, 18 September 2017, transcript of evidence, p. 6.

¹⁰³⁵ Ibid.

¹⁰³⁶ Ibid., pp. 6-7.

¹⁰³⁷ Associate Professor Michael Stewart, Director, Paediatric Infant Perinatal Emergency Retrieval Service, Family and Community Development Committee public hearing – Melbourne, 5 February 2018, transcript of evidence, p. 13.

clinical placements and for ongoing professional development.¹⁰³⁸ The Committee also heard better linkages between rural and regional and metropolitan centres would also support the retention of the perinatal workforce in rural and regional locations. At a public hearing in Melbourne, Professor Louise Newman AM, Past President of RANZCP, Professor of Women's Mental Health at the University of Melbourne and Director of the Centre for Women's Mental Health at the Royal Women's Hospital, told the Committee that it would help trainees to feel better supported and increase their likelihood to stay in those positions if there was a 'more coordinated approach' and 'willingness of the specialists in metropolitan areas' to engage in telehealth and outreach for the trainees.¹⁰³⁹

At a public hearing in Melbourne, Associate Professor Ryan Hodges, Interim Program Director, Women's and Newborn Program and Head of Obstetrics and Perinatal Services at Monash Health, stated that telemedicine or telehealth would 'formalise' the relationships that exist between Monash Health and their regional partners.¹⁰⁴⁰ Associate Professor Hodges stated:

We have some excellent relationships with our regional partners, but I think that could be formalised. A good example of that would be through telemedicine or telehealth. I think that is something that we should be really invested in. For example, I did my high-risk training in Canada, and we had a regular service where we would conduct essentially a clinic for regional partners and we would be meeting patients and obstetricians all throughout various provinces and providing expertise and ongoing care. It was such a good service, and that is something we are not doing at Monash Health but something we would want to.¹⁰⁴¹

4.8.2 The potential limitations of telehealth

The Committee heard that telehealth or telemedicine does not happen at the 'flick of a button' and that it takes some navigating and setting up by health practitioners in order for it to work well.¹⁰⁴² The Committee heard that the efficacy of telehealth is also dependent on the client's presenting issues.¹⁰⁴³

The Mercy Hospital for Women (Mercy Health) has developed a perinatal telehealth service which conducts consultations with the Royal Darwin Hospital in the Northern Territory. Women in Darwin are accompanied by their own doctor and sonographer at the Royal Darwin Hospital during their sessions with Mercy perinatal services in Melbourne, via a video link.¹⁰⁴⁴ At a public hearing in Melbourne, Dr Michael

¹⁰³⁸ Professor Louise Newman AM, Past President, Royal Australian and New Zealand College of Psychiatrists (Victorian Branch), Family and Community Development Committee public hearing – Melbourne, 18 September 2017, transcript of evidence, pp. 5-6; Associate Professor Ryan Hodges, Interim Program Director, Women's and Newborn Program, and Head of Obstetrics and Perinatal Services, Monash Health, Family and Community Development Committee public hearing – Melbourne, 16 October 2017, transcript of evidence, p. 6.

¹⁰³⁹ Professor Louise Newman AM, Past President, Royal Australian and New Zealand College of Psychiatrists (Victorian Branch), Family and Community Development Committee public hearing – Melbourne, 18 September 2017, transcript of evidence, p. 6.

¹⁰⁴⁰ Associate Professor Ryan Hodges, Interim Program Director, Women's and Newborn Program, and Head of Obstetrics and Perinatal Services, Monash Health, Family and Community Development Committee public hearing – Melbourne, 16 October 2017, transcript of evidence, p. 6.

¹⁰⁴¹ Ibid.

¹⁰⁴² Ms Julie Wright, Operational Director of Women's and Children's Services, Albury Wodonga Health, Family and Community Development Committee public hearing – Wangaratta, 25 October 2017, transcript of evidence, p. 4.

¹⁰⁴³ Ms Lois O'Callaghan, Chief Executive Officer, Mallee Track Health and Community Service, Family and Community Development Committee public hearing – Mildura, 9 November 2017, transcript of evidence, p. 11.

¹⁰⁴⁴ Mercy Perinatal, 'Telehealth', accessed 19 April 2018, <<https://mercyperinatal.com/clinic/telehealth>>.

Rasmussen, Clinical Services Director of the Mercy Hospital for Women (Mercy Health), told the Committee that while telehealth has provided women and health practitioners in Darwin with clarity on a complex perinatal situation and advice about management, telehealth cannot be considered ‘a panacea’.¹⁰⁴⁵ He further stated:

The success of it really depends on the people at each end. You cannot have an inexperienced person at one end of the telehealth and an experienced person down here in Melbourne dealing with repeated consultations. There cannot be a great disparity in knowledge at each end of the thing ... There needs to be an equivalence of comprehension and understanding. In certain remote situations for certain high-risk uncommon scenarios and some specialist scenarios it does have a potential, but it will probably remain a niche, a small initiative, and it will not replace the need for specialist doctors in rural and remote areas.¹⁰⁴⁶

At a public hearing in Mildura, Dr Nikhil Patravali, Director of Obstetrics and Gynaecology at Mildura Base Hospital, told the Committee that the Mildura Base Hospital has been using telehealth for endocrinologists and for the management of diabetes. However, Dr Patravali does not see it as appropriate in all instances:

Maternity in particular is a very challenging specialty. It is very different from anything else. You have a baby and a mum, and everything that the disease process does it does to the baby, and the pregnancy itself changes the disease process. So I think for a select population, which is perhaps low risk, it may work, but for a very high-risk population — it is that end that we are more worried for from a risk point of view — it perhaps may not work completely in its entirety ... as an obstetrician, to know if I am hearing a fetal heart, measuring and so on perhaps it may not work. So some aspects you could use it for, not in its entirety.¹⁰⁴⁷

Telehealth standards have been developed by several peak bodies in Australia to guide medical practitioners. In addition to the guidelines developed by the Australian Nursing and Midwifery Federation (ANMF), the Australian College of Rural and Remote Medicine has developed a telehealth standards framework to assist others to develop their own telehealth guidelines.¹⁰⁴⁸ The Royal Australian and New Zealand College of Psychiatrists also has professional practice standards and guides for telepsychiatry.¹⁰⁴⁹

In 2013, the Victorian Government established a Telehealth Unit ‘to drive the uptake of telehealth in Victorian public health services’.¹⁰⁵⁰ According to the Department of Health and Human Services’ (DHHS) website:

The unit works across the Department and with health services to disseminate information and provide support on telehealth models of care.¹⁰⁵¹

¹⁰⁴⁵ Dr Michael Rasmussen, Clinical Services Director, Mercy Hospital for Women (Mercy Health), Family and Community Development Committee public hearing – Melbourne, 16 October 2017, transcript of evidence, p. 6.

¹⁰⁴⁶ Ibid., p. 7.

¹⁰⁴⁷ Dr Nikhil Patravali, Director, Obstetrics and Gynaecology, Mildura Base Hospital, Family and Community Development Committee public hearing – Mildura, 9 November 2017, transcript of evidence, p. 10.

¹⁰⁴⁸ Australian Nursing and Midwifery Federation, ‘Telehealth’, accessed 19 April 2018, <<http://anmf.org.au/pages/telehealth>>; Australian College of Rural and Remote Medicine (ACRRM), ‘Telehealth Standards’, accessed 13 April 2018, <<http://www.ehealth.acrrm.org.au/sites/default/files/ATHAC%20Telehealth%20Standards%20Framework%202016.pdf>>.

¹⁰⁴⁹ Royal Australian and New Zealand College of Psychiatrists, ‘Telehealth in Psychiatry’, accessed 19 April 2018, <<https://www.ranzcp.org/Publications/Telehealth-in-psychiatry>>.

¹⁰⁵⁰ Department of Health and Human Services, ‘Telehealth’, Victorian Government, accessed 19 April 2018, <<https://www2.health.vic.gov.au/hospitals-and-health-services/rural-health/telehealth>>.

¹⁰⁵¹ Ibid.

The unit also ‘aims to identify and address key barriers to the uptake of telehealth’.¹⁰⁵²

The Committee heard there is the potential to improve access for perinatal services to women in rural and regional areas through telehealth. Accordingly, the Committee recommends that:

RECOMMENDATION 4.9: The Victorian Government investigate increasing the availability of telehealth options for perinatal healthcare, particularly in rural and regional Victoria.

4.9 Bush nursing

Bush nursing centres are community managed, not-for-profit organisations, which receive state funding and have a long history of providing health services to rural and remote communities.¹⁰⁵³ There are 15 bush nursing centres and six bush nursing hospitals across rural and remote Victoria.¹⁰⁵⁴

During the Inquiry, the Committee heard from bush nurse Ms Sue Carroll, midwife at the Swifts Creek Bush Nursing Centre in East Gippsland, at a public hearing in Bairnsdale. Ms Carroll told the Committee that the Swifts Creek Bush Nursing Centre serves a large catchment area that contains a number of isolated and small rural towns including Swifts Creek, Omeo, Benambra, and Dinner Plain.¹⁰⁵⁵

4.9.1 Swifts Creek Bush Nursing Centre

The Committee heard that being a bush nurse has significant rewards and challenges. Ms Carroll told the Committee that most bush nursing centres are a single-nurse post that operate autonomously and are supported through partnerships with regional health services. Bush nursing centres are funded by a ‘small bucket of funding’, their resources are therefore limited, and they report to the DHHS.¹⁰⁵⁶ Further, Ms Carroll told the Committee that bush nurses are often the first responders in an emergency and they carry an ambulance pager. Ms Carroll noted that the closest MICA paramedic to Swifts Creek operates four days a week from the nearby town of Omeo.¹⁰⁵⁷

Bush nursing centres provide different services to the community, depending on the ‘skill mix of the staff and their scope of practice’.¹⁰⁵⁸ Bush nurses undertake an annual remote area nurse training course, which is provided by Ambulance Victoria. Ms Carroll provides general nursing services and is also the first responder in emergencies.¹⁰⁵⁹

¹⁰⁵² Ibid.

¹⁰⁵³ For example see, S Hudson, ‘Swifts Creek Bush Nursing Centre: a centenary of dedicated rural service’, *The Weekly Times* online, 28 March 2018, accessed 11 May 2018, <<https://www.weeklytimesnow.com.au/country-living/swifts-creek-bush-nursing-centre-a-centenary-of-dedicated-rural-service/news-story/17ef58a3e0bead4e2b5cbc814a594de0>>.

¹⁰⁵⁴ Department of Health, ‘Rural Health Regions and Locations’, Victorian Government, accessed 10 April 2018, <<https://www2.health.vic.gov.au/hospitals-and-health-services/rural-health/regions-and-locations>>.

¹⁰⁵⁵ Ms Sue Carroll, Midwife, Swifts Creek Bush Nursing Centre, Family and Community Development Committee public hearing – Bairnsdale, 7 December 2017, transcript of evidence, p. 4.

¹⁰⁵⁶ Ibid., p. 2.

¹⁰⁵⁷ Ibid.

¹⁰⁵⁸ Ibid.

¹⁰⁵⁹ Ibid.

In terms of maternity services, Ms Carroll told the Committee that she is one of the only bush nurses in Victoria qualified in midwifery. She provides shared care with GP obstetricians in Bairnsdale for women in the area. Bush nurses who are not midwives are trained in antepartum haemorrhage, cord prolapse, emergency birth and neonatal resuscitation, and postpartum haemorrhage.¹⁰⁶⁰ Ms Carroll also told the Committee of the need at times to deliver emergency births for women in the catchment area with back-up support to follow from Bairnsdale.¹⁰⁶¹

According to Ms Carroll, the bush nurse's role is critical for communities in more isolated parts of rural Victoria, as bush nurses can be one of only a few medical staff in the area. Services for pregnant women are also limited in these areas. Ms Carroll told the Committee that when she is called out, there is limited back-up staff available:

So there are gaps in perinatal care. There is not always a midwife on. On weekends if I am not there, then I do have one reliever who is a trained midwife, but if she is not there or I am not there, then they do not have that antenatal care.¹⁰⁶²

The Committee heard that succession planning for bush nurses is challenging, and it is often difficult to recruit a replacement, as Ms Carroll explained:

It has been really hard. You advertise and interview. They come up and say, 'Yes, this all sounds good', and they will do a weekend and then say, 'No, this is not what I want to do, because I'm here on my own. I have to attend emergencies on my own. I don't know where I'm going'. Sometimes it is late at night and you are driving out in the middle of nowhere ... A lot are happy to work in a hospital where they have got a good backup and they have got a team, but to be out on your own and responsible for whatever happens, it is really hard to recruit people into these areas.¹⁰⁶³

Ms Carroll told the Committee that she believes the Swifts Creek Bush Nursing Centre will continue into the future but it will require sustained effort to ensure that there is a successor when she finishes in the role. Ms Carroll reflected on the type of person who would be interested in the role and stated that her replacement is likely to have had experiences working in other remote areas such as in the Northern Territory or Western Australia and be seeking to relocate to Victoria.¹⁰⁶⁴

The Committee heard of the invaluable service provided by bush nurses to communities located in remote and isolated parts of Victoria. Accordingly, the Committee recommends that:

RECOMMENDATION 4.10: The Victorian Government undertake planning to ensure a sufficient level of perinatal healthcare in remote areas of Victoria through consultation with the current bush nurses.

¹⁰⁶⁰ Ibid., p. 3.

¹⁰⁶¹ Ibid., pp. 5-6.

¹⁰⁶² Ibid., p. 5.

¹⁰⁶³ Ibid., p. 6.

¹⁰⁶⁴ Ibid., p. 10.

Workforce capacity in perinatal services

AT A GLANCE

Background

The perinatal workforce in Victoria includes a variety of health practitioners. The Committee heard throughout its Inquiry of the role played by midwives, nurses, doctors, maternal and child health nurses, mental health practitioners, lactation consultants, genetics services personnel, and sonographers in providing perinatal care. The Committee heard evidence regarding a range of medical specialties, including obstetricians and gynaecologists, paediatricians, general practitioners, anaesthetists, and geneticists.

Victoria's perinatal workforce is facing major challenges, including a shortage of midwives and nurses, population growth, and the shortage of health practitioners, particularly doctors, in rural and regional Victoria. The Committee heard of the shortage of midwives and nurses, including concerning evidence of the workplace stress that is both cause and effect of this shortage. The Committee also heard that a shortage of doctors and other health practitioners in rural and regional Victoria is a long-standing problem that extends beyond perinatal health. This chapter discusses evidence of this issue as it relates to perinatal services. This chapter will also discuss the mental health practitioner, lactation consultant, genetics services, and sonographer workforce.

Terms of reference addressed

This chapter addresses the following terms of reference:

1. the availability, quality and safety of health services delivering services to women and their babies during the perinatal period;
5. access to and provision of an appropriately qualified workforce, including midwives, paediatricians, obstetricians, general practitioners, anaesthetists, maternal and child health nurses, mental health practitioners and lactation consultants across Victoria; and
6. disparity in outcomes between rural and regional and metropolitan locations.

The perinatal workforce in Victoria includes a variety of health practitioners. The Committee heard throughout its Inquiry of the role played by midwives, nurses, doctors, maternal and child health nurses, mental health practitioners, lactation consultants, genetics services personnel, and sonographers in providing perinatal care. The Committee heard evidence regarding a range of medical specialties, including obstetricians and gynaecologists, paediatricians, general practitioners, anaesthetists, and geneticists.

Victoria's perinatal workforce is facing major challenges, including a shortage of midwives and nurses, population growth, and the shortage of health practitioners, particularly doctors, in rural and regional Victoria. The Committee heard of the shortage of midwives and nurses, including concerning evidence of the workplace stress that is both cause and effect of this shortage. The Committee also heard that a shortage of doctors and other health practitioners in rural and regional Victoria is a long-standing problem that extends beyond perinatal health. This chapter discusses evidence of this issue as it relates to perinatal services. This chapter will also discuss the mental health practitioner, lactation consultant, genetics services, and sonographer workforce.

Some aspects of Victoria's perinatal health workforce are discussed in other chapters:

- Doulas are discussed in Chapters Two and Eight;
- Evidence the Committee heard concerning the general practitioner (GP) obstetrician workforce related to the challenges of maintaining that workforce in rural and regional areas, including attracting and retaining staff, providing training, peer support in the workplace, and receiving support from higher capability regional hospitals. These issues are discussed in Chapter Four. The Committee also heard evidence that some GPs providing shared care are not qualified as GP obstetricians. For more see Chapter Two;
- The rural and regional perinatal workforce generally is discussed in this chapter. The particular challenge of attracting and retaining staff to rural and regional areas across a range of professions that are important to maintaining perinatal services in rural and regional Victoria is discussed in Chapter Four;
- Maternal and Child Health nurse workforce is discussed in Chapter Six;
- Aboriginal and Torres Strait Islander workforce and cultural training for the mainstream workforce is discussed in Chapter Seven.

5.1 Planning for population growth

The Auditor-General's report, *Effectively Planning for Population Growth*, tabled in August 2017, noted a 24 per cent growth in births at Victorian public hospitals over the 10 years from 2005–2006 to 2015–2016, with a 68 per cent growth in the northern growth corridor.¹⁰⁶⁵

¹⁰⁶⁵ Victorian Auditor-General, *Effectively Planning for Population Growth*, Victorian Auditor-General's Office, Melbourne, August 2017, p. 27.

Associate Professor Ryan Hodges, Interim Program Director of the Women’s and Newborn Program, and Head of Obstetrics and Perinatal Services at Monash Health, told the Committee at a public hearing in Melbourne of the increases Monash Health will see over the next 10 years:

We have begun some modelling for the future and within the next 10 years Monash Health is going to care for over 12 000 women. That is a lot of women. Monash Medical Centre is going to increase by 25 per cent to over 6000 births and Casey is going to increase by 80 per cent to around 3800 births.¹⁰⁶⁶

Associate Professor Hodges noted that Monash Health is currently planning how to address this demand, as current capacity is insufficient to provide care for the forecast birth numbers.¹⁰⁶⁷

The Auditor General’s report noted that meeting increased demand safely requires greater access to specialist services, including 24-hour access to such services, in growth areas, and that planning must ensure that capacity to deliver these services is available in both growth areas and established areas.¹⁰⁶⁸ An essential aspect of this is the provision of an appropriately qualified workforce.

The Department of Health and Human Services (DHHS) takes the lead in state-wide health workforce planning. Health services plan locally, including developing local workforce strategies.¹⁰⁶⁹ Ms Kym Peake, Secretary of DHHS, told the Committee at a public hearing in Melbourne:

We expect that the number of births in Victoria will reach about 90 000 over the next decade, and one of the other things that we have put a lot of effort into in the last couple of years is really improving our forecast capability, both through working with DELWP around the whole-of-government population indicators but also recognising that inevitably local health services and local communities are our front line of understanding what is actually coming through the door — so working closely with them to make sure that our projections are agile and adaptive. We do expect that public maternity services will manage about 9500 additional births over the next decade, with most of those births to occur in our northern, western and southern metropolitan region areas, with hospitals in these communities like Sunshine, Northern and Casey accommodating about an extra 5500 births over that time frame. We are responding to those changes and supporting health services to grow the maternity and newborn services that their communities need.¹⁰⁷⁰

The Auditor-General found that the way DHHS had assessed health service capability levels against the *Capability Framework for Victorian maternity and newborn services* did not give it a clear view of state-wide capability. However, recent changes following the release of *Targeting Zero: Supporting the Victorian hospital system to eliminate*

¹⁰⁶⁶ Associate Professor Ryan Hodges, Interim Program Director, Women’s and Newborn Program, and Head of Obstetrics and Perinatal Services, Monash Health, Family and Community Development Committee public hearing – Melbourne, 16 October 2017, transcript of evidence, p. 4.

¹⁰⁶⁷ Ibid., p. 5.

¹⁰⁶⁸ Victorian Auditor-General, *Effectively Planning for Population Growth*, Victorian Auditor-General’s Office, Melbourne, August 2017, p. 28.

¹⁰⁶⁹ Ibid., pp. 26–27.

¹⁰⁷⁰ Ms Kym Peake, Secretary, Department of Health and Human Services, Family and Community Development Committee public hearing – Melbourne, 27 November 2017, transcript of evidence, p. 4.

avoidable harm and strengthen quality of care: Report of the review of hospital safety and quality assurance in Victoria would strengthen DHHS' assessment of capability.¹⁰⁷¹ For more on hospital monitoring and accountability see Chapter One.

The Auditor-General's report found that DHHS forecast modelling for birthing services, which includes projecting workforce requirements, is robust, but needs greater transparency so that individual services can provide consistent planning at a local level.¹⁰⁷² The Auditor-General praised the Northern Growth Corridor Service Plan developed by DHHS to address rapid population growth in Melbourne's north as good practice, and recommended it be used to help inform local planning in other areas.¹⁰⁷³

The Committee acknowledges that population growth is a major challenge for maintaining Victoria's perinatal health workforce. The Committee supports the Auditor-General's statements regarding more transparent modelling for birthing services, and a need for the Victorian Government to implement plans to address challenges in specific growth areas. Current workforce shortages identified in this chapter will only become more acute as Victoria's population grows. Any initiatives undertaken to address shortages must take this into account.

5.2 Rural and regional workforce

The Committee heard that access to an appropriately qualified workforce across a variety of perinatal health professions is not being provided in regional and rural Victoria. This section will focus on the challenges facing all professions within the perinatal workforce in rural and regional Victoria. The particular challenge of attracting and retaining staff to rural and regional areas across a range of professions that are important to maintaining perinatal services in rural and regional Victoria is discussed in Chapter Four. This is vital for regional growth and has a positive effect on attracting people to the regions.

While some professions are facing shortages state-wide,¹⁰⁷⁴ the Committee heard that for other perinatal professions, such as obstetricians and gynaecologists, there are not workforce shortages, but they are distributed unevenly. The Committee heard that there were not enough practitioners in rural and regional Victoria.

Associate Professor Hodges and Professor Michael Permezel, Immediate Past-President of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG), both told the Committee that Victoria is training enough obstetricians and gynaecologists.¹⁰⁷⁵ However, as Professor Permezel put it, 'the distribution is all wrong'.¹⁰⁷⁶ In its submission, RANZCOG called this the 'single most

¹⁰⁷¹ Victorian Auditor-General, *Effectively Planning for Population Growth*, Victorian Auditor-General's Office, Melbourne, August 2017, pp. 29-30.

¹⁰⁷² *Ibid.*, p. 31.

¹⁰⁷³ *Ibid.*, pp. xii, 32.

¹⁰⁷⁴ See sections 5.4 and 5.8.

¹⁰⁷⁵ Associate Professor Ryan Hodges, Interim Program Director, Women's and Newborn Program, and Head of Obstetrics and Perinatal Services, Monash Health, Family and Community Development Committee public hearing – Melbourne, 16 October 2017, transcript of evidence, p. 6; Professor Michael Permezel, Immediate Past-President, Royal Australian and New Zealand College of Obstetricians and Gynaecologists, Family and Community Development Committee public hearing – Melbourne, 4 September 2017, transcript of evidence, p. 3.

¹⁰⁷⁶ Professor Michael Permezel, Immediate Past-President, Royal Australian and New Zealand College of Obstetricians and Gynaecologists, Family and Community Development Committee public hearing – Melbourne, 4 September 2017, transcript of evidence, pp. 3-4.

important issue in the medical workforce'.¹⁰⁷⁷ When asked about a historical shortage of doctors in country Victoria that continues today, DHHS representatives told the Committee that, despite making some progress, it remains a challenge that they need to keep working on.¹⁰⁷⁸

Associate Professor Rod Hunt, Director of Newborn Intensive Care at the Royal Children's Hospital, appearing in his role as part of Melbourne Children's Campus, told the Committee that the shortage in health practitioners delivering perinatal care in rural and regional areas exists across a wide range of professions:

I think there is a whole gamut of specialist care that is required in the rural sector in bolstered numbers, including midwifery, lactation consultants, specialist neonatal nurses, anaesthetic support for safe provision of caesarean sections under appropriate anaesthesia and general physicians who look after mothers and have specialty skills in complications with pregnancy that go beyond the skills of the obstetricians. So I think the whole gamut of specialist care is required.¹⁰⁷⁹

Professor Permezel echoed the importance of strategies to ensure the availability of a range of health practitioners in rural and regional areas:

Underplayed is the importance of also having the anaesthetist, the paediatrician and the surgeon, because we can put everything we would like in place to get a rural obstetrician but unless the anaesthetist, the paediatrician, the surgeon and all the supports are around them, it is not going to last.¹⁰⁸⁰

Witnesses appearing at the Committee's regional hearings and submitters from rural and regional Victoria told of the difficulties in providing an adequate workforce through their own experiences. Ms Meryn Pease, Chief Executive Officer of Orbost Regional Health, told the Committee at a public hearing in Bairnsdale that her service had been trying to recruit various health practitioners with no success:

We have had advertisements out with nine recruitment agencies across Australia for a GP with obstetric specialty. We cannot get them. We have also been looking for another GP without obstetrics. We cannot get them. We are in the mix. I think in Gippsland there were about 69 vacant GP positions. So look at Gippsland, look from Warragul, the end of the line, to Orbost. We have tried. We have applied to get a GP registrar — that is not going to give us the obstetric skills — but again it is the same thing. We need to be able to tie them somehow. We need to attract them and tie them somehow to the community for five years or eight years, and financially support them somehow.¹⁰⁸¹

¹⁰⁷⁷ Royal Australian and New Zealand College of Obstetricians and Gynaecologists, submission no. 35, p. 6.

¹⁰⁷⁸ Ms Kym Peake, Secretary and Mr Terry Symonds, Deputy Secretary, Health and Wellbeing Division, Department of Health and Human Services, Family and Community Development Committee public hearing – Melbourne, 27 November 2017, transcript of evidence, p. 10.

¹⁰⁷⁹ Associate Professor Rod Hunt, Director, Newborn Intensive Care, Royal Children's Hospital, Melbourne Children's Campus, Family and Community Development Committee public hearing – Melbourne, 18 September 2017, transcript of evidence, p. 6.

¹⁰⁸⁰ Professor Michael Permezel, Immediate Past-President, Royal Australian and New Zealand College of Obstetricians and Gynaecologists, Family and Community Development Committee public hearing – Melbourne, 4 September 2017, transcript of evidence, p. 6.

¹⁰⁸¹ Ms Meryn Pease, Chief Executive Officer, Orbost Regional Health, Family and Community Development Committee public hearing – Bairnsdale, 7 December 2017, transcript of evidence, p. 5.

Dr Liz Uren, who works in obstetrics and gynaecology at South West Healthcare, told the Committee at a public hearing in Warrnambool that her service relies on locum staff to cover weekend obstetric positions. Dr Uren referred to this as ‘a permanent state of stable workforce crisis’.¹⁰⁸² Furthermore, she said that South West Healthcare suffers from a general lack of theatre staff after hours, including orderlies and technicians.¹⁰⁸³

In Mildura, the Committee heard from Dr Kimberley Sleeman, an obstetrics and gynaecology specialist working in a private clinic. Dr Sleeman told the Committee that the biggest challenge in providing maternity services in Mildura is ‘the number and retention of staff across all areas, which includes paediatricians, obstetricians and midwives’.¹⁰⁸⁴ Dr Sleeman spoke of the challenge of staff turnover, and how despite a recent review of maternity services, any possible improvements have been frustrated by an unstable workforce:

Mildura Base Hospital did undertake an internal review of maternity services in May 2016. However, unfortunately despite this, there has not really been any substantial improvement, particularly in staffing. In recent years there have been changes in medical directors, nursing directors and midwifery managers, which has undermined the ability of the hospital to progress with the recommended changes. In the past five years there have also been five staff specialists and one [visiting medical officer] come and go from Mildura, so there has been a lot of instability in the workforce.¹⁰⁸⁵

At a public hearing in Wangaratta, the Committee heard from Dr Leo Fogarty, Director of Obstetrics at Northeast Health Wangaratta. Dr Fogarty told the Committee that the lower capability hospitals in the Wangaratta region struggle to maintain 24 hour cover of GP obstetricians, GP anaesthetists, and midwives, necessitating that patients bypass smaller hospitals to receive care at Northeast Health Wangaratta.¹⁰⁸⁶ The Victorian Healthcare Association (VHA), in their submission, told the Committee that this practice comes with significant clinical risk.¹⁰⁸⁷ Dr Fogarty further noted that at Northeast Health Wangaratta, a lack of registrar staffing outside of business hours leads to long on-call periods for specialists:

As a result of having only two registrars, we have a lack of registrar cover out of hours and on weekends. We have only registrar cover on three nights out of seven and none at all from Friday evening to Monday morning. Even to cover the nights we do cover, our registrars are working extended hours. The result of this is that the specialist consultants are very hands-on compared to, say, a tertiary hospital. We also have to work pretty long on-call sessions as a specialist, so we may work three to five 24-hour days in succession on call.¹⁰⁸⁸

¹⁰⁸² Dr Liz Uren, Obstetrics and Gynaecology, South West Healthcare, Family and Community Development Committee public hearing – Warrnambool, 11 October 2017, transcript of evidence, p. 3.

¹⁰⁸³ *Ibid.*, p. 4.

¹⁰⁸⁴ Dr Kimberley Sleeman, Obstetrics and Gynaecology Specialist, Mildura O&G Clinic, Family and Community Development Committee public hearing – Mildura, 9 November 2017, transcript of evidence, p. 2.

¹⁰⁸⁵ *Ibid.*, pp. 2-3.

¹⁰⁸⁶ Dr Leo Fogarty, Director of Obstetrics, Northeast Health Wangaratta, Family and Community Development Committee public hearing – Wangaratta, 25 October 2017, transcript of evidence, p. 2.

¹⁰⁸⁷ Victorian Healthcare Association, submission no. 53, pp. 5-6.

¹⁰⁸⁸ Dr Leo Fogarty, Director of Obstetrics, Northeast Health Wangaratta, Family and Community Development Committee public hearing – Wangaratta, 25 October 2017, transcript of evidence, p. 2.

The Committee heard that geographical variation in expertise can lead to suboptimal care.¹⁰⁸⁹ When asked if this included any avoidable deaths, Professor Euan Wallace of Safer Care Victoria told the Committee that he is not aware of any avoidable deaths in regional areas caused by staff shortages.¹⁰⁹⁰

Regional health services told the Committee what the results of inadequate staffing look like on the hospital floor. Bendigo Health told the Committee that inadequate staffing prevents it from accepting transfers from smaller hospitals through Paediatric Infant Perinatal Emergency Retrieval Service (PIPER).¹⁰⁹¹ Albury Wodonga Health struggles to achieve the principles outlined in *Postnatal Care Program Guidelines for Victorian Health Services*¹⁰⁹² due to lack of an appropriate workforce:

One of the principles states health services will ensure women have timely and consistent access to services across the continuum of care according to their needs, this principle is increasingly difficult to meet in rural areas due to lack of resources and appropriately skilled workforce.¹⁰⁹³

The Committee heard of a variety of strategies to address the inadequate perinatal workforce in regional and rural Victoria. Mr Terry Symonds of DHHS told the Committee at a public hearing in Melbourne that rural medical schools are a method for attracting doctors to rural and regional Victoria.¹⁰⁹⁴ RANZCOG, in contrast, stated in their submission that these schools are limited in encouraging future medical practice, instead recommending higher intake quotas for students from rural backgrounds as a more effective measure.¹⁰⁹⁵ Mr Symonds noted that there is a need for training in rural areas beyond the undergraduate stage, through to specialist training:

There is no shortage of graduates, but attracting and retaining doctors in rural Victoria is a real issue, and I think we need a pathway that goes from their enrolment and undergraduate education right through to their specialist exposure in GP in rural areas.¹⁰⁹⁶

This was echoed by Professor Permezel of RANZCOG and Dr Uren of South West Healthcare, who noted that the last years of training, specifically the specialist training undertaken by senior registrars, are often when people make decisions about where to settle.¹⁰⁹⁷ Dr Uren recommended further funding for such senior

¹⁰⁸⁹ Melbourne Children's Campus, submission no. 31, p. 3.

¹⁰⁹⁰ Professor Euan Wallace, Chief Executive Officer, Safer Care Victoria, Family and Community Development Committee public hearing – Melbourne, 27 November 2017, transcript of evidence, p. 6.

¹⁰⁹¹ Bendigo Health, submission no. 44, p. 1.

¹⁰⁹² Department of Health, *Postnatal Care Program Guidelines for Victorian Health Services*, Victorian Government, Melbourne, 2012.

¹⁰⁹³ Albury Wodonga Health, submission no. 55, p. 3.

¹⁰⁹⁴ Mr Terry Symonds, Deputy Secretary, Health and Wellbeing Division of the Department of Health and Human Services, Family and Community Development Committee public hearing – Melbourne, 27 November 2017, transcript of evidence, pp. 9-10. See also The University of Melbourne, submission no. 54, p. 3.

¹⁰⁹⁵ Royal Australian and New Zealand College of Obstetricians and Gynaecologists, submission no. 35, p. 6.

¹⁰⁹⁶ Mr Terry Symonds, Deputy Secretary, Health and Wellbeing Division of the Department of Health and Human Services, Family and Community Development Committee public hearing – Melbourne, 27 November 2017, transcript of evidence, p. 9.

¹⁰⁹⁷ Professor Michael Permezel, Immediate Past-President, Royal Australian and New Zealand College of Obstetricians and Gynaecologists, Family and Community Development Committee public hearing – Melbourne, 4 September 2017, transcript of evidence, pp. 5-6; Dr Liz Uren, Obstetrics and Gynaecology, South West Healthcare, Family and Community Development Committee public hearing – Warrnambool, 11 October 2017, transcript of evidence, p. 3.

registrar positions.¹⁰⁹⁸ Ms Kathy Kinrade, Director of Clinical Operations, Nursing and Midwifery at West Gippsland Healthcare Group, told the Committee that the reverse model of registrar training, which may be implemented in Gippsland in 2019, is a model that can assist by providing for registrars to spend most of their training in rural and regional areas.¹⁰⁹⁹ Also Dr Uren told the Committee that the Commonwealth Government Specialist Training Program Initiative, which allows rural and regional health services to deliver specialist medical training, helps achieve this aim.¹¹⁰⁰ The University of Melbourne, in its submission, told the Committee that diminished access to continuing professional development is a barrier to specialists working outside of the metropolitan area, which should be addressed by developing 'accessible and innovative educational programs.'¹¹⁰¹

The Committee heard similar evidence about nurses and midwives, with witnesses highlighting the importance of offering education at regional universities,¹¹⁰² and the benefits to health services of upskilling their own local staff.¹¹⁰³ For more on midwife training in regional areas, see sections 5.3.2 and 5.3.3.

At a public hearing in Wangaratta, Dr John Elcock, Director of Medical Services at Northeast Health Wangaratta, told the Committee of a model where Northeast Health Wangaratta provides outreach support and training to GP obstetricians, GP anaesthetists, and midwives in the region.¹¹⁰⁴ DHHS is working to apply this model to other regions.¹¹⁰⁵ Professor Permezel told the Committee of the importance of support for rural specialists, including the availability of locum support.¹¹⁰⁶

The Committee heard that health practitioners who grow up in rural areas are more likely to settle there.¹¹⁰⁷ Professor Permezel told the Committee at a public hearing in Melbourne that while universities maintain a certain percentage intake of rural

1098 Dr Liz Uren, Obstetrics and Gynaecology, South West Healthcare, Family and Community Development Committee public hearing – Warrnambool, 11 October 2017, transcript of evidence, p. 4.

1099 Ms Kathy Kinrade, Director, Clinical Operations, Nursing and Midwifery, West Gippsland Healthcare Group, Family and Community Development Committee public hearing – Warragul, 8 December 2017, transcript of evidence, p. 4.

1100 Dr Liz Uren, Obstetrics and Gynaecology, South West Healthcare, Family and Community Development Committee public hearing – Warrnambool, 11 October 2017, transcript of evidence, p. 4. See also Department of Health, 'Specialist Training Program', Australian Government, accessed 4 May 2018, <<http://www.health.gov.au/internet/main/publishing.nsf/content/work-spec>>.

1101 The University of Melbourne, submission no. 54, p. 3.

1102 Ms Lisa Fitzpatrick, Branch Secretary, Australian Nursing and Midwifery Federation (Victorian Branch), Family and Community Development Committee public hearing – Melbourne, 18 September 2017, transcript of evidence, p. 5.

1103 Ms Jan Jones, Coordinator, Graduate Diploma of Midwifery Program and Bachelor of Nursing Practice and Bachelor of Midwifery Program, School of Nursing, Midwifery and Healthcare, Federation University, Family and Community Development Committee public hearing – Warragul, 8 December 2017, transcript of evidence, pp. 3, 6.

1104 Dr John Elcock, Director of Medical Services, Northeast Health Wangaratta, Family and Community Development Committee public hearing – Wangaratta, 25 October 2017, transcript of evidence, p. 5.

1105 Mr Terry Symonds, Deputy Secretary, Health and Wellbeing Division of the Department of Health and Human Services, Family and Community Development Committee public hearing – Melbourne, 27 November 2017, transcript of evidence, p. 10.

1106 Professor Michael Permezel, Immediate Past-President, Royal Australian and New Zealand College of Obstetricians and Gynaecologists, Family and Community Development Committee public hearing – Melbourne, 4 September 2017, transcript of evidence, p. 6.

1107 *Ibid.*, p. 4; Mr Terry Symonds, Deputy Secretary, Health and Wellbeing Division of the Department of Health and Human Services, Family and Community Development Committee public hearing – Melbourne, 27 November 2017, transcript of evidence, pp. 9-10; Dr Leo Fogarty, Director of Obstetrics, Northeast Health Wangaratta, Family and Community Development Committee public hearing – Wangaratta, 25 October 2017, transcript of evidence, p. 4.

students, it is not high enough.¹¹⁰⁸ Professor Permezel also suggested requiring training colleges, such as RANZCOG, to adhere to a standard which increases the number of specialists working in regional and rural Victoria:

I think that the only organisation overseeing the colleges at the moment is the Australian Medical Council. They have 11 standards, and at the moment, as I understand it, there is not a standard that says, ‘What are you doing to get more rural specialists in your discipline?’. There needs to be that standard, and government, through [the Australian Health Ministers’ Advisory Council], can put pressure on the Australian Medical Council to change their standards.¹¹⁰⁹

The Committee agrees that requiring training colleges to ensure they create a supply of rural specialists through accreditation standards can help provide better access to a perinatal medical workforce in rural and regional Victoria. The Committee notes that the current Australian Medical Council Standards include a statement that education providers ‘should facilitate opportunities to increase recruitment and selection of rural origin trainees and trainees from other under-represented groups’.¹¹¹⁰ As discussed above, training people with rural and regional origins can help build a rural and regional workforce, however, the Committee believes that language focused on the outcome of providing more specialists to work in rural and regional areas is required, rather than a statement only on intake of rural students. Accordingly, the Committee recommends that:

RECOMMENDATION 5.1: The Victorian Government use its position on the Council of Australian Governments (COAG) and work with the Australian Medical Council to achieve a change in accreditation standards that requires specialist training colleges to put in place strategies to enhance and grow the rural and regional specialist perinatal workforce.

The Committee also heard that incentives, including financial incentives such as the accommodation subsidies offered to nurses in New South Wales, could aid in growing the rural and regional workforce.¹¹¹¹ The Royal Australian College of Physicians (RACP) recommended an urgent review of the incentives for skilled staff to work in rural and regional areas.¹¹¹² The Committee supports this view, and recommends that:

RECOMMENDATION 5.2: The Victorian Government review and increase the incentives in place for attracting and retaining perinatal health practitioners in rural and regional Victoria, to establish a more effective range of incentives to support a sustainable workforce.

¹¹⁰⁸ Professor Michael Permezel, Immediate Past-President, Royal Australian and New Zealand College of Obstetricians and Gynaecologists, Family and Community Development Committee public hearing – Melbourne, 4 September 2017, transcript of evidence, pp. 2-3.

¹¹⁰⁹ Ibid., p. 10.

¹¹¹⁰ Australian Medical Council Ltd Specialist Education Accreditation Committee, *Standards for Assessment and Accreditation of Specialist Medical Programs and Professional Development Programs by the Australian Medical Council 2015*, Australian Medical Council, Canberra, 2015, p. 19.

¹¹¹¹ Associate Professor Phil Maude, Council Executive Member, Council of Deans of Nursing and Midwifery (Australia & New Zealand), Family and Community Development Committee public hearing – Melbourne, 27 November 2017, transcript of evidence, p. 9; Ms Jodie Ashworth, General Manager, Surgery, Women’s and Children’s, Operating Theatres and ICU and Chief Nursing Officer, Northern Health, Family and Community Development Committee public hearing – Melbourne, 5 February 2018, transcript of evidence, p. 5; Australian Nursing and Midwifery Federation (Victorian Branch), submission no. 67, p. 17.

¹¹¹² Royal Australasian College of Physicians, submission no. 71, p. 3.

The Committee's view is that no single initiative will solve the problem of the lack of access to an appropriately qualified perinatal health workforce in rural and regional Victoria. The initiatives outlined in evidence to the Committee have merit, but need to form part of a wider, coherent strategy from the Victorian Government to alleviate the current shortage and/or poor distribution of perinatal health practitioners in rural and regional areas of the state.

The Committee acknowledges DHHS funds a range of training, scholarships, and other programs designed to attract and retain health practitioners in general in rural and regional Victoria, including some administered by the Rural Workforce Agency Victoria, which also receives funding from the Commonwealth Government.¹¹¹³ However, the evidence to the Committee during this Inquiry is that to best care for mothers, babies, and families in the perinatal period, more needs to be done.

Throughout this chapter and in Chapter Four the Committee makes recommendations to improve access to particular professions and to overcome particular challenges within the perinatal health workforce. These recommendations are important, but in order to ensure the best possible care for mothers, babies, and families in rural and regional Victoria, they need to be delivered as part of a coherent overall strategy. Accordingly, the Committee recommends that:

RECOMMENDATION 5.3: The Victorian Government develop and implement a comprehensive strategy to provide an appropriately qualified perinatal workforce in rural and regional Victoria in the short, medium and long term.

5.3 Midwife workforce

Midwives are an essential part of perinatal health care in Victoria. The Australian College of Midwives, in its submission, told the Committee of the value midwives provide:

Midwives are essential gate-keepers of health not only around the time of pregnancy and birth, but at a much broader public health level, for example advice and care pertaining to health promotion actions such as breastfeeding and immunisations, and primary prevention activities such as nutrition advice, education regarding screening and accessing resources aimed at improving psychological health and well-being.¹¹¹⁴

This section will reflect evidence the Committee heard of a midwifery workforce facing a staff shortage which has negative impacts for patients, health services, and midwives themselves. It will also discuss pathways to qualification and further education for midwives, and the challenges midwives face in these areas.

A note on midwifery and nursing workforce evidence

The Committee notes that many witnesses and submitters to the Inquiry gave evidence of issues relating to midwives and nurses working in perinatal health as one. The Committee notes changes to qualification pathways have resulted in midwives

¹¹¹³ For more see: Department of Health and Human Services, 'Working in rural Victoria', accessed 23 April 2018, Victorian Government, <<https://www2.health.vic.gov.au/health-workforce/working-in-health/working-in-rural-victoria>>.

¹¹¹⁴ Australian College of Midwives (Victoria Branch), submission no, 33, p. 1.

who are not also qualified registered nurses. The Committee recognises that many of the issues discussed in this section concerning the midwifery workforce also apply to the nursing workforce. A likely contributor to this is that the vast majority of midwives are also registered nurses, meaning that when witnesses to the Inquiry gave evidence about one, they were often also giving evidence about the other.¹¹¹⁵

The Committee will focus here on midwifery, in line with its terms of reference and midwifery's particular role in perinatal healthcare, but acknowledges that much of the evidence presented in this section applies to both midwives and nurses working in perinatal health. Section 5.4 will then discuss evidence the Committee heard about nurses, particularly neonatal nurses, noting that again many of the issues facing that workforce mirror those facing the midwifery workforce.

5.3.1 Midwife shortage

The Committee heard throughout its Inquiry of a shortage of midwives in Victoria.¹¹¹⁶ The Commonwealth Department of Employment¹¹¹⁷ undertakes ongoing skills shortage research through surveys of employers and consultation with industry associations and educational institutions.¹¹¹⁸ The Department reports the midwifery profession as facing a 'regional shortage' in Victoria:

Regional Victorian employers experienced a shortage of qualified, skilled and experienced midwives with less than half of vacancies filled.¹¹¹⁹

While the Department of Employment reports only a regional shortage, the Committee heard from both regional and metropolitan health services, such as Mercy Health, that they face difficulty in maintaining their midwifery workforce.¹¹²⁰ The particular challenge in rural and regional Victoria is discussed further in Chapter Four.

Employers reported to the Department of Employment that 'an ageing workforce; an overall preference among applicants for part time work; high rates of maternity leave, and staff movement into other practitioner roles' are impacting midwife staffing stability.¹¹²¹ Another major factor contributing to the midwifery workforce shortage

¹¹¹⁵ DHHS Knowledge Bank website, which shows data on health practitioner numbers in Victoria based on payroll data, shows that in 2014 there were 7,927 dual registered nurses and midwives, and 998 single registered midwives: Department of Health and Human Services, Knowledge Bank, 'Registered Professions', Victorian Government, accessed 24 April 2018, <<https://vicknowledgebank.net.au/current-workforce/registered-professions>>. See also Australia Government, Australian Institute of Health and Welfare, 'Nursing and midwifery workforce 2015: How many nurses and midwives are there?', accessed 16 April 2018, <<https://www.aihw.gov.au/reports/workforce/nursing-and-midwifery-workforce-2015/contents/how-many-nurses-and-midwives-are-there>>.

¹¹¹⁶ Ms Julie Wright, Operational Director of Women's and Children's Services, Albury Wodonga Health, Family and Community Development Committee public hearing – Wangaratta, 25 October 2017, transcript of evidence, p. 6; Ms Libby Fifis, Director of Clinical Services, Nursing and Midwifery, Northeast Health Wangaratta, Family and Community Development Committee public hearing – Wangaratta, 25 October 2017, transcript of evidence, p. 4; Dr Nikhil Patravali, Director, Obstetrics and Gynaecology, Mildura Base Hospital, Family and Community Development Committee public hearing – Mildura, 9 November 2017, transcript of evidence, p. 4; Mercy Health, submission no. 40, pp. 5-6.

¹¹¹⁷ Now Department of Jobs and Small Business.

¹¹¹⁸ For more see Department of Employment, 'Skill shortage research methodology', Australian Government, 2017, accessed 15 May 2018, <<https://docs.jobs.gov.au/documents/skill-shortage-research-methodology-0>>.

¹¹¹⁹ Department of Employment, *Midwife Occupational Report ANZSCO 2541-11 Midwife – VIC*, Australian Government, Canberra, May 2017, p. 1.

¹¹²⁰ Mercy Health, submission no. 40, pp. 5-6.

¹¹²¹ Department of Employment, *Midwife Occupational Report ANZSCO 2541-11 Midwife – VIC*, Australian Government, Canberra, May 2017, p. 2.

identified by the Department of Employment is Victoria's growing birth rate.¹¹²² Ms Lisa Fitzpatrick, Australian Nursing and Midwifery Federation Victorian Branch Secretary, told the Committee of the dual challenges of a growing birthrate and reduced midwifery workforce hours:

[W]hen you have got Victoria with a growing birthrate and increasing demand and then the workforce reducing in hours, that is sort of heading for a collision.¹¹²³

Ms Fitzpatrick told the Committee that Victoria's current midwifery workforce is not meeting demand.¹¹²⁴

Health services told the Committee of their struggles to recruit the midwives they need. Ms Sandra Doyle, Nurse Unit Manager, Maternity Services at Mildura Base Hospital, told the Committee that she does not have the midwifery staff necessary to fill her roster:

Currently this month and next month ... we cannot even fill the base roster. So we are 10 to 14 shifts down per week just on the base roster. So everyone picks up to fill up the base roster. Then you have the problems of sick leave and family leave. I think we are eight EFT down.¹¹²⁵

Dr Kimberley Sleeman, an obstetrics and gynaecology specialist, described the way the midwife shortage affects patients on the hospital floor. Dr Sleeman told the Committee at a public hearing in Mildura that the shortage of midwives is the biggest issue Mildura Base Hospital's maternity service faces, and that it impacts patient care:

It is the shortage of midwifery staff that leads to the biggest day-to-day issues in maternity care in the Mildura Base Hospital. This has really been an evolving crisis for about two years, with staff shortages regularly impacting on patient care on an almost daily basis. Due to a shortage of midwives we are unable to fully staff our lovely, renovated, four-bed birthing suite. We have constant limitations on the service we provide. This leads to a very stressful situation of cancelling and rescheduling patients for planned induction of labour or even having to reschedule planned elective caesareans.

...

This situation also frequently results in us having to consider transferring patients to other areas such as Ballarat, Bendigo, Melbourne or Adelaide. Transfers result in significant stresses for families, physically, emotionally and financially.¹¹²⁶

The Committee heard that the ageing and part time nature of the midwifery workforce is contributing to the overall shortage, as well as concerning evidence of high levels of workplace stress and burnout, which are both cause and effect of staff shortages. The following sections will discuss this evidence, and present a case study of a health service that has successfully built its midwifery workforce.

¹¹²² Ibid.

¹¹²³ Ms Lisa Fitzpatrick, Branch Secretary, Australian Nursing and Midwifery Federation (Victorian Branch), Family and Community Development Committee public hearing - Melbourne, 18 September 2017, transcript of evidence, p. 9.

¹¹²⁴ Ibid., pp. 9-10.

¹¹²⁵ Ms Sandra Doyle, Nurse Unit Manager, Maternity Services, Mildura Base Hospital, Family and Community Development Committee public hearing - Mildura, 9 November 2017, transcript of evidence, p. 8.

¹¹²⁶ Dr Kimberley Sleeman, Obstetrics and Gynaecology Specialist, Mildura O&G Clinic, Family and Community Development Committee public hearing - Mildura, 9 November 2017, transcript of evidence, p. 2; See also Dr Kimberley Sleeman, submission no. 93, p. 1.

Ageing workforce

The Committee heard that the midwifery workforce is ageing.¹¹²⁷ Witnesses spoke of a cohort of midwives that are approaching retirement age, placing a further risk to the midwifery workforce in maintaining capacity when this cohort does retire. Associate Professor Phil Maude, of the Council of Deans of Nursing and Midwifery, told the Committee at a public hearing in Melbourne:

It is an issue that has been around for some time — the ageing workforce. The workforce always seems to be a couple of years older than me each year I look, which kind of makes me feel a bit happier, but we are looking at a workforce that is in its 50s now.¹¹²⁸

Albury Wodonga Health's submission, in discussing the ageing workforce, stated:

[There] exists a real threat to rural and regional Maternity Services of being able to maintain high quality, safe maternity services that are appropriately staffed. Hence the capacity of rural services will continue to be eroded and regional health services compromised unless a firm and immediate work force strategy is developed and implemented. Timing is crucial and there needs to be both short term and long term action plans to address impending workforce shortages.¹¹²⁹

Part time work and burnout

Two factors that the Committee heard are both cause and effect of the midwifery shortage are a part time workforce, and stressful work environments leading to burnout. Midwives and health services told the Committee that excessive stress can lead to burnout and a reduction in workforce, either through midwives leaving the profession or working part time, and that a reduced workforce intensifies stressful work environments. The Australian Nursing and Midwifery Federation's Victorian Branch (ANMF) submission described the prevalence of part time work among midwives, and the relationship this has with stress and understaffing:

Midwives in Victoria are generally fully employed. However, the majority do not work full time and many work small time fractions eg 1-2 days per week. Anecdotally, this is the same across rural and metropolitan regions. Analysis is required of the Victorian workforce to understand whether a change in workplace factors would affect the time fraction worked. Midwives often work in more than one workplace and sometimes in employment outside midwifery and our members advise that this is to mitigate against the excessive stress of chronic understaffing that they experience in the workplace.¹¹³⁰

¹¹²⁷ Associate Professor Phil Maude, Council Executive Member, Council of Deans of Nursing and Midwifery (Australia & New Zealand), Family and Community Development Committee public hearing – Melbourne, 27 November 2017, transcript of evidence, p. 3; Ms Wilma Wallace, Maternity Unit Manager, West Gippsland Healthcare Group, Family and Community Development Committee public hearing – Warragul, 8 December 2017, transcript of evidence, pp. 4-5.

¹¹²⁸ Associate Professor Phil Maude, Council Executive Member, Council of Deans of Nursing and Midwifery (Australia & New Zealand), Family and Community Development Committee public hearing – Melbourne, 27 November 2017, transcript of evidence, p. 3.

¹¹²⁹ Albury Wodonga Health, submission no. 55, p. 2. See also Council of Deans of Nursing and Midwifery (Australia & New Zealand), submission no. 47, p. 4.

¹¹³⁰ Australian Nursing and Midwifery Federation (Victorian Branch), submission no. 67, pp. 14-15.

This was echoed by witnesses working in Victoria's public hospitals, who reported extremely low percentages of their midwifery staff working full time. The Committee heard that at Mildura Base Hospital only about three of 45 midwives are employed full time,¹¹³¹ and at Albury Wodonga Health just ten of 113 permanent midwives are employed full time.¹¹³² There is a state-wide trend towards midwives working fewer hours.¹¹³³

The Committee heard that midwives choosing to raise their own families is one reason why part time work is so prevalent. Ms Kylie Cole, a registered nurse and midwife, told the Committee at a public hearing in Geelong that in addition to this creating a part time workforce, it creates challenges with temporary staff covering maternity leave:

We are also a large cohort of childbearing women ourselves and therefore always have high numbers of staff on maternity leave. When returning from maternity leave most staff will choose to come back at reduced hours so we are largely a part-time group. And because of the amount of maternity leave, we have a large number of staff on temporary contracts so the recruitment and retention of staff is very difficult. Many of our temporary staff are wanting permanent work and seek other options or they look for options that doesn't allow shift work, particularly the night shift.¹¹³⁴

Another, far more negative, reason for midwives undertaking part time work or even disengaging from midwifery entirely was indicated by the ANMF above — stress and burnout. The Committee heard repeatedly during the Inquiry of the workplace stress midwives are facing, often due to staff shortages. Ms Cheree Jukes, who has worked as a midwife, told the Committee at a public hearing in Mildura that despite the satisfaction she got from her work, she eventually had to leave the profession:

I guess the third thing I want to talk about is as a midwife who is no longer practising as a midwife. I say this with much emotion because no role in the community has ever given me as much satisfaction as caring for women, but in the final weeks as a nursing manager I woke up every morning terrified that this was the day that something was going to happen and I was going to be responsible. In the end, after 10 years of being a midwife, I simply could not be a good manager and back my team, I could not be a mum to my family and I could not do the best thing for the organisation because I was making decisions based on fear and not the best outcomes for women. And I have seen many of my colleagues leave the profession because of the continual stress that they work under, particularly in a regional centre.¹¹³⁵

The Committee heard of a variety of factors leading to emotional and mental health issues for midwives, including increased patient complexity, increased drug use in patients, aggressive patients, fear of litigation following the cluster of perinatal deaths that occurred at Djerriwarrh Health Service, and increasing professional development

1131 Ms Sandra Doyle, Nurse Unit Manager, Maternity Services, Mildura Base Hospital, Family and Community Development Committee public hearing – Mildura, 9 November 2017, transcript of evidence, p. 8.

1132 Ms Julie Wright, Operational Director of Women's and Children's Services, Albury Wodonga Health, Family and Community Development Committee public hearing – Wangaratta, 25 October 2017, transcript of evidence, p. 6.

1133 Ms Kym Peake, Secretary, Department of Health and Human Services, Family and Community Development Committee public hearing – Melbourne, 27 November 2017, transcript of evidence, p. 7.

1134 Ms Kylie Cole, Registered Nurse and Midwife, Family and Community Development Committee public hearing – Geelong, 11 December 2017, transcript of evidence, p. 3.

1135 Ms Cheree Jukes, Family and Community Development Committee public hearing – Mildura, 9 November 2017, transcript of evidence, p. 3.

requirements.¹¹³⁶ The ANMF told the Committee that two issues in particular are common across the state: ‘excessive workload leading to stress and fatigue and limited support for formal education qualifications’.¹¹³⁷

Particularly concerning is evidence the Committee heard of the cycle of short staffing and the requirement to work overtime and double shifts leading to workplace stress for midwives, which leads to increased sick leave and midwives choosing to work fewer hours, or even leave the workforce. This in turn deepens the shortage, and feeds back into short staffing, increased overtime and stressful workplaces.¹¹³⁸ Ms Kylie Cole, a registered nurse and midwife, told the Committee at a public hearing in Geelong of the stress staffing issues place on maternity staff:

Our maternity service experiences significant staffing issues. We are the highest users of sick leave for various reasons, and our overtime usage puts us way over budget. One of the issues causing this is the daily workload and stress of the unit. With our staff working significant amounts of overtime and frequently short staffed, many of us are exhausted, prone to illness and traumatised with what we have had to deal with on an almost daily basis.

For example, someone who stays late into the next shift needs to be taken off their following rostered shift the next day and this leaves a gap to be filled. Staff are frequently shuffled around the different areas to fill gaps, often there are errors when this happens which causes yet another staffing problem. On and on it goes.¹¹³⁹

When asked about management response to these stresses that might help retain staff through providing a better work/life balance, Ms Cole told the Committee that employers tend to downplay these issues, and she did not think much had been done to address them.¹¹⁴⁰ The Committee heard that dissatisfied midwives often move to another health service in these situations, leading to a cycle of recruitment needs among health services.¹¹⁴¹

In addition to the effect on midwives themselves, the Committee heard of the negative effects for health services and patients. One effect for health services of the shortage in midwives is a reliance on agency services and permanent staff overtime, which comes with an additional financial burden.¹¹⁴² The Committee also heard that health services struggling to recruit are forced to rely on a casual workforce.¹¹⁴³ Though this

¹¹³⁶ Ms Julie Wright, Operational Director of Women’s and Children’s Services, Albury Wodonga Health, Family and Community Development Committee public hearing – Wangaratta, 25 October 2017, transcript of evidence, p. 7. See also Albury Wodonga Health, submission no. 55, pp. 1-2.

¹¹³⁷ Australian Nursing and Midwifery Federation (Victorian Branch), submission no. 67, p. 14.

¹¹³⁸ *Ibid.*, pp. 14-15; Ms Sandra Doyle, Nurse Unit Manager, Maternity Services, Mildura Base Hospital, Family and Community Development Committee public hearing – Mildura, 9 November 2017, transcript of evidence, pp. 6-7; Ms Andrea Rindt, submission no. 20, p. 1.

¹¹³⁹ Ms Kylie Cole, Registered Nurse and Midwife, Family and Community Development Committee public hearing – Geelong, 11 December 2017, transcript of evidence, p. 3.

¹¹⁴⁰ *Ibid.*, p. 9.

¹¹⁴¹ Australian Nursing and Midwifery Federation (Victorian Branch), submission no. 67, p. 15.

¹¹⁴² Ms Libby Fifis, Director of Clinical Services, Nursing and Midwifery, Northeast Health Wangaratta, Family and Community Development Committee public hearing – Wangaratta, 25 October 2017, transcript of evidence, p. 4; Associate Professor Ryan Hodges, Interim Program Director, Women’s and Newborn Program and Head of Obstetrics and Perinatal Services, Monash Health, Family and Community Development Committee public hearing – Melbourne, 16 October 2017, transcript of evidence, p. 9; Mercy Health, submission no. 40, pp. 5-6.

¹¹⁴³ Ms Claire Geldard, Director of Operations, Women and Children’s Directorate, University Hospital Geelong, Family and Community Development Committee public hearing – Geelong, 11 December 2017, transcript of evidence, pp. 5-6.

does offer flexibility both for staff and health services.¹¹⁴⁴ Even more concerning, the Committee heard of health services using non-midwives in maternity services, increasing clinical risk,¹¹⁴⁵ and the potential for a decreased level of care when midwives have been working for 16 hours continuously on a double shift.¹¹⁴⁶

Case study in building a midwifery workforce – Northern Health

The Committee heard that Northern Health has developed and implemented a plan to build a stable midwifery workforce. Ms Jodie Ashworth, General Manager, Surgery, Women’s and Children’s, Operating Theatres and ICU and Chief Nursing Officer at Northern Health, gave evidence to the Committee in Melbourne of the strategies Northern Health has used over the past four years to build a high-performing workforce.

Northern Health in 2014 had a deficit of maternity staff. One of the challenges it faces is competing with The Royal Women’s Hospital and Mercy Health for staff, which as tertiary services can offer experiences that Northern Health cannot. Northern Health decided to:

- stop relying on agency and overseas nurses, and instead focus on attracting and retaining staff from within its own geographical area;
- develop a plan for future workforce that starts with undergraduates;
- strengthen collaboration with obstetrics;
- introduce the employment model for postgraduate midwives;¹¹⁴⁷
- introduce the private practice midwife collaborative model of care pilot program;¹¹⁴⁸
- establish partnerships with local universities, increasing placement and enrolment offers with La Trobe University and Australian Catholic University;
- introduce a registered undergraduate student of nursing model;
- increase clinical support and education, including removing financial burdens on midwives for fetal surveillance training and neonatal resuscitation training.¹¹⁴⁹

¹¹⁴⁴ Ms Janet Hicks, Director of Nursing, Mildura Base Hospital, Family and Community Development Committee public hearing – Mildura, 9 November 2017, transcript of evidence, p. 12.

¹¹⁴⁵ Ms Andrea Rindt, submission no. 20, p. 1. See also Council of Deans of Nursing and Midwifery (Australia & New Zealand), submission no. 47, p. 4.

¹¹⁴⁶ Ms Lisa Fitzpatrick, Branch Secretary, Australian Nursing and Midwifery Federation (Victorian Branch), Family and Community Development Committee public hearing – Melbourne, 18 September 2017, transcript of evidence, p. 7.

¹¹⁴⁷ The Committee notes evidence from Ms Lisa Fitzpatrick, Victorian Branch Secretary of the Australian Nursing and Midwifery Federation that implementing the employment model for postgraduate midwifery education comes with a financial cost to Northern Health: Ms Lisa Fitzpatrick, Branch Secretary, Australian Nursing and Midwifery Federation (Victorian Branch), Family and Community Development Committee public hearing – Melbourne, 18 September 2017, transcript of evidence, p. 3. For more on models of postgraduate education for midwives see section 5.3.2.

¹¹⁴⁸ For more on this see Chapter Two.

¹¹⁴⁹ Ms Jodie Ashworth, General Manager, Surgery, Women’s and Children’s, Operating Theatres and ICU and Chief Nursing Officer, Northern Health, Family and Community Development Committee public hearing – Melbourne, 5 February 2018, transcript of evidence, pp. 2-3.

Ms Ashworth told the Committee that these efforts have resulted in re-employed and retained midwives, a wait-list for people to work at Northern Health, full matching of graduate midwives, with a high percentage remaining at Northern Health, and a large improvement in staff satisfaction. Further, Northern Health has also seen an improved perinatal mortality ratio from 2014–2015 to 2015–2016.¹¹⁵⁰

5.3.2 Midwife pathways to qualification

Prospective midwives have three options for gaining their midwifery qualification:

- Bachelor of Midwifery;
- Bachelor of Nursing/Bachelor of Midwifery double degree; or
- Postgraduate qualification in midwifery (must already be a registered nurse).¹¹⁵¹

The Australian Nursing and Midwifery Accreditation Council accredits university courses for nursing and midwifery.¹¹⁵² Midwives must also be registered with the Nursing and Midwifery Board of Australia, and are required to complete 20 hours of continuing professional development (CPD) to maintain their registration.¹¹⁵³

The Department of Health and Human Services provides a graduate matching process, administered by the Postgraduate Medical Council of Victoria, to match midwives with health services in their first year of practice.¹¹⁵⁴ The Committee heard that Bachelor of Midwifery graduates with no other nursing qualifications have trouble finding work. Health services, particularly rural and regional services, prefer a double qualified workforce as it allows greater flexibility.¹¹⁵⁵

The Committee heard that midwifery courses and the universities that provide them change, sometimes due to cost to the university. Associate Professor Phil Maude, of the Council of Deans of Nursing and Midwifery, told the Committee at a public hearing in Melbourne that RMIT University stopped running a midwifery only degree due to its cost, and that he believes other universities may be considering similar action:

¹¹⁵⁰ Ibid., pp. 3-4.

¹¹⁵¹ Australian College of Midwives, 'Become a midwife', accessed 16 April 2018, <<https://www.midwives.org.au/become-midwife>>. See also Australian Nursing and Midwifery Federation (Victorian Branch), submission no. 67, p. 15.

¹¹⁵² Ms Jan Jones, Coordinator, Graduate Diploma of Midwifery Program and Bachelor of Nursing Practice and Bachelor of Midwifery Program, School of Nursing, Midwifery and Healthcare, Federation University, Family and Community Development Committee public hearing – Warragul, 8 December 2017, transcript of evidence, p. 3.

¹¹⁵³ Nursing and Midwifery Board of Australia (NMBA), 'Registration Standard: Continuing Professional Development', NMBA, 2016, p. 2, accessed 31 May 2018, <<http://www.nursingmidwiferyboard.gov.au/documents/default.aspx?record=WD16%2f19507&dbid=AP&chksum=CS8Ajk6yIPcUTD5Hrrn%2bA%3d%3d>>.

¹¹⁵⁴ Department of Health and Human Services, 'Nursing and midwifery graduates', Victorian Government, accessed 16 April 2018, <<https://www2.health.vic.gov.au/health-workforce/nursing-and-midwifery/nursing-and-midwifery-graduates>>.

¹¹⁵⁵ Australian Nursing and Midwifery Federation (Victorian Branch), submission no. 67, p. 15. See also Ms Lisa Fitzpatrick, Branch Secretary, Australian Nursing and Midwifery Federation (Victorian Branch), Family and Community Development Committee public hearing – Melbourne, 18 September 2017, transcript of evidence, p. 3; Ms Julianne Clift, Director of Nursing, South West Healthcare, Family and Community Development Committee public hearing – Warrnambool, 11 October 2017, transcript of evidence, p. 3; Ms Jodie Ashworth, General Manager, Surgery, Women's and Children's, Operating Theatres and ICU and Chief Nursing Officer, Northern Health, Family and Community Development Committee public hearing – Melbourne, 5 February 2018, transcript of evidence, p. 7.

RMIT actually had a midwifery program until about four years ago. It was extremely expensive to run and to fund, so the midwifery programs have higher staff-to-student rates than does nursing, and a lot of direct supervision and the ability to actually witness births. It is very difficult to provide that, so we bought out of the market. My understanding is a number of the universities are also considering that as well, so we will have a small group providing midwifery education.¹¹⁵⁶

Federation University previously offered the double degree in nursing and midwifery, but now only offers a postgraduate midwifery program.¹¹⁵⁷ In contrast, La Trobe University in 2017 introduced the double degree at its campus in Bendigo.¹¹⁵⁸

Ms Jan Jones, Coordinator of the Midwifery Program at Federation University, expressed disappointment at the decision to discontinue the double degree.¹¹⁵⁹ The ANMF noted the need for support to continue double degree courses like that previously run by Federation University.¹¹⁶⁰

The Council of Deans of Nursing and Midwifery, in their submission, told the Committee that to ensure access to an appropriately qualified workforce, more Commonwealth Supported Places are needed for university midwifery courses.¹¹⁶¹ The Committee supports this view. If Victoria is to address its shortage of midwives there must be enough Commonwealth Supported Places at Victorian universities to maintain a sustainable midwife workforce into the future. Accordingly, the Committee recommends that:

RECOMMENDATION 5.4: The Victorian Government use its position on the Council of Australian Governments (COAG) to advocate for an increase in the number of Commonwealth Supported Places for midwifery courses at Victorian universities, with a focus on regional universities beyond the major regional centres.

The Committee heard that the cost of postgraduate midwifery education can be prohibitive for students.¹¹⁶² While DHHS provides postgraduate nursing and midwifery scholarships, which prospective recipients can apply for through their health service,¹¹⁶³ evidence to the Committee indicated a desire for an increase in

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- 1156 Associate Professor Phil Maude, Council Executive Member, Council of Deans of Nursing and Midwifery (Australia & New Zealand), Family and Community Development Committee public hearing – Melbourne, 27 November 2017, transcript of evidence, p. 2.
- 1157 Ms Jan Jones, Coordinator, Graduate Diploma of Midwifery Program and Bachelor of Nursing Practice and Bachelor of Midwifery Program, School of Nursing, Midwifery and Healthcare, Federation University, Family and Community Development Committee public hearing – Warragul, 8 December 2017, transcript of evidence, p. 2. The University's final double degree intake was in 2014.
- 1158 Ms Fiona Faulks, Deputy Director of Nursing, Women's and Children's Services, Bendigo Health, Family and Community Development Committee public hearing – Bendigo, 24 October 2017, transcript of evidence, p. 10.
- 1159 Ms Jan Jones, Coordinator, Graduate Diploma of Midwifery Program and Bachelor of Nursing Practice and Bachelor of Midwifery Program, School of Nursing, Midwifery and Healthcare, Federation University, Family and Community Development Committee public hearing – Warragul, 8 December 2017, transcript of evidence, p. 2.
- 1160 Australian Nursing and Midwifery Federation (Victorian Branch), submission no. 67, p. 15.
- 1161 Council of Deans of Nursing and Midwifery (Australia & New Zealand), submission no. 47, p. 4.
- 1162 Ms Libby Fifis, Director of Clinical Services, Nursing and Midwifery, Northeast Health Wangaratta, Family and Community Development Committee public hearing – Wangaratta, 25 October 2017, transcript of evidence, p. 8.
- 1163 Department of Health and Human Services, 'Postgraduate Nursing and Midwifery Scholarship Program Guidelines 2017-18', Victorian Government, accessed 26 April 2018, <<https://www2.health.vic.gov.au/health-workforce/nursing-and-midwifery/furthering-your-nursing-and-midwifery-career/postgraduate-nurse-scholarships>>.

the support provided through scholarships.¹¹⁶⁴ The Committee's view is that part of government efforts to better support Victoria's midwifery workforce should be an increase in support for education through scholarships. Accordingly, the Committee recommends that:

RECOMMENDATION 5.5: The Victorian Government increase the funding for scholarships to support the development of Victoria's midwifery workforce, with a focus on scholarships for rural and regional areas.

Midwifery courses include various clinical experience requirements that students must complete to achieve their qualification. The Committee heard that meeting these requirements can be a challenge for students, with the travel associated with meeting their continuity of care requirements being particularly difficult for rural students.¹¹⁶⁵ In addition to this, the Committee heard that Federation University has difficulty in finding placements for their students at tertiary health services. Ms Jones, of Federation University, told the Committee that existing agreements between some tertiary health services and other universities meant students from Federation University could not access clinical placements there.¹¹⁶⁶

The Committee heard that a cost pressure on non-metropolitan universities was in securing guest presenters – industry specialists such as RANZCOG representatives teaching through its Fetal Surveillance Education Program. Ms Jones told the Committee that while some guest presenters provide their services for free or low cost, some do not, and the University cannot afford them. In 2018, Federation University will, for the first time, not have staff from PIPER available to deliver the relevant parts of its course, as the cost is prohibitive.¹¹⁶⁷

The Committee believes developing an excellent workforce requires giving a high standard of education across all universities, no matter their location. Students at rural and regional universities should not miss out on education from relevant experts because of location. Accordingly, the Committee recommends that:

RECOMMENDATION 5.6: The Victorian Government work with regional universities to develop innovative solutions to enable experts from agencies critical to the education of midwives to present at regional and rural universities.

The Committee heard, at a public hearing in Wangaratta, that having regional universities that offer nursing and midwifery qualifications (La Trobe University in Bendigo and Charles Sturt University in Wagga Wagga) helps them to retain their staff. Furthermore, the Committee heard that having local universities allows for a relationship with health services which benefits both organisations.¹¹⁶⁸ Ms Julie

¹¹⁶⁴ Ms Lisa Fitzpatrick, Branch Secretary, Australian Nursing and Midwifery Federation (Victorian Branch), Family and Community Development Committee public hearing – Melbourne, 18 September 2017, transcript of evidence, p. 3; Ms Jodie Ashworth, General Manager, Surgery, Women's and Children's, Operating Theatres and ICU and Chief Nursing Officer, Northern Health, Family and Community Development Committee public hearing – Melbourne, 5 February 2018, transcript of evidence, p. 5.

¹¹⁶⁵ Ms Jan Jones, Coordinator, Graduate Diploma of Midwifery Program and Bachelor of Nursing Practice and Bachelor of Midwifery Program, School of Nursing, Midwifery and Healthcare, Federation University, Family and Community Development Committee public hearing – Warragul, 8 December 2017, transcript of evidence, p. 4.

¹¹⁶⁶ *Ibid.*, p. 6.

¹¹⁶⁷ *Ibid.*

¹¹⁶⁸ Ms Julie Wright, Operational Director of Women's and Children's Services, Albury Wodonga Health, Family and Community Development Committee public hearing – Wangaratta, 25 October 2017, transcript of evidence, pp. 8-9.

Wright, Operational Director of Women’s and Children’s Services at Albury Wodonga Health, told the Committee that half of her midwifery staff have come through the ‘grow your own’ employment model of postgraduate qualification:

Of the 113 midwives, 50 per cent of our midwives are graduates of what we call our grow our own program. It is a paid model, whereby they work three days a week in the health service. They do their birth suite day non-paid as a placement day and they attend university.¹¹⁶⁹

Ms Heather Daly, a midwife who gave evidence to the Committee at a public hearing in Bairnsdale, emphasised the importance of having postgraduate midwife courses available in the local area. Ms Daly told the Committee this allows nurses with families to complete postgraduate education, and encourages nurses who become midwives to remain in rural and regional areas:

In terms of providing a qualified workforce, it is important that access to scholarships and paid postgraduate midwifery training at smaller regional hospitals continues. General nurses who have settled in the local area really find it difficult to move away to metropolitan or large regional centres for ongoing education, particularly if they have young families. Midwives who do not have to move away are more likely to continue working in local maternity services, and this will hopefully ensure there are younger midwives coming through to replace the many who will be retiring in the next five to 10 years.¹¹⁷⁰

Ms Daly also told the Committee that programs which allow midwives in small rural health services to gain experience at larger regional hospitals can be helpful, but it is not always possible on a personal level for midwives to move away from their home and family for multiple weeks.¹¹⁷¹

The Committee’s view is that training midwives close to their homes and workplaces is an effective method for retaining capacity in rural and regional areas of Victoria. Registered nurses completing postgraduate midwifery qualifications, in particular, benefit from being able to work and study in their own community.

Models of postgraduate education

There are two models through which nurses gain their postgraduate midwifery qualification, the employment (paid) model and the supernumerary (unpaid) model. In the employment model, health services employ and pay nurses who are undertaking their postgraduate midwifery education part time. The nurses gain clinical experience in the various areas of the maternity service while getting paid by their health service.¹¹⁷² The Victorian Government supports the employment

¹¹⁶⁹ Ibid., p. 6.

¹¹⁷⁰ Ms Heather Daly, Midwife and Community Health Nurse, Family and Community Development Committee public hearing – Bairnsdale, 7 December 2017, transcript of evidence, p. 3. See also Ms Julianne Clift, Director of Nursing, South West Healthcare, Family and Community Development Committee public hearing – Warrnambool, 11 October 2017, transcript of evidence, p. 6.

¹¹⁷¹ Ms Heather Daly, Midwife and Community Health Nurse, Family and Community Development Committee public hearing – Bairnsdale, 7 December 2017, transcript of evidence, p. 4.

¹¹⁷² Australian Nursing and Midwifery Federation (Victorian Branch), submission no. 67, p. 15.

model through Training and Development Grants to health services.¹¹⁷³ In the supernumerary model, nurses study full time, and the Committee heard that in practice this requires ceasing their nursing work in order to study.¹¹⁷⁴ Further, it places a cost burden on the university, which must pay the health service for each hour of clinical placement the student midwife undertakes.¹¹⁷⁵

Ms Julie Wright, Operational Director of Women's and Children's Services at Albury Wodonga Health, told the Committee at a public hearing in Wangaratta that the midwives trained through the employment model are vital to maintaining their midwifery workforce:

I think again our pool of midwives that we have been able to grow through the graduate diploma program have been what has made our workforce what it is today.¹¹⁷⁶

Ms Wright told the Committee that, in contrast, midwives who are double degree graduates and matched with Albury Wodonga Health through the graduate matching program do not often become long-term employees, preferring to move back to Melbourne.¹¹⁷⁷ The Committee heard similarly from Ms Fiona Faulks, Deputy Director of Nursing, Women's and Children's Services at Bendigo Health, that they rely on the employment model to maintain their midwife workforce, and that graduates from Melbourne do not usually stay in Bendigo.¹¹⁷⁸

Ms Jones of Federation University outlined the advantages of the employment model to the Committee at a public hearing in Warragul:

Just about the different models, the employment model means it is more affordable for students because they are being paid while they are studying. It means they have much more exposure to maternity services. They are employed and they have much greater hours of experience, so by the time they finish they are actually very work ready. They do not really need a supported grad year or anything like that. They are very capable, confident beginning practitioners. Many of them are employed at the host venue after graduation. They have been employed there. Our program places the student with one particular hospital for the duration of their program, unless they need to go elsewhere for specific experiences such as special care nursery or something like that. But generally they stay with the one hospital. That means they

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- 1173** Ibid.; Associate Professor Phil Maude, Council Executive Member, Council of Deans of Nursing and Midwifery (Australia & New Zealand), Family and Community Development Committee public hearing – Melbourne, 27 November 2017, transcript of evidence, p. 6. See also Department of Health and Human Services, 'Training and Development Grant', Victorian Government, accessed 31 May 2018, <<https://www2.health.vic.gov.au/health-workforce/education-and-training/training-development-grant>>.
- 1174** Ms Lisa Fitzpatrick, Branch Secretary, Australian Nursing and Midwifery Federation (Victorian Branch), Family and Community Development Committee public hearing – Melbourne, 18 September 2017, transcript of evidence, p. 3.
- 1175** Ms Jan Jones, Coordinator, Graduate Diploma of Midwifery Program and Bachelor of Nursing Practice and Bachelor of Midwifery Program, School of Nursing, Midwifery and Healthcare, Federation University, Family and Community Development Committee public hearing – Warragul, 8 December 2017, transcript of evidence, pp. 3-4.
- 1176** Ms Julie Wright, Operational Director of Women's and Children's Services, Albury Wodonga Health, Family and Community Development Committee public hearing – Wangaratta, 25 October 2017, transcript of evidence, p. 6.
- 1177** Ibid.
- 1178** Ms Fiona Faulks, Deputy Director of Nursing, Women's and Children's Services, Bendigo Health, Family and Community Development Committee public hearing – Bendigo, 24 October 2017, transcript of evidence, pp. 3, 10.

are really embraced by the hospital, they are very well supported, and it is something that is promoted within hospitals to grow their own, so they try and get their own current nurses to enrol in it.¹¹⁷⁹

Ms Jones told the Committee that the supernumerary model does not offer these advantages and that the few students who choose the supernumerary model do so because they are dedicated to becoming a midwife, but cannot get a paid place. However, the financial and emotional costs in doing so are very challenging.¹¹⁸⁰ Ms Jones noted also that the availability of employment model places depends on hospitals being able to offer a place for the student to work. While the hospital receives funding for the student, they must have a place in their roster to accommodate them, and the Committee heard the funding they receive does not fully cover the cost of taking on the student.¹¹⁸¹ Further, finding placements has recently become more difficult, due to enterprise bargaining agreements in place at some hospitals.¹¹⁸²

Ms Fitzpatrick, of the ANMF, told the Committee that there are only a small number of health services offering the employment model, with the cost to health services being a major factor in the small number of places available, and she was concerned that without additional funding, those health services would stop offering the employment model.¹¹⁸³ The ANMF, in its submission, listed the employment model as best practice.¹¹⁸⁴ Northern Health's submission and Ms Jodie Ashworth of Northern Health advocated continuing the employment model.¹¹⁸⁵ The Committee also heard from Ms Faulks of Bendigo Health that increased funding for health services to offer more time supervising students learning through the employment model would benefit students enormously.¹¹⁸⁶

The Committee recognises the benefits the employment model of training offers to registered nurses undertaking postgraduate qualifications to become midwives. These benefits flow on from the midwifery students to health services, and ultimately patients. The Committee is concerned that this model is not being adequately funded to best support a strong midwife workforce for Victoria's future. Accordingly, the Committee recommends that:

RECOMMENDATION 5.7: The Victorian Government increase the size and number of Training and Development grants available to support the implementation of the employment model for postgraduate midwifery students.

¹¹⁷⁹ Ms Jan Jones, Coordinator, Graduate Diploma of Midwifery Program and Bachelor of Nursing Practice and Bachelor of Midwifery Program, School of Nursing, Midwifery and Healthcare, Federation University, Family and Community Development Committee public hearing – Warragul, 8 December 2017, transcript of evidence, p. 3.

¹¹⁸⁰ *Ibid.*, pp. 3-4.

¹¹⁸¹ *Ibid.*, pp. 3, 7-4; Ms Fiona Faulks, Deputy Director of Nursing, Women's and Children's Services, Bendigo Health, Family and Community Development Committee public hearing – Bendigo, 24 October 2017, transcript of evidence, p. 10.

¹¹⁸² Ms Jan Jones, Coordinator, Graduate Diploma of Midwifery Program and Bachelor of Nursing Practice and Bachelor of Midwifery Program, School of Nursing, Midwifery and Healthcare, Federation University, Family and Community Development Committee public hearing – Warragul, 8 December 2017, transcript of evidence, p. 6.

¹¹⁸³ Ms Lisa Fitzpatrick, Branch Secretary, Australian Nursing and Midwifery Federation (Victorian Branch), Family and Community Development Committee public hearing – Melbourne, 18 September 2017, transcript of evidence, pp. 3, 10.

¹¹⁸⁴ Australian Nursing and Midwifery Federation (Victorian Branch), submission no. 67, p. 18.

¹¹⁸⁵ Northern Health, submission no. 95, pp. 1-2; Ms Jodie Ashworth, General Manager, Surgery, Women's and Children's, Operating Theatres and ICU and Chief Nursing Officer, Northern Health, Family and Community Development Committee public hearing – Melbourne, 5 February 2018, transcript of evidence, p. 3.

¹¹⁸⁶ Ms Fiona Faulks, Deputy Director of Nursing, Women's and Children's Services, Bendigo Health, Family and Community Development Committee public hearing – Bendigo, 24 October 2017, transcript of evidence, p. 10.

The Committee heard evidence that rural and regional health services need to employ a flexible workforce of midwives who also have nursing qualifications and that Bachelor of Midwifery graduates with no other nursing qualifications have trouble finding work. The Committee is concerned by the challenges that producing such graduates may place on Victoria's rural and regional perinatal health services. Accordingly, the Committee recommends that:

RECOMMENDATION 5.8: The Victorian Government review the impact on rural and regional health services of single-qualification midwifery.

5.3.3 Midwife further training

Midwives are required to complete 20 hours of continuing professional development (CPD) each year.¹¹⁸⁷ During its regional hearings throughout Victoria, the Committee heard a consistent theme of the financial and travel burden of achieving this for rural and regional midwives, with most courses offered in Melbourne. Witnesses told the Committee this was an issue with all ongoing education, whether strictly for CPD or otherwise improving a midwife's capabilities.¹¹⁸⁸ Ms Kathy Kinrade, Director of Clinical Operations, Nursing and Midwifery with West Gippsland Healthcare Group, told the Committee at a public hearing in Warragul about the difficulty of maintaining ongoing education for her workforce, with staff needing to travel to the city to complete training:

One of our major issues with our workforce is keeping their upskilling and education, because we are a level 3 special care nursery. Lower level special care nursery education and training is very limited, and most of the staff need to actually travel to metro areas to get that skill base and training.¹¹⁸⁹

At a public hearing in Warragul, the Committee heard of a local program that is helping ease this burden. Ms Jones, of Federation University, told the Committee of the Gippsland Midwifery Educators Advisory Group, which enables midwives to access ongoing education in their local area:

This group was formed about 15 years ago from clinical teachers in the area and has become a really strong group offering further education to midwives throughout Gippsland. It is facilitated by a clinical midwife consultant who works out of LRH [Latrobe Regional Hospital] these days. I think she is about the only one left in the state, but she does a fantastic job and she coordinates educational programs that upskill midwives in all sorts of different areas. That means they do not have to go to Melbourne. We can run these programs in multiple sites at multiple times so that everybody gets the chance to come. If they are working a late shift when it is on at

¹¹⁸⁷ Nursing and Midwifery Board of Australia, 'Fact sheet: Continuing professional development', accessed 16 April 2018, <<http://www.nursingmidwiferyboard.gov.au/Codes-Guidelines-Statements/FAQ/CPD-FAQ-for-nurses-and-midwives.aspx>>.

¹¹⁸⁸ Ms Jan Jones, Coordinator, Graduate Diploma of Midwifery Program and Bachelor of Nursing Practice and Bachelor of Midwifery Program, School of Nursing, Midwifery and Healthcare, Federation University, Family and Community Development Committee public hearing – Warragul, 8 December 2017, transcript of evidence, pp. 7-8; Ms Alyson Smith, Registered Nurse and Midwife, Family and Community Development Committee public hearing – Geelong, 11 December 2017, transcript of evidence, p. 7; Ms Cheree Jukes, Family and Community Development Committee public hearing – Mildura, 9 November 2017, transcript of evidence, pp. 2-3; Ms Heather Daly, Midwife and Community Health Nurse, Family and Community Development Committee public hearing – Bairnsdale, 7 December 2017, transcript of evidence, p. 3.

¹¹⁸⁹ Ms Kathy Kinrade, Director, Clinical Operations, Nursing and Midwifery, West Gippsland Healthcare Group, Family and Community Development Committee public hearing – Warragul, 8 December 2017, transcript of evidence, p. 5.

their hospital, they can go up to Bairnsdale or somewhere like that and access it somewhere else. It has been a really successful model — minimal cost to the hospital, minimal cost to participants — and a great model for improving midwifery education not just for new graduates but for midwives who have been working in the field for a long time.¹¹⁹⁰

The Committee is concerned by the evidence it heard of the difficulty for midwives in rural and regional areas to complete the ongoing training they need to do to retain accreditation and do their jobs as best as they can. The Committee is encouraged by the work done by the Gippsland Midwifery Educators Advisory Group, and believes the Victorian Government should support models such as this to be implemented in other areas of Victoria. Accordingly, the Committee recommends that:

RECOMMENDATION 5.9: The Victorian Government review existing successful programs that provide ongoing training for midwives in rural and regional Victoria to develop accessible continuing professional development that would be valuable for other midwives across the state.

The Committee believes more can be done to assist midwives, particularly those in rural and regional areas, to meet their CPD requirements and otherwise increase their capability through ongoing training. Accordingly, the Committee recommends that:

RECOMMENDATION 5.10: The Victorian Government provide reimbursement, including for travel and accommodation, to enable midwives to attend the mandatory training for their specialty required to satisfy their continuing professional development responsibilities.

Maternity Connect Program

DHHS funds a training program for midwives and nurses working in maternity services called the Maternity Connect Program (MCP), which is administered by Western Health. Ms Kym Peake, Secretary of DHHS, described the program to the Committee at a public hearing in Melbourne:

The Maternity Connect Program is a program that is about providing placements for rural and regional midwives in large maternity health services so that they do get the breadth of experience and increase their clinical exposure and skills, which is obviously critical to maintaining their midwifery registration but also their experience in providing best quality care. That has been in place since 2012, and there have been 300 completed placements in the program over that period. In fact a number of midwives who have been through the program have sought repeat placements as an opportunity to really retain and refresh their skills. I think that combination of making sure that we continue to provide the access to education and the network of practice — ... the sort of clinical network that we are creating — to provide that sort of peer support to people that we see as being really important for continuous improvement but actually important for retention purposes as well.¹¹⁹¹

¹¹⁹⁰ Ms Jan Jones, Coordinator, Graduate Diploma of Midwifery Program and Bachelor of Nursing Practice and Bachelor of Midwifery Program, School of Nursing, Midwifery and Healthcare, Federation University, Family and Community Development Committee public hearing – Warragul, 8 December 2017, transcript of evidence, p. 7.

¹¹⁹¹ Ms Kym Peake, Secretary, Department of Health and Human Services, Family and Community Development Committee public hearing – Melbourne, 27 November 2017, transcript of evidence, p. 7.

The Committee heard that MCP allows nurses and midwives from rural areas to increase their skills through gaining experience at a larger hospital.¹¹⁹² This helps staff whose experience with emergencies and high risk scenarios is limited by working in a lower level health service.¹¹⁹³ Ms Wilma Wallace, Maternity Unit Manager at West Gippsland Healthcare Group, told the Committee at a public hearing in Warragul of the benefit of MCP to her workforce:

We also have Maternity Connect, in which midwives go down to Melbourne and actually do a two-week program down there — that has been really valuable to actually help and upskill them in particular areas such as special care — or they will go and do two weeks in the antenatal clinics, labour ward or that sort of thing.¹¹⁹⁴

MCP funding is available for clinical support for the hosting health service, travel and accommodation, and back-cover for the nurse or midwife undertaking the program.¹¹⁹⁵ The Committee heard that this was important, as the time and cost associated with accessing training at larger or metropolitan health services can be prohibitive.¹¹⁹⁶

The Committee is supportive of programs such as the Maternity Connect Program, which increase the capability of the midwifery and perinatal nursing workforce while also building connections between health services. Accordingly, the Committee recommends that:

RECOMMENDATION 5.11: The Victorian Government provide increased ongoing funding to continue and expand programs, such as the Maternity Connect Program, that increase the capability of Victoria's midwifery and perinatal nursing workforce across the state.

The Committee sees access to an appropriately qualified midwife workforce as essential to ensuring good perinatal health for mothers, children, and families. A shortage as evident as the Committee heard of needs to be immediately addressed, and further, should not be allowed to develop again. The Victorian Government needs to take action to both replenish the current midwifery workforce, and to develop the planning necessary to ensure such a situation does not recur. While efforts at an individual health service level, like Northern Health above, are positive and necessary, the Committee concludes from the evidence it heard that a broader plan that covers all factors that contribute to the provision of an appropriately qualified midwifery workforce is required. This requires government action which should involve extensive engagement with stakeholders including hospital leadership and the midwifery workforce. Accordingly, the Committee recommends that:

¹¹⁹² Ms Julie Wright, Operational Director of Women's and Children's Services, Albury Wodonga Health, Family and Community Development Committee public hearing – Wangaratta, 25 October 2017, transcript of evidence, p. 7.

¹¹⁹³ Victorian Healthcare Association, submission no. 53, p. 5.

¹¹⁹⁴ Ms Wilma Wallace, Maternity Unit Manager, West Gippsland Healthcare Group, Family and Community Development Committee public hearing – Warragul, 8 December 2017, transcript of evidence, p. 5.

¹¹⁹⁵ Western Health, 'Maternity Connect Program (MCP)', accessed 19 April 2018, <<http://www.westernhealth.org.au/EducationandResearch/Education/Pages/Maternity-Connect-Program.aspx>>.

¹¹⁹⁶ Ms Heather Daly, Midwife and Community Health Nurse, Family and Community Development Committee public hearing – Bairnsdale, 7 December 2017, transcript of evidence, p. 3.

RECOMMENDATION 5.12: The Victorian Government, in consultation with midwives and relevant stakeholders, develop and implement a plan to ensure access to and provision of an appropriately qualified midwifery workforce across Victoria. The plan should include:

- short term measures to address the current shortage;
- long term measures to ensure a sustainable workforce;
- pathways to qualification;
- support for continuing education and professional development; and
- greater support for the emotional and mental health of midwives.

5.4 Perinatal nursing workforce

The Committee notes that nursing as a profession provides care for a far broader group of patients than mothers, babies, and families in the perinatal period. The Committee is not examining the nursing profession as a whole, but notes that some information presented here relates to the overall nursing workforce in Victoria, not just nurses working in perinatal health.

The Inquiry's terms of reference did not explicitly call for investigation of the nursing workforce, outside of Maternal and Child Health (MCH) nurses. However, witnesses and submitters to the Inquiry gave the Committee evidence relating to the nursing workforce that is relevant to the health, care, and wellbeing of mothers and babies in Victoria during the perinatal period. The Committee wishes to represent this evidence.

In many cases, witnesses and submitters gave evidence about midwives and nurses working in perinatal health in the same breath. As noted in section 5.3 above, a likely contributor to this is that the vast majority of midwives are also registered nurses,¹¹⁹⁷ meaning that when witnesses to the Inquiry are talking about one, they are often also talking about the other. Though the Committee notes they are different professions, many of the issues discussed in section 5.3 concerning the midwifery workforce also apply to the nursing workforce. These issues include staff shortage, challenges in accessing training for rural and regional staff, an ageing workforce, and a prevalence of part time employment. This section will discuss these issues, including a focus on neonatal nurses.

5.4.1 Registered nurse shortage

The Commonwealth Department of Employment¹¹⁹⁸ reports no shortage of enrolled nurses, but a shortage of registered nurses in Victoria:

¹¹⁹⁷ DHHS Knowledge Bank website, which shows data on health practitioner numbers in Victoria based on payroll data, shows that in 2014 there were 7,927 dual registered nurses and midwives, and 998 single registered midwives: Department of Health and Human Services, Knowledge Bank, 'Registered Professions', Victorian Government, accessed 24 April 2018, <<https://vicknowledgebank.net.au/current-workforce/registered-professions>>; See also: Australian Institute of Health and Welfare, 'Nursing and midwifery workforce 2015: How many nurses and midwives are there?', Australia Government, accessed 16 April 2018, <<https://www.aihw.gov.au/reports/workforce/nursing-and-midwifery-workforce-2015/contents/how-many-nurses-and-midwives-are-there>>.

¹¹⁹⁸ Now Department of Jobs and Small Business.

Victorian employers experienced difficulty recruiting specialised registered nurses across all locations and are experiencing a shortage of registered nurses for the first time in five years.¹¹⁹⁹

The nursing shortage is not unique to Victoria. A 2014 Commonwealth Government investigation into Australia's future nursing workforce found that 'in the medium to long-term, Australia's demand for nurses will significantly exceed supply (with a projected shortfall of approximately 85,000 nurses by 2025, or 123,000 nurses by 2030 under current settings)'.¹²⁰⁰ The report stated that no single policy can relieve the predicted shortage, but that a combined approach including improved student retention, improved pay after graduation, and increased early career retention can reduce the shortfall.¹²⁰¹

Bendigo Health, in its submission, told the Committee that a shortage of perinatal nurses leads the service to rely on casual staffing:

Limited access to suitably qualified staff in all aspects of perinatal nursing is a constant challenge for the managers. This is due to the small numbers of staff available in the Region and the retention of staff who frequently use the positions to propel them into high level perinatal nursing positions in Metropolitan areas.

Due to the current staffing issues in meeting safe patient ratios across the Women's and Children's Service, many units are using casual staff on a daily basis. This significantly dilutes the pool available to other areas in the division due to the number of shifts they are being utilized for in order to cover the basic roster resulting in less staff available to cover short notice leave such as sick leave and increases in acuity.¹²⁰²

Nurses, like midwives, are an ageing workforce, with many nearing retirement age. The Victorian Healthcare Association (VHA) told the Committee:

The VHA membership reports concerns regarding the existing and future workforce, namely that the current nursing and midwifery workforce is ageing as many reach retirement; and recruitment to fill key positions in rural hospitals can be extremely challenging.¹²⁰³

Ms Janet Hicks, Director of Nursing at Mildura Base Hospital, told the Committee that the nursing workforce at the Hospital is a mix of those nearing retirement age, and young nurses. What is missing, according to Ms Hicks, is the middle cohort, who take time off to raise their own families:

Fifty-three per cent of our nursing staff across the hospital have less than five years experience, so we have actually got a very junior workforce compared to most hospitals that have an ageing workforce. We seem to have that band at the top who are close to retirement, and then we have this band at the bottom. It is the middle

¹¹⁹⁹ Department of Employment, *Registered Nurses Occupational Report ANZSCO 2544 Registered Nurse – VIC*, Australian Government, Canberra, May 2017, p. 1.

¹²⁰⁰ Health Workforce Australia, *Australia's Future Health Workforce – Nurses Detailed Report*, Australian Government Department of Health, Canberra, 2014, p. 3.

¹²⁰¹ Ibid.

¹²⁰² Bendigo Health, submission no. 44, pp. 2-3.

¹²⁰³ Victorian Healthcare Association, submission no. 53, p. 5.

grade — you know, the medium to high level of experience — that is really missing from the workforce, most often because that is when they have their families. They take a break from working and they reduce their hours.¹²⁰⁴

5.4.2 Neonatal nurse shortage

Throughout the Inquiry the Committee heard evidence in relation to neonatal nurses working in neonatal intensive care units (NICUs) and special care nurseries. Neonatal nurses are registered nurses or midwives who gain further training and experience to care for preterm or ill neonatal babies.¹²⁰⁵ The University of Melbourne, La Trobe University, and Deakin University offer qualifications in neonatal nursing.¹²⁰⁶

The Committee heard that Victoria is facing a shortage of neonatal nurses in NICUs.¹²⁰⁷ Further, due to the current workforce limitation, any expansion of NICU beds would require ‘significant planning and significant input of resources’.¹²⁰⁸ Dr Andrew Watkins, neonatologist at Mercy Hospital for Women, outlined some of the difficulties in training and retaining neonatal nurses:

The issue is mostly in the provision of trained neonatal intensive care nurses, because of ... the cost of doing the course, the availability of the course and what you get for your money if you do the course. If you do the course, you get a more interesting job, but you get a lot more stress and not much more money. There is an issue of retention. We have noticed at the Mercy that a lot of our older staff are now moving on to less demanding jobs and we have got a lot of young staff coming through, who are the future, but some of them are still quite wet behind the ears. There has been a significant exodus of senior, experienced staff from the system, and this often accelerates after periods of high workload.¹²⁰⁹

The Committee heard that the workforce shortage in neonatal nursing leads to staff working double shifts and overtime, impacting on their health and safety.¹²¹⁰ In addition, having inadequate staff skill and numbers in and of itself leads to workplace stress.¹²¹¹ Ms Suzanne Hartney, neonatal nurse and midwife, told the Committee at a public hearing in Bendigo that clinical leadership is essential to grow the neonatal nursing workforce, noting systems of duty allocation are ad hoc without appropriate clinical leadership, such as that provided by Associate Nurse Unit Managers.¹²¹²

¹²⁰⁴ Ms Janet Hicks, Director of Nursing, Mildura Base Hospital, Family and Community Development Committee public hearing – Mildura, 9 November 2017, transcript of evidence, p. 6.

¹²⁰⁵ Australian College of Neonatal Nurses, ‘Neonatal Nursing’, accessed 16 April 2018, <<https://www.acnn.org.au/about/neonatal-nursing>>.

¹²⁰⁶ Australian College of Neonatal Nurses, ‘Victoria’, accessed 16 April 2018, <<https://www.acnn.org.au/about/neonatal-nursing/victoria>>.

¹²⁰⁷ Associate Professor Rod Hunt, Director, Newborn Intensive Care, Royal Children’s Hospital, Melbourne Children’s Campus, Family and Community Development Committee public hearing – Melbourne, 18 September 2017, transcript of evidence, p. 5; Ms Suzanne Hartney, Neonatal Nurse and Midwife, Family and Community Development Committee public hearing – Bendigo, 24 October 2017, transcript of evidence, p. 2; Albury Wodonga Health, submission no. 55, p. 2.

¹²⁰⁸ Dr Andrew Watkins, Neonatologist, Family and Community Development Committee public hearing – Melbourne, 18 September 2017, transcript of evidence, p. 6.

¹²⁰⁹ Ibid.

¹²¹⁰ Ms Suzanne Hartney, Neonatal Nurse and Midwife, Family and Community Development Committee public hearing – Bendigo, 24 October 2017, transcript of evidence, p. 2.

¹²¹¹ Australian Nursing and Midwifery Federation (Victorian Branch), submission no. 67, p. 13.

¹²¹² Ms Suzanne Hartney, Neonatal Nurse and Midwife, Family and Community Development Committee public hearing – Bendigo, 24 October 2017, transcript of evidence, p. 3.

At regional public hearings in Bendigo and Wangaratta, the Committee heard that a barrier to maintaining a workforce of appropriately skilled neonatal nurses is the travel required to undergo training in Melbourne.¹²¹³ Ms Hartney told the Committee in Bendigo that a proposed neonatal course in Bendigo would help attract local staff:

Bendigo La Trobe University and Bendigo Health are considering the feasibility of running a level 2 neonatal course in the future so we can locally attract staff. Currently those courses were offered in Melbourne, and that is where I did mine many years ago. We see this as a fantastic opportunity for regional areas to grow their workforce.¹²¹⁴

The Committee sees access to an appropriately qualified nursing workforce as essential to ensuring good perinatal health for mothers, children, and families. As mentioned above, much of the evidence the Committee heard in regards to midwives, discussed in section 5.3 above, also applies to nurses working in perinatal health. The challenges of staff shortages, an ageing workforce that will weaken the workforce as staff retire, staff stress and burnout which is both a symptom and cause of the staff shortage, and difficulty in accessing ongoing training and education all apply to both the midwifery and nursing workforces. As such, the Committee believes that, just as for the midwifery workforce, the Victorian Government needs to take action to address all factors that contribute to the provision of an appropriately qualified perinatal nursing workforce. As stated in *Australia's Future Health Workforce – Nurses Detailed Report*, no single policy will close the gap in nursing supply and demand. Government approaches need to be multi-faceted. This requires extensive engagement with stakeholders including hospital leadership and the nursing workforce. Accordingly, the Committee recommends that:

RECOMMENDATION 5.13: The Victorian Government, in consultation with nurses and relevant stakeholders, develop and implement a plan to ensure access to and provision of an appropriately qualified perinatal nursing workforce, with a focus on neonatal nurses, across Victoria. The plan should include:

- short term measures to address the current shortage;
- long term measures to ensure a sustainable workforce;
- pathways to qualification;
- support for continuing education and professional development; and
- greater support for the emotional and mental health of nurses.

¹²¹³ Ms Julie Wright, Operational Director of Women's and Children's Services, Albury Wodonga Health, Family and Community Development Committee public hearing – Wangaratta, 25 October 2017, transcript of evidence, p. 6; Ms Suzanne Hartney, Neonatal Nurse and Midwife, Family and Community Development Committee public hearing – Bendigo, 24 October 2017, transcript of evidence, p. 3.

¹²¹⁴ Ms Suzanne Hartney, Neonatal Nurse and Midwife, Family and Community Development Committee public hearing – Bendigo, 24 October 2017, transcript of evidence, p. 3.

5.5 Obstetricians and gynaecologists, paediatricians, general practitioners, and other specialists

The Inquiry's terms of reference called for the Committee to inquire into access to and provision of doctors working in perinatal health, including paediatricians, obstetricians, general practitioners, and anaesthetists. As discussed in section 5.2 above, the Committee heard that the 'single most important issue in the medical workforce is maldistribution away from rural centres'.¹²¹⁵

The Committee heard that while there is no shortage of medical graduates¹²¹⁶ and some specialties, including neonatology¹²¹⁷ and obstetrics and gynaecology,¹²¹⁸ are experiencing full supply or oversupply of practitioners, the distribution of those specialists is not properly servicing rural and regional Victorians.¹²¹⁹ The Committee heard that market forces are helping to a certain extent, particularly in paediatrics and anaesthetics, but getting doctors to where patients are remains a huge issue.¹²²⁰ Melbourne Children's Campus, in its submission, stated the problem simply: 'More specialists with expertise in perinatal medicine are needed in rural/regional Victoria'.¹²²¹

This issue of access to the perinatal health workforce in rural and regional Victoria is discussed in section 5.2 above, in relation to all health practitioners working in perinatal services, including doctors. The particular challenge of attracting and retaining obstetricians and gynaecologists and GP obstetricians in rural and regional Victoria is addressed in Chapter Four. This section will outline evidence the Committee heard of other issues affecting the perinatal medical workforce, including training, recruitment in peri-urban Melbourne and Geelong, and the cost of accessing private obstetricians.

In their submission, The University of Melbourne told the Committee that building a 'skilled medical workforce in obstetrics and neonatology, including regional and rural Victoria, starts with creating practice-ready clinicians through medical training and through specialist and sub-specialist post graduate training program'.¹²²² RANZCOG,

¹²¹⁵ Royal Australian and New Zealand College of Obstetricians and Gynaecologists, submission no. 35, p. 6.

¹²¹⁶ Mr Terry Symonds, Deputy Secretary, Health and Wellbeing Division, Department of Health and Human Services, Family and Community Development Committee public hearing – Melbourne, 27 November 2017, transcript of evidence, p. 9.

¹²¹⁷ Dr Andrew Watkins, Neonatologist, Family and Community Development Committee public hearing – Melbourne, 18 September 2017, transcript of evidence, p. 6.

¹²¹⁸ Associate Professor Ryan Hodges, Interim Program Director, Women's and Newborn Program, and Head of Obstetrics and Perinatal Services, Monash Health, Family and Community Development Committee public hearing – Melbourne, 16 October 2017, transcript of evidence, pp. 5-6; Professor Michael Permezel, Immediate Past-President, Royal Australian and New Zealand College of Obstetricians and Gynaecologists, Family and Community Development Committee public hearing – Melbourne, 4 September 2017, transcript of evidence, pp. 3-4.

¹²¹⁹ Professor Michael Permezel, Immediate Past-President, Royal Australian and New Zealand College of Obstetricians and Gynaecologists, Family and Community Development Committee public hearing – Melbourne, 4 September 2017, transcript of evidence, pp. 3-4; Ms Kym Peake, Secretary, Department of Health and Human Services, Family and Community Development Committee public hearing – Melbourne, 27 November 2017, transcript of evidence, p. 7; Royal Australian and New Zealand College of Obstetricians and Gynaecologists, submission no. 35, p. 6.

¹²²⁰ Dr Michael Rasmussen, Clinical Services Director, Mercy Hospital for Women (Mercy Health), Family and Community Development Committee public hearing – Melbourne, 16 October 2017, transcript of evidence, p. 4.

¹²²¹ Melbourne Children's Campus, submission no. 31, p. 3.

¹²²² The University of Melbourne, submission no. 54, p. 3.

in their rationale for building a fifth NICU at Western Health's Sunshine Hospital, noted that adding a NICU would allow the Hospital to offer comprehensive obstetric and gynaecological training:

Western Hospital Sunshine has the volume of both Obstetrics and Gynaecology to become a full-training hospital for Obstetricians & Gynaecologists. Despite its large number of births and particularly good gynaecology training, the absence of a NICU at Sunshine currently prevents the hospital becoming a comprehensive centre for O&G training. Although training in each of obstetrics and gynaecology can occur at different locations, this is far from ideal from service delivery perspective where "safe working hours" mean that those undertaking gynaecology rotations will usually need to participate in the emergency obstetric on-call roster.¹²²³

Dr Liz Uren, of South West Healthcare, told the Committee at a public hearing in Warrnambool that GPs are lacking in obstetric training:

I think general practice has become a bit of an area where there is a very small group who have done any obstetric training and the rest have not done any at all. So there is a very limited number of GPs who have actually done any formalised training in obstetrics during their junior medical years, other than as a medical student. I think it would be nice if more of the GPs did a bit more training, because sometimes we do get things that are left too late or things that have gone past their time issue.¹²²⁴

Further, while professional development in obstetrics is available, Dr Uren is concerned it is not equipping GPs with the skills they need.¹²²⁵

The Committee heard from Dr Leo Fogarty, Director of Obstetrics at Northeast Health Wangaratta, that a barrier to specialists accessing continuing professional development is the cost. Dr Fogarty told the Committee at a public hearing in Wangaratta:

Continuing education and CPD is something that we all welcome and we realise it is necessary, but in our particular situation where we are non-salaried specialists, it is very expensive for us to do CPD. It is rarely funded by anyone. We have to pay for it ourselves. We usually have to leave town, and when you have to leave town you still have to keep your medical practice running and be paying employees et cetera.

In particular I do not think we should have to pay for CPD, such as the annual foetal surveillance that we do, which is basically foetal monitoring revision each year, and neonatal resuscitation. We are all very happy to do it, but it is sort of a little bit galling to have to pay for it when you are actually taking time out from your own practice to do it.¹²²⁶

Dr Joe Garra, a GP obstetrician working in Werribee, told the Committee in his submission that capability in electronic fetal monitoring, particularly interpreting cardiotocography traces, is variable among both doctors and midwives, and that training in this area should be compulsory.¹²²⁷ Similarly, Associate Professor Rod Hunt

¹²²³ Royal Australian and New Zealand College of Obstetricians and Gynaecologists, submission no. 35, p. 5.

¹²²⁴ Dr Liz Uren, Obstetrics and Gynaecology, South West Healthcare, Family and Community Development Committee public hearing – Warrnambool, 11 October 2017, transcript of evidence, p. 7.

¹²²⁵ *Ibid.*, pp. 7, 9.

¹²²⁶ Dr Leo Fogarty, Director of Obstetrics, Northeast Health Wangaratta, Family and Community Development Committee public hearing – Wangaratta, 25 October 2017, transcript of evidence, pp. 2-3.

¹²²⁷ Dr Joe Garra, submission no. 15, p. 2.

of Melbourne Children's Campus told the Committee that all health practitioners providing perinatal care, including GPs and anaesthetists, should be trained in neonatal resuscitation.¹²²⁸

While the shortage of specialists in rural and regional areas was widespread in evidence to the Committee (as discussed above, see section 5.2) the Committee also heard of difficulties in medical staffing at health services in Geelong and peri-urban Melbourne.

Dr Michael Rasmussen, Clinical Services Director at Mercy Hospital for Women, told the Committee at a public hearing in Melbourne that Commonwealth Government changes to 457 visas may negatively impact the Werribee Mercy Hospital:

The recent government changes to the 457 visa arrangements may I think impact on us at hospitals such as Werribee. We very much rely on overseas-trained specialists, it has to be said, to staff our hospitals. With the change in those 457 rules there will be some challenges coming.¹²²⁹

Dr David Fuller, Clinical Director of University Hospital Geelong, told the Committee at a public hearing in Geelong that while his health service has a healthy senior paediatrics workforce, attracting obstetric and gynaecological staff is an issue, both for junior and senior medical staff.¹²³⁰

Northern Health and The Kilmore & District Hospital, both affected by growth in Melbourne's north, find recruiting and retaining staff difficult.¹²³¹ The Kilmore & District Hospital, in their submission, told the Committee that its location helps it attract a medical workforce during the day, 'however few medical staff are willing to remain on site overnight to support an essential on-call service'.¹²³² Furthermore, they noted that the Hospital cannot access regional funding support due to its peri-urban location, despite facing similar challenges in staffing its obstetric workforce.¹²³³

The Committee also heard that accessing specialists such as obstetricians or paediatricians comes with a financial cost for families.¹²³⁴ Ms Ofri Marton, in her submission, told the Committee that she had to choose between waiting a long time to see a public obstetrician or paying to see a private obstetrician:

[S]ome women may be recommended to see an obstetrician during the early stages of pregnancy. Most public hospitals do not see pregnant women prior to 16 weeks gestation which is when the first midwife appointment is usually booked by a public hospital. Being able to see a public obstetrician following the initial appointment can take several weeks longer. The issue of affordability comes up when a woman

¹²²⁸ Associate Professor Rod Hunt, Director, Newborn Intensive Care, Royal Children's Hospital, Melbourne Children's Campus, Family and Community Development Committee public hearing – Melbourne, 18 September 2017, transcript of evidence, p. 4.

¹²²⁹ Dr Michael Rasmussen, Clinical Services Director, Mercy Hospital for Women (Mercy Health), Family and Community Development Committee public hearing – Melbourne, 16 October 2017, transcript of evidence, p. 4.

¹²³⁰ Dr David Fuller, Clinical Director, University Hospital Geelong, Family and Community Development Committee public hearing – Geelong, 11 December 2017, transcript of evidence, p. 6.

¹²³¹ Northern Health, submission no. 95, p. 1; The Kilmore & District Hospital, submission no. 50, p. 4.

¹²³² The Kilmore & District Hospital, submission no. 50, p. 4.

¹²³³ Ibid.

¹²³⁴ Glenelg Shire Maternal and Child Health Service, submission no. 89, p. 1.

is experiencing pregnancy related health issues prior to 16 weeks gestation, and is obliged to access a private obstetrician. The costs for seeing a private obstetrician vary enormously and are usually several hundred dollars per appointment.¹²³⁵

The Committee makes recommendations to grow the rural and regional perinatal medical workforce in section 5.2.

5.6 Mental health practitioners

The Committee heard recommendations from witnesses and submitters of a need for an increased perinatal and infant mental health workforce, including training all perinatal health staff in identifying and responding to mental illness.¹²³⁶ The loss of Commonwealth funding for the National Perinatal Depression Initiative (NPDI) limits workforce capacity building in this area.¹²³⁷ The Committee addresses perinatal mental health generally and makes recommendations around these issues in Chapter Three.

This section will discuss evidence the Committee heard about challenges for the perinatal mental health workforce, including psychologists, psychiatrists, and mental health nurses.

The Committee heard that Victoria faces a shortage of perinatal mental health experts.¹²³⁸ The Commonwealth Department of Employment¹²³⁹ in its occupational skill shortages information report for nurses in Victoria noted that:

Employers who sought to fill positions in mental health received the fewest suitable applicants of all the specialties surveyed, attracting only 0.3 suitable applicants on average per vacancy.¹²⁴⁰

The Australian Psychological Society's (APS) submission noted that even in large maternity hospitals, mother baby units, and Early Parenting Centres, not many psychologists are employed. This is despite the APS hearing feedback from the services themselves that they need more psychologists:

While psychologists in general and those with additional training and experience within the perinatal period are qualified to support women in the perinatal period, there is extremely limited access to them, particularly in publicly available services. One of Melbourne's largest maternity hospitals for example, has only one psychologist (P4) in the Perinatal Mental Health service employed at .8 EFT and

¹²³⁵ Ms Ofri Marton, submission no. 56, p. 2.

¹²³⁶ Charles Sturt University, submission no. 36, p. 7; Royal Australian and New Zealand College of Psychiatrists (Victorian Branch), submission no. 25, p. 2; Mindful Centre for Training and Research in Developmental Health, submission no. 74, p. 2. Note that during the course of the Committee's Inquiry, the Centre of Perinatal Excellence (COPE) released a training program aimed at 'supporting best practice in screening, assessment and referral for perinatal mental health', available here: Centre of Perinatal Excellence, 'Basic Skills in Perinatal Mental Health', accessed 24 April 2018, <<http://training.cope.org.au/p/cope-basic-skills-in-perinatal-mental-health>>.

¹²³⁷ Royal Australian and New Zealand College of Psychiatrists (Victorian Branch), submission no. 25, p. 8; Australian Nursing and Midwifery Federation (Victorian Branch), submission no. 67, p. 10; Mindful Centre for Training and Research in Developmental Health, submission no. 74, p. 2.

¹²³⁸ Ms Christine Hoyne, Nurse Unit Manager, Parent and Infant Unit, Latrobe Regional Hospital, Family and Community Development Committee public hearing – Warragul, 8 December 2017, transcript of evidence, p. 8; City of Greater Geelong Maternal and Child Health Service, submission no. 96, p. 3.

¹²³⁹ Now Department of Jobs and Small Business.

¹²⁴⁰ Department of Employment, *Registered Nurses Occupational Report ANZSCO 2544 Registered Nurses- VIC*, Australian Government, Canberra, May 2017, p. 1.

another (P3) at .2 EFT, with no current psychologist employed in the Mother Baby unit. Feedback from these services would indicate that there is a need for at least 3 full time psychologists.

[T]here are extremely limited services within each of Victoria's three Early Parenting Centres (not one full-time psychologist at any of these services). Psychology roles were cut with the NPDI funding.¹²⁴¹

This was echoed by Professor Louise Newman AM, Director of the Royal Women's Hospital Centre for Women's Mental Health and Professor of Psychiatry at The University of Melbourne, who told the Committee that her health service does not employ enough psychologists or mental health nurses, necessitating the use of expensive external staff.¹²⁴²

Outside of the public health system, referrals to private practice psychologists are limited by cost, limited capacity for practitioners to provide case management, and difficulty in finding a perinatal specialist.¹²⁴³ While there is a Medicare item for perinatal psychological counselling via GP referral, it 'is not well known about or accessed.'¹²⁴⁴ The APS told the Committee in its submission:

Some women with perinatal mental health disorders seek a referral to perinatal psychologists in private practice utilising Commonwealth Funding via the Better Access to Mental Health Care scheme. However many low income and higher risk families are not able to utilise these services because of the cost. Private practitioners have limited capacity to take case management duties, and for referrers, the identification of practitioners with specialised training in perinatal mental health is not always easy to discern. Women in rural and remote areas are disadvantaged by limited access to trained practitioners.¹²⁴⁵

The Committee also heard that referrals to a private practice psychologist by hospital-based psychiatric registrars mean a loss in continuity of care. Ms Viviane Lebnan, Convenor of the Perinatal Interest Group with the APS, told the Committee 'that those in most need usually drop out of treatment at this point, as they struggle with having to meet someone new, retell their story and develop yet another therapeutic and trusting relationship'.¹²⁴⁶

Many witnesses told the Committee that access to perinatal mental health practitioners had been severely restricted by the withdrawal of funding for the NPDI and, in particular, the Perinatal Emotional Health Programs (PEHPs).¹²⁴⁷ This includes a reduction in psychological services at maternity hospitals, Early Parenting Centres, community health centres, outreach services, and secondary and tertiary consultation.¹²⁴⁸ For more on this see Chapter Three.

¹²⁴¹ Australian Psychological Society, submission no. 80, p. 15. See also Ms Viviane Lebnan, Convenor, Perinatal Interest Group, Australian Psychological Society, Family and Community Development Committee public hearing – Melbourne, 5 February 2018, transcript of evidence, p. 4.

¹²⁴² Professor Louise Newman AM, Director, Royal Women's Hospital Centre for Women's Mental Health, Family and Community Development Committee public hearing – Melbourne, 16 October 2017, transcript of evidence, p. 10.

¹²⁴³ Ballarat Health Services, submission no. 34, p. 3; Australian Psychological Society, submission no. 80, p. 8.

¹²⁴⁴ Australian Psychological Society, submission no. 80, p. 15.

¹²⁴⁵ *Ibid.*, p. 8.

¹²⁴⁶ Ms Viviane Lebnan, Convenor, Perinatal Interest Group, Australian Psychological Society, Family and Community Development Committee public hearing – Melbourne, 5 February 2018, transcript of evidence, p. 4.

¹²⁴⁷ Tweddle Child and Family Health Service, submission no. 45, p. 9; Australian Psychological Society, submission no. 80, p. 13; Families where a Parent has a Mental Illness (FAPMI), submission no. 28, p. 2.

¹²⁴⁸ Australian Psychological Society, submission no. 80, p. 13.

The Committee heard that even where PEHPs are still running, the number of staff available does not meet the demand.¹²⁴⁹ Ms Christine Hoyne, Nurse Unit Manager of the Parent and Infant Unit at Latrobe Regional Hospital, told the Committee that more PEHP clinicians would be beneficial:

There should be an increase of the EFT for the PEHP clinicians, because at the moment there are three clinicians doing 2.5 EFT for 44 000 square kilometres. It is pretty tricky.¹²⁵⁰

Professor Newman told the Committee of the maldistribution of perinatal mental health specialists, noting that most are in the city, and formal arrangements for consultations to other areas are limited.¹²⁵¹ Other witnesses also told the Committee of a lack of psychologists and specialist psychiatrists in rural and regional areas.¹²⁵² This is discussed further in Chapter Four.

Mental health practitioners told the Committee that appropriately qualified staff were hard to find, and that when they recruit they target staff who can be trained after they have been hired.¹²⁵³ Ms Cheree Cosgriff, Grampians Coordinator of Families where a Parent has a Mental Illness (FaPMI), told the Committee at a public hearing in Geelong of the difficulty in finding staff with perinatal mental health training.¹²⁵⁴ Ms Cosgriff noted it is a fairly new field and university training is hard to find, and has found the most success in either employing midwives and then training them in mental health, or employing mental health clinicians and then training them in midwifery:

We talk about how they haven't been able to recruit to those positions because that's part of the problem because we don't have perinatal specific trained staff in any area really, it's very difficult to find them. It's a very new and evolving area and even training from university purposes is very hard to find. I've actually been the manager of the Mother and Family Unit at Ballarat in the last 12 months and staffing that unit itself has been really difficult because we've either had to get midwives and train them up to be mental health clinicians, or the other way around, train mental health clinicians to have a midwifery component. Perinatal specific training is really challenging to actually have in that space. Fantastic, we need to have it, but it's not there at the moment so that's been a big issue.¹²⁵⁵

The Royal Women's Hospital noted the lack of standardised training options for those looking to work in perinatal mental health. The Hospital's Centre for Women's Mental Health runs an elective in perinatal mental health for The University of

¹²⁴⁹ Loddon Mallee Aboriginal Reference Group, submission no. 66, p. 2.

¹²⁵⁰ Ms Christine Hoyne, Nurse Unit Manager, Parent and Infant Unit, Latrobe Regional Hospital, Family and Community Development Committee public hearing – Warragul, 8 December 2017, transcript of evidence, pp. 8-9.

¹²⁵¹ Professor Louise Newman AM, Past President, Royal Australian and New Zealand College of Psychiatrists (Victorian Branch), Family and Community Development Committee public hearing – Melbourne, 18 September 2017, transcript of evidence, pp. 5-6.

¹²⁵² Dr Virginia Loftus, Committee Member, Faculty of Child and Adolescent Psychiatry, Royal Australian and New Zealand College of Psychiatrists (Victorian Branch), Family and Community Development Committee public hearing – Melbourne, 18 September 2017, transcript of evidence, p. 9; Dr Sarah Hancock, GP, Benalla Carrier Street Clinic, Family and Community Development Committee public hearing – Wangaratta, 25 October 2017, transcript of evidence, p. 5.

¹²⁵³ Ms Christine Hoyne, Nurse Unit Manager, Parent and Infant Unit, Latrobe Regional Hospital, Family and Community Development Committee public hearing – Warragul, 8 December 2017, transcript of evidence, p. 8.

¹²⁵⁴ Ms Cheree Cosgriff, Grampians Coordinator, Families where a Parent has a Mental Illness (FaPMI), Family and Community Development Committee public hearing – Geelong, 11 December 2017, transcript of evidence, p. 8.

¹²⁵⁵ Ibid.

Melbourne Masters of Psychiatry students.¹²⁵⁶ The Committee heard that the Victorian Government funds training positions in infant psychiatry at health services in Melbourne.¹²⁵⁷

Professor Newman noted that while there is interest from trainees in the area of perinatal mental health, there is a need for proper supervision, teaching, and support.¹²⁵⁸ Ms Lebnan recommended that to increase the psychology workforce, more student placements need to be available:

Finally, to improve and increase the psychology workforce, with specialist skills in perinatal mental health, opportunities for student placements and secondments for registered clinical psychologists already working in public mental health need to become more frequently available. For this to be achieved, there needs to be an existing adequate staffing of perinatal psychologists already within the service, who can provide the clinical supervision and mentoring.¹²⁵⁹

The Committee notes that in Chapter Three it recommends that the Victorian Government create a Perinatal Mental Health Plan as a matter of priority to address the perinatal mental health needs of mothers, fathers, and families. The Committee also recommends in Chapter Three that the Victorian Government provide ongoing funding for the existing Perinatal Emotional Health Programs (PEHPs), and fund the expansion of the program state-wide to be delivered as a key element of supporting women at risk of, or experiencing, mental illness in the perinatal period.

The Committee expects that part of the implementation of these recommendations will include an increase in the perinatal mental health workforce across Victoria. However, the evidence presented above of the lack of perinatal mental health practitioners within the public health system is so concerning to the Committee that it wishes to make this expectation of an increased workforce clear. Accordingly, the Committee recommends that:

RECOMMENDATION 5.14: The Victorian Government, in creating and implementing a Perinatal Mental Health Plan as per Recommendation 3.1, increase the availability of the perinatal mental health workforce in the public health system, including maternity hospitals, mother baby units, and Early Parenting Centres.

The Committee is concerned by the negative cycle of a lack of perinatal psychologists currently working in public health services leading to a difficulty in finding appropriately supervised student and secondment places for prospective perinatal psychologists to gain further experience and qualifications in perinatal mental health, therefore limiting the expansion of the perinatal psychological workforce. Accordingly, the Committee recommends that:

¹²⁵⁶ The Royal Women's Hospital, submission no. 75, p. 9.

¹²⁵⁷ Dr Virginia Loftus, Committee Member, Faculty of Child and Adolescent Psychiatry, Royal Australian and New Zealand College of Psychiatrists (Victorian Branch), Family and Community Development Committee public hearing – Melbourne, 18 September 2017, transcript of evidence, p. 4.

¹²⁵⁸ Professor Louise Newman AM, Past President, Royal Australian and New Zealand College of Psychiatrists (Victorian Branch), Family and Community Development Committee public hearing – Melbourne, 18 September 2017, transcript of evidence, pp. 5-6.

¹²⁵⁹ Ms Viviane Lebnan, Convenor, Perinatal Interest Group, Australian Psychological Society, Family and Community Development Committee public hearing – Melbourne, 5 February 2018, transcript of evidence, pp. 4-5.

RECOMMENDATION 5.15: The Victorian Government provide incentives to support clinical placements and secondments for psychologists and psychology students who wish to gain experience and qualifications in perinatal mental health.

5.7 Lactation consultants

The Committee heard evidence relating to workforce challenges facing lactation consultants in Victoria, including that ‘there are insufficient midwives and lactation consultants to provide the necessary support to assist women’.¹²⁶⁰ The Committee discusses this evidence here, and makes a recommendation to support lactation consultants and mothers in Victoria. The Committee discusses lactation consultants in the broader context of public policy around breastfeeding and breastfeeding support in Chapter Two, including recommending Medicare rebates for lactation consultancy services in Recommendation 2.11.

Much like the other professions discussed in this chapter, the Committee heard that lactation consultants are difficult to access in rural and regional Victoria. Ms Susan Day, President of the Australian Breastfeeding Association, told the Committee at a public hearing in Melbourne:

Predominantly the lactation consultants are city based. Of course there are some through the country, but there is a lot less access to services in rural and regional Victoria ...¹²⁶¹

The Committee heard that some maternity services and Maternal and Child Health (MCH) Service providers run lactation clinics, but they are often only open a few days a week at the most.¹²⁶² While some MCH nurses are qualified as lactation consultants,¹²⁶³ there is a lack of funding for staff to actually deliver a lactation consultancy service.¹²⁶⁴ University Hospital Geelong, in their submission, recommended that funding be provided to allow seven day lactation services in acute and community services.¹²⁶⁵

The lack of accessible lactation consultants in the public sector leads mothers to look to private lactation consultants for breastfeeding support, an option which carries a cost, and may require travel, both barriers for those looking for breastfeeding support.¹²⁶⁶

¹²⁶⁰ Australian Nursing and Midwifery Federation (Victorian Branch), submission no. 67, p. 7.

¹²⁶¹ Ms Susan Day, President, Australian Breastfeeding Association, Family and Community Development Committee public hearing – Melbourne, 4 September 2017, transcript of evidence, p. 12.

¹²⁶² Ms Julie Wright, Operational Director of Women’s and Children’s Services, Albury Wodonga Health, Family and Community Development Committee public hearing – Wangaratta, 25 October 2017, transcript of evidence, pp. 4-5. And see for example: Ms Maree Burgess, Maternal and Child Health Nurse, Branch President, Australian Nursing and Midwifery Federation (Victorian Branch), Family and Community Development Committee public hearing – Melbourne, 18 September 2017, transcript of evidence, pp. 7-8; Ms Hilary Skelton, submission no. 72, p. 1. For more on hospital lactation clinics see Chapter Two.

¹²⁶³ Ms Maree Burgess, Maternal and Child Health Nurse, Branch President, Australian Nursing and Midwifery Federation (Victorian Branch), Family and Community Development Committee public hearing – Melbourne, 18 September 2017, transcript of evidence, p. 7.

¹²⁶⁴ Ms Helen Lees, Maternal and Child Health Clinical Coordinator, City of Greater Bendigo, Family and Community Development Committee public hearing – Bendigo, 24 October 2017, transcript of evidence, p. 5.

¹²⁶⁵ University Hospital Geelong, submission no. 32, p. 2.

¹²⁶⁶ Mount Alexander Shire, submission no. 23, p. 2; Ms Jane Perry, Family and Community Development Committee public hearing – Warrnambool, 11 October 2017, transcript of evidence, p. 2; Ms Ruth Berkowitz, submission no. 90, p. 2.

At a public hearing in Wangaratta the Committee heard that demand for existing lactation consultants at Northeast Health Wangaratta is growing, with availability of lactation services in the area shrinking. Ms Cate Gemmill, lactation consultant with Northeast Health Wangaratta, told the Committee:

We have seen increasing demand year on year. Last year was the highest number ever, with 896 clients. We will overtake that number this year. Five years ago we were seeing about 530, so we have seen significant growth. Some of that is attributable to the loss of lactation support services in our smaller rural towns. We had some maternal child health nurses, for example, who were also lactation consultants. We do not have that anymore, so most of the lactation support in the region falls to us.¹²⁶⁷

Ms Gemmill suggested that support for those wishing to gain lactation consultancy qualifications would help reduce the problem of women in her area needing to travel multiple hours in order to access Northeast Health Wangaratta's service, with no closer options.¹²⁶⁸

The Committee agrees that support for health practitioners wishing to become lactation consultants can help improve access to Victorian mothers who need breastfeeding support. There is an opportunity for perinatal health practitioners, such as Maternal and Child Health nurses, to become lactation consultants in order to support mothers in their region. Accordingly, the Committee recommends that:

RECOMMENDATION 5.16: The Victorian Government fund improved lactation support services in Victoria including ongoing lactation education for midwives and neonatal nurses and delivery of a best practice model to ensure consistency of advice.

In addition to education for the existing perinatal health workforce, the Committee believes that to provide the best support for mothers in Victoria, there is a need for better access to a lactation consultant workforce. Accordingly, the Committee recommends that:

RECOMMENDATION 5.17: The Victorian Government investigate unmet need and develop a strategy to build lactation consultant workforce capability and access across the state.

5.8 Genetics services providers and sonographers

While not part of its terms of reference, the Committee heard evidence relating to medical geneticists, genetic counsellors, maternal fetal medicine specialists, obstetric imaging specialists, and sonographers. The following sections address this evidence.

5.8.1 Genetics services providers

The Committee heard that the genetics services workforce includes genetic counsellors, medical geneticists, and maternal fetal medicine and obstetric imaging specialists. This workforce provides prenatal genetic screening and testing, and

¹²⁶⁷ Ms Cate Gemmill, Lactation Consultant, Northeast Health Wangaratta, Family and Community Development Committee public hearing – Wangaratta, 25 October 2017, transcript of evidence, p. 3.

¹²⁶⁸ Ibid.

the further investigation necessary to determine the implications of any identified abnormality for pregnancy, labour, and the baby's short and long term health.¹²⁶⁹ Importantly, this includes providing counselling and support for families in these situations.¹²⁷⁰

RANZCOG told the Committee, in their submission, that prenatal genetics is under resourced in both salaries and testing, and that '[g]reater resourcing is required to ensure a skilled prenatal genetics workforce, and to support informed decision-making for families'.¹²⁷¹ The Committee heard that the demand for genetics services is growing, and that appropriate support services for genetics services staff are required to mitigate the risk staff burnout poses to the genetics workforce.¹²⁷²

The Committee heard that access to genetics services was limited in rural and regional Victoria.¹²⁷³ Professor Permezel of RANZCOG recommended a hub and spoke model in conjunction with telemedicine to help address this inequity.¹²⁷⁴

Genetics in the North East (GeNE), a collaborative network comprising genetics services at Austin Hospital, the Mercy Hospital for Women, and the Northern Hospital, told of an increased acuity in the services provided by genetic counsellors, as well as increased consumer demand for prenatal diagnosis. GeNE recommended:

That workforce projections also include Genetic Counsellors, Medical Geneticists, Maternal Fetal Medicine and Obstetric Imaging specialists. These practitioners need to be trained and maintained in the workforce to address the current and future prenatal screening requirements of pregnant women and their families.¹²⁷⁵

GeNE also recommended that other perinatal health practitioners need to be trained in prenatal genetic screening.¹²⁷⁶

The Committee did not hear extensive evidence on the genetics workforce, but is concerned at the evidence it did hear from RANZCOG and GeNE of a workforce that is not easily accessible outside of Melbourne, and that is facing increased demand. The Committee believes the Victorian Government should include genetics services in workforce projections and planning to ensure Victorian women can access genetic screening and related services. Accordingly, the Committee recommends that:

RECOMMENDATION 5.18: The Victorian Government give consideration to including an appropriately qualified genetics workforce in its short and long term projections and planning for perinatal services.

¹²⁶⁹ Genetics in the North East, submission no. 41, pp. 1-2.

¹²⁷⁰ Ibid., pp. 1, 5-6.

¹²⁷¹ Royal Australian and New Zealand College of Obstetricians and Gynaecologists, submission no. 35, p. 2.

¹²⁷² Genetics in the North East, submission no. 41, pp. 4-5.

¹²⁷³ Royal Australian and New Zealand College of Obstetricians and Gynaecologists, submission no. 35, p. 2; Ms Julie Wright, Operational Director of Women's and Children's Services, Albury Wodonga Health, Family and Community Development Committee public hearing – Wangaratta, 25 October 2017, transcript of evidence, pp. 3-4.

¹²⁷⁴ Professor Michael Permezel, Immediate Past-President, Royal Australian and New Zealand College of Obstetricians and Gynaecologists, Family and Community Development Committee public hearing – Melbourne, 4 September 2017, transcript of evidence, p. 3.

¹²⁷⁵ Genetics in the North East, submission no. 41, p. 5.

¹²⁷⁶ Ibid.

5.8.2 Sonographers

The Committee heard that most pregnant women will see a sonographer in their first and/or second trimester for perinatal medical diagnostic ultrasound services such as screening for anomalies and monitoring fetal development.¹²⁷⁷ Furthermore, that across Australia in 2016–2017 there were 1.2 million referred perinatal medical ultrasound services, with sonographers responsible for delivering a significant number of those services.¹²⁷⁸

Sonographers require specific training to work in a particular area, such as obstetrics or special care nurseries. This training includes a focus on regular clinical practice to gain the skills needed to perform ultrasound scans and interpret images.¹²⁷⁹

The Committee received submissions from the Australasian Sonographers Association (ASA) and the Australasian Society for Ultrasound in Medicine (ASUM). The ASA told the Committee of the role of sonography in perinatal care:

Many perinatal services rely on access to qualified and experienced sonographers to provide medical diagnostic ultrasound throughout pregnancy.¹²⁸⁰

Both organisations noted a persistent shortage of sonographers in Victoria.¹²⁸¹ This was echoed by the Commonwealth Department of Employment¹²⁸² in its occupational skill shortages information report, which shows a shortage of sonographers in Victoria:

A shortage of qualified, skilled and experienced sonographers was identified across Victoria.¹²⁸³

This shortage has persisted for the seven years through to 2017, the date of the most recent occupational skill shortages report.¹²⁸⁴

The ASA and the occupational skill shortages information report both tell of a lack of clinical placements for trainee sonographers as a major barrier to developing the workforce, citing the cost and supervision time required to take on a trainee for both public and private sector employers.¹²⁸⁵ The ASUM submission to the Inquiry also reflected this view:

Many hospitals and private practices can no longer afford to take on a sonographer trainee due to the cost of the student as an employee, cost of senior staff who become less productive while supervising trainees and the cost of equipment. A funding model for this type of traineeship would assist in creating training positions.¹²⁸⁶

¹²⁷⁷ Australasian Sonographers Association, submission no. 100, p. 3.

¹²⁷⁸ Ibid.

¹²⁷⁹ Australasian Society for Ultrasound in Medicine, submission no. 101, p. 4.

¹²⁸⁰ Australasian Sonographers Association, submission no. 100, p. 4.

¹²⁸¹ Ibid.; Australasian Society for Ultrasound in Medicine, submission no. 101, p. 3.

¹²⁸² Now Department of Jobs and Small Business.

¹²⁸³ Department of Employment, *Sonographer Occupational Report ANZSCO 2512-14 Sonographer - VIC*, Australian Government, Canberra, May 2017, p. 1.

¹²⁸⁴ Ibid.

¹²⁸⁵ Ibid., p. 2; Australasian Sonographers Association, submission no. 100, p. 4.

¹²⁸⁶ Australasian Society for Ultrasound in Medicine, submission no. 101, p. 3.

The Committee heard that employers are even reluctant to take on trainees looking to gain clinical experience through unpaid work due to insurance costs and occupational health and safety concerns.¹²⁸⁷ The ASUM recommended funding for businesses to take on trainee sonographers, particularly in rural areas.¹²⁸⁸

The Victorian Government has published a strategic plan to address the medical radiation and imaging workforce: *Medical radiations and imaging technology workforce strategy: Strategic plan to enhance supply, recruitment and retention in the medical radiations and imaging (allied health) workforce from 2013 to 2017*.¹²⁸⁹ However, the ASA told the Committee that while the Victorian Government worked with the ASA to address workforce issues in 2014 and 2015, none of the options discussed had been implemented.¹²⁹⁰ The ASA recommended the Victorian Government engage with key stakeholders to find solutions to the persistent sonographer shortage.¹²⁹¹

The Committee is concerned that the sonography workforce has faced such a long term shortage in Victoria, and that the planned strategy to address this issue has not been implemented. The Victorian Government needs to work with the industry to address this problem. Accordingly, the Committee recommends that:

RECOMMENDATION 5.19: The Victorian Government work with key stakeholders to develop a funding model to support public and private employers to take on sonographer trainees.

1287 Ibid.

1288 Ibid., pp. 3-4.

1289 Department of Health, *Medical radiations and imaging technology workforce strategy: Strategic plan to enhance supply, recruitment and retention in the medical radiations and imaging (allied health) workforce from 2013 to 2017*, Victorian Government, Melbourne, 2013. Note the longer term report *Victorian Medical Radiations Workforce Supply and Demand Projections (2010–2030)*, Department of Health, Victorian Government, Melbourne, 2010, specifically excluded sonographers.

1290 Australasian Sonographers Association, submission no. 100, p. 4.

1291 Ibid.

6

Maternal and Child Health Service

AT A GLANCE

Background

The Committee heard that the Maternal and Child Health (MCH) Service is a free, universal service that supports families and their children with an emphasis on parenting, health promotion, early detection and intervention, and social support. The challenges and expectations of a changing community place an increased pressure on Victoria's MCH Service and workforce.

This chapter describes the MCH Service, its governance and funding, and outlines key issues identified in submission and public hearing evidence to the Inquiry. This evidence includes the experience of mothers with the MCH Service, challenges facing the MCH workforce, including staff attrition through retirement, pathways for treatment referral available to MCH nurses, the impact of complicated presentations, communication between hospitals and MCH Service providers, and funding for the MCH Service in the 2017-18 Budget.

This chapter will also summarise findings and recommendations made in the Victorian Auditor-General's 2017 report *Effectively Planning for Population Growth*, which addresses MCH Service governance, participation rates, data collection, and ability to meet the demands of a growing population.

Terms of reference addressed

This chapter addresses the following terms of reference:

1. the availability, quality and safety of health services delivering services to women and their babies during the perinatal period;
5. access to and provision of an appropriately qualified workforce, including midwives, paediatricians, obstetricians, general practitioners, anaesthetists, maternal and child health nurses, mental health practitioners and lactation consultants across Victoria;
6. disparity in outcomes between rural and regional and metropolitan locations; and
7. identification of best practice.

The Committee heard that the Maternal and Child Health (MCH) Service is a free, universal service that supports families and their children with an emphasis on parenting, health promotion, early detection and intervention, and social support. The challenges and expectations of a changing community place an increased pressure on Victoria's MCH Service and workforce.

This chapter describes the MCH Service, its governance and funding, and outlines key issues identified in submission and public hearing evidence to the Inquiry. This evidence includes the experience of mothers with the MCH Service, challenges facing the MCH workforce, including staff attrition through retirement, pathways for treatment referral available to MCH nurses, the impact of complicated presentations, communication between hospitals and MCH Service providers, and funding for the MCH Service in the 2017-18 Budget.

This chapter will also summarise findings and recommendations made in the Victorian Auditor-General's 2017 report *Effectively Planning for Population Growth*, which addresses MCH Service governance, participation rates, data collection, and ability to meet the demands of a growing population.

6.1 Maternal and Child Health Service in Victoria

2017 marked 100 years of the Maternal and Child Health (MCH) Service in Victoria. The MCH Service grew from a single Baby Health Centre in Richmond in 1917 into the state-wide service that it is today. The Municipal Association of Victoria described this growth:

This movement spread rapidly and by 1950 state and local government were contributing to 398 baby health centres and fifteen mobile circuits.

Today, as we celebrate the 100th year of what's now known as the Maternal and Child Health Service, there are around 1200 maternal and child health nurses making sure Victorian communities get the best start in life.¹²⁹²

From the small beginning described above, the MCH Service has grown such that in 2015-2016 there were 79,000 birth notifications to the MCH Service, with a total of 480,000 children enrolled, and 668,736 Key Ages and Stages consultations. As outlined below, local government delivers the majority of the MCH Service.¹²⁹³

The Memorandum of Understanding between Department of Education and Training and Municipal Association of Victoria in relation to the Maternal and Child Health Service 2017-2020 describes the Service:

¹²⁹² Municipal Association of Victoria, 'Maternal and Child Health Centenary', accessed 14 March 2018, <<http://www.mav.asn.au/policy-services/social-community/children-families/maternal-child-health/Pages/maternal-and-child-health-service-100-years.aspx>>.

¹²⁹³ Ms Kim Little, Assistant Deputy Secretary, Early Childhood Portfolio, Department of Education and Training, Family and Community Development Committee public hearing – Melbourne, 27 November 2017, transcript of evidence, pp. 2-3.

The MCH Service is a free, universally accessible, statewide health, wellbeing and development service provided for all families with children aged from birth to school age. The MCH Service supports families and their children with an emphasis on parenting, prevention and health promotion, developmental and psychosocial screening, early detection and intervention, and referral and social support.¹²⁹⁴

Ms Kim Little, Assistant Deputy Secretary of the Early Childhood Portfolio at the Department of Education and Training (DET), gave the Committee the following description at a public hearing in Melbourne:

[T]he Victorian MCH service provides a universally accessible health, wellbeing and development service for all families with children aged from birth to school age. By being a universal platform, it provides a really crucial non-stigmatising opportunity for the promotion, prevention and early identification of a range of issues. They include concerns with a child's physical or cognitive development, parental physical or mental health concerns, a risk of family violence, child safety, immunisation, breastfeeding, nutrition and family planning. It is the first community-based service that most families access post-birth and it provides more comprehensive and regular checks and support for families than other comparable programs in Australia, which is something that Victoria historically can be quite proud of.¹²⁹⁵

6.1.1 Core components

Victoria's MCH Service comprises three core components:

- the Universal MCH Service;
- the Enhanced MCH Service; and
- the MCH Line.¹²⁹⁶

The Universal MCH Service

The *Maternal and Child Health Service Guidelines 2011* describe the Universal MCH Service:

The Service supports families and their children with an emphasis on parenting, prevention and health promotion, developmental assessment, early detection and referral and social support. In addition, the MCH Service provides a universal platform that can:

- help to identify children and families who require further assessment, intervention, referral and/or support
- bring families together, foster social networks, support playgroups and strengthen local community connections

¹²⁹⁴ Department of Education and Training and the Municipal Association of Victoria, *Memorandum of Understanding between Department of Education and Training and Municipal Association of Victoria in relation to the Maternal and Child Health Service 2017-2020*, Department of Education and Training and Municipal Association of Victoria, 2017, p. 4.

¹²⁹⁵ Ms Kim Little, Assistant Deputy Secretary, Early Childhood Portfolio, Department of Education and Training, Family and Community Development Committee public hearing – Melbourne, 27 November 2017, transcript of evidence, p. 2.

¹²⁹⁶ Ibid.

- deliver other services and supports, such as family support services and immunisation.¹²⁹⁷

The Universal MCH Service provides for every Victorian child and mother to attend ten consultations from birth through to three and a half years of age, seven of which are in the child's first year.¹²⁹⁸ These are called the ten Key Ages and Stages (KAS) consultations. At each visit, a MCH nurse reviews the growth and development of the child, and provides an opportunity for the mother to discuss her own health and experience as a parent.¹²⁹⁹ In 2015–2016 the MCH Service provided 668,736 KAS consultations.¹³⁰⁰

The Universal MCH Service also provides group sessions including First-Time Parent Group sessions and other sessions for groups such as culturally and linguistically diverse (CALD) communities.¹³⁰¹

The Universal MCH Service includes flexible funding for services beyond the ten KAS consultations and group sessions:

Funding for flexible service capacity is based on three hours of service for 40 per cent of children 0–1 year of age and three hours of service for 40 per cent of the average number of children of each age in the 0–6 year age-group. This component of the Universal MCH Service funding can be used to provide any of the following flexible service capacity activities:

- additional consultations
- telephone consultations
- group work, typically two hours a session over six to eight weeks
- community strengthening activities that don't involve clients.¹³⁰²

For more on the programs offered as part of the flexible service capacity model see section 6.1.2.

The Committee heard that the Universal MCH Service plays an important role in prevention and early intervention, with MCH nurses well positioned to provide this through helping new mothers and families develop the skills they need to raise healthy children.¹³⁰³

¹²⁹⁷ Department of Education and Early Childhood Development, *Maternal and Child Health Service Guidelines 2011*, Melbourne, Victorian Government, 2011, p. 16.

¹²⁹⁸ Department of Education and Training, 'About the service', Victorian Government, accessed 15 February 2018, <<http://www.education.vic.gov.au/childhood/parents/mch/Pages/about.aspx>>.

¹²⁹⁹ Department of Education and Training, 'Your Maternal and Child Health service visits', Victorian Government, accessed 15 February 2018, <<http://www.education.vic.gov.au/childhood/parents/mch/Pages/visits.aspx>>.

¹³⁰⁰ Ms Kim Little, Assistant Deputy Secretary, Early Childhood Portfolio, Department of Education and Training, Family and Community Development Committee public hearing – Melbourne, 27 November 2017, transcript of evidence, p. 3.

¹³⁰¹ Department of Education and Early Childhood Development, *Maternal and Child Health Service Guidelines 2011*, Melbourne, Victorian Government, 2011, p. 17.

¹³⁰² *Ibid.*, p. 22.

¹³⁰³ Australian Nursing and Midwifery Federation (Victorian Branch), submission no. 67, p. 10.

The Enhanced MCH Service

The *Maternal and Child Health Service Guidelines 2011* describe the Enhanced MCH Service:

The Enhanced MCH Service responds assertively to the needs of children and families at risk of poor outcomes, in particular where there are multiple risk factors. This service is provided in addition to the suite of services offered through the Universal MCH Service. It provides a more intensive level of support, including short-term case management in some circumstances. Support may be provided in a variety of settings, such as the family's home, the MCH centre or another location within the community.¹³⁰⁴

The Enhanced MCH Service¹³⁰⁵ is funded to support ten per cent of families for up to 15 hours per family.¹³⁰⁶ In 2015–2016, 11,356 families received support from the Enhanced MCH Service.¹³⁰⁷ The funding included in the 2017–18 Budget will allow the Service to be expanded to support 15 per cent of families with children from birth to three years of age.¹³⁰⁸

The *Enhanced Maternal and Child Health Service Guidelines (2003-2004)*, which were produced by the former Department of Human Services, are currently being updated to reflect best practice.¹³⁰⁹

Ms Marilyn Humphrey, Maternal and Child Health Coordinator with Baw Baw Shire Maternal and Child Health Services, described the Enhanced MCH Service at a public hearing in Warragul, and what issues might cause a referral to the Enhanced MCH Service:

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

¹³⁰⁴ Department of Education and Early Childhood Development, *Maternal and Child Health Service Guidelines 2011*, Melbourne, Victorian Government, 2011, p. 18.

¹³⁰⁵ Previously called the Maternal and Child Health Enhanced Home Visiting Service: *Ibid.*, p. 1.

¹³⁰⁶ Ms Kim Little, Assistant Deputy Secretary, Early Childhood Portfolio, Department of Education and Training, Family and Community Development Committee public hearing – Melbourne, 27 November 2017, transcript of evidence, p. 3.

¹³⁰⁷ *Ibid.*

¹³⁰⁸ Department of Education and Training, 'Maternal and Child Health services', Victorian Government, accessed 14 March 2018, <<http://www.education.vic.gov.au/about/educationstate/Pages/ecmch.aspx>>. For more on funding see section 6.1.3.

¹³⁰⁹ Ms Kim Little, Assistant Deputy Secretary, Early Childhood Portfolio, Department of Education and Training, Family and Community Development Committee public hearing – Melbourne, 27 November 2017, transcript of evidence, p. 3.

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.¹³¹⁰

Ms Ursula Kiel, Senior Mental Health Clinician at St John of God Raphael Services, praised the Enhanced MCH Service at a public hearing in Bendigo, and noted the relationship the mental health service she works for has with the Enhanced MCH Service:

Enhanced maternal and child health is a fantastic service. We have a lot of relationships with the workers on the ground. Sometimes they are holding cases that really need mental health care and the parents are not quite ready to engage. Sometimes we support them in a secondary consult way, but there can be more demand for that sort of service.¹³¹¹

The Committee recognises the value of the support the Enhanced MCH Service provides to families at risk of poor outcomes. Further, the Committee wishes to express its appreciation for the efforts of MCH nurses in providing this service in what the Committee has heard are often difficult family situations.

The MCH Line

The final core component is the MCH Line. The MCH Line is a 24-hour telephone support, counselling, and referral service. The MCH Line offers referrals to the Universal MCH Service and other support services.¹³¹²

Ms Kim Little, Assistant Deputy Secretary, Early Childhood Portfolio, DET, described the MCH Line to the Committee:

That is owned and operated by the Department of Education and Training. It is staffed by maternal and child health nurses, and it is a 24-hour advice service. It links parents to the universal MCH service, it offers advice where appropriate on the phone, and you can also be referred into enhanced MCH straight from the line. It is a very well used and patronised service. Last financial year there were close to 99 000 calls to that service, which runs out of the building across the road.¹³¹³

Ms Little told the Committee that the 2017–18 Budget funding will enable the MCH Line to take an extra 20,000 calls per year.¹³¹⁴

The Committee notes that, while less visible than the other components of the MCH Service, the MCH Line offers important access to 24-hour support for mothers and families.

¹³¹⁰ Ms Marilyn Humphrey, Maternal and Child Health Coordinator, Baw Baw Shire Maternal and Child Health Services, Family and Community Development Committee public hearing – Warragul, 8 December 2017, transcript of evidence, pp. 2-3.

¹³¹¹ Ms Ursula Kiel, Senior Clinician, St John of God Raphael Services, Family and Community Development Committee public hearing – Bendigo, 24 October 2017, transcript of evidence, p. 4.

¹³¹² Department of Education and Early Childhood Development, *Maternal and Child Health Service Guidelines 2011*, Melbourne, Victorian Government, 2011, p. 19.

¹³¹³ Ms Kim Little, Assistant Deputy Secretary, Early Childhood Portfolio, Department of Education and Training, Family and Community Development Committee public hearing – Melbourne, 27 November 2017, transcript of evidence, p. 3.

¹³¹⁴ *Ibid.*, p. 4.

6.1.2 Flexible services and services in addition to the core components

The Committee heard from multiple MCH Service providers about the services and programs they offer either as part of the flexible service capacity aspect of the Universal MCH Service¹³¹⁵ or as part of a collaborative model of care that links with Department of Health and Human Services (DHHS) programs including Healthy Mothers, Healthy Babies, Cradle to Kinder, and Child FIRST and child protection programs such as the Parenting Assessment and Skill Development service.

At a public hearing in Melbourne, Ms Lynne Smith, Acting Team Leader, Family Services at the City of Melbourne, told the Committee:

We also offer further services, including, for example, breastfeeding drop-in clinics, open sessions, new parent groups, playgroups and parenting information programs.¹³¹⁶

The Committee heard that these programs include lactation consultants,¹³¹⁷ additional home visits for women who had caesarean sections,¹³¹⁸ young parenting groups,¹³¹⁹ programs for fathers,¹³²⁰ interpreter sessions for refugees,¹³²¹ and mental health support programs.¹³²²

Of the collaborative approach to delivering the Enhanced MCH Service and DHHS programs the Committee heard:

The MCH service in Geelong includes both a universal centre based service delivered by MCH nurses and Child & Family Support officers. The Enhanced MCH service is one of four programs that is included within an Outreach team – the other three programs are funded by DHHS – Integrated Family Services; specialist infant component of the Stronger Families program; Parenting Assessment and Skill Development.¹³²³

¹³¹⁵ See Department of Education and Early Childhood Development, *Maternal and Child Health Service Guidelines 2011*, Melbourne, Victorian Government, 2011, p. 22.

¹³¹⁶ Ms Lynne Smith, Acting Team Leader, Family Services, City of Melbourne, Family and Community Development Committee public hearing – Melbourne, 18 September 2017, transcript of evidence, p. 2.

¹³¹⁷ Ms Samantha Cooke, Community Health Coordinator, Mildura Rural City Council, Family and Community Development Committee public hearing – Mildura, 9 November 2017, transcript of evidence, p. 2.

¹³¹⁸ Ibid.

¹³¹⁹ Ms Helen Lees, Maternal and Child Health Clinical Coordinator, City of Greater Bendigo, Family and Community Development Committee public hearing – Melbourne, 24 October 2017, transcript of evidence, pp. 2, 3; Ms Ailsa Carr, Executive Manager, Family, Youth and Children's Services, Gippsland Lakes Community Health, Family and Community Development Committee public hearing – Bairnsdale, 7 December 2017, transcript of evidence, p. 3.

¹³²⁰ Ms Ailsa Carr, Executive Manager, Family, Youth and Children's Services, Gippsland Lakes Community Health, Family and Community Development Committee public hearing – Bairnsdale, 7 December 2017, transcript of evidence, p. 3.

¹³²¹ Ms Helen Lees, Maternal and Child Health Clinical Coordinator, City of Greater Bendigo, Family and Community Development Committee public hearing – Melbourne, 24 October 2017, transcript of evidence, pp. 2, 3.

¹³²² Ms Ailsa Carr, Executive Manager, Family, Youth and Children's Services, Gippsland Lakes Community Health, Family and Community Development Committee public hearing – Bairnsdale, 7 December 2017, transcript of evidence, p. 3; City of Whitehorse, submission no. 46, p. 1.

¹³²³ City of Greater Geelong Maternal and Child Health Service, submission no. 96, p. 1.

Further, the Committee heard from the City of Melbourne and Gippsland Lakes Community Health Service that they provide models of care wherein the MCH Service is provided collaboratively with other services.¹³²⁴

The Committee notes the benefits of collaboratively providing the MCH Service with various DHHS programs that share the intention of improving the health and wellbeing outcomes of young children and their families. This model of care allows a more flexible workforce and delivery of services that ultimately benefits MCH Service providers, their staff, and their clients. Accordingly, the Committee recommends that:

RECOMMENDATION 6.1: The Victorian Government support the collaborative delivery of the Maternal and Child Health Service with Department of Health and Human Services programs aimed at young children and their families.

- This support to include developing training packages/learning experiences based on existing collaborative models that would be valuable for other Maternal and Child Health Service providers around the state.

6.1.3 Governance and funding

The *Child Wellbeing and Safety Act 2005* (Vic) requires local councils to be notified of births, which is the trigger for interaction with the MCH Service. For more on the *Child Wellbeing and Safety Act 2005* (Vic) and birth notifications see section 6.9.

The MCH Service is provided in partnership by DET and local councils. This partnership is described by a Memorandum of Understanding (MOU) between DET and the Municipal Association of Victoria — the *Memorandum of Understanding between Department of Education and Training and Municipal Association of Victoria in relation to the Maternal and Child Health Service 2017–2020*.¹³²⁵

The MOU is an ‘implementation agreement’¹³²⁶ that sits below the overarching framework of *Supporting Children and Families in the Early Years: A Compact between the Department of Education and Training (DET), Department of Health and Human Services (DHHS) and Local Government (represented by MAV)*.¹³²⁷

DET develops policy, monitors attendance, and has a role in developing the MCH workforce.¹³²⁸ This includes:

- the development of comprehensive, evidence-based policies, initiatives, guidelines and standards
- contribution to the funding of the MCH Service

¹³²⁴ Ms Lynne Smith, Acting Team Leader, Family Services, City of Melbourne, Family and Community Development Committee public hearing – Melbourne, 18 September 2017, transcript of evidence, p. 2; Ms Ailsa Carr, Executive Manager, Family, Youth and Children’s Services, Gippsland Lakes Community Health, Family and Community Development Committee public hearing – Bairnsdale, 7 December 2017, transcript of evidence, p. 6.

¹³²⁵ Department of Education and Training and the Municipal Association of Victoria, *Memorandum of Understanding between Department of Education and Training and Municipal Association of Victoria in relation to the Maternal and Child Health Service 2017–2020*, Department of Education and Training and Municipal Association of Victoria, 2017.

¹³²⁶ *Ibid.*, p. 1.

¹³²⁷ For more on the Compact see Department of Education and Training, ‘The Early Years Compact’, Victorian Government, accessed 21 March 2018, <<http://www.education.vic.gov.au/about/educationstate/Pages/theearlyyearscompact.aspx>>.

¹³²⁸ Victorian Auditor-General, *Effectively Planning for Population Growth*, Melbourne, Victorian Auditor-General’s Office, August 2017, p. 10.

- support for the professional development of the MCH workforce
- provision of regionally-based Performance and Planning Advisors (PAPAs)
- provision of the MCH Line and employment of the MCH workforce delivering this service component.¹³²⁹

DET also employs a Principal Maternal and Child Health Nurse. The position was established in 2015, and provides ‘high-level strategic and expert clinical practice advice to inform statewide policy and also work on and improve guidelines and support to the sector’.¹³³⁰

DET provides 50 per cent of the funding for the Universal MCH Service, and 100 per cent of the funding for the Enhanced MCH Service. Both the Universal and the Enhanced MCH Service funding allocation include a weighted component based on social disadvantage and rurality.¹³³¹ DET also funds 100 per cent of the MCH Line, and employs the MCH nurses who provide this service.¹³³² See section 6.1.1 for a description of each of these components.

Local councils plan and deliver services on the ground, and provide the remaining 50 per cent of funding for the Universal MCH Service. Ms Kim Little, Assistant Deputy Secretary, Early Childhood Portfolio, DET, described the arrangement to the Committee:

The delivery model essentially is a partnership between the Department of Education and Training and the Municipal Association of Victoria as the representative of local government. We partner in the planning, funding and provision of the service. It is delivered in all 79 local government areas. There were 480 000 children enrolled in the MCH service in 2015–16 and it is delivered from 644 locations across the state, so it genuinely is a local service for families. The vast majority of that service delivery is done by local government either directly or through contract arrangements with a small number of other community health providers, and there is one Aboriginal community-controlled organisation that we fund to deliver.¹³³³

The Committee also heard that the MCH Service has a flexible funding component to support programs including ‘first-time parents groups, health promotions, play groups or additional targeted consultations’.¹³³⁴ For more on these programs see section 6.1.2.

¹³²⁹ Department of Education and Training and the Municipal Association of Victoria, *Memorandum of Understanding between Department of Education and Training and Municipal Association of Victoria in relation to the Maternal and Child Health Service 2017–2020*, Department of Education and Training and Municipal Association of Victoria, 2017, pp. 1–2.

¹³³⁰ Ms Kim Little, Assistant Deputy Secretary, Early Childhood Portfolio, Department of Education and Training, Family and Community Development Committee public hearing – Melbourne, 27 November 2017, transcript of evidence, p. 3.

¹³³¹ Dr Anastasia Gabriel, Director Of Prevention and Health Promotion, Department of Education and Training, Family and Community Development Committee public hearing – Melbourne, 27 November 2017, transcript of evidence, p. 8.

¹³³² Department of Education and Training and the Municipal Association of Victoria, *Memorandum of Understanding between Department of Education and Training and Municipal Association of Victoria in relation to the Maternal and Child Health Service 2017–2020*, Department of Education and Training and Municipal Association of Victoria, 2017, p. 7.

¹³³³ Ms Kim Little, Assistant Deputy Secretary, Early Childhood Portfolio, Department of Education and Training, Family and Community Development Committee public hearing – Melbourne, 27 November 2017, transcript of evidence, p. 2.

¹³³⁴ Ibid.

MCH Service providers are supported by a range of guidelines, frameworks, and standards in addition to the MOU and Compact referred to above.¹³³⁵

Ms Ailsa Carr, Executive Manager of Family, Youth and Children's Services at Gippsland Lakes Community Health, told the Committee of the challenge of managing various funding streams for programs. This includes funding from DHHS for programs that technically are not part of the MCH Service.¹³³⁶ Ms Carr told the Committee how she worked to ensure effective services could be delivered despite the peculiarities of funding streams:

Our big thing is that when you get out to rural areas you get little bits of money that come through based on obviously a statistical formula, which is fair enough, but they come down in independent streams with their own individual reporting. What we end up having to do in organisations like ours, which is what we have done in our early teams, is bundle it all up together to be able to provide service that is viable and able to be provided. So, our Health[y] Mothers, Healthy Babies is basically just a little bit under one EFT. If we ran it as an independent program as a single EFT, it would not be viable; you would not be able to cover sick leave and annual leave, those sorts of things. You would have the service coming in and out.

By combining it all with our maternal and child health nursing and our Cradle to Kinder, we now have 11 staff in that team who understand all the programs and therefore will respond to the needs of the client based on the needs of the client, not based on the label of a program or a funding stream that they might fit under. The challenge for that is then staff have multiple programs they need to come back to to say, 'So that visit was which program?' and 'What do I need to report for the minimum dataset for that program so that the department has its required data?'.¹³³⁷

The Committee notes that following its hearing in Bendigo, Ms Alana Cooper, Early Years Coordinator with the City of Greater Bendigo, provided a submission to the Inquiry stating that in practice, City of Greater Bendigo pays more than 50 per cent in order to provide its desired level of service:

The MCH program is funded under an agreement between Department of Education (DET) and Municipal Association of Victoria (MAV) for 50:50 funding arrangement. While we have received an increase in the unit rate the City of Greater Bendigo are still funding well above the 50:50 agreement. We are unable to deliver an adequate service at 50:50 funding and the current ratio is 50:92 (DET funding \$808,353 and City's budgeted cost / contribution \$1,146,770)¹³³⁸

2017-18 funding

The Committee notes expanded funding for the MCH Service in the 2017-18 Budget as part of the Victorian Government's Early Childhood Reform Plan. A total of \$81.1 million has been allocated in the following areas:

¹³³⁵ *Maternal and Child Health Service Guidelines, Maternal and Child Health Service: Practice Guidelines 2009, Maternal and Child Health Service Program Standards, Enhanced Maternal and Child Health Service Guidelines, 2003-2004, Innovation Practice Guide for Maternal and Child Health Services.* For more see Department of Education and Training, 'MCH Practice and Service Guidelines', Victorian Government, accessed 8 May 2018, <<http://www.education.vic.gov.au/childhood/professionals/health/Pages/mchpolicy.aspx>>.

¹³³⁶ For example Healthy Mothers, Healthy Babies, Cradle to Kinder, and Child FIRST. For more on these programs see Chapter One.

¹³³⁷ Ms Ailsa Carr, Executive Manager, Family, Youth and Children's Services, Gippsland Lakes Community Health, Family and Community Development Committee public hearing - Bairnsdale, 7 December 2017, transcript of evidence, p. 6.

¹³³⁸ Ms Alana Cooper, submission no. 94, p. 1.

- \$4.9 million to respond to demand on the telephone information line (MCH line)
- \$37.7 million to progressively expanding the Enhanced MCH Service to support children up to the age of three
- \$11 million to fund an additional MCH visit to women and children at risk of family violence
- \$5.2 million to attract new MCH nurses to the Service and support the development of all MCH nurses in the latest techniques and practices to support families, including those struggling with trauma.

To increase the availability of supported playgroups so they are available across the state, and better connect first time MCH parent groups with community playgroups, \$22.3 million has also been provided.¹³³⁹

The Committee welcomes the funding and programs announced by the Victorian Government.

6.1.4 MCH Service App

During the course of the Committee's Inquiry, DET released a smartphone MCH App. Dr Anastasia Gabriel, Director of Prevention and Health Promotion for DET, told the Committee that after releasing the App in English, the Department would provide it in other languages.¹³⁴⁰ Dr Gabriel stated that DET had heard that CALD and refugee families were accessing information from websites based in other countries, and that providing credible information was a priority:

[W]e did a lot of work with the CALD and refugee community, who told us that one way of engaging with the service is to have some very credible information for them at their fingertips. So through the last budget process, \$950 000 was committed to developing a smartphone MCH app, which will have very credible information. They wanted information that they could rely on about all the things that impact on them, about their child and about themselves. So the app is currently being developed and will have basically a whole raft of information around the child's development.¹³⁴¹

The Committee welcomes the development of an MCH App, and looks forward to the benefit it should provide to Victorian families as an accessible and credible source of information for parents.

6.1.5 Programs for fathers

The Committee heard throughout its hearing process that there is a lack of programs for supporting fathers in the MCH Service. First-Time Parent Groups are a required aspect of the Universal MCH Service, and these can include fathers, but the Committee heard that even these are not well suited to attracting fathers.

¹³³⁹ Department of Education and Training, 'Maternal and Child Health services', Victorian Government, accessed 27 February 2018, <<http://www.education.vic.gov.au/about/educationstate/Pages/ecmch.aspx>>.

¹³⁴⁰ Dr Anastasia Gabriel, Director Of Prevention and Health Promotion, Department of Education and Training, Family and Community Development Committee public hearing – Melbourne, 27 November 2017, transcript of evidence, p. 13.

¹³⁴¹ *Ibid.*, pp. 12-13.

Ms Maryanne Purcell, MCH Nurse Coordinator with Warrnambool City Council, told the Committee at a public hearing in Warrnambool that support for fathers is underwhelming.¹³⁴² Ms Purcell outlined some of the barriers to engaging with fathers:

There are certain barriers to men. We are always thinking inclusively, even though our title of ‘maternal and child health’ does not indicate that that is the case. We did a survey back a few years ago about how often men were attending appointments. We had about a 30 per cent attendance, which was really pleasing. I thought that that was really good, so we are sort of a little way there. I think they think it is not their business to be attending appointments. They are run during the day, which can be a barrier for them, the same as groups are often run during the day — support groups, playgroups. Yes, that can be a bit of a barrier for men’s attendance. And not to bag the men, but sometimes communication can be a barrier in itself for a lot of men.¹³⁴³

Ms Kate Ravenscroft also told the Committee in her submission that her MCH centre had ‘little to offer my husband, or to support him as he became a parent for the first time’.¹³⁴⁴ At a public hearing in Melbourne, Ms Ravenscroft expanded on this, highlighting how building a relationship with an entire family can improve care:

I think anything where there can be an investment in building a relationship with a family. I think it is also really important that we are actually thinking of families. My husband was just out there; he just seemed completely irrelevant to the process, so I think really including the whole family. If there was an opportunity to build a relationship with the whole family from the moment you found out you were pregnant through to postpartum and the fourth trimester and you were actually working with somebody who knew you and your family and knew what obstacles you faced and what your values and beliefs were and who kind of felt like a partner through the process with you.¹³⁴⁵

Ms Purcell also told the Committee of a correlation between a lack of support for fathers and increased instances of family violence in the perinatal period:

Again with reflection, there is the correlation of the fact that there is not a lot of support in that perinatal period and the fact that family violence is at its height or there is a higher risk in that perinatal period as well. Are we addressing their frustrations, the changes and all of those things?¹³⁴⁶

The Committee notes the *Maternal and Child Health Service Program Standards* include in ‘Standard 2: Optimal health and development’ a requirement to recognise and support the role of the father in the health and development of the child.¹³⁴⁷ However, evidence to the Committee is that fathers are not being adequately supported. Noting Recommendation 3.10 the Committee makes in Chapter Three concerning perinatal mental health programs for fathers, the Committee recommends that:

¹³⁴² Ms Maryanne Purcell, Maternal and Child Health Nurse Coordinator, Warrnambool City Council, Family and Community Development Committee public hearing – Warrnambool, 11 October 2017, transcript of evidence, p. 2.

¹³⁴³ Ibid., p. 5.

¹³⁴⁴ Ms Kate Ravenscroft, submission no. 22, p 3.

¹³⁴⁵ Ms Kate Ravenscroft, Family and Community Development Committee public hearing – Melbourne, 4 September 2017, transcript of evidence, p. 7.

¹³⁴⁶ Ms Maryanne Purcell, Maternal and Child Health Nurse Coordinator, Warrnambool City Council, Family and Community Development Committee public hearing – Warrnambool, 11 October 2017, transcript of evidence, p. 4.

¹³⁴⁷ Department of Education and Early Childhood Development (DEECD), *Maternal and Child Health Service Program Standards*, Melbourne, Victorian Government, 2009, p. 26.

RECOMMENDATION 6.2: The Victorian Government review and enhance the programs provided by the Maternal and Child Health Service to engage and support fathers.

6.2 Participation rates and planning for population growth

The Committee notes that during the course of the Inquiry the Auditor-General released the report *Effectively Planning for Population Growth*.¹³⁴⁸ This report, tabled in Parliament in August 2017, addressed issues surrounding MCH Service participation and data collection and planning for population growth, making recommendations which DET has accepted, including providing an action plan.¹³⁴⁹ The Committee notes that the actions relevant to the MCH Service are due to be completed by June 2018 and January 2019. The Committee supports the Auditor-General's recommendations, and looks forward to DET delivering on its action plan.

In this section, the Committee highlights some of the findings of the Auditor-General's report, along with evidence provided by DET to the Committee. Aboriginal and Torres Strait Islander community participation in the MCH Service is discussed in Chapter Seven. Culturally and Linguistically Diverse community participation in the MCH Service is discussed in Chapter Eight.

6.2.1 Participation rates

MCH Service participation rates are reported by DET in the *Maternal & Child Health Services Annual Report*.¹³⁵⁰ The Committee notes that the most recent data available is from financial year 2015–2016, and that this is only available as state-wide data, unlike in previous years where region by region data is available.¹³⁵¹ The *Maternal & Child Health Services Annual Report 2015-2016* notes that a new record keeping system has contributed to limitations in its data.¹³⁵²

The Auditor-General's report *Effectively Planning for Population Growth* notes that difficulty implementing the Child Development Information System (CDIS) has resulted in 'inaccurate reporting due to the loss of data during migration from the old to the new system, the same information being able to be stored in multiple locations, and system navigation difficulties for users wishing to extract information or enter data'.¹³⁵³

¹³⁴⁸ Victorian Auditor-General, *Effectively Planning for Population Growth*, Melbourne, Victorian Auditor-General's Office, August 2017.

¹³⁴⁹ Ibid., pp. 53-56.

¹³⁵⁰ Department of Education and Training, *Maternal & Child Health Services Annual Report 2015-2016*, Victorian Government, 2017.

¹³⁵¹ Department of Education and Training, 'Maternal and Child Health Reporting and Data', Victorian Government, accessed 29 March 2018, <<http://www.education.vic.gov.au/childhood/providers/support/Pages/mchannualreport.aspx>>.

¹³⁵² Department of Education and Training, *Maternal & Child Health Services Annual Report 2015-2016*, Victorian Government, 2017, p. 1.

¹³⁵³ Victorian Auditor-General, *Effectively Planning for Population Growth*, Melbourne, Victorian Auditor-General's Office, August 2017, p. 35.

While the Committee is pleased at the development of a centralised database for MCH record keeping in CDIS, and heard of the benefit of such a system during its public hearings,¹³⁵⁴ it is disappointed that the process has resulted in late and unreliable data. The Committee notes that DET is working with the Municipal Council of Victoria (MAV) to resolve these issues.¹³⁵⁵

Ms Kim Little, Assistant Deputy Secretary, Early Childhood Portfolio with DET, reported to the Committee on 2015–2016 participation rates in the MCH Service:

[T]here is a very high participation rate, particularly early on. For that first visit, which is in the home as you would expect, it is between 99 and 100 per cent of families who are happy to have that visit. It does start to taper, particularly after about the eight-month visit, so by the time you get to the one-year visit you have got between around the early 80 per cent — between 79 per cent and 83 per cent is the data from the last five years — participation for all families across the state by the time you get to that first-year visit.¹³⁵⁶

Ms Little told the Committee of reasons why KAS consultations may taper as a child gets older:

There are a number of reasons why that occurs. Some of them can relate to families who might be experiencing vulnerability and need extra outreach. Some might be families who have had several children before and might feel that they do not need to go for that extra visit, although we would encourage them to do so. Some people might go late to some of their visits.¹³⁵⁷

Ms Little also told the Committee that participation rates are similar in metropolitan, rural, and regional areas.¹³⁵⁸ The Auditor-General's 2017 report *Effectively Planning for Population Growth* reiterates that participation drops off as children age, and also noted that this effect is more pronounced in growth areas, likely due to the demographics within growth areas, rather than the fact that they are growth areas.¹³⁵⁹

The Auditor-General's report notes that there has been some research into participation rates, but there is a lack of comprehensive data. Apart from DET research focused on specific demographics including Aboriginal and Torres Strait Islander and CALD families, analysis of demand, participation, and system capacity in the MCH Service is limited, making it difficult to measure performance against policy.¹³⁶⁰ The recently renewed partnership agreement¹³⁶¹ between DET and local governments recognises the need to address this.¹³⁶²

¹³⁵⁴ Ms Helen Lees, Maternal and Child Health Clinical Coordinator, City of Greater Bendigo, Family and Community Development Committee public hearing – Bendigo, 24 October 2017, transcript of evidence, p. 3.

¹³⁵⁵ Victorian Auditor-General, *Effectively Planning for Population Growth*, Melbourne, Victorian Auditor-General's Office, August 2017, p. 35.

¹³⁵⁶ Ms Kim Little, Assistant Deputy Secretary, Early Childhood Portfolio, Department of Education and Training, Family and Community Development Committee public hearing – Melbourne, 27 November 2017, transcript of evidence, p. 3.

¹³⁵⁷ Ibid.

¹³⁵⁸ Ibid., p. 5.

¹³⁵⁹ Victorian Auditor-General, *Effectively Planning for Population Growth*, Melbourne, Victorian Auditor-General's Office, August 2017, p. 36.

¹³⁶⁰ Ibid., p. 32.

¹³⁶¹ Department of Education and Training and the Municipal Association of Victoria, *Memorandum of Understanding between Department of Education and Training and Municipal Association of Victoria in relation to the Maternal and Child Health Service 2017–2020*, Department of Education and Training and Municipal Association of Victoria, 2017.

¹³⁶² Victorian Auditor-General, *Effectively Planning for Population Growth*, Melbourne, Victorian Auditor-General's Office, August 2017, p. 32.

The Auditor-General's report highlights a number of issues in relation to participation rates, including a lack of state-wide oversight and leadership, a lack of understanding of the reasons for low participation in some areas, and a lack of a systemic check by hospitals and local councils of proper birth notification delivery.¹³⁶³

The Auditor-General made, and DET accepted, recommendations to improve MCH participation data, and undertake analyses of the reasons for under-participation in the MCH Service.¹³⁶⁴

The Committee notes the value in easily transferrable data between municipalities, and the benefit this has for those caring for families. The Committee also notes that DET accepted the Auditor-General's recommendations regarding participation data and under-participation in the MCH Service, and provided an action plan in response to the recommendation.¹³⁶⁵

The Committee agrees with the Auditor-General that 'A robust understanding of the drivers of demand and reasons for lower and non-participation is necessary to inform assessments of MCH service performance',¹³⁶⁶ and supports the implementation of the action plan provided by DET. DET's action plan includes improving the accuracy of CDIS reports, and encouraging MCH Service providers to use CDIS.¹³⁶⁷

6.2.2 Planning for population growth

The Victorian Auditor-General in the 2017 report *Effectively Planning for Population Growth* examined how population growth would affect a variety of services, including the MCH Service, and whether 'effective strategic service planning arrangements are in place for birthing, MCH and funded kindergarten services for areas experiencing rapid population growth'.¹³⁶⁸ The report also noted the role of land use in service planning for the MCH Service.¹³⁶⁹

The Auditor-General identified gaps in the information on demand for the MCH Service which reduce DET and local government's ability to plan effectively and DET's ability to monitor MCH Service outcomes, including in areas of rapid growth.¹³⁷⁰

Further, the report notes that there is a lack of leadership in strategic oversight of the MCH Service, with 'no statewide perspective on whether policy objectives are being met across Victoria, particularly in areas of rapid population growth'.¹³⁷¹

The Auditor-General noted that the recent *Early Childhood Reform Plan* and the Early Years Compact are positive steps to address this lack of oversight.¹³⁷²

¹³⁶³ Ibid., pp. vii, viii, x, xi, xii, xiii.

¹³⁶⁴ Ibid., p. xiii.

¹³⁶⁵ Ibid.

¹³⁶⁶ Ibid., p. 38.

¹³⁶⁷ Ibid., p. 55.

¹³⁶⁸ Ibid., p. 12.

¹³⁶⁹ Ibid., p. 12.

¹³⁷⁰ Ibid., p. xii.

¹³⁷¹ Ibid., p. x.

¹³⁷² Ibid., p. xii.

The Committee notes that DET accepted the Auditor-General's recommendation concerning completeness and accuracy of MCH data, and provided an action plan in response to the recommendation.¹³⁷³ The Committee supports the Auditor-General's recommendations and makes a recommendation on this topic in section 6.5.2.

6.3 Adequacy of the Ten Key Ages and Stages consultations

A key aspect of the Universal MCH Service is the ten Key Ages and Stages (KAS) consultations. The consultations take place from birth through to when the child is three and a half years old, and at each visit an MCH nurse reviews the growth and development of the child, and provides an opportunity for the mother to discuss her own health and experience as a parent.¹³⁷⁴ Ms Kim Little, Assistant Deputy Secretary, Early Childhood Portfolio with DET told the Committee at a public hearing in Melbourne:

There are 10 key ages and stages visits, which are scheduled visits which cover a specified series of activities in each one. They happen from birth through to 3.5 years old. There is an initial home visit, and that happens within the first two weeks of life, and then there are consultations at two, four and eight weeks and at four months, eight months, 12 months, 18 months and at two years old and three and a half years old. All up, it is 6.75 hours worth of service, and that is provided universally along with those flexible opportunities. Seven of the 10 visits are in the first year of life, and that is because we recognise there can be more issues emerging, more concerns, more risks to parents and to children.¹³⁷⁵

Ms Helen Lees, MCH Clinical Coordinator with the City of Greater Bendigo, told the Committee that the way the MCH Service is funded, with a focus on the KAS consultations, does not properly address the needs of families. Ms Lees suggests funding should instead be based on outcome, rather than throughput:

In relation to access for vulnerable clients, maternal and child health funding currently is not really aligned with service direction. The maternal and child health key age and stage program, plus a small amount of flexible service capacity funding, is incongruent with the overarching focus on engaging those families with higher needs and most vulnerable children. It is still valuable, but it seems to be around the wrong way. The measuring of outcome rather than throughput, which is the current practice, is where the MCH service wants to head. The question is what to measure and what demographic data to incorporate within our workload tools to ensure we are servicing those who require the most service with an adequate allocation of time.¹³⁷⁶

Ms Kate Glenie, a Loddon Mallee Aboriginal Reference Group Early Years Project Worker with Mallee District Aboriginal Services, told the Committee that the ten KAS consultations may work for some families, but that something different would be more appropriate for more complex situations:

¹³⁷³ Ibid., pp. xiii, 53-6.

¹³⁷⁴ Department of Education and Training, 'Your Maternal and Child Health service visits', Victorian Government, accessed 15 February 2018, <<http://www.education.vic.gov.au/childhood/parents/mch/Pages/visits.aspx>>.

¹³⁷⁵ Ms Kim Little, Assistant Deputy Secretary, Early Childhood Portfolio, Department of Education and Training, Family and Community Development Committee public hearing – Melbourne, 27 November 2017, transcript of evidence, p. 2.

¹³⁷⁶ Ms Helen Lees, Maternal and Child Health Clinical Coordinator, City of Greater Bendigo, Family and Community Development Committee public hearing – Bendigo, 24 October 2017, transcript of evidence, p. 2.

I suppose if you think about maternal child health nurse services, they are set up for everybody, aren't they? They are set up for middle-class, white people who live in Melbourne to go and get their 10 ages and stages, and often the workforce is really expecting to see those women. Most of their clients are those women: middle-class women coming with their babies to have the 10 ages and stages. So it is almost like there needs to be a specialised workforce that actually works with families with more complex stories really; that are not there just to get their 10 checks, but maybe need a whole lot of different services in a different way.¹³⁷⁷

Ms Liz Flamsteed, Head of Innovation Fund Project in Antenatal Engagement at the Rural City of Wangaratta, told the Committee of an innovative project in Wangaratta that engaged vulnerable families in the MCH Service before their child was born:

We implemented the innovation project to engage families antenatally in the maternal and child health service. We were successful in securing a state government grant of \$40 000, which was really well utilised over the period of 12 months. The grant was used to implement a project which aimed to improve continuity of care by engaging with vulnerable women and their families in the antenatal period and by increasing collaboration and communication between agencies involved in the care of pregnant women and their families in this Rural City of Wangaratta.

The idea for the project emerged through informal observations by our team on what successful engagement looked like for maternal and child health practitioners, especially in the role that I do, which is the enhanced maternal and child health service. We observed that we had often had improved outcomes for vulnerable families when they were already familiar with the service, and that came through having seen the families previously, and then we knew that they were pregnant again and already had a good relationship developed. But our key was securing a really good relationship with the families who we had not met before.

...

We identified that where a supportive and collaborative rapport had been established prior to the birth, families had more understanding of and confidence in our service and were more willing to engage over the longer term, which is the key.¹³⁷⁸

Ms Flamsteed explained that the project included working with Northeast Health Wangaratta and other organisations, and that this collaboration was key to the project's success.¹³⁷⁹ Ultimately the project led to almost 100 per cent participation in the KAS consultations.¹³⁸⁰

The Committee heard that women are receptive to education before they give birth, and that by building a relationship before birth, the MCH Service can support, educate, and when necessary refer to foster better outcomes.¹³⁸¹

¹³⁷⁷ Ms Kate Glenie, Loddon Mallee Aboriginal Reference Group Early Years Project Worker, Mallee District Aboriginal Services, Family and Community Development Committee public hearing – Mildura, 9 November 2017, transcript of evidence, p. 7.

¹³⁷⁸ Ms Liz Flamsteed, Head of Innovation Fund Project in Antenatal Engagement, Rural City of Wangaratta, Family and Community Development Committee public hearing – Wangaratta, 25 October 2017, transcript of evidence, p. 3.

¹³⁷⁹ *Ibid.*, p. 4.

¹³⁸⁰ *Ibid.*

¹³⁸¹ Ms Rebecca Sacco, Maternal and Child Health Team Leader, Rural City of Wangaratta, Family and Community Development Committee public hearing – Wangaratta, 25 October 2017, transcript of evidence, p. 5; Ms Liz Flamsteed, Head of Innovation Fund Project in Antenatal Engagement, Rural City of Wangaratta, Family and Community Development Committee public hearing – Wangaratta, 25 October 2017, transcript of evidence, p. 5.

The Committee heard from multiple rural and regional MCH Service providers that contact with other perinatal health service providers before a child is born can be very beneficial to the child and family's eventual engagement with the MCH Service. For more and the Committee's recommendation on this topic see section 6.9.3.

6.4 Breastfeeding support

This section briefly represents evidence the Committee heard of breastfeeding support available from the MCH Service. The Committee heard that many women find breastfeeding support from sources other than the MCH Service. These support systems and breastfeeding in general is discussed in Chapter Two.

MCH Service providers told the Committee that breastfeeding support within the MCH Service is limited.¹³⁸² Ms Helen Lees of the City of Greater Bendigo told the Committee at a public hearing in Bendigo that while some of her nurses hold lactation consultant qualifications there is no funding to increase the services her team can offer:

In relation to lactation consultants, we do have maternal and child health nurses on our staff with these qualifications. However, this is not currently funded to enable increased LC services by our team.¹³⁸³

The Committee heard from Ms Maree Burgess, Maternal and Child Health Nurse, Branch President of the Australian Nursing and Midwifery Federation (Victorian Branch), that in her experience local government is supportive of MCH nurses getting lactation consultant training:

As far as additional people training as lactation consultants goes, local government is actually really supportive of people who want to go on and do an additional specialty. They do support them, because some of that education is really expensive. That has seen the growth of maternal and child health nurses with that specialty, and that has leant itself to them setting up lactation clinics where parents, in addition to their drop-in visits they have with the universal service nurses, can actually drop in to, say, the City of Melbourne. They have three lactation clinics every week spread over the week that women can drop in to at no cost. They can stay there for up to 3 hours and have that additional support.¹³⁸⁴

Ms Burgess also told the Committee that some local councils offer drop-in lactation support sessions.¹³⁸⁵ Ms Alice Martin, local representative of the Australian Breastfeeding Association in Wangaratta, also told the Committee that while the Australian Breastfeeding Association gives talks to MCH parent groups, they usually come too late.¹³⁸⁶

¹³⁸² City of Greater Geelong Maternal and Child Health Service, submission no. 96, p. 5.

¹³⁸³ Ms Helen Lees, Maternal and Child Health Clinical Coordinator, City of Greater Bendigo, Family and Community Development Committee public hearing – Melbourne, 24 October 2017, transcript of evidence, p. 5.

¹³⁸⁴ Ms Maree Burgess, Maternal and Child Health Nurse, Branch President, Australian Nursing and Midwifery Federation (Victorian Branch), Family and Community Development Committee public hearing – Melbourne, 18 September 2017, transcript of evidence pp. 7-8.

¹³⁸⁵ Ibid., p. 8.

¹³⁸⁶ Ms Alice Martin, Australian Breastfeeding Association, Family and Community Development Committee public hearing – Wangaratta, 25 October 2017, transcript of evidence, p. 2.

Ms Ruth Berkowitz, a lactation consultant and Baby Friendly Health Initiative (BFHI) Educator and Assessor, told the Committee of the importance of breastfeeding support being provided in the period immediately after birth, and recommended that all MCH centres should be required to meet BFHI standards.¹³⁸⁷ The BFHI was developed by the World Health Organization and is centred around a ten step framework. It is now administered in Australia by the Australian College of Midwives.¹³⁸⁸ Gaining accreditation involves meeting a set of criteria surrounding breastfeeding practice. Some Victorian hospitals have accreditation.¹³⁸⁹

Along with Ms Berkowitz, the Committee heard from Dr Alison Stuebe, Associate Professor, Maternal-Fetal Medicine, at The University of North Carolina School of Medicine, that the BFHI has a positive impact on breastfeeding rates:

[I]f we were able to have more baby-friendly hospitals in Australia that practised the 10 steps, we would enable more women to be successful. And it is not necessarily all 10 steps — any number of steps convey improvement.

This was a study in the US looking at the number of steps a mum had experienced and her chances of meeting her own breastfeeding goals, and what the authors found was that if none of those steps were encountered — if the mum had baby-hostile care — 30 per cent of women failed to meet their own goals of breastfeeding for at least two months. So we are setting mothers up to fail if we do not deliver baby-friendly care. In contrast if women received all six of those steps, just 3 per cent were unable to meet their goals. So when we do a good job in the maternity care we provide and when we follow WHO recommendations, we enable women to meet their own goals.¹³⁹⁰

The Committee notes that the BFHI accreditation is available to community services as well as hospitals.¹³⁹¹ The evidence outlined above regarding breastfeeding support leads the Committee to believe that more can be done to support breastfeeding women through the MCH Service. Accordingly, the Committee recommends that:

RECOMMENDATION 6.3: The Victorian Government support all Maternal and Child Health centres to demonstrate a commitment to ensuring that every mother is supported to make informed choices about infant feeding during her transition to motherhood.

¹³⁸⁷ Ms Ruth Berkowitz, submission no. 90, p. 1.

¹³⁸⁸ Australian College of Midwives, 'Baby Friendly Health Initiative (BFHI)', accessed 21 March 2018, <<https://www.midwives.org.au/baby-friendly-health-initiative-bfhi>>. For more on the Baby Friendly Health Initiative see Chapter Two.

¹³⁸⁹ Bairnsdale Regional Health Service, Ballarat Health Services' Benalla Health Maryborough District Health Service, Royal Women's Hospital, Sunshine Hospital (Western Health), The Bays Healthcare (Formerly Hospital), West Gippsland Healthcare Group, Western District Health Service (Hamilton Hospital).

¹³⁹⁰ Dr Alison Stuebe, Associate Professor, Maternal-Fetal Medicine, The University of North Carolina School of Medicine, Family and Community Development Committee public hearing – Warrnambool, 11 October 2017, transcript of evidence, pp. 3-4.

¹³⁹¹ Australian College of Midwives, 'BFHI Information Pack for Community Facilities', accessed 7 March 2018, <<https://www.midwives.org.au/resources/bfhi-information-pack-community-facilities>>.

6.5 Mothers' experiences

The Committee wishes to represent the experience of mothers in the Inquiry, and is grateful to those mothers who made submissions or gave evidence at hearings about their personal experiences. In this section the Committee outlines common concerns it heard of the experiences of mothers with the MCH Service, particularly a lack of focus on mothers' health and wellbeing and a lack of continuity of care.

6.5.1 Focus on children, and not mothers

The Committee heard evidence that mothers felt the care given by the MCH Service did not adequately meet their needs and the focus was almost entirely on the child, while the mother's health concerns or risks were not addressed.

Ms Kate Ravenscroft, who gave birth at the Mercy Hospital in 2016, told the Committee in her submission that:

I think it would be better to remove the word 'maternal' from the Maternal and Child Health Centres as their attention to maternal health is cursory at best, in my experience. Although I mentioned my experience of postpartum haemorrhage to my Maternal and Child Health Nurse, neither did she speak to me about how to look after myself after such an experience, nor did she enquire as to what support I might need, either physically or mentally. Again and again during my Maternal and Child Health visits, I received attention and advice regarding my daughter's health and wellbeing but never did I receive anything but the most cursory enquiries as to my health and wellbeing.¹³⁹²

The City of Greater Geelong's submission also noted that the MCH Service focuses on the infant:

Today the MCH service continues to keep the infant at the centre of their care, supporting care givers to be the best they can be and keeping in mind "what is it like for the infant to experience this parenting."

The transition to parenthood is one of life's most significant events and can be the most challenging.¹³⁹³

Ms Ravenscroft told the Committee that her attempts to get help through the MCH Line yielded:

[D]epersonalised, general advice which didn't seem to really respond to me or my unique situation. As a result it was a service which didn't seem particularly useful or relevant.¹³⁹⁴

And that to truly support mothers, MCH centres need to incorporate lactation support, mental health support, GPs, specialists, and support for fathers:

It is my belief that Maternal and Child Health Centres, to truly provide quality, responsive care need to be multi-disciplinary centres with a range of professionals available to mothers, fathers and infants. For example, to truly meet the needs of

¹³⁹² Ms Kate Ravenscroft, submission no. 22, p. 2.

¹³⁹³ City of Greater Geelong Maternal and Child Health Service, submission no. 96, pp. 1-2.

¹³⁹⁴ Ms Kate Ravenscroft, submission no. 22, p. 3.

families in those crucial first months of life, access to lactation consultants, mental health professionals, doctors with experience in postpartum care and paediatricians or doctors specialised in infant care and physiotherapists. A single visit with a GP at six weeks after birth and weigh ins for your infant at a Maternal and Child Health Centre are not adequate for truly supporting mothers postpartum or supporting the establishment of breastfeeding and a strong maternal-infant relationship.¹³⁹⁵

Ms Helen Parker, Director of The Babes Project, told the Committee at a public hearing in Melbourne that a feeling of judgement or inadequacy is something she sees in her clients too, and that this may be a disincentive to engage with the MCH Service:

There is no incentive for them. I think a lot of them try and keep going until — I think it is that two years they get measured and they can tell how big their child is going to be when they are fully grown. That is actually an incentive for a lot of women, but unfortunately there is not a lot of other incentive, apart from someone telling me what to do and I feel shame or I feel inadequate.¹³⁹⁶

6.5.2 Continuity of care

Mothers told the Committee that they were not able to see the same MCH nurse every time they visited the MCH centre, and that this reduced the quality of care they received. Ms Sarah van Ree, a psychologist and mother, told the Committee that mothers may see a different MCH nurse at every Key Age and Stage consultation:

I wanted to draw your attention to the fact that in many local government areas, including Brimbank. [Y]ou see a different Maternal and Child Health Nurse at every appointment. Other LGAs allow you to see the same nurse improving a sense of continuity, increasing the likelihood of healthy rapport and taking on services offered. I think continuity of care is paramount to making the parents feel comfortable with the Maternal and Child Nurse.¹³⁹⁷

Ms Helen Parker, Director of The Babes Project, told the Committee at a public hearing in Melbourne that if an MCH nurse moves from a service, the relationship and trust mothers had with that nurse can be lost:

Also those nurses do move around, so they feel sometimes that they have trusted someone and then they have moved on. It is an issue.¹³⁹⁸

Ms Parker also told the Committee that when families move from one local government area to another, reengaging with the MCH Service can be a challenge:

Also our women move quite a lot, and so reengaging with another maternal and child health nurse is a challenge for them.¹³⁹⁹

¹³⁹⁵ Ibid.

¹³⁹⁶ Ms Helen Parker, Director, The Babes Project, Family and Community Development Committee public hearing – Melbourne, 5 February 2018, transcript of evidence, p. 6.

¹³⁹⁷ Ms Sarah van Ree, submission no. 12, p. 1.

¹³⁹⁸ Ms Helen Parker, Director, The Babes Project, Family and Community Development Committee public hearing – Melbourne, 5 February 2018, transcript of evidence, p. 6.

¹³⁹⁹ Ibid.

This is an issue the Auditor-General addressed in the 2017 report *Effectively Planning for Population Growth*, which noted that while the Child Development Information System (CDIS) developed by MAV and used by 62 councils should help with this issue, the CDIS is facing implementation issues. DET has agreed to improve the accuracy and take-up of the CDIS.¹⁴⁰⁰ For more see section 6.2.

To ensure that no women or families are disadvantaged when moving between local government areas and to ensure continuity of care, the Committee recommends that:

RECOMMENDATION 6.4: The Victorian Government and the Department of Education and Training work with local government to examine the Child Development Information System to ensure and strengthen access and delivery of information to best serve families using the Maternal and Child Health Service.

6.6 Maternal and Child Health workforce

6.6.1 Training for Maternal and Child Health nurses

MCH nurses must be ‘registered with the Nurses Board of Victoria as Registered Nurses Division 1, registered midwives holding an accredited post-graduate qualification in maternal and child health nursing’.¹⁴⁰¹ All MCH nurses in Victoria must have the following qualifications:

- Bachelor of Nursing (three year degree);
- midwifery training (either included in general training of a four year degree or as a separate post graduate one year course); and
- a recognised postgraduate qualification in child and family health.¹⁴⁰²

MCH nurses are required to complete 40 hours of continuing professional development (CPD) as part of their registration with the Australian Health Practitioner Regulation Agency.¹⁴⁰³

Ms Lisa Fitzpatrick, Branch Secretary of the Australian Nursing and Midwifery Federation (Victorian Branch), summarised the benefits of these requirements and other training in evidence to the Committee at a public hearing in Melbourne:

Before I stop I would say that in relation to maternal and child health nurses in Victoria we are very fortunate. We have the most well-educated maternal and child health nurses in the country. They are registered nurses. They have also completed

¹⁴⁰⁰ Victorian Auditor-General, *Effectively Planning for Population Growth*, Melbourne, Victorian Auditor-General's Office, August 2017, pp. 35, 55.

¹⁴⁰¹ Department of Education and Early Childhood Development (DEECD), *Maternal and Child Health Service Program Standards*, Melbourne, Victorian Government, 2009, p. 35.

¹⁴⁰² Recognised post graduate programs are offered at RMIT and La Trobe Universities, see Maternal & Child Health Nurses Victoria Inc, ‘Courses for Child and Family Health Nursing’, accessed 19 March 2018, <<http://www.mchnv.com/courses-for-child-and-family-health-nursing>>.

¹⁴⁰³ Ms Marilyn Humphrey, Maternal and Child Health Coordinator, Baw Baw Shire Maternal and Child Health Services, Family and Community Development Committee public hearing – Warragul, 8 December 2017, transcript of evidence, p. 2.

their midwifery postgraduate studies, and they have also done postgraduate studies in maternal and child health. They are well equipped and are doing much more work, particularly now, in the area of domestic violence.¹⁴⁰⁴

Cost of training

The Committee heard evidence that the cost of education required to become an MCH nurse can be a barrier to qualification. Ms Maryanne Purcell, of Warrnambool City Council, told the Committee at a public hearing in Warrnambool:

It is a postgraduate course. On top of that, the prerequisites for maternal and child health in Victoria are that you have general training with some experience, you have midwifery training with experience and then you are doing a postgrad on top of that. People get into the rhythm of earning money and then taking time away from an income, and paying out \$16 000 or \$17 000 for a uni course probably does not look that attractive, maybe. I am not sure.¹⁴⁰⁵

The cost of training for nurses was echoed at a public hearing in Wangaratta by Ms Rebecca Sacco, Maternal and Child Health Team Leader at the Rural City of Wangaratta, along with her belief that the requirement for extensive training ‘brings a vast wealth of knowledge and experience to the role to better support our families throughout the early years experience’.¹⁴⁰⁶

Associate Professor Phil Maude, Council Executive Member, Council of Deans of Nursing and Midwifery (Australia & New Zealand), reinforced the cost and commitment required to become an MCH nurse at a public hearing in Melbourne:

It tends to be that industry will tap you on the shoulder and say, ‘Do you want to work in this area? If you want to work in this area, we’ll bring you into this area, but you must do postgraduate qualifications’. For child and family health nursing, for example, they do most of their training through councils, so the nurse that goes off to do that has completed midwifery and general and has then gone to the council in unpaid clinical work time, and that is again a very big commitment.¹⁴⁰⁷

In evidence given at a public hearing in Warragul, Ms Marilyn Humphrey, MCH Coordinator at Baw Baw Shire, told the Committee of the scholarships available to access MCH nurse training:

[T]here 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.¹⁴⁰⁸

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- 1404** Ms Lisa Fitzpatrick, Branch Secretary, Australian Nursing and Midwifery Federation (Victorian Branch), Family and Community Development Committee public hearing – Melbourne, 18 September 2017, transcript of evidence, p. 4.
- 1405** Ms Maryanne Purcell, Maternal and Child Health Nurse Coordinator, Warrnambool City Council, Family and Community Development Committee public hearing – Warrnambool, 11 October 2017, transcript of evidence, p. 6.
- 1406** Ms Rebecca Sacco, Maternal and Child Health Team Leader, Rural City of Wangaratta, Family and Community Development Committee public hearing – Wangaratta, 25 October 2017, transcript of evidence, p. 2.
- 1407** Associate Professor Phil Maude, Council Executive Member, Council of Deans of Nursing and Midwifery (Australia & New Zealand), Family and Community Development Committee public hearing – Melbourne, 27 November 2017, transcript of evidence, p. 4.
- 1408** Ms Marilyn Humphrey, Maternal and Child Health Coordinator, Baw Baw Shire Maternal and Child Health Services, Family and Community Development Committee public hearing – Warragul, 8 December 2017, transcript of evidence, p. 8.

In addition to university education, the Committee heard of nurses having to shoulder the financial burden of professional development,¹⁴⁰⁹ including nurses working in regional areas paying for accommodation.¹⁴¹⁰

The Committee constantly heard of skills shortages and lack of MCH nurses and believes that the cost of training contributes towards these shortages.

The Committee supports the efforts by DET to enable MCH nurses to gain and maintain their qualifications, including an increase in the value of scholarships,¹⁴¹¹ and funding to support student and graduate placements.¹⁴¹² However, the Committee believes more can be done to assist MCH nurses, particularly those in rural and regional areas, to meet their CPD requirements and otherwise increase their capability through training. Accordingly, the Committee recommends that:

RECOMMENDATION 6.5: The Victorian Government provide reimbursements of costs to allow Maternal and Child Health nurses to attend the training required to satisfy their continuing professional development responsibilities.

Training in identifying mental illnesses

The Committee heard extensive evidence on perinatal mental health, which is examined in Chapter Three. This section provides a brief description of evidence the Committee heard on training for MCH nurses in identifying and reacting to mental health issues.

The *Perinatal Mental Health and Psychosocial Assessment: Practice Resource Manual for Victorian Maternal and Child Health Nurses* provides guidance for MCH nurses on mental health problems in the perinatal period, screening tools, interpersonal skills that help with psychosocial assessment, and referral options based on assessment via the Edinburgh Postnatal Depression Scale.¹⁴¹³

Professor Jane Fisher, Director of the Jean Hailes Research Unit, told the Committee at a public hearing in Melbourne that the MCH Service is the best location for addressing perinatal mental health.¹⁴¹⁴ Professor Fisher also told the Committee that MCH nurses can be trained in the What Were We Thinking! program the Jean Hailes Research Unit developed:

What we have shown is that we can train maternal and child health nurses how to implement this approach within their routine care of first-time parents and that it can have a very beneficial impact on preventing mental health problems. It

¹⁴⁰⁹ Ms Liz Flamsteed, Head of Innovation Fund Project in Antenatal Engagement, Rural City of Wangaratta, Family and Community Development Committee public hearing – Wangaratta, 25 October 2017, transcript of evidence, p. 5.

¹⁴¹⁰ Glenelg Shire Maternal and Child Health Service, submission no. 89, p. 1.

¹⁴¹¹ Dr Anastasia Gabriel, Director Of Prevention and Health Promotion, Department of Education and Training, Family and Community Development Committee public hearing – Melbourne, 27 November 2017, transcript of evidence, p. 7.

¹⁴¹² Department of Education and Training, correspondence, dated 12 December 2018.

¹⁴¹³ Department of Education and Early Childhood Development, *Perinatal Mental Health and Psychosocial Assessment: Practice Resource Manual for Victorian Maternal and Child Health Nurses*, Melbourne, Victorian Government, 2013.

¹⁴¹⁴ Professor Jane Fisher, Director, Jean Hailes Research Unit, Family and Community Development Committee public hearing – Melbourne, 4 September 2017, transcript of evidence, p. 2.

addresses, first of all, teaching parents how to understand and respond to infant behaviour, how to understand each other's changed needs and respond to these, and how to name and recognise gender stereotypes.¹⁴¹⁵

Ms Terri Smith, Chief Executive Officer of Perinatal Anxiety and Depression Australia (PANDA), told the Committee at a public hearing in Melbourne that MCH nurses may lack the skills for holding conversations around mental illness.¹⁴¹⁶ However, with training, MCH nurses can learn to more effectively talk to families about mental illness:

It is really about shifting how you have a conversation, being able to have a conversation and being able to open up a conversation. Those staff will tell us consistently that they are scared to open up the conversation, because 'What are we going to do with it?'. We say, 'Hang on. What is so scary about mental health? You open up those other conversations'.¹⁴¹⁷

Ms Jennifer Ericksen of the Parent Infant Research Institute gave evidence at a public hearing in Melbourne that MCH nurses are now well versed in screening for mental health issues, noting that they are moving toward helping women to 'help-seek' particularly in the Enhanced MCH Service:

When we first started training we were talking about screening, and that was the new frontier. Now they are very much across that. They are interested in how to have conversations with women that can help them to help-seek, which is the motivational interviewing approach — a woman-centred approach to care. Even some of them are getting a bit more into treatment as well through the enhanced maternal and child health programs.¹⁴¹⁸

Training in identifying family violence

Chapter Three discusses family violence in the context of mental health, the Royal Commission into Family Violence, hospital domiciliary staff, and screening. This section provides a brief description of evidence the Committee heard on training for MCH nurses in identifying and reacting to family violence.

The Committee heard from MCH Service providers that in addition to training concerning their own safety in a situation involving family violence,¹⁴¹⁹ MCH staff have training in identifying family violence through the Common Risk Assessment Framework. Ms Lynne Smith from City of Melbourne family services told the Committee at a public hearing in Melbourne:

We all did training initially when it was first rolled out in Victoria, and we are going through the CRAF [Common Risk Assessment Framework] training again at the moment. All of our nurses are doing that training again to refresh their training.¹⁴²⁰

¹⁴¹⁵ Ibid., p. 3. For more on the What Were We Thinking! Program see Chapter Three and What Were We Thinking!, 'Welcome to WWWT!', accessed 19 March 2018, <<http://www.whatwerewethinking.org.au>>.

¹⁴¹⁶ Ms Terri Smith, Chief Executive Officer, Perinatal Anxiety and Depression Australia, Family and Community Development Committee public hearing – Melbourne, 16 October 2017, transcript of evidence, p. 4.

¹⁴¹⁷ Ibid., pp. 5, 7.

¹⁴¹⁸ Ms Jennifer Ericksen, Coordinator, Infant Clinic, Parent-Infant Research Institute, Family and Community Development Committee public hearing – Melbourne, 27 November 2017, transcript of evidence, p. 5.

¹⁴¹⁹ Ms Helen Lees, Maternal and Child Health Clinical Coordinator, City of Greater Bendigo, Family and Community Development Committee public hearing – Bendigo, 24 October 2017, transcript of evidence, p. 7.

¹⁴²⁰ Ms Lynne Smith, Acting Team Leader, Family Services, City of Melbourne, Family and Community Development Committee public hearing – Melbourne, 18 September 2017, transcript of evidence, p. 5.

The Common Risk Assessment Framework (also known as the Family Violence Risk Assessment and Risk Management Framework) was published by the then Department of Human Services in 2007, with a second edition published in 2012.¹⁴²¹ The Framework ‘helps practitioners from a wide range of fields understand and identify risk factors associated with family violence and respond consistently’.¹⁴²²

Ms Samantha Cooke, Community Health Coordinator at the Mildura Rural City Council, told the Committee at a public hearing in Mildura that she encourages her staff to enquire with families about family violence at every visit, despite only being required to do so at the four-week and 12-month consultations:

I guess it is about building a rapport with these families and being honest, I guess, and being able to then ask that question. I think we find that the more that we ask it, the more likely we are to get an answer. It is only required to be asked at that four-week key age and stage visit, but I have encouraged my staff to ask it at every visit, for that reason, because it can happen at any time. It is no good asking it at the four-week one and then you are at the 12-month visit and it has happened then and we do not ask the question. So we do encourage them to ask it at every visit.¹⁴²³

The Committee notes the Victorian Government’s commitment of an additional \$11 million to provide up to 12,000 hours of additional MCH Service consultations and outreach visits to those at risk of family violence, including professional development for MCH nurses.¹⁴²⁴ As stated in the Victorian Government media release:

Given discussing family violence can be difficult due to the presence of a partner, or insufficient time, the additional consultations will allow discussions to take place at a time and place that suits the mother and her kids.

MCH nurses will be provided with professional development and support so they can confidently discuss family violence with parents, assess the risk, and respond in a timely and meaningful way.¹⁴²⁵

Ms Kim Little, Assistant Deputy Secretary, Early Childhood Portfolio for DET, told the Committee at a public hearing in Melbourne that this includes an extra visit in the Universal MCH Service for families where family violence is a concern, along with training and a new risk assessment framework.¹⁴²⁶

¹⁴²¹ Department of Human Services, *Family Violence Risk Assessment and Risk Management Framework and Practice Guides 1-3* ed 2, Melbourne, Victorian Government, 2012, p 1.

¹⁴²² Department of Health and Human Services, ‘Family violence risk assessment and risk management framework’, Victorian Government, accessed 20 March 2018, <<https://providers.dhhs.vic.gov.au/family-violence-risk-assessment-and-risk-management-framework>>.

¹⁴²³ Ms Samantha Cooke, Community Health Coordinator, Mildura Rural City Council, Family and Community Development Committee public hearing – Mildura, 9 November 2017, transcript of evidence, pp. 4-5.

¹⁴²⁴ Hon. Jenny Mikakos, Minister for Families and Children, ‘Supporting mums and bubs affected by family violence’, media release, Victorian Government, 3 January 2018.

¹⁴²⁵ Ibid.

¹⁴²⁶ Ms Kim Little, Assistant Deputy Secretary, Early Childhood Portfolio, Department of Education and Training, Family and Community Development Committee public hearing – Melbourne, 27 November 2017, transcript of evidence, pp. 11-12.

6.6.2 Ageing and part time workforce

The Committee notes that during the course of the Inquiry the Auditor-General released the report *Effectively Planning for Population Growth*.¹⁴²⁷ This report, tabled in Parliament in August 2017, addressed issues surrounding the MCH nurse workforce, particularly supply planning for the MCH Service. In this section the Committee highlights some of the findings of the Auditor-General's report, along with evidence provided to the Committee by DET and other witnesses.

The report, *Effectively Planning for Population Growth*, noted that DET assessed the MCH workforce in 2015 and concluded:

[T]hat Victoria was not experiencing a shortage of MCH nurses overall, but that factors such as the ageing MCH nursing labour force and a growing demand for services due to population growth were likely to result in an inadequate supply of MCH nurses in future years.¹⁴²⁸

The Auditor-General reported an ageing workforce, noting that 'DET estimated in 2014 that over 65 per cent [of the MCH nurse workforce] were over 51 years old' and noted efforts by DET to respond to future MCH workforce needs, including a postgraduate scholarship program, and funding from the *Early Childhood Reform Plan* to attract new MCH nurses.¹⁴²⁹

While the Auditor-General did not make any specific recommendations regarding the MCH workforce, the report found that a lack of understanding of the demand for and supply of MCH nurses, and noted that MCH nurses need to be taken into account in state-wide health workforce planning.¹⁴³⁰ The report also noted limited involvement by DET in assessing the supply and demand for MCH nurses.¹⁴³¹

At a public hearing in Melbourne Ms Kim Little, Assistant Deputy Secretary, Early Childhood Portfolio for DET, told the Committee there is no state-wide shortage, but there are shortages in certain areas:

While at a statewide level — and I do emphasise at a statewide level — there is currently not a shortage, although there are shortages in particular areas; there is a distribution issue. We do know, exactly as you said, that with the ageing of the maternal and child health workforce — which because they are triple-qualified amongst other things, is an older workforce — there is likely to be pressure on supply in future years.¹⁴³²

And that the Department is working to address those issues:

That is why the workforce development and attraction initiatives have effectively been put in place.

¹⁴²⁷ Victorian Auditor-General, *Effectively Planning for Population Growth*, Melbourne, Victorian Auditor-General's Office, August 2017.

¹⁴²⁸ *Ibid.*, p. 39.

¹⁴²⁹ *Ibid.*

¹⁴³⁰ *Ibid.*

¹⁴³¹ *Ibid.*, p. x.

¹⁴³² Ms Kim Little, Assistant Deputy Secretary, Early Childhood Portfolio, Department of Education and Training, Family and Community Development Committee public hearing – Melbourne, 27 November 2017, transcript of evidence, p. 7.

But we are also continuing to work through what is known as the MCH Expert Reference Group, which is something that was established under this government and which includes MCH leaders from across the state and is co-chaired with the Municipal Association of Victoria. We are continuing to work with them on workforce attraction, supply and retention as well in this space and how to make the most of this very valuable resource of MCH-qualified nurses.¹⁴³³

The Committee heard evidence from MCH Service providers throughout Victoria, with many echoing the issues outlined by the Auditor-General and DET. Multiple witnesses told the Committee that an issue for the MCH workforce is the approaching retirement of a cohort of the workforce.¹⁴³⁴ Ms Maryanne Purcell, Maternal and Child Health Nurse Coordinator at Warrnambool City Council, told the Committee:

Looking at it regionally, we are definitely an ageing workforce, and it does worry me a little bit about how that is going to look in five, six or 10 years time.¹⁴³⁵

Ms Purcell told the Committee that along with the challenge of an ageing workforce, her service has not had any student placements recently and that her service finds it hard to backfill nurses on leave.¹⁴³⁶

Ms Marilyn Humphrey of Baw Baw Shire noted that in her experience, staff shortages in nursing are cyclical:

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.¹⁴³⁷

Along with the challenge of an ageing workforce, the Committee also heard that many MCH nurses work part time, but that this was not seen as a disadvantage, and in fact allowed for valuable flexibility.¹⁴³⁸ Ms Alana Cooper, Early Years Coordinator with the City of Greater Bendigo, told the Committee in her submission:

[M]any MCH Nurses choose to work part time for personal reasons which may be for family or to enable employment at local hospitals as midwife or lactation consultant.¹⁴³⁹

When asked about the prevalence of part time maternal and child health nurses, Ms Rebecca Sacco, Maternal and Child Health Team Leader at the Rural City of Wangaratta, told the Committee she finds part time employees help bring a diversity of approaches:

¹⁴³³ Ibid.

¹⁴³⁴ Caroline Chisholm Society, submission no. 29, p. 33; Ms Alana Cooper, submission no. 94, p. 1; Hobson’s Bay City Council, submission no. 26, p. 2.

¹⁴³⁵ Ms Maryanne Purcell, Maternal and Child Health Nurse Coordinator, Warrnambool City Council, Family and Community Development Committee public hearing – Warrnambool, 11 October 2017, transcript of evidence, p. 6.

¹⁴³⁶ Ibid., p. 4.

¹⁴³⁷ Ms Marilyn Humphrey, Maternal and Child Health Coordinator, Baw Baw Shire Maternal and Child Health Services, Family and Community Development Committee public hearing – Warragul, 8 December 2017, transcript of evidence, p. 9.

¹⁴³⁸ Ms Helen Lees, Maternal and Child Health Clinical Coordinator, City of Greater Bendigo, Family and Community Development Committee public hearing – Melbourne, 24 October 2017, transcript of evidence, p. 6.

¹⁴³⁹ Ms Alana Cooper, submission no. 94, p. 1.

I think that for a lot of people it is a step down from working full-time in a midwifery ward. So there are all those sorts of factors to it. There is low EFT, and my personal belief is it is good to have a few different people working in a service because we all have such different personalities and we bring different things to our clients. I do like that diversity in the staffing, but I think there are a lot of different factors for that. We do not have the births to support full-time work most of the time too.¹⁴⁴⁰

In correspondence to the Committee, DET outlined initiatives it is working on to address future MCH workforce needs. These include:

- hard to staff incentives to attract MCH staff to remote local government areas (grants available to certain local governments);
- student placements (funding available to local governments to support student placement and training for MCH nurses supervising students);
- professional development training for MCH nurses around the changing Victorian community, family violence, and the Enhanced MCH framework;
- graduate program to support local government to take on graduates (grants available to local government, with priority for those with workforce shortages); and
- Clinical Supervision Guidelines for the Enhanced MCH Service.¹⁴⁴¹

The Committee shares the concerns of witnesses to the Inquiry that the MCH workforce is ageing, and that population growth may lead to an inadequate supply. The Committee supports the efforts by DET to address an ageing MCH workforce and ensure the MCH workforce meets the needs of the community.

6.7 Pathways for treatment referral

The Committee heard that one of the aims of the MCH Service is detection and intervention of a range of issues affecting mothers, babies and families. Ms Maryanne Purcell, MCH Nurse Coordinator with Warrnambool City Council, told the Committee:

The services provide a comprehensive and focused approach for the promotion, prevention, early detection and intervention of the physical, emotional and social factors affecting children and their families in contemporary communities.¹⁴⁴²

The *Maternal and Child Health Service: Practice Guidelines 2009* include a section outlining referral options for the MCH Service, and also encourage services to develop a list of local relevant sources for referrals.¹⁴⁴³ The *Perinatal Mental Health*

¹⁴⁴⁰ Ms Rebecca Sacco, Maternal and Child Health Team Leader, Rural City of Wangaratta, Family and Community Development Committee public hearing – Wangaratta, 25 October 2017, transcript of evidence, p. 7.

¹⁴⁴¹ Department of Education and Training, correspondence, dated 12 January 2018.

¹⁴⁴² Ms Maryanne Purcell, Maternal and Child Health Nurse Coordinator, Warrnambool City Council, Family and Community Development Committee public hearing – Warrnambool, 11 October 2017, transcript of evidence, p. 2.

¹⁴⁴³ Department of Education and Early Childhood Development, *Maternal and Child Health Service: Practice Guidelines 2009*, Victorian Government, pp. 81-9.

and *Psychosocial Assessment: Practice Resource Manual for Victorian Maternal and Child Health Nurses* provides referral options based on assessment via the Edinburgh Postnatal Depression Scale.¹⁴⁴⁴

The Committee heard throughout the Inquiry that in situations where an MCH nurse had detected an issue that required referral to another health practitioner, pathways for referral were lacking, because of issues such as a lack of available services, a lack of services close to families, long waiting periods, or failures in communication between the MCH Service and other providers. This is particularly the case in rural and regional Victoria, and for mental health issues. These issues are discussed further in Chapters Four and Three, respectively.

Hobsons Bay City Council, in their submission to the Committee, told of the challenges faced by families in a service system that changes, with fragmented communication between the MCH Service and other service providers:

The service system itself is often changing in structure; processes and service offering can vary resulting in families being placed on a waiting list for extended periods of time only to find out a service provider cannot help them and then re-directed on to another organisations wait list. In addition, communication between a service provider and MCH is fragmented causing long delays. For example, practitioners are often finding out from families that a nurse's referral has not been accepted or that the service is unable to help the family and then need to restart a referral process.¹⁴⁴⁵

The Committee heard that centralisation of services in regional centres and Melbourne,¹⁴⁴⁶ along with a lack of specialist staff in rural areas, were barriers to effective referral pathways.¹⁴⁴⁷ Barriers also include poor communication between MCH Service providers and GPs.¹⁴⁴⁸

In the area of mental health services, the *Perinatal Mental Health and Psychosocial Assessment: Practice Resource Manual for Victorian Maternal and Child Health Nurses* provides guidance for MCH nurses on mental health in the perinatal period, screening tools, interpersonal skills that help with psychosocial assessment, and referral options based on assessment via the Edinburgh Postnatal Depression Scale.¹⁴⁴⁹

The Committee heard that a lack of available mother baby units makes referral difficult,¹⁴⁵⁰ and that a lack of expertise in infant mental health and a high threshold for access to infant mental health make for a gap in secondary services for infants with mental health issues.¹⁴⁵¹

1444 Department of Education and Early Childhood Development, *Perinatal Mental Health and Psychosocial Assessment: Practice Resource Manual for Victorian Maternal and Child Health Nurses*, Melbourne, Victorian Government, 2013, p. 7.

1445 Hobsons Bay City Council, submission no. 26, p. 1.

1446 Mount Alexander Shire, submission, no. 23, p. 1.

1447 Ms Helen Lees, Maternal and Child Health Clinical Coordinator, City of Greater Bendigo, Family and Community Development Committee public hearing – Melbourne, 24 October 2017, transcript of evidence, pp. 4-5; Ms Ailsa Carr, Executive Manager, Family, Youth and Children's Services, Gippsland Lakes Community Health, Family and Community Development Committee public hearing – Bairnsdale, 7 December 2017, transcript of evidence, p. 3.

1448 Ms Liz Flamsteed, Head of Innovation Fund Project in Antenatal Engagement, Rural City of Wangaratta, Family and Community Development Committee public hearing – Wangaratta, 25 October 2017, transcript of evidence, p. 8-9.

1449 Department of Education and Early Childhood Development, *Perinatal Mental Health and Psychosocial Assessment: Practice Resource Manual for Victorian Maternal and Child Health Nurses*, Melbourne, Victorian Government, 2013.

1450 Mount Alexander Shire, submission, no. 23, p. 2.

1451 City of Greater Geelong Maternal and Child Health Service, submission no. 96, p. 3.

Ms Viviane Lebnan, Convenor of the Perinatal Interest Group with the Australian Psychological Society, reinforced that even with mental health screening by the MCH Service, a lack of services to meet families' needs means some still fall through the gaps:

[W]e need to screen and identify those women antenatally through the maternity hospitals and then subsequently through maternal and child health. The problem is, though, once we have identified them, they still fall within the gaps if there are no services there to meet their needs and if they have long waiting periods before they can see someone. That is where my concern is. We need to identify them, but then we also need to provide them with something once we have.¹⁴⁵²

Ms Ailsa Carr, Executive Manager, Family, Youth and Children's Services at Gippsland Lakes Community Health, told the Committee that referrals for mental health services were problematic, with families having to travel to Melbourne, and that even travelling to Bairnsdale from some areas in Gippsland was a challenge for families. Ms Carr told the Committee that the Agnes Parent and Infant Unit at Latrobe Regional Hospital had been of great benefit.¹⁴⁵³

The City of Greater Geelong's submission highlighted the gap left by the loss of funding for the Perinatal Emotional Health Program, to which the City's MCH Service was a major referrer, and that requirements for a GP referral for certain services caused delays in response.¹⁴⁵⁴

While evidence to the Committee told of difficulties in effective referrals from the MCH Service, the Committee also heard some examples of referral pathways that were working well. Ms Rebecca Sacco of the Rural City of Wangaratta told the Committee of an MCH nurse who had concerns about the mental health of a client who could refer that client to the early motherhood service at Northeast Health Wangaratta:

With permission, the nurse then contacted the early motherhood service, who after discussion with the nurse and talking to the client visited that client a couple of hours later. The client was actually admitted to hospital for treatment. Once she was stabilised she was sent to a mother and baby unit in Melbourne for help with bonding and caring for her child.

Without the support of the early motherhood service this is a very complex time and consuming task for a maternal and child health nurse, who is often not equipped with specific skills to give the client the care and direction required. I believe that support from them is vital for us ...¹⁴⁵⁵

Ms Sacco also told the Committee of monthly meetings across services in Wangaratta that help promote continuity of care and a collaborative approach to care.¹⁴⁵⁶ Ms Sacco noted, however, that if their clients need access to a mother baby unit, the closest is in Melbourne or Canberra.¹⁴⁵⁷

¹⁴⁵² Ms Viviane Lebnan, Convenor, Perinatal Interest Group, Australian Psychological Society, Family and Community Development Committee public hearing – Melbourne, 5 February 2017, transcript of evidence, p. 7.

¹⁴⁵³ Ms Ailsa Carr, Executive Manager, Family, Youth and Children's Services, Gippsland Lakes Community Health, Family and Community Development Committee public hearing – Bairnsdale, 7 December 2017, transcript of evidence, p. 6.

¹⁴⁵⁴ City of Greater Geelong Maternal and Child Health Service, submission no. 96, pp. 2-3.

¹⁴⁵⁵ Ms Rebecca Sacco, Maternal and Child Health Team Leader, Rural City of Wangaratta, Family and Community Development Committee public hearing – Wangaratta, 25 October 2017, transcript of evidence, p. 2.

¹⁴⁵⁶ Ibid.

¹⁴⁵⁷ Ibid., p. 3.

Ms Carr told the Committee how the integrated service at Gippsland Lakes Community Health, which the East Gippsland Shire Council has contracted to deliver the MCH Service, allows for strong referral pathways:

Our strength we say is that the maternal and child health nursing service is sitting within a community health service and within a whole range of supports so that it allows us to provide an actual integrated service. We are able to identify things such as family violence, and then we are able to link the women or whoever it may be to the appropriate other supports that they might need. We have very much a partnership approach with our clients and also our other workers. It is about being client driven — family driven — and focusing on what their needs are and what they would see as the supports that they would require to help them address any of their issues.

...

Being established in the one unit with all of those programs around means that we are able to do quite a large amount of inter-program education and support and that we are able to have staff work together to be able to support in the understanding of the different frameworks each of the programs work under.¹⁴⁵⁸

The Committee heard that the MCH Service provides an excellent opportunity to detect and refer health issues for children, mothers, and families. However, the ability to effectively refer is limited by issues such as poor communication, a lack of services close to families, long waiting periods, and a lack of services overall.

The Committee addresses a lack of services for effective referral of mental health issues in Chapter Three, including the establishment of a taskforce to investigate referral pathways in Recommendation 3.2. The Committee also addresses workforce capacity, which impacts the availability of services, in Chapter Five.

6.8 Impact of increasingly complicated presentations

The Committee heard that a variety of factors are leading to increasingly complicated presentations for MCH nurses to deal with when providing care to mothers and babies. These include mental health issues, drug and alcohol use, and family violence.

Ms Maryanne Purcell of Warrnambool City Council noted that the complicated nature of modern families contributes to the complexity MCH nurses are required to deal with:

[W]e have got all these additional visits that we are somewhat funded for, but they are increasing at a really high rate. What is the cause for that? My team feed me back information all the time about the complexities of families — every family that comes through even the universal doors. There are marriage breakups and a lot of relationship issues. There is just a mountain of complexities to families. This is the way society is now. It is just very complex.¹⁴⁵⁹

¹⁴⁵⁸ Ms Ailsa Carr, Executive Manager, Family, Youth and Children's Services, Gippsland Lakes Community Health, Family and Community Development Committee public hearing – Bairnsdale, 7 December 2017, transcript of evidence, p. 3.

¹⁴⁵⁹ Ms Maryanne Purcell, Maternal and Child Health Nurse Coordinator, Warrnambool City Council, Family and Community Development Committee public hearing – Warrnambool, 11 October 2017, transcript of evidence, pp. 5-6.

Noting that vulnerabilities for families often come in clusters, Ms Purcell said:

I think there is an increasing amount of, certainly, ice use, and it causes havoc with families. You tend to find a lot of the vulnerable families would have those clusters of vulnerabilities, where there is domestic violence, there is illicit drug use or alcohol use, and then they are socially and economically disadvantaged as well. So they do tend to cluster together.¹⁴⁶⁰

Ms Helen Lees, MCH Clinical Coordinator with the City of Greater Bendigo, told the Committee at a public hearing in Bendigo that mental health, drug and alcohol, and family violence issues are the main challenges facing the MCH Service, and that this has an impact on her team:

On the worker, I would say, particularly for our enhanced maternal and child health team, it can have a large impact depending on their relationship with the family. The impact is larger when those women want to stay with our service and do not want to engage with another service in addition to that. Part of our role is around assisting them to engage with other services, and we work very hard on that. But yes, we do hold a reasonable amount of risk in that sense.¹⁴⁶¹

The City of Greater Geelong's submission noted that a risk of complicated presentations and services responding to the needs of vulnerability is a reduced ability to deliver a universal service, and that this may include families without complex needs missing out.¹⁴⁶²

The Committee notes that the increased funding for the Enhanced MCH Service in the 2017–18 Budget can go some way to addressing these issues.

6.8.1 Family violence

Witnesses to the Inquiry told the Committee that one of the difficulties in providing services to families experiencing family violence is the risk to MCH staff. Ms Alana Cooper, Early Years Coordinator with the City of Greater Bendigo, in her submission told the Committee:

The MCH staff and Enhanced MCH (EMCH) staff undertake home visits in clients homes, this poses occupational health and safety concerns in regard to clients or other people living or visiting at the clients homes who may have mental health or drug and alcohol issues. We undertake a safety screen over the phone before staff visit a client's home however this does not eliminate all risks. Homes we visit may be experiencing domestic violence or child protection may be involved, these issues can make for an unstable environment for staff.¹⁴⁶³

Ms Ailsa Carr, Executive Manager, Family, Youth and Children's Services with Gippsland Lakes Community Health, told the Committee at a public hearing in Bairnsdale of the risk, and the policies her staff use to mitigate it:

¹⁴⁶⁰ Ibid., p. 8.

¹⁴⁶¹ Ms Helen Lees, Maternal and Child Health Clinical Coordinator, City of Greater Bendigo, Family and Community Development Committee public hearing – Melbourne, 24 October 2017, transcript of evidence, p. 7.

¹⁴⁶² City of Greater Geelong Maternal and Child Health Service, submission no. 96, pp. 1, 3.

¹⁴⁶³ Ms Alana Cooper, submission no. 94, p. 1.

We have a home visiting risk assessment process that we would use. If there is perceived to be an increased risk, we would have two staff attend. I have to say for maternal and child health nurses it can be quite risky. They are well trained on how to read circumstances. We have clear policies around when to enter a home and when not to enter a home. We have a policy around where you should park your car — you do not park it in the drive, you park it on the street. If you get to a house and there is a whole heap of people there and you were not expecting that or you do not know who they are, you would not enter. You would reschedule an appointment.

As I said, if we are thinking there are concerns, we might do two up, or we would see the family in another venue, which would depend upon the family. It could be in the clinic for our Aboriginal clients. We will often make arrangements to see them in our Aboriginal controlled organisation. It might be in another family member's home or wherever they are actually comfortable that also ensures privacy and security for them.¹⁴⁶⁴

Other MCH staff also told the Committee of strategies their team either used or considered to reduce risk for staff around family violence, including joint visits, electronic safety cards which initiate an emergency response if activated, and GPS phone tracking.¹⁴⁶⁵ The Committee also heard of clear pathways to follow when family violence is disclosed, as well as support for staff from their managers.¹⁴⁶⁶

Some MCH Service providers told the Committee that because of the nature of the MCH Service, and how it is viewed, MCH staff are not seen as threatening, which helps staff stay safe.¹⁴⁶⁷ When asked whether she sees an increase in risk or concern for staff safety at a public hearing in Warragul, Ms Marilyn Humphrey, Maternal and Child Health Coordinator at Baw Baw Shire, told the Committee:

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.¹⁴⁶⁸

¹⁴⁶⁴ Ms Ailsa Carr, Executive Manager, Family, Youth and Children's Services, Gippsland Lakes Community Health, Family and Community Development Committee public hearing – Bairnsdale, 7 December 2017, transcript of evidence, p. 4.

¹⁴⁶⁵ Ms Maryanne Purcell, Maternal and Child Health Nurse Coordinator, Warrnambool City Council, Family and Community Development Committee public hearing – Warrnambool, 11 October 2017, transcript of evidence, p. 8; Ms Helen Lees, Maternal and Child Health Clinical Coordinator, City of Greater Bendigo, Family and Community Development Committee public hearing – Bendigo, 24 October 2017, transcript of evidence, p. 7; Ms Maree Crellin, Maternal and Child Health Coordinator, City of Greater Geelong – Maternal and Child Health Service, Family and Community Development Committee public hearing – Geelong, 11 December 2017, transcript of evidence, p. 4.

¹⁴⁶⁶ Ms Patti Reilly, Acting Family Health Coordinator, City of Melbourne, Family and Community Development Committee public hearing – Melbourne, 18 September 2017, transcript of evidence, p. 5.

¹⁴⁶⁷ Ms Helen Lees, Maternal and Child Health Clinical Coordinator, City of Greater Bendigo, Family and Community Development Committee public hearing – Bendigo, 24 October 2017, transcript of evidence, p. 7.

¹⁴⁶⁸ Ms Marilyn Humphrey, Maternal and Child Health Coordinator, Baw Baw Shire Maternal and Child Health Services, Family and Community Development Committee public hearing – Warragul, 8 December 2017, transcript of evidence, p. 7.

On the necessity for MCH nurses to screen for issues such as family violence and mental health issues, Ms Kim Little, Assistant Deputy Secretary, Early Childhood Portfolio for DET, noted that these sorts of tasks have been part of the KAS consultations for some time, and that DET is now better supporting those tasks.¹⁴⁶⁹

The Committee recognises the Victorian Government's efforts to support MCH nurses in the difficult task of dealing with family violence. This includes resources such as the Family Violence Risk Assessment and Risk Management Framework, also known as the Common Risk Assessment Framework (CRAF), and its associated practice guides. The Committee was also encouraged to hear from MCH Service providers that they have policies in place to ensure the safety of their staff when dealing with family violence.

6.8.2 Low weight discharge

The Committee heard that early discharge of babies from hospitals, including discharge of babies weighing less than 2.5kgs, places pressure on MCH Service providers. Early discharge is discussed in Chapter One and communication between hospitals and MCH Service providers around this and other issues is discussed in section 6.9. This section will include evidence the Committee heard on the particular pressure discharge of babies weighing less than 2.5kgs places on MCH Service providers.

The Committee heard that while some MCH Service providers work with hospitals to provide shared care of babies discharged below 2.5kgs,¹⁴⁷⁰ some do not accept babies weighing less than 2.5kgs.¹⁴⁷¹ Ms Maree Crellin, MCH Coordinator with the City of Greater Geelong, told the Committee at a public hearing in Geelong that as a result of this, discharging babies weighing less than 2.5kgs creates a gap in care:

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

...

There has been a number of babies that go home under 2.5 kilos. They are still seen as receiving service from the hospital. It certainly raised some issues for us in the private sector, St John of God was sending babies home 2.1 kilos and we were saying we won't pick them up, so families are actually having to access their private health insurance to cover additional domiciliary visits.¹⁴⁷²

¹⁴⁶⁹ Ms Kim Little, Assistant Deputy Secretary, Early Childhood Portfolio, Department of Education and Training, Family and Community Development Committee public hearing – Melbourne, 27 November 2017, transcript of evidence, p. 11.

¹⁴⁷⁰ Ms Helen Lees, Maternal and Child Health Clinical Coordinator, City of Greater Bendigo, Family and Community Development Committee public hearing – Bendigo, 24 October 2017, transcript of evidence, p. 4

¹⁴⁷¹ Australian Nursing and Midwifery Federation (Victorian Branch), submission no. 67, p. 18; City of Greater Geelong Maternal and Child Health Service, submission no. 96, p. 4.

¹⁴⁷² Ms Maree Crellin, Maternal and Child Health Coordinator, City of Greater Geelong – Maternal and Child Health Service, Family and Community Development Committee public hearing – Geelong, 11 December 2017, transcript of evidence, p. 5.

The Committee heard from Ms Patti Reilly, Acting Family Health Coordinator of the City of Melbourne Family Health Service, at a public hearing in Melbourne that even when an MCH Service provider will provide care, a failure to communicate that a low weight baby has been discharged can lead to adverse health outcomes and readmission to hospital:

Babies used to be kept in hospital until they were 2.5 kilograms. That was considered a weight at which they could maintain their temperature and have enough energy to feed well. Now we are finding babies are discharged at 2 kilograms and often do not have enough energy to feed very well. We are not notified that they have been discharged at that low weight, so we have had the experience — and one of our team had the experience last week — of going into the home and finding a very unwell baby that was extremely dehydrated and required readmission for hydration. And because we were not notified — there is no coordination between discharge and pick-up of our service — there was no impetus to get in their early. Had we been informed, we could have sent someone in earlier to prevent that from developing into the situation that it did.¹⁴⁷³

When asked about how better to deal with low weight babies being discharged, Ms Reilly told the Committee a focus on communication would be sufficient.¹⁴⁷⁴

Ms Marilyn Humphrey, MCH Coordinator for Baw Baw Shire, told the Committee at a public hearing in Warragul that the gap between hospital and MCH care needed to be addressed by more home visiting provided by hospitals, noting that the care required for low weight babies is more than the MCH Service can or should provide:

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 ...

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.¹⁴⁷⁵

The Committee is concerned about a gap in care for babies discharged at less than 2.5kgs, and has recommended in Chapter One that the Victorian Government review hospital discharge policies. Section 6.9 below discusses communication between hospitals and MCH Service providers in more detail, and includes recommendations to improve communication, with particular reference to low weight babies.

¹⁴⁷³ Ms Patti Reilly, Acting Family Health Coordinator, City of Melbourne, Family and Community Development Committee public hearing – Melbourne, 18 September 2017, transcript of evidence, p. 3.

¹⁴⁷⁴ *Ibid.*, p. 9.

¹⁴⁷⁵ Ms Marilyn Humphrey, Maternal and Child Health Coordinator, Baw Baw Shire Maternal and Child Health Services, Family and Community Development Committee public hearing – Warragul, 8 December 2017, transcript of evidence, p. 4.

6.9 Communication between hospitals and MCH Service providers

This section outlines the legislative requirement for communication between hospitals and councils in the form of a birth notification, and the experience on the ground of MCH Service providers that the Committee heard in evidence throughout the Inquiry.

Evidence the Committee received concerning communication between hospitals and MCH Service providers showed a stark contrast between the experience of metropolitan and regional services. The Committee heard from local governments in metropolitan areas that communication was poor, affecting service delivery and outcomes for families. In its hearings in regional centres, the Committee heard of excellent communication and planning between hospitals and MCH Service providers. In particular witnesses told the Committee of antenatal communication systems that benefit families through increased information sharing. This evidence is discussed in sections 6.9.2 and 6.9.3.

The Committee also heard evidence about how long mothers and babies are kept in hospital before being discharged. This is discussed in Chapter One.

6.9.1 Birth notifications

The Committee heard from Ms Kim Little, Assistant Deputy Secretary of the Early Childhood Portfolio at DET, that there is legislation which provides for the MCH Service to be notified of every birth in Victoria:

The comprehensive nature of the MCH service actually has a legislative underpinning which is in the Child Wellbeing and Safety Act 2005. That requires hospitals or midwives in the case of homebirths to notify the relevant council of every new birth so that a locally-based MCH nurse can make contact with the family and provide the service to that family.¹⁴⁷⁶

The *Child Wellbeing and Safety Act 2005* (Vic) requires the responsible person to notify the Chief Executive Officer of the local council where the mother usually resides that the mother has given birth.¹⁴⁷⁷ This is required whether the child is born alive or dead, except for the delivery of a non-viable fetus. Not giving notice attracts a penalty of not more than one penalty unit.¹⁴⁷⁸

For babies born in a hospital, or brought to a hospital within 24 hours after birth, the responsible person is the Chief Executive Officer of the hospital. For babies not born in or brought to a hospital, the responsible person is the doctor or midwife responsible for the professional care of the mother at the birth or a doctor who examined the body of the still-born child after the birth or, if no doctor or midwife was in attendance at the birth, any other person in attendance at the birth.¹⁴⁷⁹

¹⁴⁷⁶ Ms Kim Little, Assistant Deputy Secretary, Early Childhood Portfolio, Department of Education and Training, Family and Community Development Committee public hearing – Melbourne, 27 November 2017, transcript of evidence, p. 2.

¹⁴⁷⁷ *Child Wellbeing and Safety Act 2005* (Vic) s. 43.

¹⁴⁷⁸ *Ibid.*, ss. 42-46.

¹⁴⁷⁹ *Ibid.*, s. 42(2); *Births, Deaths and Marriages Registration Act 1996* (Vic) s. 12(6).

Ms Lynne Smith, Acting Team Leader, Family Services with the City of Melbourne, told the Committee at a public hearing in Melbourne that the notification must be delivered within 48 hours of the birth:

Under the Child Wellbeing and Safety Act 2005, when a baby is born to a mother residing in the City of Melbourne, the birth notice is sent to the service within 48 hours of the delivery. The new mother is contacted to arrange an initial home visit and subsequent appointments.¹⁴⁸⁰

The Chief Executive Officer of the local council must send a copy of the birth notice to the nurse or midwife who is responsible for making contact with the family. If the council does not run an MCH centre, the Chief Executive Officer must send the notice to the Secretary of the Department of Education.¹⁴⁸¹

The form of a birth notice is laid out by Schedule 1 to the Child Wellbeing and Safety Regulations 2017,¹⁴⁸² which is reproduced in Appendix 6.

The Committee notes the Auditor-General's 2017 report *Effectively Planning for Population Growth* found a lack of a systemic check either by hospitals or local councils to ensure birth notifications have been properly delivered or received.¹⁴⁸³

While the Auditor-General did not make a specific recommendation in this area, the report states that DET acknowledges 'that there is an opportunity to improve the process for passing birth notifications between hospitals and councils'.¹⁴⁸⁴

The Committee is aware of Victorian Government documentation which provides guidance to hospitals and MCH Service providers in communication to enhance continuity of care. The 2004 document published by the Community Care Division of the Department of Human Services, *Continuity of care: A communication protocol for Victorian public maternity services and the Maternal and Child Health Service* 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.¹⁴⁸⁵

¹⁴⁸⁰ Ms Lynne Smith, Acting Team Leader, Family Services, City of Melbourne, Family and Community Development Committee public hearing – Melbourne, 18 September 2017, transcript of evidence, p. 2. See also: *Child Wellbeing and Safety Act 2005* (Vic) s. 44.

¹⁴⁸¹ *Child Wellbeing and Safety Act 2005* (Vic) s. 45.

¹⁴⁸² Statutory Rule No. 62/2017.

¹⁴⁸³ Victorian Auditor-General, *Effectively Planning for Population Growth*, Melbourne, Victorian Auditor-General's Office, August 2017, p. 34.

¹⁴⁸⁴ Ibid.

¹⁴⁸⁵ Department of Human Services, *Continuity of care: A communication protocol for Victorian public maternity services and the Maternal Child Health Service*, Melbourne, Victorian Government, 2004, p 1.

The communication protocol outlines good practice in communication between maternity services and the MCH Service. Further, the *Maternal and Health Service Guidelines 2011* note that in relation to the communication protocol:

Since the protocol was developed there have been changes to the Health Act 1958 and subsequent changes to birth notification, changes to the Children, Youth and Families Act 2005 and the introduction of Child FIRST. Consequently, the protocol has become out of date. A revised protocol is required to provide an adequate framework for the care of vulnerable families, including those from CALD or Indigenous backgrounds and young single mothers. This protocol will also reflect the role of Koori Maternity Services, and will provide an opportunity for private maternity services to be included.

The Continuity of Care Protocol will be revised in 2010-2011.¹⁴⁸⁶

The Protocol has not been updated since 2004.

The *Postnatal Care Program Guidelines for Victorian Health Services*, published by the Department of Health in 2012, outlines ‘the Victorian Government’s expectations of public health services, including Koori Maternity Services, in the delivery of postnatal care to ensure best quality care is provided to all women and their babies’.¹⁴⁸⁷ These Guidelines state Victorian Government expectations of health services, including:

1. Health services must establish and maintain effective linkages with other health services and community-based providers of maternity and newborn care to enable women to access appropriately qualified and skilled health professionals.
2. Health services must ensure MCH services are appropriately notified of infants and children that are vulnerable, including those known to Child Protection, Placement and Family Services.
3. Health services must ensure MCH services are appropriately notified of women who are vulnerable or disadvantaged or who have high needs. Health services must take measures to ensure continuity of care, a seamless transition between services and that there is no gap in care provision.
4. Health services must clearly document the provision and outcomes of postnatal services in the woman’s patient record and Child Health Record to ensure seamless referral and transfer of care.
5. The Child Health Record must provide the woman with sufficiently detailed information to take with her to her first MCH appointment.¹⁴⁸⁸

While the aims and expectations in these documents are commendable, evidence to the Committee from practitioners on the ground is that in many cases, particularly in metropolitan areas, they are not being achieved. The following sections 6.9.2 and 6.9.3 represent the evidence the Committee received on this issue, and include recommendations for improvements.

¹⁴⁸⁶ Department of Education and Early Childhood Development, *Maternal and Child Health Service Guidelines 2011*, Melbourne, Victorian Government, 2011, p. 27.

¹⁴⁸⁷ Department of Health, *Postnatal Care Program Guidelines for Victorian Health Services*, Victorian Government, Melbourne, 2012, p. 1.

¹⁴⁸⁸ *Ibid.*, p. 16.

6.9.2 Poor communication in metropolitan areas

The Committee heard from multiple metropolitan MCH Service providers that there are problems in communication between hospitals and local government.¹⁴⁸⁹ MCH Service providers told the Committee that currently communication is ad hoc, and relies on individual staff rather than a robust system.

Ms Patti Reilly, Acting Family Health Coordinator with the City of Melbourne, told the Committee that there is a lack of an agreed communication pathway between hospitals and MCH Service providers:

Domiciliary services are under pressure with the current hospital discharge policies. They work hard to communicate with us and they have some flexibility, but this is limited. The lack of any agreed communication pathway between domiciliary services and maternal and child health reinforces the ad hoc nature of communication between the two, making it unreliable.¹⁴⁹⁰

And further, the City of Melbourne's submission noted that for babies who required extra care, such as those who had been in a Neonatal Intensive Care Unit (NICU), the problem is exacerbated:

When babies have been admitted to a specialist unit like a Neonatal Intensive Care Unit, due to prematurity or other health issues the sharing of information encounters further barriers. It is often dependent on individual staff from MCH networking with staff in these units to ensure that communication occurs in the timeliest manner.

When this is absent, MCH are often informed of the discharge of premature and very low birth weight babies after the fact and, are not included in any of the discharge planning processes. This issue is worse when the special care unit is situated in a private setting. This lack of information can lead to a delay in getting MCH into the home to support the transition to care by parents, impacting on breastfeeding, bonding and the mental health of family members.¹⁴⁹¹

Communication failures included, in the case of the City of Melbourne, birth notifications with incorrect information,¹⁴⁹² and a lack of inclusion in discharge planning.¹⁴⁹³ The City of Greater Geelong, in its submission, noted that poor communication between service providers leads to poor outcomes,¹⁴⁹⁴ and suggested a common communication tool as a solution.¹⁴⁹⁵

The Committee heard that when family violence has been identified by a hospital, it may not be communicated to the relevant MCH Service provider, resulting in risk to staff. The City of Melbourne, in its submission, told the Committee that hospitals may not send domiciliary staff to homes in order to protect them from family violence,

¹⁴⁸⁹ See City of Melbourne, submission no. 21; City of Greater Geelong Maternal and Child Health Service, submission no. 96; City of Whitehorse, submission no. 46; Hume City Council, submission no. 69.

¹⁴⁹⁰ Ms Patti Reilly, Acting Family Health Coordinator, City of Melbourne, Family and Community Development Committee public hearing – Melbourne, 18 September 2017, transcript of evidence, p. 3.

¹⁴⁹¹ City of Melbourne, submission no. 21, p. 4.

¹⁴⁹² Ms Lynne Smith, Acting Team Leader, Family Services, City of Melbourne, Family and Community Development Committee public hearing – Melbourne, 18 September 2017, transcript of evidence, p. 3.

¹⁴⁹³ Ms Patti Reilly, Acting Family Health Coordinator, City of Melbourne, Family and Community Development Committee public hearing – Melbourne, 18 September 2017, transcript of evidence, p. 3.

¹⁴⁹⁴ City of Greater Geelong Maternal and Child Health Service, submission no. 96, p. 2.

¹⁴⁹⁵ *Ibid.*, p. 4.

resulting in risk for both the family and MCH staff.¹⁴⁹⁶ This was emphasised by Ms Patti Reilly, Acting Family Health Coordinator with the City of Melbourne, in her evidence at a public hearing:

For families where family violence has been identified, in the hospital there is a decision not to send domiciliary staff in to do a home visit. While this is understandable for the safety of the staff, it leaves women and children in a more vulnerable position, with fewer people watching out for them, isolating them further at a time that is universally identified as one of extra risk for family violence.¹⁴⁹⁷

The Committee shares the concern of those who presented evidence regarding poor communication between hospitals and MCH Service providers. These services should work together as much as possible to remove any gaps in care in the perinatal period so as to lead to better outcomes for babies, mothers and families. Before making any recommendations in this area, the Committee wishes to highlight instances of good communication it encountered during the Inquiry.

6.9.3 Good communication in rural and regional areas

The Committee's Inquiry process included visiting regional centres to hear about disparities in outcomes between rural and regional and metropolitan locations. The Committee heard that MCH Service providers and other perinatal health services in Bendigo, Warragul, Mildura, Bairnsdale, and Wangaratta were involved in meetings and planning with hospital and other services before children were born, facilitating better communication. In some cases the meetings witnesses refer to in this section are high risk infant panels, which are discussed briefly in Chapter One.¹⁴⁹⁸

The Committee heard from Ms Helen Lees, Maternal and Child Health Clinical Coordinator at the City of Greater Bendigo, that her service had been communicating and working with Bendigo Health before children were born in order to understand complex care requirements. Ms Lees noted that the increased communication before birth has resulted in better outcomes for families with risk factors such as family violence, substance abuse, and mental health issues. This planning includes her staff being included in Bendigo Health pre-birth/discharge conferences:

Having this complex pregnancy care program has enabled planning for workload, communication in relation to supports and the development of pre-birth case conferences or pre-discharge case conferences facilitating communication with all services involved, including the family — so a more prompt and approach response to families when they take their baby home. The issues for the family are identified and spoken about, rather than it taking a long time in some cases for the family to tell their story.¹⁴⁹⁹

¹⁴⁹⁶ City of Melbourne, submission no. 21, p. 2.

¹⁴⁹⁷ Ms Patti Reilly, Acting Family Health Coordinator, City of Melbourne, Family and Community Development Committee public hearing – Melbourne, 18 September 2017, transcript of evidence, pp. 3-4.

¹⁴⁹⁸ For more on high risk infant panels, see Department of Health and Human Services, 'High-risk panels and schedules – advice', Victorian Government, accessed 22 March 2018, <<http://www.cpmanual.vic.gov.au/advice-and-protocols/advice/high-risk/high-risk-panels-and-schedules>>.

¹⁴⁹⁹ Ms Helen Lees, Maternal and Child Health Clinical Coordinator, City of Greater Bendigo, Family and Community Development Committee public hearing – Bendigo, 24 October 2017, transcript of evidence, p. 6.

The Committee heard that working in a regional area is advantageous in this situation, with fewer health services involved, allowing staff to develop good relationships and communication systems.¹⁵⁰⁰

Ms Lees also told the Committee that when women are transferred to Melbourne to birth the birth notifications are less likely to be delivered on time:

If there have been complications and the baby has been born prematurely after the mother has been transferred to Melbourne to birth there, receiving the birth notice in the legislated time frame is less likely.¹⁵⁰¹

Ms Samantha Cooke, Community Health Coordinator at the Mildura Rural City Council, also told the Committee of antenatal meetings her staff were involved in, as part of a collective impact initiative known as Hands Up Mallee, along with high risk infant meetings. Ms Cooke told the Committee these meetings help them plan for their service delivery:

Hands Up Mallee have invited a lot of the services to join them with our pre-parenting work group, which is identifying priority areas during pregnancy and before pregnancy. Another service we do is our enhanced maternal and child health nurse attends the hospital for a regular meeting there to discuss women or identify women who are at risk and then to make sure that they are engaged with maternal and child health and especially for our enhanced services. We also attend the high-risk infant panel meeting at child protection, which helps us work with those families as well.¹⁵⁰²

Ms Cooke also reinforced what the Committee had heard from other regional MCH Service providers, that they have a good relationship and communication with the local hospital, allowing any issues with birth notices to be quickly addressed:

We have a great relationship with the hospital and we are notified [of a birth] within the 48 hours. We can ring if we need to. If there is an incorrect address that we find, we are quite happy to call and find that the address is a different address. We have a great relationship with the hospital.¹⁵⁰³

The Committee heard of similar positive communication from the Gippsland Lakes Community Health Service in Bairnsdale,¹⁵⁰⁴ Baw Baw Shire,¹⁵⁰⁵ and the Rural City of Wangaratta.¹⁵⁰⁶ This included that there is a benefit to fathers and extended families as well.¹⁵⁰⁷

¹⁵⁰⁰ Ibid., p. 5; Ms Marilyn Humphrey, Maternal and Child Health Coordinator, Baw Baw Shire Maternal and Child Health Services, Family and Community Development Committee public hearing – Warragul, 8 December 2017, transcript of evidence, p. 9.

¹⁵⁰¹ Ms Helen Lees, Maternal and Child Health Clinical Coordinator, City of Greater Bendigo, Family and Community Development Committee public hearing – Melbourne, 24 October 2017, transcript of evidence, p. 5.

¹⁵⁰² Ms Samantha Cooke, Community Health Coordinator, Mildura Rural City Council, Family and Community Development Committee public hearing – Mildura, 9 November 2017, transcript of evidence, p. 4.

¹⁵⁰³ Ibid.

¹⁵⁰⁴ Ms Ailsa Carr, Executive Manager, Family, Youth and Children's Services, Gippsland Lakes Community Health, Family and Community Development Committee public hearing – Bairnsdale, 7 December 2017, transcript of evidence, pp. 2-3, 8-9.

¹⁵⁰⁵ Ms Marilyn Humphrey, Maternal and Child Health Coordinator, Baw Baw Shire Maternal and Child Health Services, Family and Community Development Committee public hearing – Warragul, 8 December 2017, transcript of evidence, p. 9.

¹⁵⁰⁶ Ms Liz Flamsteed, Head of Innovation Fund Project in Antenatal Engagement, Rural City of Wangaratta, Family and Community Development Committee public hearing – Wangaratta, 25 October 2017, transcript of evidence, p. 3.

¹⁵⁰⁷ Ms Marilyn Humphrey, Maternal and Child Health Coordinator, Baw Baw Shire Maternal and Child Health Services, Family and Community Development Committee public hearing – Warragul, 8 December 2017, transcript of evidence, p. 4.

Ms Cooke noted one challenge her service faces through being closer to Adelaide than Melbourne. Ms Cooke told the Committee that when mothers give birth in Adelaide her service does not receive a notification:

We do not get a notification. So we have to wait for them to come home and contact us. Sometimes we are notified by domiciliary that people are back in town from Melbourne and places like that, but there is difficulty with when they are going out of the state, although Adelaide is closer for us; it is only a four-hour drive.¹⁵⁰⁸

The Committee is encouraged by the success stories it heard during its regional hearings. Effective communication and relationships between MCH Service providers and other perinatal health services have a positive impact on outcomes for babies, mothers, and families. What concerns the Committee are the gaps and failings in communication it heard evidence of between hospitals and MCH Service providers in Melbourne and Geelong.

While the aims and expectations in *Continuity of care: A communication protocol for Victorian public maternity services and the Maternal and Child Health Service*¹⁵⁰⁹ and *Postnatal Care Program Guidelines for Victorian Health Services*¹⁵¹⁰ referred to above are commendable, the evidence the Committee heard from practitioners on the ground is that in Victoria's largest cities, they are not being achieved.

Accordingly, the Committee recommends that:

RECOMMENDATION 6.6: The Victorian Government develop and promote updated protocols to complement birth notifications such that the responsible person under the *Child Wellbeing and Safety Act 2005* (Vic) must provide, along with a birth notification, relevant information regarding the health and care of the mother and child.

- This protocol should include particular provisions for providing information regarding premature, high risk, and low birth weight babies, risk factors for or existence of mental illness, risk factors for or existence of family violence, breastfeeding difficulties, and transitioning into any required allied services.
- In the case of low birth weight babies on discharge, the responsible person or their delegate should be required to engage in joint discharge planning with the relevant Maternal and Child Health Service provider.

The Committee recognises the value of the MCH Service engaging with families before a child is born. Evidence to the Committee showed that through meetings and communication facilitated by high risk infant panels, the complex pregnancy care program in Bendigo, and the innovation program described by Ms Liz Flamsteed in Wangaratta (see section 6.3), interaction with families before a child is born is greatly beneficial to families. Accordingly, the Committee recommends that:

RECOMMENDATION 6.7: The Victorian Government fund programs to promote antenatal contact with vulnerable families by the Maternal and Child Health Service.

¹⁵⁰⁸ Ms Samantha Cooke, Community Health Coordinator, Mildura Rural City Council, Family and Community Development Committee public hearing – Mildura, 9 November 2017, transcript of evidence, p. 3.

¹⁵⁰⁹ Department of Human Services, *Continuity of care: A communication protocol for Victorian public maternity services and the Maternal Child Health Service*, Melbourne, Victorian Government, 2004, p. 1.

¹⁵¹⁰ Department of Health, *Postnatal Care Program Guidelines for Victorian Health Services*, Melbourne, Victorian Government, 2012.

The Committee received evidence that birth notifications are not always received by the relevant MCH Service when a Victorian child is born interstate. The Committee's view is that this is a gap in communication that can and should be addressed by the Victorian Government, through improving and streamlining processes with other states and territories, especially those with which Victoria shares a border. Accordingly, the Committee recommends that:

RECOMMENDATION 6.8: The Victorian Government use its position on the Council of Australian Governments (COAG) to advocate, as a priority, to improve and streamline processes for the communication of birth notifications or their equivalent in other jurisdictions when a child is born outside of its home state.

The Committee heard during the Inquiry of errors or delays in delivery of birth notifications, and read in the Auditor-General's report *Effectively Planning for Population Growth* that MCH Service providers and hospitals lack strong systems to track birth notifications. While the Auditor-General did not make a specific recommendation in this area, the Committee believes this issue is worthy of Government action. Accordingly the Committee recommends that:

RECOMMENDATION 6.9: The Victorian Government require health services and Maternal and Child Health Service providers to implement systems to ensure delivery and receipt of accurate birth notifications occurs promptly.

- Systems to include reporting mechanisms which can confirm appropriate action on all birth notifications, and communication protocols between health services and Maternal and Child Health Service providers.
- The Victorian Government to investigate a method for hospitals to communicate birth notifications that takes advantage of the Child Development Information System used by the vast majority of local government Maternal and Child Health Services.

The Committee heard that the complexity and challenges that are part of the role of the MCH Service have broadened significantly over recent years, partly due to changes to traditional families and often the absence of extended family support. This has seen changes to the original role of the MCH nurse. Many of these challenges are being met through ad hoc programs such as Cradle to Kinder and Baby Makes 3. The current model of the ten Key Ages and Stages consultations is not always meeting the needs of modern, complex family life. The Committee believes that the MCH Service is highly valued and has adapted well to the growing complexity and challenges. The Committee believes the MCH Service will benefit from additional support. Accordingly, the Committee recommends that:

RECOMMENDATION 6.10: The Victorian Government, through the Department of Education and Training and in consultation with Maternal and Child Health Service providers and nurses, examine the model of the Maternal and Child Health Service to strengthen and provide a more holistic approach to perinatal care encompassing mental, social, emotional and physical health of the family.

7 Perinatal services for Aboriginal and Torres Strait Islander communities

AT A GLANCE

Background

The Committee heard that there have been improvements to perinatal outcomes for Aboriginal and Torres Strait Islander mothers and babies, however, there remain significant disparities in health and perinatal outcomes between Aboriginal and Torres Strait Islander communities and non-Aboriginal and Torres Strait Islander communities. This chapter outlines key issues identified in the submissions and in public hearings to the Inquiry, provides the latest published data on outcomes for Aboriginal and Torres Strait Islander communities, and examines barriers to accessing maternity and perinatal services.

This chapter will also discuss some of the positive initiatives that the Committee heard about during the Inquiry, including Aboriginal and Torres Strait Islander birthing rooms, Koori Maternity Services, initiatives to increase attendance at Maternal and Child Health services, cultural training for the healthcare workforce, scholarships to encourage an Aboriginal and Torres Strait Islander workforce, and programs to support vulnerable families.

Terms of reference addressed

This chapter addresses the following terms of reference:

1. the availability, quality and safety of health services delivering services to women and their babies during the perinatal period;
3. the adequacy of the number, location, distribution, quality and safety of health services capable of dealing with high risk and premature births in Victoria;
4. the quality, safety and effectiveness of current methods to reduce the incidence of maternal and infant mortality and premature births;
5. access to and provision of an appropriately qualified workforce, including midwives, paediatricians, obstetricians, general practitioners, anaesthetists, maternal and child health nurses, mental health practitioners and lactation consultants across Victoria;
6. disparity in outcomes between rural and regional and metropolitan locations; and
7. identification of best practice.

The Committee heard that there have been improvements to perinatal outcomes for Aboriginal and Torres Strait Islander mothers and babies, however, there remain significant disparities in health and perinatal outcomes between Aboriginal and Torres Strait Islander communities and non-Aboriginal and Torres Strait Islander communities. This chapter outlines key issues identified in the submissions and in public hearings to the Inquiry, provides the latest published data on outcomes for Aboriginal and Torres Strait Islander communities, and examines barriers to accessing maternity and perinatal services.

This chapter will also discuss some of the positive initiatives that the Committee heard about during the Inquiry, including Aboriginal and Torres Strait Islander birthing rooms, Koori Maternity Services, initiatives to increase attendance at Maternal and Child Health services, cultural training for the healthcare workforce, scholarships to encourage an Aboriginal and Torres Strait Islander workforce, and programs to support vulnerable families.

The Committee heard from many witnesses who were concerned about the health, safety and welfare of Aboriginal and Torres Strait Islander women during the perinatal period, including from the Wathaurong Aboriginal Co-operative, the Gippsland & East Gippsland Aboriginal Co-Operative (GEGAC), Mallee District Aboriginal Services (MDAS), and Bendigo and District Aboriginal Co-operative (BDAC).

7.1 Aboriginal and Torres Strait Islander women in the perinatal period

In 2016, 1,107 Aboriginal and Torres Strait Islander women gave birth to 1,117 babies, comprising 1.4 per cent of all mothers and 1.4 per cent of all babies born in Victoria.¹⁵¹¹ As noted in the Consultative Council on Obstetric and Paediatric Mortality and Morbidity (CCOPMM) report, the proportion of women giving birth who are Aboriginal and Torres Strait Islander in Victoria has increased from 0.6 per cent of all women giving birth in 2000 to 1.4 per cent in 2016.¹⁵¹²

CCOPMM's *Victoria's mothers, babies and children 2016* report notes that Aboriginal and Torres Strait Islander women are more likely to live in a rural area (52.7 per cent) compared with non-Aboriginal and Torres Strait Islander women (23.1 per cent).¹⁵¹³ Furthermore, Aboriginal and Torres Strait Islander women are more likely to be classified 'in the most disadvantaged socioeconomic quintile' (42.9 per cent) than non-Aboriginal and Torres Strait Islander women (19.7 per cent).¹⁵¹⁴

Aboriginal and Torres Strait Islander women are also more likely than non-Aboriginal and Torres Strait Islander women to be aged younger than 20 years when they give birth (11.0 per cent and 1.3 per cent respectively).¹⁵¹⁵

¹⁵¹¹ Consultative Council on Obstetric and Paediatric Mortality and Morbidity (CCOPMM), *Victoria's mothers, babies and children 2016*, Melbourne, 2017, p. 34.

¹⁵¹² Ibid.

¹⁵¹³ Ibid. See also: S Kildea, S Kruske, L Barclay and S Tracy, "Closing the Gap": How maternity services can contribute to reducing poor maternal infant health outcomes for Aboriginal and Torres Strait Islander women', *Rural and Remote Health*, vol. 10, 2010 (Online), p. 1.

¹⁵¹⁴ Index of Relative Social Disadvantage (IRSD): Consultative Council on Obstetric and Paediatric Mortality and Morbidity (CCOPMM), *Victoria's mothers, babies and children 2016*, Melbourne, 2017, p. 35.

¹⁵¹⁵ Consultative Council on Obstetric and Paediatric Mortality and Morbidity (CCOPMM), *Victoria's mothers, babies and children 2016*, Melbourne, 2017, p. 34.

The Committee heard from Ms Raylene Harradine, Chief Executive Officer, Bendigo and District Aboriginal Co-operative, and Chair of the Loddon Mallee Aboriginal Reference Group, that:

A lot of the young mums that come through the doors actually want to be mums too. I do not want to put a negative sort of spin on it. Sometimes there are unplanned pregnancies, but sometimes young people just want to have their babies early and they want someone to love.¹⁵¹⁶

Aboriginal and Torres Strait Islander women are also more likely to have diabetes before pregnancy than non-Aboriginal and Torres Strait Islander women (1.3 per cent and 0.8 per cent respectively), although the rates of gestational diabetes are similar among Aboriginal and Torres Strait Islander and non-Aboriginal and Torres Strait Islander women.¹⁵¹⁷

At a public hearing in Geelong, Ms Mandy Miller, a midwife at the Wathaurong Aboriginal Co-operative's Koori Maternity Service, stated that for many of Wathaurong Aboriginal Co-operative's clients, 'the fact that they are Aboriginal automatically classes their pregnancy as high risk', noting that late presentations and poor attendance for perinatal care has increased this risk historically.¹⁵¹⁸ The Committee also heard that Aboriginal and Torres Strait Islander children are 8.3 times more likely to be the subject of a child protection substantiation.¹⁵¹⁹ Mr Jason Spratt, of Mallee Family Care, told the Committee how previous contact with child protection can make all mothers, not just Aboriginal and Torres Strait Islander mothers, reluctant to connect with services:

Particularly for mums who have experienced significant contact with child protection services, they are wary. When we talk about retraumatising and we talk about their own family histories a lot of the time, being able to trust services like ours is really challenging, particularly when you are responding to a referral someone else has made.¹⁵²⁰

7.2 Aboriginal and Torres Strait Islander perinatal mortality in Victoria

As noted in Chapter One, Victoria's perinatal mortality rate (PMR) has continued to fall and is 8.8 per 1,000 births, down from 9.0 per 1,000 births in 2015.¹⁵²¹ The PMR for babies born to Aboriginal and Torres Strait Islander women has, until 2016, been

¹⁵¹⁶ Ms Raylene Harradine, Chief Executive Officer, Bendigo and District Aboriginal Co-operative, and Chair, Loddon Mallee Aboriginal Reference Group, Family and Community Development Committee public hearing – Bendigo, 24 October 2017, transcript of evidence, p. 8.

¹⁵¹⁷ Consultative Council on Obstetric and Paediatric Mortality and Morbidity (CCOPMM), *Victoria's mothers, babies and children 2016*, Melbourne, 2017, p. 34.

¹⁵¹⁸ Ms Mandy Miller, Midwife, Koori Maternity Service, Wathaurong Aboriginal Co-operative, Family and Community Development Committee public hearing – Geelong, 11 December 2017, transcript of evidence, p. 4.

¹⁵¹⁹ Department of Premier and Cabinet, *Victorian Government Aboriginal Affairs Report 2017*, Victorian Government, Melbourne, November 2017, p. 11. See also: Loddon Mallee Aboriginal Reference Group, submission no. 66, p. 1.

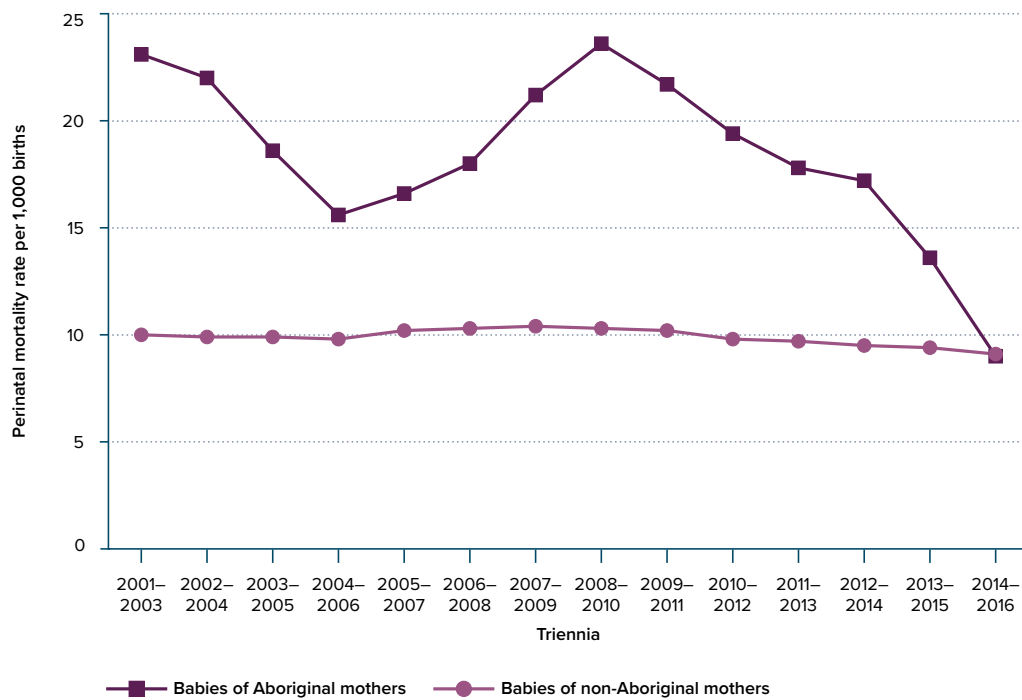
¹⁵²⁰ Mr Jason Spratt, Manager, Family Services, Mallee Family Care., Family and Community Development Committee public hearing – Mildura, 9 November 2017, transcript of evidence, p. 6.

¹⁵²¹ Consultative Council on Obstetric and Paediatric Mortality and Morbidity (CCOPMM), *Victoria's mothers, babies and children 2016*, Melbourne, 2017, p. 62.

substantially higher than those born to non-Aboriginal and Torres Strait Islander women. For the 2014-2016 triennium, the perinatal death rate for babies born to Aboriginal and Torres Strait Islander women was 9.0 per 1,000, and for non-Aboriginal and Torres Strait Islander women it was 9.1 per 1,000.¹⁵²²

Figure 7.1, taken from the most recent CCOPMM report, illustrates the trend in PMR for babies of Aboriginal and Torres Strait Islander and non-Aboriginal and Torres Strait Islander mothers.

Figure 7.1 Adjusted perinatal mortality by maternal Aboriginal and Torres Strait Islander status, Victoria, 2001-2016



Source: Consultative Council on Obstetric and Paediatric Mortality and Morbidity (CCOPMM), *Victoria's mothers, babies and children 2016*, Melbourne, 2017, p. 36.

Describing the falling stillbirth rate, Professor Euan Wallace, the Chief Executive Officer of Safer Care Victoria, told the Committee at a public hearing in Melbourne:

[F]rom about 2008 onwards we have seen a consistent progressive decline in the stillbirth rate in our Aboriginal women, a decline that we have not seen in non-Indigenous women, such that in the most recent triennium the stillbirth rate among Aboriginal women is lower than among non-Aboriginal women. Again, I am not aware of any other jurisdiction in Australia where that is so.¹⁵²³

Regarding the improvements made, Ms Kym Peake, the Secretary of the Department of Health and Human Services, said at a public hearing in Melbourne:

¹⁵²² According to the CCOPMM report, as there is a smaller number of Aboriginal perinatal deaths in any single year, results are pooled for three years and reported for rolling triennia. Consultative Council on Obstetric and Paediatric Mortality and Morbidity (CCOPMM), *Victoria's mothers, babies and children 2016*, Melbourne, 2017, p. 10.

¹⁵²³ Professor Euan Wallace, Chief Executive Officer, Safer Care Victoria, Family and Community Development Committee public hearing – Melbourne, 27 November 2017, transcript of evidence, p. 3.

I think those improvements ... in the outcomes for Aboriginal women are in large part due to the investment we have made over a number of years in the Koori maternity services program, which provides tailored flexible maternity care which is culturally safe. Those Koori maternity services are now providing antenatal care to about 75 per cent of Aboriginal women birthing in Victoria and, in partnership with the Victorian Aboriginal Community Controlled Health Organisation, released Koori maternity services guidelines, again to help inform practice.¹⁵²⁴

In recent years, many improvements have been made to perinatal outcomes for Aboriginal and Torres Strait Islander births. Despite this, some indicators remain high, such as the smoking cessation rate, which refers to the relative reduction of smoking in Aboriginal and Torres Strait Islander mothers in the second half of pregnancy as compared with the first half.¹⁵²⁵ The rate of smoking in the first half of pregnancy remained high among Aboriginal and Torres Strait Islander women (36.9 per cent) compared with non-Aboriginal and Torres Strait Islander women (8.2 per cent).¹⁵²⁶ Ms Brianna Ellis, of the Gippsland & East Gippsland Aboriginal Co-Operative told the Committee:

Smoking is not uncommon in the community, and I think the KMS [Koori Maternity Service] team do an amazing job trying to improve the knowledge and the awareness of some of those issues for families.¹⁵²⁷

Other indicators have decreased but remain higher than the indicators for non-Aboriginal and Torres Strait Islander women, for example, although babies of Aboriginal and Torres Strait Islander mothers having low birthweight (<2,500g) reduced from 11.5 per cent in 2015 to 9.8 per cent in 2016, it is higher than for babies of non-Aboriginal and Torres Strait Islander women (6.8 per cent).¹⁵²⁸

According to the CCOPMM report, Aboriginal and Torres Strait Islander women were less likely to initiate breastfeeding (87.0 per cent) than non-Aboriginal and Torres Strait Islander women (94.6 per cent).¹⁵²⁹ The preterm birth rate (having a baby born before 37 weeks' gestation) for babies of Aboriginal and Torres Strait Islander women is 60 per cent higher than for those of non-Aboriginal and Torres Strait Islander women.¹⁵³⁰

The Committee welcomes the recent CCOPMM data from 2016, which shows substantial declines in Aboriginal and Torres Strait Islander perinatal mortality. However, the Committee is cautious given the long history of significantly higher perinatal mortality rates for Aboriginal and Torres Strait Islander babies and believes that more data will be required to confirm or support the fact that this trend is being maintained. The Committee is keen to see improvements in other perinatal indicators, such as low birthweights and smoking cessation rates, and the 'closing of the gap' between health outcomes among Aboriginal and Torres Strait Islander and non-Aboriginal and Torres Strait Islander mothers birthing in Victoria.

¹⁵²⁴ Ms Kym Peake, Secretary, Department of Health and Human Services, Family and Community Development Committee public hearing – Melbourne, 27 November 2017, transcript of evidence p. 5.

¹⁵²⁵ Consultative Council on Obstetric and Paediatric Mortality and Morbidity (CCOPMM), *Victoria's mothers, babies and children 2016*, Melbourne, 2017, p. 10.

¹⁵²⁶ *Ibid.*, p. 35.

¹⁵²⁷ Ms Brianna Ellis, General Manager, Gippsland & East Gippsland Aboriginal Co-Operative, Family and Community Development Committee public hearing – Bairnsdale, 7 December 2017, transcript of evidence, p. 3.

¹⁵²⁸ Consultative Council on Obstetric and Paediatric Mortality and Morbidity (CCOPMM), *Victoria's mothers, babies and children 2016*, Melbourne, 2017, p. 10.

¹⁵²⁹ *Ibid.*, p. 35.

¹⁵³⁰ *Ibid.*, p. 34.

At a public hearing in Geelong, Ms Mandy Miller, midwife at the Wathaurong Aboriginal Co-operative's Koori Maternity Service (KMS), told the Committee that they would like to run pre-conception and sexual health education classes to reduce perinatal risks, but that there was no funding for sexual health education.¹⁵³¹ The Committee recognises the link between certain indicators, such as low birthweight and smoking during pregnancy, and believes that pre-conception and sexual health education would be beneficial in reducing perinatal risks and closing the gap. Thus, the Committee recommends that:

RECOMMENDATION 7.1: The Victorian Government fund all Aboriginal community controlled organisations to provide pre-conception and sexual health education to Aboriginal and Torres Strait Islander clients in order to address smoking rates and other contributors to perinatal mortality.

7.3 Closing the gap

The Committee believes that improving perinatal outcomes is paramount to improving the lifetime outcomes of Aboriginal and Torres Strait Islander people, and crucial to playing a part to closing the gap between Aboriginal and Torres Strait Islander and non-Aboriginal and Torres Strait Islander outcomes. The *Victorian Government Aboriginal Affairs Report 2017* notes:

Delivering enhanced maternal and early childhood services means removing system barriers, promoting genuine and effective partnerships and supporting Aboriginal families to access culturally safe services. Research has shown that the first five years of a child's life are fundamental to shaping a child's future. Ongoing investment in community-led responses to optimise maternal health and the development of Aboriginal children is an essential platform for self-determination; ensuring that all children have an equal chance to thrive and grow.¹⁵³²

Maternal and child health has been central to Aboriginal and Torres Strait Islander health strategies developed by both state and federal governments, such as the Closing the Gap annual reports, the Victorian Government Aboriginal Affairs reports,¹⁵³³ the *National Aboriginal and Torres Strait Islander Health Plan 2013-2023*,¹⁵³⁴ and the *Korin Korin Balit-Djak Aboriginal health, wellbeing and safety strategic plan 2017-2027*.¹⁵³⁵

In particular, the *Korin Korin Balit-Djak Aboriginal health, wellbeing and safety strategic plan 2017-2027* stated, in strategic direction 4.2.1, that over the next three years the Department of Health and Human Services (DHHS) will increase the number of Koori Maternity Services (KMS) across Victoria, and work with these

¹⁵³¹ Ms Mandy Miller, Midwife, Koori Maternity Service, Wathaurong Aboriginal Co-operative, Family and Community Development Committee public hearing – Geelong, 11 December 2017, transcript of evidence, p. 4.

¹⁵³² Department of Premier and Cabinet, *Victorian Government Aboriginal Affairs Report 2017*, Victorian Government, Melbourne, November 2017, p. 24.

¹⁵³³ For example, one of the six strategic areas in the Victorian Government Aboriginal Affairs Report 2017 is maternal and early childhood health and development: Department of Premier and Cabinet, *Victorian Government Aboriginal Affairs Report 2017*, Victorian Government, Melbourne, November 2017, p. 7.

¹⁵³⁴ Australian Department of Health and Ageing, *National Aboriginal and Torres Strait Islander Health Plan 2013-2023*, Commonwealth of Australia, Canberra, 2013.

¹⁵³⁵ Department of Health and Human Services, *Korin Korin Balit-Djak Aboriginal health, wellbeing and safety strategic plan 2017-2027*, DHHS, Melbourne, August 2017.

organisations and birthing hospital partners to implement the KMS guidelines.¹⁵³⁶ The plan also states that the Department will ‘increase the number of Aboriginal mothers and babies receiving culturally safe and high-quality perinatal care through the uptake of the KMS guidelines in mainstream maternity services’.¹⁵³⁷

The Committee understands that there are structural issues that contribute to placing Aboriginal and Torres Strait Islander women at a higher risk during the perinatal period, which need to be addressed. These include fear of removal of children and mainstream health institutions, lack of stable accommodation, domestic violence, higher exposure to drug and alcohol abuse, isolation, and poverty.

Ms Mandy Miller, midwife with the Koori Maternity Service, Wathaurong Aboriginal Co-operative outlined some of these issues:

It is well documented that the perinatal period can be a time for increased social and emotional difficulties, increased anxiety, mood disorders and mental health issues for Aboriginal women. Our clients have complex family issues, with domestic violence and drug and alcohol, child protection involvement, housing uncertainty, and involvement in the justice system, all of which have an adverse impact on the social and emotional wellbeing of our families.¹⁵³⁸

Ms Christine Gibbins, Health Services Coordinator with the Bendigo and District Aboriginal Co-operative, reinforced the obstacles that need to be overcome for some Aboriginal and Torres Strait Islander women when accessing perinatal health care:

We also have another program called Bringing them Home, which is around the stolen generation, and without even going into that, it is a huge mental health issue. By the time we get somebody coming in to general practice for an appointment for a sore throat, you have worked through a lot of mental health issues.¹⁵³⁹

Therefore, the Committee welcomes the goals in the *Victorian Government Aboriginal Affairs Report 2017*, both those in relation to maternal and early childhood health and development, and those of broader relevance to the health and wellbeing of Aboriginal and Torres Strait Islander communities.¹⁵⁴⁰

7.4 Barriers to accessing maternity and perinatal services

The Committee heard that there were cases of Aboriginal and Torres Strait Islander women not accessing any antenatal care, which increases the risk to both the mother and baby. As noted in the submission by the Loddon Mallee Aboriginal Reference Group:

¹⁵³⁶ Ibid., p. 60.

¹⁵³⁷ Ibid.

¹⁵³⁸ Ms Mandy Miller, Midwife, Koori Maternity Service, Wathaurong Aboriginal Co-operative, Family and Community Development Committee public hearing – Geelong, 11 December 2017, transcript of evidence, p. 3.

¹⁵³⁹ Ms Christine Gibbins, Health Services Coordinator, Bendigo and District Aboriginal Co-operative; Family and Community Development Committee public hearing – Bendigo, 24 October 2017, transcript of evidence, p. 7.

¹⁵⁴⁰ Department of Premier and Cabinet, *Victorian Government Aboriginal Affairs Report 2017*, Victorian Government, Melbourne, November 2017.

Unfortunately, the days when Aboriginal women were forced to give birth on the verandah of a local hospital is still within living memory, there is often a lack of trust in mainstream institutions and there are still cases of Aboriginal women arriving at hospitals in our region, in labour with no record of any antenatal care.¹⁵⁴¹

There are many barriers to accessing healthcare for Aboriginal and Torres Strait Islander women, including:

- intergenerational trauma and the fear of having their children taken away;
- the cost of accessing services;
- a lack of culturally appropriate services;
- homelessness;
- drug and alcohol abuse;
- domestic violence issues;
- isolation; and
- a fear of judgement from health providers.¹⁵⁴²

The Committee heard that the hospital environment could be threatening for Aboriginal and Torres Strait Islander people. At a public hearing in Mildura, the Committee heard from Ms Jacinta Molloy, the Manager of Early Years Services at Mallee District Aboriginal Services, who stated:

I think for the Aboriginal community hospitals are not necessarily seen as safe places, not places they really feel — I do not think welcome is the right word but historically there have been issues around birthing and the removal of children from birth suites and hospitals. These are the grandmothers and the great-grandmothers of the babies birthing now. So that continues to be challenging for those women and families. There is an ongoing fear of DHHS and also of [NSW Department of Family and Community Services] from across the river. So often they want to leave early even when there is no need for them to leave early, because they are fearful of what may come if they stay or what may be heard or found out about them.¹⁵⁴³

There are many factors that can make health services, including perinatal services, more accessible to Aboriginal and Torres Strait Islander people, including having Aboriginal and Torres Strait Islander Health Workers, increasing the number of Aboriginal and Torres Strait Islander people working in health services, funding health services so that they are affordable for Aboriginal and Torres Strait Islander people, and having culturally competent non-Aboriginal and Torres Strait Islander staff.¹⁵⁴⁴ It is also important to make health services available in rural and remote locations as Aboriginal and Torres Strait Islander women are more likely to live in rural areas.¹⁵⁴⁵

¹⁵⁴¹ Loddon Mallee Aboriginal Reference Group, submission no. 66, p. 3.

¹⁵⁴² See: Loddon Mallee Aboriginal Reference Group, submission no. 66, p. 3; Ms Mandy Miller, Midwife, Koori Maternity Service, Wathaurong Aboriginal Co-operative, Family and Community Development Committee public hearing – Geelong, 11 December 2017, transcript of evidence, pp. 3, 6.

¹⁵⁴³ Ms Jacinta Molloy, Manager, Early Years Services, Mallee District Aboriginal Services, Family and Community Development Committee public hearing – Mildura, 9 November 2017, transcript of evidence, p. 4.

¹⁵⁴⁴ Australian Indigenous HealthInfoNet, 'Summary of Aboriginal and Torres Strait Islander health, 2016', accessed 17 January 2018, <<http://www.healthinonet.edu.au/health-facts/summary>>.

¹⁵⁴⁵ Consultative Council on Obstetric and Paediatric Mortality and Morbidity (CCOPMM), *Victoria's mothers, babies and children 2016*, Melbourne, 2017, p. 34. See also: S Kildea, S Kruske, L Barclay and S Tracy, 'Closing the Gap': How maternity services can contribute to reducing poor maternal infant health outcomes for Aboriginal and Torres Strait Islander women', *Rural and Remote Health*, vol. 10, 2010 (Online), p. 1.

For example, at a public hearing in Mildura, Ms Molloy told the Committee of the cultural benefit of having an Aboriginal and Torres Strait Islander person employed in the service:

I think that it ensures women and families receive holistic care delivered and strengthened by Aboriginal culture and practice. In each Koori Maternity Service an Aboriginal person who is also a health professional is employed for not only their health knowledge but also their cultural knowledge locally and their knowledge of local families. So they live and work in their own community.¹⁵⁴⁶

7.5 Intrastate transfers and transport

The Committee heard that due to many Aboriginal and Torres Strait Islander pregnancies being categorised as high risk,¹⁵⁴⁷ the need to travel to tertiary centres, such as maternity hospitals in Melbourne, is not uncommon. The Committee heard that transfers were difficult for many reasons, including cultural and financial. At a public hearing in Mildura, Ms Molloy, the Manager of Early Years Services at Mallee District Aboriginal Services, discussed the difficulty of intrastate transfers:

Transfers to tertiary centres are often really difficult. Lots of our women have never been on a plane. They have never been to the city. They have no family in the city and no means of supporting their partner or other family members to go to that tertiary centre. So it is better for us if they go to a tertiary centre that has a KMS because we can liaise.¹⁵⁴⁸

Ms Molloy also drew attention to other difficulties, including staffing:

I think it needs to be recognised that most Aboriginal women in this town do not drive; they do not have licences. The public transport system is poor. If they are discharged at the weekend, they cannot get home. That is a challenge for us. The KMS midwives are not paid or supported by guidelines from the Department of Health to work on weekends but we do have to enable our clients to get home, or we provide taxi vouchers, but sometimes obviously we do not know they are going to be at the hospital. So that is challenging.¹⁵⁴⁹

Dr Nikhil Patravali, Director of Obstetrics and Gynaecology at Mildura Base Hospital, told the Committee that when Aboriginal and Torres Strait Islander patients need to be transferred the Hospital tries to find a situation that they are comfortable with, but this is not always possible:

¹⁵⁴⁶ Ms Jacinta Molloy, Manager, Early Years Services, Mallee District Aboriginal Services, Family and Community Development Committee public hearing – Mildura, 9 November 2017, transcript of evidence, p. 3.

¹⁵⁴⁷ For example, see Loddon Mallee Aboriginal Reference Group, submission no. 66, p. 2.

¹⁵⁴⁸ Ms Jacinta Molloy, Manager, Early Years Services, Mallee District Aboriginal Services, Family and Community Development Committee public hearing – Mildura, 9 November 2017, transcript of evidence, p. 4.

¹⁵⁴⁹ *Ibid.*, pp. 3-4.

We try our best, though, if a patient was identified in the antenatal period and if she were an Aboriginal and so on then we ask for a preference from the woman — for them to choose a tertiary hospital that they would like to go to or if they have had an experience with their relatives and so on. But in an emergency it is almost impossible.¹⁵⁵⁰

Many Aboriginal and Torres Strait Islander health services drew attention to the difficulty in funding their clients' trips to Melbourne when needed for high risk pregnancies. Ms Brianna Ellis, General Manager of Gippsland & East Gippsland Aboriginal Co-Operative (GEGAC), told the Committee at a public hearing in Bairnsdale that one of the challenges faced by GEGAC was the difficulty in supporting women who required medical transport, emergency relief, and accommodation for high risk pregnancies that required their transfer to Sale or Melbourne, or even transport to attend appointments in Melbourne:

A Melbourne trip for us we have worked out costs about \$900, because you have got the car, the travel allowance, staff wages — all of the other overheads that come with getting a person to Melbourne and back. We have also got safety risks. We try really hard to book appointments around midday so that they can do an up and back in one day, because we are 4 hours from Melbourne. If for any reason they get waylaid or the appointment is running late, we have got staff that are sometimes out for 12, 14 or 16 hours, who have left early in the morning and then come back. We have tried bundling people together in terms of taking three or four people on a trip, and that is quite challenging too because some people are waiting around all day.¹⁵⁵¹

Ms Ellis noted that there is often no accommodation available for families to support the mothers who are transferred, so they often rely on other programs and community support to try to support the families.¹⁵⁵²

At a public hearing in Geelong, Ms Miller from the Wathaurong Aboriginal Co-operative told the Committee:

The majority of our clients' medical/obstetric needs can be met by University Geelong Hospital, however, on occasion there is a need to attend a tertiary hospital in Melbourne. This often causes a number of issues for our families. Namely because we are under 100kms from Melbourne, accommodation for partner and family support is unfunded, transport is difficult, parking is expensive as is buying food. This makes the prospect of accessing care in Melbourne very difficult for our families.¹⁵⁵³

The Committee heard that one strategy that worked well for the Wathaurong Aboriginal Co-operative was that they received state funding for a vehicle and their Chief Executive Officer allowed that car to be used only for the KMS.¹⁵⁵⁴

At a public hearing in Bendigo, Ms Christine Gibbins, of the Bendigo and District Aboriginal Co-operative, told the Committee that patient transport arrangements were ad hoc and lacking in coordination, which does not service patients well, and puts pressure on staff:

¹⁵⁵⁰ Dr Nikhil Patravali, Director, Obstetrics and Gynaecology, Mildura Base Hospital, Family and Community Development Committee public hearing - Mildura, 9 November 2017, transcript of evidence, p. 11.

¹⁵⁵¹ Ms Brianna Ellis, General Manager, Gippsland & East Gippsland Aboriginal Co-Operative, Family and Community Development Committee public hearing - Bairnsdale, 7 December 2017, transcript of evidence, p. 9.

¹⁵⁵² Ibid., p. 3.

¹⁵⁵³ Ms Mandy Miller, Midwife, Koori Maternity Service, Wathaurong Aboriginal Co-operative, Family and Community Development Committee public hearing - Geelong, 11 December 2017, transcript of evidence, p. 4.

¹⁵⁵⁴ Ibid., p. 8.

It is about how we get somebody home to their family, or how we get them say from St Arnaud to the hospital safely. Again we have been asked to put them in a taxi. Well, you cannot put a mum and a newborn in a taxi, even if it is a half hour ride. And we have been asked to put them on buses. You just cannot do that. Even if the mum is pregnant and willing to come, often she will have anxiety around leaving home, let alone putting them on a bus. And they are going into the unknown with no support, which is hard for anybody, let alone our clientele. And often the coordination is not done. We are so insular when we work — the hospital does this, we do this and somebody else does this. We are not coordinating that. At the start of the day we must know somebody is going to be going home. So to get a phone call at 5 to 5 to my office to say, ‘Can you get this girl home tonight to St Arnaud?’, how do you do that?

You do not have the staff. And if you have someone who puts their hand up, they are already fatigued from doing a huge day of their own job, let alone then getting in a car, safely transporting precious cargo and still getting back to our workplace. Then you are looking at time in lieu, which cuts down your resources for the next day. It is really ad hoc, but I think we could do a lot better on the coordination of transport across the region so that it is not just about an infant but it is also about the adult and the family. To me, if I can say this safely in this room, it is almost like, ‘Well, somebody will pick it up’. It just does not work like that.¹⁵⁵⁵

The Committee believes that Aboriginal and Torres Strait Islander health organisations need more support and guidance in facilitating transfers for Aboriginal and Torres Strait Islander women with high risk pregnancies. Thus, the Committee recommends that:

RECOMMENDATION 7.2: The Victorian Government review intrastate transfers and transport with a view to providing more support to Aboriginal and Torres Strait Islander families living in rural and remote areas, and to provide funding for Aboriginal and Torres Strait Islander health services to facilitate transport and transfers.

7.6 Koori Maternity Services

There are many Aboriginal and Torres Strait Islander health and community organisations that provide services to particular regions. One initiative that DHHS described as ‘uniquely Victorian’ is the Koori Maternity Services (KMS), which has been providing maternity care to Aboriginal and Torres Strait Islander women, babies, and families since 2000.¹⁵⁵⁶

The KMS, which are funded by the Victorian Government, are provided by Aboriginal community controlled organisations and public health services. There are 14 KMS across Victoria. The KMS also develop strong links and working relationships with birthing hospitals and obstetricians, and around 60 per cent of Aboriginal and Torres

¹⁵⁵⁵ Ms Christine Gibbins, Health Services Coordinator, Bendigo and District Aboriginal Co-operative, Family and Community Development Committee public hearing – Bendigo, 24 October 2017, transcript of evidence, p. 5.

¹⁵⁵⁶ Department of Health and Human Services, ‘Koori Maternity Services guidelines’, DHHS website, p. 32, accessed 23 January 2018, <<https://www2.health.vic.gov.au/about/publications/policiesandguidelines/koori-maternity-services-guidelines-mar-2017>>.

Strait Islander women who give birth in Victoria's public hospitals receive antenatal care from a KMS.¹⁵⁵⁷ Importantly, Aboriginal and Torres Strait Islander women have a choice to access a KMS or a mainstream service.

The principles of service delivery of KMS include providing care that is culturally safe and responsive.¹⁵⁵⁸ Continuity of care is an important aspect of Koori Maternity Services and forms part of their program requirements in the DHHS Koori Maternity Services guidelines (objective 7).¹⁵⁵⁹ The Committee heard that continuity of care, discussed in detail in Chapter Two, is particularly important to enhancing perinatal outcomes for Aboriginal and Torres Strait Islander women.¹⁵⁶⁰

During the Inquiry, the Committee heard from several Aboriginal community controlled organisations that ran a KMS, such as the Wathaurong Aboriginal Co-operative, the Gippsland & East Gippsland Aboriginal Co-Operative (GEGAC), and Mallee District Aboriginal Services (MDAS). The KMS at MDAS has about 40 Aboriginal births a year and sees around 60 antenatal families.¹⁵⁶¹

GEGAC offers a KMS with two people employed in their KMS (around 35 per cent of their 170 staff members at GEGAC are Aboriginal and Torres Strait Islander).¹⁵⁶² Ms Ellis, General Manager of the Gippsland & East Gippsland Aboriginal Co-Operative, stated that Aboriginal and Torres Strait Islander workers are able to 'engage the families in a non-threatening way'.¹⁵⁶³ She also noted that a key to the success of KMS is self-determination for Aboriginal and Torres Strait Islander communities:

If you give the power back to Aboriginal communities to take responsibility, take ownership, that is where the solutions are going to come from, because where we have been able to provide at each step it is where we have been able to make a real difference.¹⁵⁶⁴

At a public hearing in Geelong, the Committee heard from Ms Miller from the Wathaurong Aboriginal Co-operative about the importance of the KMS program and how it fits in with other early years programs in improving outcomes and closing the gap:

The KMS program at Wathaurong Aboriginal Co-Operative provides a continuity of care model that is culturally responsive, evidence-based, focuses on decreasing health inequity and includes the full continuum of maternity care. In order to close the health gap for Aboriginal people, we need to ensure our children have the best possible start to life. In order to achieve this, we need healthy Aboriginal mothers receiving best practice antenatal care, birthing healthy babies within a healthy weight range who develop into healthy children who are school ready. This takes a

¹⁵⁵⁷ Department of Health and Human Services, *Koori Maternity Service Guidelines: Delivering culturally responsive and high-quality care*, Victorian Government, Melbourne, March 2017, p. 12.

¹⁵⁵⁸ Department of Health and Human Services, *Koori Maternity Service Guidelines: Delivering culturally responsive and high-quality care*, Victorian Government, Melbourne, March 2017.

¹⁵⁵⁹ *Ibid.*, p. 15.

¹⁵⁶⁰ Ms Mandy Miller, Midwife, Koori Maternity Service, Wathaurong Aboriginal Co-Operative, Family and Community Development Committee public hearing – Geelong, 11 December 2017, transcript of evidence, p. 3.

¹⁵⁶¹ Ms Jacinta Molloy, Manager, Early Years Services, Mallee District Aboriginal Services, Family and Community Development Committee public hearing – Mildura, 9 November 2017, transcript of evidence, p. 7.

¹⁵⁶² Ms Brianna Ellis, General Manager, Gippsland & East Gippsland Aboriginal Co-Operative, Family and Community Development Committee public hearing – Bairnsdale, 7 December 2017, transcript of evidence, pp. 2, 4.

¹⁵⁶³ *Ibid.*, p. 7.

¹⁵⁶⁴ *Ibid.*

multidisciplinary team based approach across the early years, starting with Koori Maternity Service, following onto maternal and child health and supported by programs like Cradle to Kinder, Aboriginal Stronger Families, Child First Innovations, in home support and Kinship Care, all working together to provide care, support and capacity building for our families.¹⁵⁶⁵

The Committee heard that the Wathaurong Aboriginal Co-operative has a strong collaboration with University Hospital Geelong and that an obstetric clinic is held once a month at the Co-operative, providing care for both low and high risk women in a community setting which has a high attendance rate.¹⁵⁶⁶ The Wathaurong Aboriginal Co-operative KMS program also provided other assistance for Aboriginal and Torres Strait Islander clients and acted as an important gateway to MCH services, discussed later in this chapter. Ms Miller from the Wathaurong Aboriginal Co-operative stated:

While KMS provide most of the perinatal care for their clients, they also play a very important role in the co-ordination of care, including assistance to access other service providers, inclusive of ultrasound, housing, attending appointments, transport, advocacy and support with child protection matters, Centrelink obligations and making appropriate referrals to other services such as domestic violence and drug and alcohol services.¹⁵⁶⁷

The table below shows the location of Koori Maternity Services in Victoria, three of which are located in hospitals.¹⁵⁶⁸

Table 7.1 Location of Koori Maternity Services around Victoria

Region	Koori Maternity Service
North and West Metropolitan	Victorian Aboriginal Health Service Western Health (Sunshine Hospital) Northern Health (The Northern Hospital)
Southern Metropolitan	Dandenong and District Aborigines Co-operative Peninsula Health (Frankston Hospital)
Barwon South West	Wathaurong Aboriginal Co-operative Gunditjmara Aboriginal Co-operative
Hume	Rumbalara Aboriginal Co-operative Mungabareena Aboriginal Corporation
Gippsland	Gippsland & East Gippsland Aboriginal Co-Operative Central Gippsland Aboriginal Health Service
Loddon Mallee	Mallee District Aboriginal Services – Mildura Mallee District Aboriginal Health Service – Swan Hill Njernda Aboriginal Corporation

Source: Department of Health and Human Services, 'Aboriginal maternity services', Victorian Government, accessed 4 June 2017, <<https://www2.health.vic.gov.au/hospitals-and-health-services/patient-care/perinatal-reproductive/maternity-newborn-services/aboriginal-maternity-services>>.

¹⁵⁶⁵ Ms Mandy Miller, Midwife, Koori Maternity Service, Wathaurong Aboriginal Co-operative, Family and Community Development Committee public hearing – Geelong, 11 December 2017, transcript of evidence, p. 2.

¹⁵⁶⁶ Ibid., p. 3.

¹⁵⁶⁷ Ibid.

¹⁵⁶⁸ Department of Health and Human Services, *Koori Maternity Service Guidelines: Delivering culturally responsive and high-quality care*, Victorian Government, Melbourne, March 2017, p. 9.

7.6.1 Koori Maternity Service minimum data set

As detailed in Chapter One, data is collected on every woman giving birth in Victoria in the form of the Victorian Perinatal Data Collection (VPDC). The VPDC is a population-based surveillance system that collects information on obstetric conditions, procedures and outcomes, neonatal morbidity and congenital anomalies, and covers more than 100 data items.¹⁵⁶⁹ In addition to this data collection, health services and Aboriginal community controlled health organisations providing Koori Maternity Services are required to submit program data twice a year to DHHS. The KMS data set, which started in 2010, includes aggregated, de-identified data on:

- the number of women giving birth;
- the number of births attended by Program midwives and Aboriginal and Torres Strait Islander Health Workers;
- the number of women receiving pregnancy care, the woman's risk level, and the settings the care is delivered in;
- the number of women referred to other services during the antenatal period;
- the number of women referred to support services for alcohol and drug dependencies and smoking cessation strategies;
- the gestational age at first antenatal contact;
- the woman's age and BMI at first contact with the KMS program;
- cigarette smoking and drug/alcohol use at first contact with the KMS program;
- cigarette smoking and drug/alcohol use in the third trimester;
- the gestational age at birth;
- birth weight; and
- breastfeeding.¹⁵⁷⁰

The Committee heard that not all areas were adequately serviced by KMS programs. In their submission, the Loddon Mallee Aboriginal Reference Group stated that while KMS provide 'an excellent model of care', they do not exist in all local areas (such as Robinvale and Bendigo).¹⁵⁷¹ Likewise, Ms Miller from the Wathaurong Aboriginal Co-operative stated that while the Wathaurong KMS program provides 'a gold standard model of care' for their community, it is 'extremely difficult to provide the same level of care to areas outside of Geelong' with the current workforce.¹⁵⁷²

The Committee is pleased that there is a commitment to increase access to culturally responsive early years programs, particularly KMS programs, in the recent *Korin Korin Balit-Djak Aboriginal health, wellbeing and safety strategic plan 2017-2027*. The

¹⁵⁶⁹ Department of Health and Human Services, 'Victorian Perinatal Data Collection (VPDC)', accessed 9 May 2018, <<https://www2.health.vic.gov.au/hospitals-and-health-services/quality-safety-service/consultative-councils/council-obstetric-paediatric-mortality/perinatal-data-collection>>.

¹⁵⁷⁰ Department of Health and Human Services, 'Data specifications: Koori Maternity Service minimum data set', Victorian Government, accessed 9 May 2018, <<https://www2.health.vic.gov.au/about/publications/policiesandguidelines/Data%20specifications%20for%20the%20Koori%20Maternity%20Service%20Minimum%20Data%20Set>>.

¹⁵⁷¹ Loddon Mallee Aboriginal Reference Group, submission no. 66, p. 3.

¹⁵⁷² Ms Mandy Miller, Midwife, Koori Maternity Service, Wathaurong Aboriginal Co-operative, Family and Community Development Committee public hearing – Geelong, 11 December 2017, transcript of evidence, p. 4.

Committee believes that all Aboriginal and Torres Strait Islander women should be able to access KMS programs, or alternatively, be able to access mainstream services which are staffed by health professionals trained in cultural awareness. Accordingly, the Committee recommends that:

RECOMMENDATION 7.3: Consistent with the *Korin Korin Balit-Djak Aboriginal health, wellbeing and safety strategic plan 2017-2027*, the Victorian Government identify areas not currently serviced by Koori Maternity Service programs with a view to expanding programs and funding, in collaboration with Aboriginal community controlled organisations and other mainstream services.

7.7 Aboriginal and Torres Strait Islander birthing rooms

The Committee heard about several mainstream hospitals opening Aboriginal and Torres Strait Islander birthing rooms to cater for Aboriginal and Torres Strait Islander women giving birth at their hospital. In February 2017, the Northern Hospital opened their first Koori Maternity Birthing Room.¹⁵⁷³ Ms Jodie Ashworth, General Manager of Surgery, Women’s and Children’s, Operating Theatres and ICU and Chief Nursing Officer at Northern Health, told the Committee at a public hearing in Melbourne that the birthing room was very popular not only with the Aboriginal and Torres Strait Islander community but with culturally and linguistically diverse families.¹⁵⁷⁴ Media reporting when the room opened described the room’s unique setting:

Unlike conventional “birthing suites” gum leaves are scattered across the room and a vibrant mural covers a feature wall. When commissioned to create the piece, local artist Kahli Luttrell says she drew on her own experience as a mother-of-four - and added a series of culturally “appropriate” references.

“There was a selected tree and it was known as the ‘birthing tree’ and that was hollowed out by fire burnt out in the middle and they’d go at that time and give birth in the tree,” she said.¹⁵⁷⁵

The University Hospital Geelong will also open an Aboriginal Birthing Unit in 2018. Ms Miller from Wathaurong Aboriginal Co-operative said that while there is no guarantee that an Aboriginal and Torres Strait Islander woman birthing at the hospital will get that room, ‘the fact that they know it is there actually makes a huge difference’.¹⁵⁷⁶

We have a local artist who is doing the artwork. Traditionally we had a birthing cave here at Geelong, down at Portarlington, so the artist is going to be doing a mural that is the view from the birth cave which will be of the bay and the You Yangs. The women are very, very excited about that. The wall then goes onto a wall where the window is and what we’re planning is to have a birth tree that goes around the

¹⁵⁷³ SBS, ‘Medicine and art combine at Melbourne’s first Indigenous birthing room’, accessed 2 March 2018, <<https://www.sbs.com.au/news/medicine-and-art-combine-at-melbourne-s-first-indigenous-birthing-room>>.

¹⁵⁷⁴ Ms Jodie Ashworth, General Manager, Surgery, Women’s and Children’s, Operating Theatres and ICU and Chief Nursing Officer, Northern Health, Family and Community Development Committee public hearing – Melbourne, 5 February 2018, transcript of evidence, p. 4.

¹⁵⁷⁵ SBS, ‘Medicine and art combine at Melbourne’s first Indigenous birthing room’, accessed 2 March 2018, <<https://www.sbs.com.au/news/medicine-and-art-combine-at-melbourne-s-first-indigenous-birthing-room>>.

¹⁵⁷⁶ Ms Mandy Miller, Midwife, Koori Maternity Service, Wathaurong Aboriginal Co-operative, Family and Community Development Committee public hearing – Geelong, 11 December 2017, transcript of evidence, p. 5.

window. The women don't want their babies to come until that room is done now; they're a bit worried they're going to miss out, but I'm sure they will get there with number two, three and four.¹⁵⁷⁷

As the percentage of Aboriginal and Torres Strait Islander women birthing at Geelong Hospital is small in comparison to non-Aboriginal and Torres Strait Islander births, the room is available for non-Aboriginal and Torres Strait Islander women, which is seen as an opportunity for community education:

Because Geelong Hospital has such a large birth rate, and we have at most 50, 55 births a year, you can't hold a room aside for that amount of people. I think it's also an opportunity for education of the wider community and for all the midwives, they will have to know the story of why we have this room, and to be able to give some education to women around Aboriginal health and why the things are important I think is a great opportunity as well. Last year Northern Hospital did a birth room and they are finding that non-Indigenous women are actually asking for it because it's so beautiful and it makes them feel relaxed, which is fantastic, so that education I think is really, really valuable as well.¹⁵⁷⁸

The Committee was very interested to hear about Aboriginal and Torres Strait Islander birthing rooms and their potential to provide a culturally safe space for Aboriginal and Torres Strait Islander women giving birth. Accordingly, the Committee recommends that:

RECOMMENDATION 7.4: The Victorian Government conduct a review of Aboriginal birthing rooms across the state to expand and develop training packages/learning experiences that would be valuable for other maternity services around the state.

7.8 Maternal and Child Health Services

The Committee heard that Aboriginal and Torres Strait Islander families were less likely to attend maternal and child health services.¹⁵⁷⁹ Ms Miller from the Wathaurong Aboriginal Co-operative stated that a lot of vulnerable families in their region hadn't been accessing the universal services through the council 'for a number of reasons':

Sometimes it's cultural safety, they don't feel culturally safe; they see maternal and child health as an arm of child protection so they're very frightened — transgenerational trauma is very high around that ...¹⁵⁸⁰

Ms Miller noted that some of the criticisms of the service was that it was not flexible in their appointment book, and that language used is 'very prescriptive' and 'not culturally safe'.¹⁵⁸¹ She told the Committee:

¹⁵⁷⁷ Ibid.

¹⁵⁷⁸ Ibid.

¹⁵⁷⁹ Ms Kim Little, Assistant Deputy Secretary, Early Childhood Portfolio, Department of Education and Training, Family and Community Development Committee public hearing – Melbourne, 27 November 2017, transcript of evidence, p. 3.

¹⁵⁸⁰ Ms Mandy Miller, Midwife, Koori Maternity Service, Wathaurong Aboriginal Co-operative, Family and Community Development Committee public hearing – Geelong, 11 December 2017, transcript of evidence, p. 6.

¹⁵⁸¹ Ibid., pp. 6-7.

We know the recommendation is not to co-sleep with your baby, we know that there is increased risks of SIDS and sleep accidents, but the reality is our women culturally will sleep with their baby so they will just say: oh, no, I don't sleep with my baby. So, you've lost an opportunity to discuss that and to discuss what is the harm minimisation approach we can use here, how can we do it safely? Okay, we don't have our baby in our bed if we've been drinking alcohol or taking any other drugs, or if you're really, really tired. You can get little inserts that can go in your bed so baby has their own space. All of those sorts of things. What we've found in the research is that mums, all mums, are so scared about sleeping with their baby that they fall asleep on the couch with their baby and babies are falling off the couch and becoming injured or slipping between the cushions and smothering. We're scaring mothers out of doing one thing but they're actually replacing it with something that's unsafe because we don't have that conversation. Some of our mums have been in trouble because they've got a mattress on the floor in the lounge room and everyone is sleeping in there. But that is culturally very, very appropriate for our families so there's lots of those sorts of things.¹⁵⁸²

Ms Miller noted that for the last 12 months they have been working on a pilot program where an MCH nurse from the local council comes to Wathaurong Aboriginal Co-operative which has been very successful and resulted in 14 families who had never accessed the mainstream service and 12 families who have re-engaged with the service. She stated:

The community is really speaking up loud that this is their preferred model of care, that they get to know the KMS midwife and health worker very well in the pregnancy and it's our office that is used by the maternal and child health nurse so they feel very comfortable. It becomes a one-stop-shop, they can have their immunisations done on the same day that they have their key age and stage check. If the maternal and child health nurse is concerned about something we've got a GP that can come and participate in the consultation. We have a direct referral process with the pediatrician who comes out to visit and it all happens at home, it all happens at Wathaurong, so it makes a really big difference.¹⁵⁸³

In Mildura, Ms Samantha Cooke, Community Health Coordinator at Mildura Rural City Council, told the Committee that they work with Mallee District Aboriginal Services (MDAS), the local service provider for Aboriginal and Torres Strait Islander people. This gives Aboriginal and Torres Strait Islander families a choice of provider:

We do get notification of all babies, and that includes Aboriginal babies. We have an MOU with MDAS that if people choose to use their maternal and child health service, we will transfer them over to that service. Some people do go over there, but we still do provide services to Aboriginal people.¹⁵⁸⁴

Ms Maree Crellin, Maternal and Child Health Coordinator with the City of Greater Geelong, told the Committee of current efforts to make their centres more culturally inclusive:

¹⁵⁸² Ibid., p. 7.

¹⁵⁸³ Ibid.

¹⁵⁸⁴ Ms Samantha Cooke, Community Health Coordinator, Mildura Rural City Council, Family and Community Development Committee public hearing – Mildura, 9 November 2017, transcript of evidence, p. 5.

Part of our service improvement plan this year is to try and do an audit to make sure that all of our centres are as culturally inclusive as possible. Again, talking about the flyer, we are hoping to be able to pull those out and adapt the information packs that we give to families. We've got a copy of the apology in all of our centres so we're working towards making sure that our centres are as inclusive as possible.¹⁵⁸⁵

The Department of Education and Training (DET) is working with Aboriginal community controlled organisations, such as the Victorian Aboriginal Health Service in Fitzroy, on a project to address the issue of Aboriginal and Torres Strait Islander participation in MCH services.¹⁵⁸⁶ Ms Kim Little, the Assistant Deputy Secretary of DET's Early Childhood Portfolio, described the project to the Committee at a public hearing in Melbourne:

[O]ne of the things that was funded in not this budget but the previous budget was a project to work with Aboriginal community controlled organisations and local government in order to shape up some different ways of delivering MCH services in partnership and in some cases actually out of the premises and controlled by Aboriginal community controlled organisations. There are nine sites that have been selected for piloting of those different approaches, those different partnership approaches, starting now and two towards the end of next year. The aim is to better engage Aboriginal families in those services, given that their participation rates are lower and they have told us that they often prefer services delivered out of Aboriginal community controlled organisations because it gives them continuity of care and it gives them the cultural safety that they want and are entitled to. As part of that as well we are working with the mainstream services on better cultural safety training within the MCH service as a whole, so that is specifically around Aboriginal families.¹⁵⁸⁷

There were three different approaches outlined by DET at a public hearing in Melbourne.¹⁵⁸⁸ The first was the local government MCH service having 'heavy involvement' from the local Aboriginal community controlled organisation (ACCO) 'to help make that service have a more effective outreach, to be more culturally safe and to be more acceptable and of high quality for Aboriginal and Torres Strait Islander families'.¹⁵⁸⁹ The second model is where the local government has a MCH nurse employed by it to go to the ACCO and be placed within that organisation, working with those services. The third model, described by Ms Little as a 'genuine innovation', is to have MCH nurses 'actually employed by the ACCO themselves but to then have partnerships back into the local government'.¹⁵⁹⁰ The Committee heard that all of these models have been funded across Victoria, including in rural and regional areas.¹⁵⁹¹

The Committee heard about several local government initiatives to increase participation rates in maternal and child health services for the Aboriginal and Torres Strait Islander population. For example, Baw Baw Shire has an Aboriginal and Torres

¹⁵⁸⁵ Ms Maree Crellin, Maternal and Child Health Coordinator, City of Greater Geelong Maternal and Child Health Service, Family and Community Development Committee public hearing – Geelong, 11 December 2017, transcript of evidence, p. 7.

¹⁵⁸⁶ Ms Kim Little, Assistant Deputy Secretary, Early Childhood Portfolio, Department of Education and Training, Family and Community Development Committee public hearing – Melbourne, 27 November 2017, transcript of evidence, pp. 3, 10-11.

¹⁵⁸⁷ *Ibid.*, p. 6.

¹⁵⁸⁸ *Ibid.*, p. 11.

¹⁵⁸⁹ *Ibid.*

¹⁵⁹⁰ *Ibid.*

¹⁵⁹¹ *Ibid.*

Strait Islander population of 1.1 per cent, which is higher than the Victorian average of 0.8 per cent, and a fertility rate of 2.1 children per woman, higher than the Victorian rate of 1.8 children per woman.¹⁵⁹² Ms Marilyn Humphrey, the Maternal and Child Health Coordinator, told the Committee at a public hearing in Warragul that there was a 68.56 per cent participation rate in the maternal and child health service, which was ‘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.¹⁵⁹³

At a public hearing in Warragul, Ms Nicky Lappin, the Coordinator of Family Health and Development at Latrobe City Council Maternal and Child Health Service, told the Committee about the monthly outreach service provided by two of their MCH nurses to Koori Maternity Services, an Aboriginal and Torres Strait Islander childcare centre and Orana Gunya, a women’s refuge:

We are really working on increasing, obviously, Aboriginal children’s number of key age and stage visits. They have 100 per cent participation in home visits when a child is born, but then that drops to 59 per cent when the children are two or three years old. So that is what we are working on. That has really improved our relationships with the Aboriginal community and helped to improve trust within the community; however, the numbers have still not risen to where we would like them to be, which would actually be 100 per cent.

As part of the Aboriginal maternal and health child health initiative, we have received funding to employ a universal maternal and child health nurse to work within Koori maternity services for two days per week, so actually working within the service rather than just providing outreach to that service. As well an Aboriginal health worker will be employed for four days a week, and they will work two days a week in the Koori maternity services and two days a week within the universal service and the enhanced maternal and child health service to help families engage in whatever way they need to engage with us, so giving us a choice about how they engage with the maternal and child health service.¹⁵⁹⁴

The Committee believes that attending maternal and child health services is an important step toward improving the outcomes of both mothers and their babies, and is pleased that there are several initiatives being piloted to engage the Aboriginal and Torres Strait Islander community and encourage participation in the program. Accordingly, the Committee recommends that:

¹⁵⁹² Mrs Carmel Riley, President, Olivia’s Place, Family and Community Development Committee public hearing – Warragul, 8 December 2017, transcript of evidence, p. 3.

¹⁵⁹³ Ms Marilyn Humphrey, Maternal and Child Health Coordinator, Baw Baw Shire Maternal and Child Health Services, Family and Community Development Committee public hearing – Warragul, 8 December 2017, transcript of evidence, pp. 3-4.

¹⁵⁹⁴ Ms Nicky Lappin, Coordinator, Family Health and Development, Latrobe City Council Maternal and Child Health Service, Family and Community Development Committee public hearing – Warragul, 8 December 2017, transcript of evidence, p. 2.

RECOMMENDATION 7.5: The Victorian Government conduct ongoing assessment of the various pilot programs being delivered in partnership with Maternal and Child Health Services to ensure that postnatal care of Aboriginal and Torres Strait Islander women and children is culturally appropriate, accessible and meeting the needs of Aboriginal and Torres Strait Islander families in their communities.

7.9 Mental health services

Ms Miller from the Wathaurong Aboriginal Co-operative told the Committee that while the perinatal period can be a time of increased social and emotional difficulties, mood disorders, increased anxiety, and mental health issues for Aboriginal and Torres Strait Islander women, it is also a time in which Aboriginal and Torres Strait Islander women are more likely to access health services:

Our clients have complex family issues, with [domestic violence, alcohol and other drug use], child protection involvement, housing uncertainty, and involvement in the justice system, all of which have an adverse impact on the social and emotional wellbeing of our families.

Pregnancy, however, is a great opportunity for families to receive assistance when they access the health service.¹⁵⁹⁵

However, Ms Miller noted that accessing support services is not always easy with many mainstream services lacking cultural responsiveness, clients facing long waiting lists, and a lack of availability of female counsellors, which often meant that 'emotional and social support falls to the Midwife and Aboriginal health worker further increasing workloads'.¹⁵⁹⁶

In 2014, the Centre for Perinatal Excellence (COPE) released a report into Aboriginal and Torres Strait Islander perinatal mental health which stated that there are 'extensive' mental health problems in Aboriginal and Torres Strait Islander communities, more than in the broader population, with high rates of depression, anxiety, trauma, grief, self-harm, suicide and domestic violence.¹⁵⁹⁷ COPE notes that, despite this, Aboriginal and Torres Strait Islander people are less likely to engage with mental health services 'due in large part to the potential for culturally inappropriate services that fail to embrace Aboriginal concepts of health and wellbeing'.¹⁵⁹⁸ Regarding mental health screening and the barriers to accessing mental health services, the report stated:

When investigating the potential barriers and enablers to screening and assessment, interestingly the most frequently identified issues were *fear, trust* and *stigma*. In turn, these barriers are perceived by health professionals to be impacting on disclosure and ultimately the effectiveness of screening and assessment practices. These issues, together with the perceived *unavailability of culturally appropriate referral*

¹⁵⁹⁵ Ms Mandy Miller, Midwife, Koori Maternity Service, Wathaurong Aboriginal Co-operative, Family and Community Development Committee public hearing – Geelong, 11 December 2017, transcript of evidence, p. 3.

¹⁵⁹⁶ Ibid.

¹⁵⁹⁷ NJ Hightet and AK Goddard, *Aboriginal and Torres Strait Islander Perinatal Mental Health Mapping Project: A scoping of current practice surrounding the screening, assessment and management of perinatal mental health across Australia's New Directions: Mothers and Baby Service program*, Centre of Perinatal Excellence (COPE), June 2014, p. 14.

¹⁵⁹⁸ Ibid.

services were also perceived by almost all health professionals to be preventing post-screening referrals being acted upon by women. This is being further impeded by current poor communication between services – another major barrier to effective referral practices. Further, in some cases more logistical issues such as transport were also commonly identified barriers to screening and referral practice.¹⁵⁹⁹

Given the increased risk of mental health issues for Aboriginal and Torres Strait Islander women during the perinatal period, the Committee recommends that:

RECOMMENDATION 7.6: The Victorian Government ensure that all mental health workers providing perinatal care are trained in cultural awareness and engagement with Aboriginal and Torres Strait Islander communities.

7.10 Cultural training for mainstream workforce

Throughout the Inquiry, the Committee heard about cultural training programs for mainstream healthcare workers. At the university level, the Committee heard that every Bachelor of Nursing program has an Aboriginal and Torres Strait Islander health course.¹⁶⁰⁰ Ms Jan Jones, the Coordinator of Federation University’s midwifery and nursing programs, told the Committee, at a public hearing in Warragul, that they have Aboriginal and Torres Strait Islander cultural training in their course and that Koori Maternity Service midwives and healthcare workers talk to the students in an informal way.¹⁶⁰¹

The Royal Women’s Hospital runs workshops on cultural competence around the state through their Maternity Services Education Program. The Koori Maternity Services Maternity Update Program and the Cultural Safety in Maternity and Newborn Emergencies (MANE) Program are two programs currently running in Victoria.¹⁶⁰²

The Committee was encouraged to hear about the training offered at many health services. Ms Ailsa Carr, the Executive Manager of Family, Youth and Children’s Services at Gippsland Lakes Community Health, told the Committee at a public hearing in Bairnsdale:

We have generic Aboriginal cultural training that is offered to all staff members. Then we have a tiered approach, I would say. When those staff are going to be working with clients we have a more in-depth process for training. Everyone, including our accounts payable people, will do some level of training, but then we have more comprehensive training for those staff that are actually working out with clients. Then we have a supported program through our scholarship program for those staff

¹⁵⁹⁹ Emphasis in original. *Ibid.*, p. 5.

¹⁶⁰⁰ Associate Professor Phil Maude, Council Executive Member, Council of Deans of Nursing and Midwifery (Australia & New Zealand), Family and Community Development Committee public hearing – Melbourne, 27 November 2017, transcript of evidence, p. 7.

¹⁶⁰¹ Ms Jan Jones, Coordinator, Graduate Diploma of Midwifery Program and Bachelor of Nursing Practice and Bachelor of Midwifery Program, School of Nursing, Midwifery and Healthcare, Federation University, Family and Community Development Committee public hearing – Warragul, 8 December 2017, transcript of evidence, p. 8.

¹⁶⁰² The Royal Women’s Hospital, ‘Koori Maternity Services (KMS) Program’, accessed 11 January 2017, <<https://www.thewomens.org.au/health-professionals/clinical-education-training/the-womens-maternity-services-education-program-msep/koori-maternity-services-kms-program>>.

that might want to go on and do a higher level qualification or experience around Aboriginal culture, working with Aboriginal communities. That is supported through the organisation's scholarship fund.¹⁶⁰³

Ms Bernadette Hammond, the Director of Clinical Operations/Chief Nurse and Midwife at Bairnsdale Regional Health Service (BRHS), described the cultural awareness training at BRHS:

Probably two years ago we ran a day and a half program around cultural awareness that was scenario based in our maternity units so that midwives and doctors could get a sense of what it would be really like. That was very popular and very helpful. We have general cultural awareness training across the organisation. Over the last three to four years we have done a lot of work in engaging with the Aboriginal community and making them feel like it is a safe place for them to come, and the feedback from them is that there has been a great deal of improvement there. They feel that access is easier for them.¹⁶⁰⁴

The Committee also heard that the Australian Breastfeeding Association (ABA) are trained to support women from Aboriginal and Torres Strait Islander backgrounds. Ms Susan Day, the President of the ABA, and Dr Susan Tawia, the Manager of Breastfeeding Information and Research at the ABA, told the Committee at a public hearing in Melbourne about the work the ABA had been doing in engaging with Aboriginal and Torres Strait Islander communities in embedding breastfeeding knowledge within the community. Ms Day told the Committee:

We have done quite a bit of work in New South Wales and Victoria with the Indigenous communities, and we actually train some of their community members — the aunties and the elders — to become not breastfeeding counsellors but mentors to the young girls coming through, like a breastfeeding champion in their community. We have been running that community breastfeeding mentor course in a number of areas, and although it is early days we are getting positive results from those communities that they are seeing increased breastfeeding rates in their local communities, because they are getting the support from the people around them.¹⁶⁰⁵

Dr Tawia added that their experience has been that Aboriginal and Torres Strait Islander women are 'more comfortable getting the information from their mothers and their aunties and the women in their community'.¹⁶⁰⁶

The Committee is pleased that many mainstream organisations work in strong partnership with their local Aboriginal community controlled organisations to provide healthcare for women.¹⁶⁰⁷ Nonetheless, the Committee also heard that

¹⁶⁰³ Ms Ailsa Carr, Executive Manager, Family, Youth and Children's Services, Gippsland Lakes Community Health, Family and Community Development Committee public hearing – Bairnsdale, 7 December 2017, transcript of evidence, p. 5.

¹⁶⁰⁴ Ms Bernadette Hammond, Director of Clinical Operations/Chief Nurse and Midwife, Bairnsdale Regional Health Service, Family and Community Development Committee public hearing – Bairnsdale, 7 December 2017, transcript of evidence, p. 6.

¹⁶⁰⁵ Ms Susan Day, President, Australian Breastfeeding Association, Family and Community Development Committee public hearing – Melbourne, 4 September 2017, transcript of evidence, p. 7.

¹⁶⁰⁶ Dr Susan Tawia, Manager, Breastfeeding Information and Research, Australian Breastfeeding Association, Family and Community Development Committee public hearing – Melbourne, 4 September 2017, transcript of evidence, p. 7.

¹⁶⁰⁷ Ms Ailsa Carr, Executive Manager, Family, Youth and Children's Services, Gippsland Lakes Community Health, Family and Community Development Committee public hearing – Bairnsdale, 7 December 2017, transcript of evidence, p. 5.

there were several barriers impacting a mainstream organisation's ability to provide culturally appropriate care and build relationships with Aboriginal and Torres Strait Islander clients, such as staffing resources.¹⁶⁰⁸

Funding was also an issue for many organisations. The Committee heard from Ms Kirsten Finger, Co-Founder of Olivia's Place, a pregnancy support service in Warragul, at a public hearing in Warragul, that the cost of cultural awareness training was 'very prohibitive' and that they had not been successful in any of their funding applications to date, and thus had not undergone cultural awareness training.¹⁶⁰⁹

The Committee recognises the importance of cultural training for staff working in maternity services and thus, the Committee recommends that:

RECOMMENDATION 7.7: The Victorian Government mandate and provide funding to ensure maternity service staff at Victorian public hospitals receive training in cultural awareness and engagement and supporting Aboriginal and Torres Strait Islander women and families.

7.11 Aboriginal and Torres Strait Islander staff in the perinatal workforce

Throughout the Inquiry, the Committee heard about the importance of strengthening the Aboriginal and Torres Strait Islander healthcare workforce. There are several scholarships for Aboriginal and Torres Strait Islander students in health related disciplines that are funded by government, non-government organisations, peak industry bodies, individuals and universities.¹⁶¹⁰ The Committee also heard that Aboriginal and Torres Strait Islander nurses who want to train as maternal and child health nurses are a 'priority cohort'.¹⁶¹¹ Out of the 43 successful applicants awarded the Victorian MCH Nursing scholarship in 2017, three identified as Aboriginal and Torres Strait Islander, up from zero of the 38 successful applicants in 2016.¹⁶¹²

Gippsland & East Gippsland Aboriginal Co-Operative (GEGAC) runs traineeships internally to support training and capacity-building development opportunities for the Aboriginal and Torres Strait Islander community in East Gippsland, which also helps with their recruitment.¹⁶¹³ Ms Ellis, General Manager of GEGAC, described their training program, which they called the GEGAC academy:

¹⁶⁰⁸ For example, see Ms Heather Daly, Midwife and Community Health Nurse, Family and Community Development Committee public hearing – Bairnsdale, 7 December 2017, transcript of evidence, p. 5.

¹⁶⁰⁹ Ms Kirsten Finger, Co-Founder, Olivia's Place, Family and Community Development Committee public hearing – Warragul, 8 December 2017, transcript of evidence, p. 8.

¹⁶¹⁰ For example, see Australian Government, Department of Health, 'Aboriginal and Torres Strait Islander scholarships', 15 January 2016, accessed 11 January 2017, <<http://www.health.gov.au/internet/main/Publishing.nsf/Content/work-ab-atsis>>; Royal Australasian College of Physicians, 'RACP Indigenous Health Scholarship Program', accessed 11 January 2017, <<https://www.racp.edu.au/about/racp-foundation-awards/indigenous-and-international-awards/racp-indigenous-health-scholarship-program>>.

¹⁶¹¹ Dr Anastasia Gabriel, Director of Prevention and Health Promotion, Department of Education and Training, Family and Community Development Committee public hearing – Melbourne, 27 November 2017, transcript of evidence, p. 6.

¹⁶¹² Department of Education and Training, correspondence, dated 12 January 2018.

¹⁶¹³ Ms Brianna Ellis, General Manager, Gippsland & East Gippsland Aboriginal Co-operative, Family and Community Development Committee public hearing – Bairnsdale, 7 December 2017, transcript of evidence, p. 4.

The GEGAC academy was probably one of the main initiatives, because we are finding that the fear of what the role might look like is a barrier to people even applying. So the idea of the academy is to get on-the-ground shadowing of people in roles and also development with a little bit of pre-employment training, hoping to find there is a good fit, and then, rather than advertising, we will use it as a method of succession planning and training into roles. It is only brand new. We are advertising at the moment to take the first five trainees. They could end up anywhere within the organisation, and medical will be one of the places that they do spend a bit of their work placement time.¹⁶¹⁴

The Committee heard that Aboriginal and Torres Strait Islander medical students applying to specialise in obstetrics and gynaecology received more ‘points’, which often helped to get them to the interview stage.¹⁶¹⁵ Nonetheless, Professor Michael Permezel, Immediate Past-President of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists, told the Committee at a public hearing in Melbourne that there was a problem recruiting Aboriginal and Torres Strait Islander people into studying medicine:

The issue really comes down to the universities providing that prevocational doctor from which we can then draw them into obstetrics and gynaecology. We believe we are quite a popular discipline. We have more than 200 applicants for 80 positions. We need Indigenous doctors sitting there who have been graduated by the universities. If the universities do not get them into the universities, they are not there for us to take into our specialties. The same with the rural background — unless the universities are getting medical students from rural backgrounds, they are not there for us to recruit into our discipline and produce specialists that actually want to go and practise in a rural centre.¹⁶¹⁶

The Committee heard that there were many organisations wanting to recruit Aboriginal and Torres Strait Islander health practitioners, but there were not any Aboriginal and Torres Strait Islander people available in those professions.¹⁶¹⁷ Other challenges that the Committee heard about were getting students into employment post-school and progressing the Aboriginal and Torres Strait Islander workforce into higher positions and full-time employment. Ms Ellis from GEGAC told the Committee:

You have families where there are no role models, so you might have a mum and dad who have never had a job or have only ever had casual employment. We have done an analysis of our workforce and certainly the Aboriginal staff within GEGAC tend to be more in part-time or casual roles or in the lower 20 per cent of the level of pay within the organisation. So one of our challenges and where we are trying to focus is to move people into full-time employment, but in a way that is safe and is not setting people up to fail, because there have been plenty of times when we have got someone with lots of potential but they have still got lots of challenges. So it might be a young

¹⁶¹⁴ Ibid., p. 5.

¹⁶¹⁵ Medical doctors wanting to specialise in obstetrics and gynaecology are prioritised during the selection process according to a ‘point’ system, by which medical doctors who are Aboriginal and Torres Strait Islander or come from a rural background or have other qualifications, such as a PhD, can score higher points than medical doctors without those attributes, enhancing their chances of being selected. Professor Michael Permezel, Immediate Past-President, Royal Australian and New Zealand College of Obstetricians and Gynaecologists, Family and Community Development Committee public hearing – Melbourne, 4 September 2017, transcript of evidence, pp. 5, 9.

¹⁶¹⁶ Ibid., p. 9.

¹⁶¹⁷ Ms Nicky Lappin, Coordinator, Family Health and Development, Latrobe City Council Maternal and Child Health Service, Family and Community Development Committee public hearing – Warragul, 8 December 2017, transcript of evidence, p. 3.

family or it might be they have got extended family members or there is family violence and those sorts of things happening in the background that inhibit whether or not they are able to really take up the opportunities, because we have got plenty of opportunities.

We have been trying to work really closely with providing those supports and career pathways. So they are stepped out, and it gives people the option to sort of go, 'I'm not quite there yet, but I'm going to sit here and I know that once I've got myself together we're going to move forward'.¹⁶¹⁸

The Committee heard of the need for more Aboriginal and Torres Strait Islander graduates to be trained in health professions to support Aboriginal and Torres Strait Islander women throughout the perinatal period. The Committee is pleased that there are scholarships to support Aboriginal and Torres Strait Islander students, however it is concerned that these are not being taken up at the desired rate and that more can be done to promote scholarships in Aboriginal and Torres Strait Islander communities. Thus, the Committee recommends that:

RECOMMENDATION 7.8: The Victorian Government conduct a public education campaign targeted at Aboriginal and Torres Strait Islander communities to raise awareness of scholarships that are currently available for Aboriginal and Torres Strait Islander health professional trainees.

- This campaign should also include a funded schools-based element to support and encourage Aboriginal and Torres Strait Islander students and school leavers.

7.12 Programs for Aboriginal and Torres Strait Islander communities

The Committee heard about several programs that had been tailored or adapted for Aboriginal and Torres Strait Islander communities during the perinatal and early childhood period, such as the Mallee District Aboriginal Services' (MDAS) Early Years Services, Aboriginal Cradle to Kinder, and Healthy Mothers, Healthy Babies (discussed in Chapter One). The Committee also heard that the Aboriginal Stronger Families program and Aboriginal Family-Led Decision Making Program had achieved positive results in reducing child protection involvement.¹⁶¹⁹

7.12.1 Aboriginal Cradle to Kinder

Cradle to Kinder is an antenatal and postnatal support service in Victoria that has provided intensive family and early parenting support to vulnerable mothers and their children since 2012, and includes an Aboriginal Cradle to Kinder program.

The Aboriginal Cradle to Kinder program is for pregnant Aboriginal and Torres Strait Islander women under 25 where:

¹⁶¹⁸ Ms Brianna Ellis, General Manager, Gippsland & East Gippsland Aboriginal Co-operative, Family and Community Development Committee public hearing - Bairnsdale, 7 December 2017, transcript of evidence, p. 9.

¹⁶¹⁹ Mr Rodney Jackson, Chief Executive Officer, and Ms Mandy Miller, Midwife, Koori Maternity Service, Wathaurong Aboriginal Co-operative, Family and Community Development Committee public hearing - Geelong, 11 December 2017, transcript of evidence, p. 9.

- there are a number of indicators of vulnerability or concerns about the wellbeing of an unborn or newborn child and child protection is not involved; or
- a report to child protection or a referral to Child FIRST has been received for an unborn child and the referrer has significant concerns about the wellbeing of the unborn child.¹⁶²⁰

The service commences in pregnancy and continues until the child reaches four years of age. The program provides pre-birth support, intensive and longer term interventions, and case work support, and is designed to improve parenting capacity. It was announced in April 2017 that the program would be expanded from two Aboriginal Cradle to Kinder locations to 10.¹⁶²¹ Below is a list of new and existing Aboriginal Cradle to Kinder programs by catchment area and community service organisation:

- Rumbalara Aboriginal Cooperative (Goulburn catchment)
- Victorian Aboriginal Child Care Agency (VACCA) (Hume and Moreland catchment)
- Njernda Aboriginal Cooperative (Loddon catchment)
- Mallee District Aboriginal Services Ltd (MDAS) (Mallee catchment)
- Victorian Aboriginal Child Care Agency (VACCA) (North Eastern Melbourne catchment)
- Victorian Aboriginal Child Care Agency (VACCA) (Inner Gippsland catchment)
- Gippsland & East Gippsland Aboriginal Co-Operative (GEGAC) (lead agency for the Outer Gippsland catchment)
- Wathaurong Aboriginal Co-operative (Barwon catchment)
- Victorian Aboriginal Child Care Agency (West) (Brimbank and Melton catchment)
- Victorian Aboriginal Child Care Agency (VACCA) (Western Melbourne catchment)
- Goolum Goolum Aboriginal Co-operative (lead agency for Wimmera and South West).¹⁶²²

At a public hearing in Mildura, Ms Molloy, the Manager of Early Years Services at Mallee District Aboriginal Services, told the Committee that she believed that Aboriginal and Torres Strait Islander women should be accessing the service at 12 weeks rather than 26 weeks as Aboriginal and Torres Strait Islander women had higher rates of premature births and needed intensive case management earlier.¹⁶²³

¹⁶²⁰ Department of Health and Human Services, 'Cradle to Kinder and Aboriginal Cradle to Kinder', 18 November 2017, Victorian Government, accessed 21 February 2018, <<https://services.dhhs.vic.gov.au/cradle-kinder-and-aboriginal-cradle-kinder>>.

¹⁶²¹ Hon. Jenny Mikakos, Minister for Families and Children, *Support For Vulnerable Families From Cradle To Kinder*, media release, 5 April 2017.

¹⁶²² Department of Health and Human Services, 'Expansion of Cradle to Kinder and Aboriginal Cradle to Kinder', Victorian Government, May 2017, accessed 9 April 2018, <<https://services.dhhs.vic.gov.au/sites/default/files/2017-11/Cradle-to-kinder-program-area-list.docx>>.

¹⁶²³ Ms Jacinta Molloy, Manager, Early Years Services, Mallee District Aboriginal Services, Family and Community Development Committee public hearing – Mildura, 9 November 2017, transcript of evidence, p. 4.

An evaluation of the program stated that the program is specifically tailored to provide a culturally competent, sensitive, and respectful service for Aboriginal and Torres Strait Islander families which includes working with 'extended family members to strengthen connections to family, community and culture.'¹⁶²⁴ The evaluation further stated:

The program recognises the role of strong kinship connections and networks in supporting families and young children in the early years and aimed to strengthen ties to Aboriginal culture. Some Aboriginal families adopt a collective model of parenting which is shared with family and community members. Where young people have been placed out of their parents' care, the Aboriginal Cradle to Kinder program can access the support of these communities and family members to maintain their cultural connection.¹⁶²⁵

The evaluation also noted that Aboriginal and Torres Strait Islander children and their families are a priority for all Cradle to Kinder services and thus Aboriginal and Torres Strait Islander families can access the mainstream Cradle to Kinder service.¹⁶²⁶

7.12.2 Mallee District Aboriginal Services (MDAS)

At a public hearing in Mildura, the Committee heard from Ms Jacinta Molloy, Manager of Early Years Services at the Mallee District Aboriginal Services (MDAS), who told the Committee about the MDAS Early Years Services, which she described as a 'key worker, family-centred, strength-based wraparound model of engagement from conception to school'.¹⁶²⁷

The Early Years Services provide intensive in-home support from when a pregnancy is confirmed until the child turns three, a supported play group, home-based learning to prepare a child for kinder or school and a Koori preschool assistant. The program includes Koori Maternity Services, Maternal and Child Health services, Family Support Services, and Family Capacity Building Groups, and is mostly based in Mildura.¹⁶²⁸ In 2012, the Early Years Services at MDAS was funded by DHHS as part of the Victorian Government's Closing the Health Gap Strategy.¹⁶²⁹ Since 2014, the program has been funded under the Victorian Government's Koolin Balit strategy.¹⁶³⁰ Ms Molloy spoke about the rationale for the program:

Back in 2012 an 18-year-old Aboriginal girl committed suicide at 37 weeks gestation. It became obvious that there were lots of people working with this young woman outside and within MDAS but not necessarily talking to each other, so not being collaborative and perhaps working in silos. MDAS's response to this was to really focus on the early years.¹⁶³¹

¹⁶²⁴ Department of Health and Human Services, *Cradle to Kinder: Evaluation summary*, evaluated by the Australian Institute of Families Studies in partnership with the Centre for Community Child Health at the Murdoch Children's Research Institute, Victorian Government, Melbourne, August 2017, p. 7.

¹⁶²⁵ *Ibid.*, p. 15.

¹⁶²⁶ *Ibid.*, p. 7.

¹⁶²⁷ Ms Jacinta Molloy, Manager, Early Years Services, Mallee District Aboriginal Services, Family and Community Development Committee public hearing – Mildura, 9 November 2017, transcript of evidence, p. 2.

¹⁶²⁸ Loddon Mallee Aboriginal Reference Group, submission no. 66, attachment p. 9.

¹⁶²⁹ *Ibid.*, p. 4.

¹⁶³⁰ *Ibid.*

¹⁶³¹ Ms Jacinta Molloy, Manager, Early Years Services, Mallee District Aboriginal Services, Family and Community Development Committee public hearing – Mildura, 9 November 2017, transcript of evidence, p. 2.

DHHS commissioned an evaluation of the Early Years Services, which found that no children were permanently removed during the 2014-2016 financial years and that the program had good results in terms of antenatal care appointments, breastfeeding, and maternal and child health.¹⁶³² Ms Molloy told the Committee about the evaluation:

[T]he results of the external evaluation found that there were many outstanding features, including a high standard of training, intensive use of theory, solid community connections and an emphasis on culture. It made a great impact. It gave a visible point of entry for Aboriginal families into the service system and a place where they felt safe to come to, and it has effectively supported families with young children. For some of those families it has been life changing.¹⁶³³

Tammy, one of the clients of MDAS Early Years Services, described her experience with the services:

I was 16 and pregnant. I had to leave home and had nowhere to live. The welfare was on my back. I stayed for a while with my friend's parents. My doctor suggested I go to MDAS. My worker got me a house and furniture. I also did some program to help me with caring for kids. I get picked up and it goes on 3 days every week. It is a group of young mums where you talk about what's up and how to cope. You get info about kids. My worker helped me learn how to care for my baby and helps her play with other children. They treat you same as anyone else here. Everything has changed. I had no clues then. I did not know what to do with kids. I had no idea how to keep a home, like shopping and cleaning. It has made a lot of difference. I am now confident and have a home. I am going to TAFE. I would score them 9 out of 10. I don't know where I would be without them. I would recommend my friends come here and I have done that.¹⁶³⁴

The Committee was pleased to hear that over the last three or four years, the Loddon Mallee Aboriginal Reference Group has been working towards rolling out the Early Years model to other areas.¹⁶³⁵ Considering the success of the Early Years Services program, and the continuity of care it offers, the Committee recommends that:

RECOMMENDATION 7.9: The Victorian Government work with and fund Aboriginal community controlled organisations across the state to develop early intervention programs to improve the health and wellbeing of Aboriginal and Torres Strait Islander women, their babies and their families throughout the perinatal period.

¹⁶³² Ibid., p. 3.

¹⁶³³ Ibid.

¹⁶³⁴ Loddon Mallee Aboriginal Reference Group, submission no. 66, attachment p. 22.

¹⁶³⁵ Ms Kate Glenie, Loddon Mallee Aboriginal Reference Group Early Years Project Worker, Mallee District Aboriginal Services, Family and Community Development Committee public hearing – Mildura, 9 November 2017, transcript of evidence, p. 5.

8

Perinatal services for culturally and linguistically diverse communities

AT A GLANCE

Background

Throughout the Inquiry, the Committee heard evidence that women from culturally and linguistically diverse (CALD) and refugee communities face disadvantages and barriers in accessing perinatal services. These women often experience social isolation and may not have their families or support networks around them. These women are particularly vulnerable to developing mental health conditions during the perinatal period and often struggled to receive the support and services they need. They may also have difficulty communicating and navigating health and social services. Likewise, the Committee heard that health professionals and services were often inexperienced in working with families from CALD backgrounds. There were complexities involved with interpreters, including their underutilisation or unavailability.

This chapter examines the perinatal services provided to women from CALD communities, in terms of access, availability, birthing options, communication, hospital staff training, and support services. It also discusses evidence that the Committee heard about various avenues to better support and empower these communities through the use of technology, training, and continuity of care midwifery models.

Terms of reference addressed

This chapter addresses the following terms of reference:

1. the availability, quality and safety of health services delivering services to women and their babies during the perinatal period;
3. the adequacy of the number, location, distribution, quality and safety of health services capable of dealing with high risk and premature births in Victoria;
4. the quality, safety and effectiveness of current methods to reduce the incidence of maternal and infant mortality and premature births;
5. access to and provision of an appropriately qualified workforce, including midwives, paediatricians, obstetricians, general practitioners, anaesthetists, maternal and child health nurses, mental health practitioners and lactation consultants across Victoria;
6. disparity in outcome between rural and regional and metropolitan locations; and
7. identification of best practice.

Throughout the Inquiry, the Committee heard evidence that women from culturally and linguistically diverse (CALD) and refugee communities face disadvantages and barriers in accessing perinatal services. These women often experience social isolation and may not have their families or support networks around them. These women are particularly vulnerable to developing mental health conditions during the perinatal period and often struggled to receive the support and services they need. They may also have difficulty communicating and navigating health and social services. Likewise, the Committee heard that health professionals and services were often inexperienced in working with families from CALD backgrounds. There were complexities involved with interpreters, including their underutilisation or unavailability.

This chapter examines the perinatal services provided to women from CALD communities, in terms of access, availability, birthing options, communication, hospital staff training, and support services. It also discusses evidence that the Committee heard about various avenues to better support and empower these communities through the use of technology, training, and continuity of care midwifery models.

8.1 The experience of women from culturally and linguistically diverse backgrounds

In Victoria, 38.5 per cent of women giving birth in 2016 were born outside of Australia, with China and India being the most common countries of birth for women born in non-English-speaking countries.¹⁶³⁶ At a public hearing in Melbourne, Dr Adele Murdolo, Executive Director of the Multicultural Centre for Women's Health (MCWH), told the Committee that many migrant women 'actually come to Australia in good health' but that their health declines over time:

It is called the "healthy migrant effect", because there are a lot of health tests that migrants need to go through. They need to show a good clean bill of health in order to be accepted into the migration program, so we do get really the fittest. They are the healthiest. They tend to come in their healthiest years — you know, aged 20 to 30 — so we do get very healthy women, but there is a trend downwards in health over the first five years of living and working in Australia, and that is consistent with international data as well for migrants in general.¹⁶³⁷

Dr Murdolo told the Committee that the social context has changed quite significantly in recent years and that Victoria has a much more diverse cohort than in the past with higher rates of temporary migrants. The Committee heard from Dr Murdolo that women migrating to Victoria have a mix of visa statuses and high unemployment which contributes to social isolation:

¹⁶³⁶ Consultative Council on Obstetric and Paediatric Mortality and Morbidity (CCOPMM), *Victoria's mothers, babies and children 2016*, Melbourne, 2017, p. 10.

¹⁶³⁷ Dr Adele Murdolo, Executive Director, Multicultural Centre for Women's Health, Family and Community Development Committee public hearing – Melbourne, 27 November 2017, transcript of evidence, p. 4. The Multicultural Centre for Women's Health (MCWH) is a Victorian women's health service established in 1978 that works across Victoria to promote the health and wellbeing of immigrant and refugee women through advocacy, social action, multilingual education, research, and capacity building. MCWH is partially funded through the Victorian Department of Health and Human Services as a part of the Victorian Women's Health Program. MCWH has 17 bilingual health educators. MCWH provides research, expert advice, and professional development to stakeholders on improving the health and wellbeing of immigrant and refugee women. MCWH also works directly with women in the community providing capacity building and multilingual education on women's health and wellbeing, through the use of trained, community-based, bilingual health educators.

Some of the trends that we note in our data collection are that there is quite a mix of temporary and permanent visa status amongst those women, and it is roughly half and half. There is a high unemployment rate. It is higher especially amongst newly arrived women than other women and higher than among men who are newly arrived, and there is a low labour force participation rate. We also know that there are high levels of social isolation amongst migrant women, a high level of financial stress and vulnerability to family violence, and I will go through a little bit of the research as well that shows us all of that.¹⁶³⁸

According to the Consultative Council on Obstetric and Paediatric Mortality and Morbidity (CCOPMM), perinatal mortality rates (PMR) continued to be higher for women from north Africa and the Middle East, southern and central Asia, the Americas, Sub-Saharan Africa, and southern and eastern Europe compared with women born in Australia.¹⁶³⁹ The following table shows the PMR adjusted by the mother's place of birth in Victoria.

Table 8.1 Perinatal mortality rate (PMR) adjusted^(a) by maternal place of birth, Victoria, 2016

	Adjusted total births	Live births ^(b)	Adjusted stillbirths	Neonatal deaths	Adjusted perinatal deaths	Per cent of all perinatal deaths	PMR ^{Adjusted} by maternal place of birth
North-East Asia	4,591	4,571	20	5	25	3.5	5.4
North-West Europe	2,374	2,365	9	5	14	2.0	5.9
Oceania and Antarctica (excluding Australia)	2,249	2,238	11	7	18	2.5	8.0
South-East Asia	5,162	5,138	24	18	42	5.9	8.1
Australia	49,772	49,457	315	119	434	60.8	8.7
North Africa and The Middle East	2,878	2,861	17	10	27	3.8	9.4
Southern and Central Asia	8,793	8,729	64	21	85	11.9	9.7
Americas	1,089	1,081	8	5	13	1.8	11.9
Sub-Saharan Africa	1,830	1,816	14	8	22	3.1	12.0
Southern and Eastern Europe	1,473	1,463	10	10	20	2.8	13.6
Missing	523	514	9	5	14	2.0	26.8
Total	80,734	80,233	501	213	714	100	8.8

(a) The figures and calculations in this table exclude 125 stillbirths from terminations of pregnancy (TOP) for maternal psychosocial indications (MPI).

(b) Live births include all livebirths, including those who later die as neonatal deaths.

Note: This table is ranked by PMR (excluding missing data).

Source: Consultative Council on Obstetric and Paediatric Mortality and Morbidity (CCOPMM), *Victoria's mothers, babies and children 2016*, Melbourne, 2017, p. 63.

¹⁶³⁸ Ibid., p. 3.

¹⁶³⁹ Consultative Council on Obstetric and Paediatric Mortality and Morbidity (CCOPMM), *Victoria's mothers, babies and children 2016*, Melbourne, 2017, p. 61.

At a public hearing in Melbourne, Ms Rebecca Bartlett, a nurse and midwife, cited the following statistics from the MCWH's recent report, *Sexual and Reproductive Health Data Report (2016)*:

Mothers born overseas were more likely to have instrumental vaginal birth or caesarean sections compared to Australian-born women. Both first-time mothers and mothers who had previously given birth in east African countries had elevated odds of unplanned caesarean labour. South Asian-born women were more than twice as likely to have a late-term pregnancy stillbirth than other Australian-born or south-east Asian born women. Lebanese-born women had the highest rate of stillbirth compared to the low-risk women in Australia and other women born overseas. Women born in east African countries experienced increased perinatal deaths and other adverse perinatal outcomes compared with Australian-born women, and women from Eritrean Sudan are particularly at increased risk of adverse outcomes.¹⁶⁴⁰

The Committee also heard that teenage pregnancy rates were higher among certain groups of migrant women, such as Lebanese-born women, than among Australian-born women.¹⁶⁴¹

At a public hearing in Melbourne, Professor Louise Newman AM, the Director of the Centre for Women's Mental Health at the Royal Women's Hospital (RWH), talked to the Committee about the issues facing some women from CALD communities. She spoke about the RWH's African Women's Clinic, which is a nurse-led clinic run by women's health nurses who are experienced in providing care for women who have experienced female circumcision or traditional cutting. Professor Newman said:

In terms of the CALD background we have significant populations, and we have some specialist clinics. We have clinics for women from African communities because we offer pregnancy care. Those women have experienced female genital mutilation, so it is a very specialist area, and they are staffed with bicultural and bilingual workers and are linked to a whole range of supports. We have some specialist obstetricians who can deal with some of the issues that those women are facing. That is particularly important.¹⁶⁴²

Dr Michael Rasmussen, Clinical Services Director at Mercy Hospital for Women (Mercy Health), told the Committee at a public hearing in Melbourne that they have a full-time African liaison officer at Heidelberg and will also have one in Werribee in the future.¹⁶⁴³ He also spoke of the Mercy's growing Karen population at Werribee and that they are 'very mindful' of their responsibilities there.¹⁶⁴⁴

The City of Melbourne has a large culturally diverse population, including people from refugee backgrounds and international students residing in Australia while studying. In their submission, they raised concerns about vulnerable populations whose needs were not being met in the community sector:

¹⁶⁴⁰ Ms Rebecca Bartlett, Nurse and Midwife, mAdapt Project, Family and Community Development Committee public hearing – Melbourne, 16 October 2017, transcript of evidence, p. 3. See also: Multicultural Centre for Women's Health, *Sexual and reproductive health: Data report, June 2016*, MCWH, accessed 24 April 2018. <http://www.mcwh.com.au/downloads/MCWH_SRH_Data_Report_July_2016.pdf>.

¹⁶⁴¹ Dr Adele Murdolo, Executive Director, Multicultural Centre for Women's Health, Family and Community Development Committee public hearing – Melbourne, 27 November 2017, transcript of evidence, p. 5.

¹⁶⁴² Professor Louise Newman AM, Director, Royal Women's Hospital Centre for Women's Mental Health, Family and Community Development Committee public hearing – Melbourne, 16 October 2017, transcript of evidence, p. 11.

¹⁶⁴³ Dr Michael Rasmussen, Clinical Services Director, Mercy Hospital for Women (Mercy Health), Family and Community Development Committee public hearing – Melbourne, 16 October 2017, transcript of evidence, p. 8.

¹⁶⁴⁴ Ibid.

These groups may be especially vulnerable due to a range of complex interrelated factors such as isolation, language difficulties, lack of awareness of, or limited access to services and supports, increased mental health issues, family violence, poor health outcome and developmental delays. The complexities of spousal and student immigration bureaucracy can also increase stress on families. Often family violence has been identified for many of these women.¹⁶⁴⁵

In their submission to the Inquiry, Hume City Council told the Committee that they are among the most disadvantaged local government areas in Victoria and have a high percentage of overseas born residents (32 per cent). Included in this group of overseas born residents are refugee and asylum seeker women:

The difficulty faced by refugee and asylum seeker women in negotiating the health system within their new country combined with the mental health issues which are frequent throughout the cohort requires a higher level of support.¹⁶⁴⁶

Hume City Council noted that these women often experience poorer maternal outcomes than Australian born women:

Further anecdotal evidence suggests that the rate of stillbirths within this cohort appears higher than Australian born women. Although there is no data to support this it is clear from the Maternal Child Health Annual Report 2014-2015 that there were 482 stillbirths in Victoria compared to 77,668 births, a rate of 0.62%. Hume City had 2627 births and 22 stillbirths which is a rate of 0.83% of all births. (Department of Education and Training 2014-2015).¹⁶⁴⁷

Dr Nicole Highet, the Founder and Executive Director of the Centre of Perinatal Excellence (COPE), told the Committee at a public hearing in Melbourne that support for CALD communities is 'very variable from one place to another' and that it was up to the local services to provide support.¹⁶⁴⁸ Nonetheless, she noted that programs and services were sometimes at risk of being defunded.¹⁶⁴⁹

The Committee heard that information on ethnicity is not routinely collected in perinatal data collections, particularly information on whether women were recent immigrants or refugees.¹⁶⁵⁰ An earlier CCOPMM report drew attention to this, noting that many recent migrants face barriers to accessing healthcare and that further research is needed in this area:

An emerging theme from the review of recent maternal deaths is the barriers to accessing care that recent immigrants, refugees and asylum seekers may face. As well as these challenges, these women may face social isolation and negative psychological impacts from experiencing pregnancy and motherhood

¹⁶⁴⁵ City of Melbourne, submission no. 21, p. 3.

¹⁶⁴⁶ Hume City Council, submission no. 69, p. 11.

¹⁶⁴⁷ Ibid.

¹⁶⁴⁸ Dr Nicole Highet, Founder and Executive Director, Centre of Perinatal Excellence (COPE), Family and Community Development Committee public hearing – Melbourne, 4 September 2017, transcript of evidence, p. 8.

¹⁶⁴⁹ Ibid., p. 9.

¹⁶⁵⁰ Multicultural Centre for Women's Health, submission no. 88, p. 2. See also: Dr Adele Murdolo, Executive Director, Multicultural Centre for Women's Health, Family and Community Development Committee public hearing – Melbourne, 27 November 2017, transcript of evidence, p. 7. On the lack of data on CALD communities, see also: Associate Professor Rod Hunt, Director, Newborn Intensive Care, Royal Children's Hospital, Family and Community Development Committee public hearing – Melbourne, 18 September 2017, transcript of evidence, p. 7.

in an unfamiliar environment. Information about these maternal factors is not comprehensively collected and further research is needed to fully understand this issue.¹⁶⁵¹

RECOMMENDATION 8.1: The Victorian Government work with the Consultative Council on Obstetric and Paediatric Mortality and Morbidity to ensure that a comprehensive and routine data set is collected to understand the barriers facing culturally and linguistically diverse communities.

It is important to note that the Committee did not hear from many mothers from culturally and linguistically diverse backgrounds. While the Committee sought to ascertain the views of women from refugee, migrant, and culturally and linguistically diverse backgrounds, the Committee heard that the parliamentary committee environment was not felt to be a 'safe space' for these women.¹⁶⁵² The Committee appreciates and acknowledges that the physical set up of the committee room and the formalised nature of the Inquiry process could be intimidating for many women, particularly those from non-English speaking backgrounds. The Committee raises these issues as they warrant further consideration and elucidate the barriers for people from CALD communities in being heard and included in matters that affect them.

8.2 Barriers to accessing perinatal care

Many women from CALD and refugee backgrounds face barriers in accessing healthcare, such as language difficulties, cultural differences, a lack of culturally appropriate care available, lack of awareness of services, or a lack of an understanding of the healthcare system. The Committee heard that migrant women felt discriminated against in the healthcare system, and felt that they were not treated equally or with respect.¹⁶⁵³ The Committee also heard that there are often late presentations for antenatal care among migrant and refugee women, which means women and their babies miss out on screening and monitoring during that period.¹⁶⁵⁴ Dr Murdolo told the Committee:

We also know that there is limited access to satisfactory culturally appropriate perinatal care, and by that we know that migrant women are dissatisfied with the care that they get and they talk about there being communication difficulties and they do not experience what they expect to experience. Many women report that interpreters are not used or family members are used, and this is another point here, but they experience discrimination, prejudice and communication problems during maternity care. So there is quite a body of literature out there that is showing that we are not providing the kind of services that we need to provide in our health system.¹⁶⁵⁵

¹⁶⁵¹ Consultative Council on Obstetric and Paediatric Mortality and Morbidity (CCOPMM), *Victoria's mothers, babies and children 2012 and 2013*, Melbourne, May 2016, p. 53.

¹⁶⁵² Ms Jen Branscombe, Programs Manager, Birth for HumanKIND, Family and Community Development Committee public hearing – Melbourne, 16 October 2017, transcript of evidence, p. 2.

¹⁶⁵³ Dr Adele Murdolo, Executive Director, Multicultural Centre for Women's Health, Family and Community Development Committee public hearing – Melbourne, 27 November 2017, transcript of evidence, pp. 7-8.

¹⁶⁵⁴ Ibid., p. 4. See also: Multicultural Centre for Women's Health, *Sexual and reproductive health: Data report*, MCWH, June 2016, p. 6, accessed 24 April 2018, <http://www.mcwh.com.au/downloads/MCWH_SRH_Data_Report_July_2016.pdf>.

¹⁶⁵⁵ Dr Adele Murdolo, Executive Director, Multicultural Centre for Women's Health, Family and Community Development Committee public hearing – Melbourne, 27 November 2017, transcript of evidence, p. 4.

The MCWH's Sexual and Reproductive Health: Data Report cites a study which found that interactions with healthcare professionals were critical to migrant and refugee women's access to healthcare.¹⁶⁵⁶ The report noted that the following act as facilitators to accessing sexual and reproductive healthcare in Australia:

- the provision of interpreters and bilingual health professionals;
- multilingual resources, including information on how to reach healthcare facilities;
- appointment reminding services;
- home visits;
- provision of female health professionals; and
- health professionals using their time to listen to concerns, answer questions and explain treatment options.¹⁶⁵⁷

In their submission, Birth for HumanKIND identified two key challenges for CALD women in accessing perinatal healthcare: the use and provision of interpreter services to women who do not speak English, and access to services delivered within a culturally appropriate framework.¹⁶⁵⁸

Furthermore, finances act as a barrier for many women accessing antenatal care. The Committee heard that international students and asylum seekers may have very limited access to publicly funded healthcare as they are not covered by Medicare.¹⁶⁵⁹ They also cannot access early parenting centres.¹⁶⁶⁰ Furthermore, the compulsory private insurance that international students are required to have has a waiting period for pregnancy related claims, meaning that students who are pregnant within a year of arriving in Australia have to pay for their pregnancy care. Dr Murdolo noted that many women were left without access to pregnancy related services:

We now have the challenges that are posed to us from increased temporary migration. Whereas before, with permanent migration, all women had access to our health system without having to rely on health insurance or without having to pay out of pocket, today we have a huge cohort of temporary migrants who are relying on the private health insurance that they have to take out in order to use our health system, and there are exemptions to what is claimable under their health insurance. Most notably for international students, for the first 12 months they cannot claim on pregnancy-related matters. From contraception right to birth in the first 12 months they are not able to claim on their health insurance, so they have to pay out of pocket for all of those expenses. That creates huge difficulties for women.¹⁶⁶¹

¹⁶⁵⁶ Z Mengesha, T Dune and J Perz, 'Culturally and linguistically diverse women's views and experiences of accessing sexual and reproductive health care in Australia: A systematic review', *Sexual Health*, 2016, cited in: Multicultural Centre for Women's Health, *Sexual and reproductive health: Data report*, MCWH, June 2016, p. 13, accessed 24 April 2018, <http://www.mcwh.com.au/downloads/MCWH_SRH_Data_Report_July_2016.pdf>.

¹⁶⁵⁷ Z Mengesha, T Dune and J Perz, 'Culturally and linguistically diverse women's views and experiences of accessing sexual and reproductive health care in Australia: A systematic review', *Sexual Health*, 2016, cited in: Multicultural Centre for Women's Health, *Sexual and reproductive health: Data report*, MCWH, June 2016, p. 13, accessed 24 April 2018, <http://www.mcwh.com.au/downloads/MCWH_SRH_Data_Report_July_2016.pdf>.

¹⁶⁵⁸ Birth for HumanKIND, submission no. 59, p. 5.

¹⁶⁵⁹ Ms Patti Reilly, Acting Family Health Coordinator, City of Melbourne, Family and Community Development Committee public hearing – Melbourne, 18 September 2017, transcript of evidence, pp. 4-5.

¹⁶⁶⁰ *Ibid.*, p. 5.

¹⁶⁶¹ Dr Adele Murdolo, Executive Director, Multicultural Centre for Women's Health, Family and Community Development Committee public hearing – Melbourne, 27 November 2017, transcript of evidence, p. 6.

RECOMMENDATION 8.2: The Victorian Government work with the Council of Australian Governments (COAG) to address the highlighted gap in perinatal healthcare for temporary visa holders to ensure the safety of mothers and babies.

8.3 The availability of culturally appropriate information

The Committee heard that many women from CALD and refugee backgrounds were disempowered throughout the perinatal period as they did not have access to interpreters, and access to appropriate and culturally sensitive information.

8.3.1 Translated information

The Committee heard that women from CALD and refugee communities are at a disadvantage when translated information contains missing, incorrect, outdated, inappropriate, or culturally insensitive material.¹⁶⁶² Furthermore, many women from these backgrounds may have low literacy levels and require more visual information.¹⁶⁶³ The Committee heard that health practitioners act as gatekeepers to health information.¹⁶⁶⁴ At a public hearing in Melbourne, the Committee heard from Ms Rebeccah Bartlett, the Founder and Chief Executive Officer of mAdapt and a registered nurse and midwife:

Women who do not speak or read English as a first or subsequent language, as well as those who do not read in their own language, or any language for that matter, are at a systematic disadvantage in accessing both information and services that relate to pregnancy, childbirth and family planning methods, including general, sexual and reproductive health. This not only violates their fundamental human right to quality, accessible and safe health care, it ultimately places an undue burden on both the local and national health systems within Australia. Despite this there is a noted absence of quality, evidence-based, easy-to-understand information relating to maternal health services in Victoria and Australia at large for women from culturally and linguistically diverse backgrounds, and this is even more true in the regional areas.¹⁶⁶⁵

Ms Bartlett told the Committee that it was very difficult for people from CALD and refugee backgrounds to access information in their own language as they often had to navigate English webpages:

Within Victoria the current health promotion websites for non-English-speaking communities require you to navigate three screens in English before you can find the relevant material in your native language. You also need to be able to know how your language is spelt in English, or at least how the letters look, and you need to be

¹⁶⁶² See, for example: Ms Rebeccah Bartlett, submission no. 6; Ms Rebeccah Bartlett, Nurse and Midwife, mAdapt Project, Family and Community Development Committee public hearing – Melbourne, 16 October 2017, transcript of evidence.

¹⁶⁶³ Ms Rebeccah Bartlett, submission no. 6, p. 3.

¹⁶⁶⁴ Ms Rebeccah Bartlett, Nurse and Midwife, mAdapt Project, Family and Community Development Committee public hearing – Melbourne, 16 October 2017, transcript of evidence, p. 5.

¹⁶⁶⁵ *Ibid.*, pp. 2-3. See also: Ms Rebeccah Bartlett, submission no. 6, p. 1.

able to decipher the overly medical and clinical documents, few of which offer visual learning opportunities for low-literate users and almost none of which offer anything but token efforts towards cultural relevance.¹⁶⁶⁶

Furthermore, Ms Bartlett noted that while these websites are helpful, they have been designed for the health professional ‘to locate and decide which information is relevant for the health seeker’:

This once again takes away the agency of the women within their care and prevents them from becoming autonomous decision-makers over their own care pathway and, ultimately, their own body. This also increases their chance of experiencing an adverse outcome as a direct result of their pregnancy or birth.¹⁶⁶⁷

Ms Bartlett said that it was important to create website interfaces where a person does not have to navigate English to get to the language they want.¹⁶⁶⁸ She also raised concerns with the quality of translated websites:

I have had countless interpreters tell me that a lot of what we offer is Google-translated documents, or documents that do not quite meet the nuanced aspects. So I think we need to work with the communities, particularly the bicultural women’s health workers and the Multicultural Centre for Women’s Health, which is working with me on this, to find out what are the key areas that, in this case, women want information in, and we have done that; to create the interface so that she is not required to go through an English-speaking or English-reading app; and also to make sure that if she does not read, there is a lot of video and visual, comic-based content.¹⁶⁶⁹

As mentioned above, Ms Bartlett is the Founder and Chief Executive Officer of mAdapt, which is a mobile health platform connecting women from refugee and CALD backgrounds with local, culturally sensitive information about reproductive health needs, in their own language.¹⁶⁷⁰ The app launched in August 2017 in Arabic and English and is targeted towards the Syrian and Iraqi communities who have recently resettled in northwest Melbourne. Her submission, on behalf of mAdapt, raised concerns about translated materials. She stated:

I have audited the Health Translations Directory and found many of the links for maternal health information are broken, lead to incorrect websites or are simply inappropriate. The content is often culturally offensive or stereotyped, language translation inaccurate and outdated and for certain topics, completely absent of best practice.¹⁶⁷¹

Ms Bartlett’s submission argues that enhancing CALD content surrounding sexual reproductive health and maternity services is important because health literate communities are better engaged with their own health decision-making which improves health outcomes and satisfaction with services. Health literate communities also engage more with preventative health services and cost less to the tertiary

¹⁶⁶⁶ Ms Rebeccah Bartlett, Nurse and Midwife, mAdapt Project, Family and Community Development Committee public hearing – Melbourne, 16 October 2017, transcript of evidence, p. 3.

¹⁶⁶⁷ Ibid.

¹⁶⁶⁸ Ibid., p. 7.

¹⁶⁶⁹ Ibid.

¹⁶⁷⁰ Ibid., p. 2.

¹⁶⁷¹ Ms Rebeccah Bartlett, submission no. 6, p. 2.

healthcare system.¹⁶⁷² Ms Bartlett said that when women refrain from accessing healthcare services altogether, they rely on community information sharing which is ‘often inaccurate and sometimes dangerous’.¹⁶⁷³ She told the Committee:

When information is not accessible, it might as well not exist. In the words of childbirth author and journalist Diana Korte, ‘If you don’t know your options, you don’t have any’. Health professionals like myself are the gatekeepers to knowledge within the maternity and reproductive health sectors. We need to be supported to loosen our grip on the keys ...¹⁶⁷⁴

Throughout the Inquiry, the Committee heard of the need for inclusive and culturally appropriate services. Several witnesses spoke of the work they were doing in this area to support women from CALD backgrounds and provide inclusive, translated materials, such as mental health resources and parenting support, in their resources, programs, and phone apps.

At a public hearing in Melbourne, the Committee heard from Professor Jane Fisher, Director of the Jean Hailes Research Unit, that the parenting support program *What Were We Thinking!* materials had been translated into three community languages: Vietnamese, Mandarin, and Sinhala, and there is work to translate the materials into Japanese and Spanish.¹⁶⁷⁵

The Centre of Perinatal Excellence (COPE) has also translated their digital mental health screening platform (iCOPE) into 11 languages.¹⁶⁷⁶ In their submission, they note that this increases the accuracy of screening as all questions are uniformly presented rather than subject to the accuracy of the individual interpreter’s translation.¹⁶⁷⁷ COPE also stated in their submission that their digital screening platform saves time ‘by not requiring lengthy processes when trying to undertake screening using interpreters’.¹⁶⁷⁸ The platform can also generate instant tailored reports to the client in their own language, which they state ‘ensures that for the first time, *consumers have access to timely, relevant information* at the point of screening’.¹⁶⁷⁹

Dr Nicole Highet, the Founder and Executive Director of COPE, told the Committee at a public hearing in Melbourne that COPE is currently in discussions with the Commonwealth Government regarding having their ‘Ready to COPE’ newsletter translated into ten languages.¹⁶⁸⁰

At a public hearing in Melbourne, the Committee heard from Dr Anastasia Gabriel, Director of Prevention and Health Promotion at the Department of Education and Training, who told the Committee that they were releasing a smartphone Maternal

¹⁶⁷² Ibid., p. 3.

¹⁶⁷³ Ms Rebecca Bartlett, Nurse and Midwife, mAdapt Project, Family and Community Development Committee public hearing – Melbourne, 16 October 2017, transcript of evidence, p. 4.

¹⁶⁷⁴ Ibid., p. 5.

¹⁶⁷⁵ Professor Jane Fisher, Director, Jean Hailes Research Unit, Family and Community Development Committee public hearing – Melbourne, 4 September 2017, transcript of evidence, p. 4.

¹⁶⁷⁶ Centre of Perinatal Excellence (COPE), submission no. 4, p. 4.

¹⁶⁷⁷ Ibid.

¹⁶⁷⁸ Ibid.

¹⁶⁷⁹ Italics in original. Centre of Perinatal Excellence (COPE), submission no. 4, attachment p. 27.

¹⁶⁸⁰ Dr Nicole Highet, Founder and Executive Director, Centre of Perinatal Excellence (COPE), Family and Community Development Committee public hearing – Melbourne, 4 September 2017, transcript of evidence, p. 3.

and Child Health app in the top ten languages which would be publicised in the green book that all mothers in Victoria receive when they leave hospital.¹⁶⁸¹ Dr Gabriel told the Committee:

[W]e did a lot of work with the CALD and refugee community, who told us that one way of engaging with the service is to have some very credible information for them at their fingertips. So through the last budget process, \$950 000 was committed to developing a smartphone MCH app, which will have very credible information. They wanted information that they could rely on about all the things that impact on them, about their child and about themselves. So the app is currently being developed and will have basically a whole raft of information around the child's development.¹⁶⁸²

The Committee believes that women should have access to information in their own language. Being able to access information in their own language empowers women and aids medical decision-making. The Committee heard that translated information on Victorian Government websites, such as the Health Translations Directory, often contained missing, incorrect, outdated, inappropriate or culturally insensitive material. The Committee also heard that it was often difficult for culturally and linguistically diverse communities to access translated information as it routinely required navigating several pages in English. Furthermore, for women who have low levels of literacy, an increase in visual information is required. The Committee was impressed by the processes used by Koori Maternity Services in this area. Accordingly, to address the current weaknesses the Committee recommends that:

RECOMMENDATION 8.3: The Victorian Government in consultation with culturally and linguistically diverse communities review the process for creating translated information on Victorian Government materials to ensure that it is up-to-date, accessible and culturally appropriate.

- The Victorian Government review the accessibility of translated information on its websites so that culturally and linguistically diverse communities with low levels of English and low levels of literacy can access information, including using visual and aural information.

8.3.2 The use of interpreters in maternity services

Many hospitals employ qualified interpreters for the most frequently spoken languages in their area based at the hospital, such as the Royal Women's Hospital, Northern Health and Western Health.¹⁶⁸³ For other languages, hospitals often use experienced interpreters from accredited external agencies or use a telephone interpreter service.¹⁶⁸⁴

¹⁶⁸¹ Dr Anastasia Gabriel, Director of Prevention and Health Promotion, Department of Education and Training, Family and Community Development Committee public hearing – Melbourne, 27 November 2017, transcript of evidence, pp. 12-13.

¹⁶⁸² Ibid.

¹⁶⁸³ Ms Jodie Ashworth, General Manager, Surgery, Women's and Children's, Operating Theatres and ICU and Chief Nursing Officer, Northern Health, Family and Community Development Committee public hearing – Melbourne, 5 February 2018, transcript of evidence, p. 6; The Royal Women's Hospital, 'Interpreters', accessed 18 May 2018, <<https://www.thewomens.org.au/patients-visitors/clinics-and-services/support-services/interpreters>>; Western Health, 'Interpreter services', accessed 18 May 2018, <http://www.westernhealth.org.au/PatientsandVisitors/Interpreter_Services/Pages/default.aspx>.

¹⁶⁸⁴ For example, see: Mercy Health, 'Translating and interpreting services', accessed 18 May 2018, <<https://health-services.mercyhealth.com.au/patients-and-visitors/translating-interpreting-service>>.

Other organisations, such as Birth for HumanKIND, reported using the Translating and Interpreting Service (TIS) if, for example, a doula is meeting a client in their house or external to the hospital.¹⁶⁸⁵ They told the Committee that they also make use of in-house interpreters through the Victorian Foundation for Survivors of Torture, also known as Foundation House (if the client is referred through Foundation House), or the in-house interpreters at hospitals.¹⁶⁸⁶ Perinatal Anxiety and Depression Australia (PANDA) reported using telephone interpreters where necessary.¹⁶⁸⁷

The Committee heard that there were many barriers to using interpreter services, including not knowing that the client requires an interpreter, a lack of knowledge and understanding from health practitioners about the use of interpreters, workforce issues, and limited availability of interpreters for smaller languages.¹⁶⁸⁸

Ms Jodie Ashworth, General Manager of Surgery, Women's and Children's, Operating Theatres and ICU and Chief Nursing Officer at Northern Health, told the Committee at a public hearing in Melbourne that Northern Health provides services for people from 185 countries who speak 106 languages and practice 90 religions. She said that it was difficult to provide patient-centred care to such a diverse community:

We struggle with health literacy and having our families informed. We do have our own in-house interpreter service at Northern Health. In addition in maternity services alone we are still spending around \$300 000 a year on outside phone call and other interpreter services. It is a challenge that we think we are managing, but, as I said, it is still a challenge and it is difficult to provide patient-centred care to such a diverse community.¹⁶⁸⁹

Ms Ashworth explained that they have to rely on an interpreter service rather than using bilingual staff to interpret due to hospital policies:

There are quite strict policies and procedures around who can interpret for medical decision-making. We will find that with some of the midwives who are up here, we might grab a midwife to say, 'Can you ask if her feeding was okay overnight or if she slept?'. But when it comes to urgent clinical, medical decision-making, they cannot ask those questions purely because of the procedures around medical decision-making. So yes, we do on a daily basis, and it is not unusual for us to even get the environmental service Indian lady to go and speak Punjabi and ask, 'When's your husband coming to pick you up?', but medical decision-making is still where it gets difficult at times because we have to rely on a straight interpreter service.¹⁶⁹⁰

¹⁶⁸⁵ Ms Kirstan Flannery, Chairperson and Co-Founder, Birth for HumanKIND, Family and Community Development Committee public hearing – Melbourne, 16 October 2017, transcript of evidence, p. 10. TIS provides free interpreting services to non-English speaking Australian citizens and permanent residents communicating with certain approved groups and individuals, such as private medical practitioners and community-based not-for-profit organisations. Australian Government, Department of Home Affairs, Fact sheet – Translating and Interpreting Service (TIS National), accessed 27 April 2018, <<https://www.homeaffairs.gov.au/about/corporate/information/fact-sheets/91tis#e>>.

¹⁶⁸⁶ Ms Kirstan Flannery, Chairperson and Co-Founder, Birth for HumanKIND, Family and Community Development Committee public hearing – Melbourne, 16 October 2017, transcript of evidence, p. 10. See also: Ms Rebecca Bartlett, Nurse and Midwife, mAdapt Project, Family and Community Development Committee public hearing – Melbourne, 16 October 2017, transcript of evidence, p. 3.

¹⁶⁸⁷ Ms Terri Smith, Chief Executive Officer, Perinatal Anxiety and Depression Australia, Family and Community Development Committee public hearing – Melbourne, 16 October 2017, transcript of evidence, p. 10.

¹⁶⁸⁸ See: Victorian Foundation for Survivors of Torture (Foundation House), *Promoting the engagement of interpreters in Victorian health services*, June 2013, accessed 9 May 2018, <<http://refugeehealthnetwork.org.au/promoting-the-engagement-of-interpreters-in-victorian-health-services>>.

¹⁶⁸⁹ Ms Jodie Ashworth, General Manager, Surgery, Women's and Children's, Operating Theatres and ICU and Chief Nursing Officer, Northern Health, Family and Community Development Committee public hearing – Melbourne, 5 February 2018, transcript of evidence, p. 6.

¹⁶⁹⁰ Ibid.

At a public hearing in Melbourne, Dr Michael Rasmussen, Clinical Services Director at the Mercy Hospital for Women, told the Committee that some people do not want to disclose that they have difficulty understanding English:

Certainly there is an issue with people not admitting to needing an interpreter, because people are embarrassed to say they do not speak English. They speak a bit of English but not enough, and we have got to be careful of how we put the question to them and how we flag them as needing an interpreter. If they need an interpreter, then they will always need an interpreter.¹⁶⁹¹

The Committee heard that many women report that interpreters are not being used or family members, such as husbands and children, are used to interpret.¹⁶⁹² Ms Bartlett told the Committee:

Despite the 24-hour availability of interpreters by phone there is an overreliance on family members, including children, to translate for the women we care for. This is not only inappropriate; it actually violates our duty of care in many instances where we are expected to responsibly and discreetly ascertain risks of family violence and mental health concerns using potential perpetrators or survivors as translators.¹⁶⁹³

Ms Bartlett noted the importance of having an interpreter or a bicultural birth support worker for women during labour:

For many of the women I have spoken to, having an interpreter or a bicultural birth support during labour who can offer explanations and comfort is more important than having access to an anaesthetist who can offer an epidural. Many of the women from our at-risk communities mentioned earlier experience a systematic community-wide distrust of government institutions, and this extends to hospitals and healthcare system as a whole. For some it relates to torture and trauma experienced within medical facilities in their home country or in detention offshore.¹⁶⁹⁴

At a public hearing, Ms Bartlett gave an example of a woman who she advocated for who had no interpreter arranged:

Many women from non-English speaking backgrounds are routinely sidelined from their own decision-making when a healthcare professional decides interpreters are only needed for important conversations. In one study across Victorian emergency departments it was found that only one in every 86 patients with low-level English was connected with an interpreter. Another study averaged 1.6 per cent of usage across some general practices. This may seem surprising, yet this past August I had to advocate for a woman to have a phone interpreter at the very time a set of forceps were being placed on her baby's head because the doctor did not think her lack of

¹⁶⁹¹ Dr Michael Rasmussen, Clinical Services Director, Mercy Hospital for Women (Mercy Health), Family and Community Development Committee public hearing – Melbourne, 16 October 2017, transcript of evidence, p. 8.

¹⁶⁹² Dr Adele Murdolo, Executive Director, Multicultural Centre for Women's Health, Family and Community Development Committee public hearing – Melbourne, 27 November 2017, transcript of evidence, p. 4; Ms Jen Branscombe, Programs Manager, Birth for HumanKIND, Family and Community Development Committee public hearing – Melbourne, 16 October 2017, transcript of evidence, p. 7; Ms Rebeccah Bartlett, Nurse and Midwife, mAdapt Project, Family and Community Development Committee public hearing – Melbourne, 16 October 2017, transcript of evidence.

¹⁶⁹³ Ms Rebeccah Bartlett, Nurse and Midwife, mAdapt Project, Family and Community Development Committee public hearing – Melbourne, 16 October 2017, transcript of evidence, p. 4.

¹⁶⁹⁴ Ibid.

English warranted one sooner. No conversation was had with this woman after the birth, of her instrumental delivery, her extended episiotomy or why her baby was now in NICU.¹⁶⁹⁵

The Committee heard that there were often not enough female interpreters. At a public hearing in Melbourne, Ms Kirstan Flannery, Chairperson and Co-Founder, Birth for HumanKIND, raised concerns about the use of male interpreters for women's health matters and cited an example of a woman referred to Birth for HumanKIND who had experienced rape. A counselling session was arranged with two male psychologists and a male interpreter and the woman was unable to disclose what had happened to her, which resulted in her not receiving the support she needed.¹⁶⁹⁶ Ms Flannery told the Committee:

We are quite concerned about it [the use of male interpreters] in terms of what the women are holding back or not divulging around their health because they do not want to speak through a male interpreter. The hospitals keep saying, 'Well this is the only option you've got. You've got to work with this'. I think the women are pretty understanding when they need to have a male doctor because there are no female doctors to access, but when it comes to interpreters I think there could be a lot more done in terms of accessing female interpreters.¹⁶⁹⁷

Hume City Council has a high percentage of residents (18.1 per cent) who do not speak English well or who do not speak English at all, which is higher than the metropolitan average of 12.9 per cent.¹⁶⁹⁸ Their submission noted that it is often difficult to find interpreters for certain languages and to find female interpreters:

There is increased concern that communities with low levels of English would be more at risk due to difficulties in understanding the health and wellbeing messages, the delivery of services in appropriate languages (need for interpreters and more broadly in accessing relevant information on support services). Although the Department of Education and Training provide support to Council Maternal Child Health clients to access interpreter services there are a number of languages where there are insufficient interpreters available. This is also compounded by the need for interpreters to be female due to the cultural requirements of clients.¹⁶⁹⁹

Dr Murdolo told the Committee that there was a problem getting interpreters for smaller languages 'because there is just not enough of a workforce out there'.¹⁷⁰⁰ However, she said that people have also reported having trouble getting interpreters for larger languages in the inner city, such as Greek interpreters.¹⁷⁰¹ She wondered whether there was an understanding within the health system of the importance of using interpreters:

¹⁶⁹⁵ Ibid., p. 3.

¹⁶⁹⁶ Ms Kirstan Flannery, Chairperson and Co-Founder, Birth for HumanKIND, Family and Community Development Committee public hearing – Melbourne, 16 October 2017, transcript of evidence, p. 9.

¹⁶⁹⁷ Ibid.

¹⁶⁹⁸ Hume City Council, submission no. 69, p. 11.

¹⁶⁹⁹ Ibid.

¹⁷⁰⁰ Dr Adele Murdolo, Executive Director, Multicultural Centre for Women's Health, Family and Community Development Committee public hearing – Melbourne, 27 November 2017, transcript of evidence, p. 9.

¹⁷⁰¹ Ibid.

Often the way we see it is that the woman needs help communicating. But I think that if we could turn it around a little bit and think about the need for a GP or a health practitioner to actually communicate, then we can see the interpreters as being there to assist the health professional rather than the woman, because communication is probably about 70 per cent of the effectiveness of that consultation.¹⁷⁰²

Dr Murdolo said that the phone interpreter service is being used ‘but not to the degree that they are needed’ and that while there were shortages of interpreters ‘across the board’, many health practitioners are not using the phone interpreter service or arranging for an interpreter to be present.¹⁷⁰³

The Committee heard support for the following initiatives: investing in video interpreting; strengthening in-house accessibility of hospital interpreting services; increasing female interpreters; training more bicultural workers, particularly in regional and rural areas; and auditing of consent for non-English speaking patients.¹⁷⁰⁴

The Committee believes that the use of interpreters is fundamental to empowering women and giving agency in medical decision-making to women from CALD communities. The Committee was disappointed to hear evidence that interpreters were often not used in medical consultations and in situations such as giving birth, episiotomies, and caesarean sections. Women cannot give informed consent if they cannot understand what is happening to them and health practitioners risk inflicting further trauma on these communities by failing to use interpreters when needed. Health practitioners have a responsibility to ensure that women from CALD communities understand their care and hospital treatment. Wherever possible, the use of family members to interpret medical consultations should also be avoided. Accordingly, the Committee recommends that:

RECOMMENDATION 8.4: The Victorian Government review the use of interpreters in public hospitals, and work with the Department of Health and Human Services and maternity hospitals to ensure that interpreters are being used for every consultation with a woman who needs an interpreter.

On the issue of the bicultural health worker and interpreter workforce, the Committee recommends that:

RECOMMENDATION 8.5: The Victorian Government put in place a strategy to recruit more interpreters and bicultural health workers in the area of women’s health, particularly female interpreters, interpreters of emerging languages and interpreters in rural and regional areas.

¹⁷⁰² Ibid.

¹⁷⁰³ Ibid.

¹⁷⁰⁴ Ms Rebeccah Bartlett, Nurse and Midwife, mAdapt Project, Family and Community Development Committee public hearing – Melbourne, 16 October 2017, transcript of evidence, p. 5.

8.4 Continuity of care models – the role of doulas

As discussed in Chapter Two, doulas are non-medical birth companions who provide emotional and physical support to a woman before, during, and after childbirth. At a public hearing in Melbourne, the Committee heard from Birth for HumanKIND, a registered charity which provides birth support and continuity of care to women in at-risk and vulnerable circumstances. The majority of their clients are women from migrant, refugee, or asylum seeker backgrounds who have recently arrived in Australia, do not speak English fluently, and do not have a network of family and friends to support them. Birth for HumanKIND also supports pregnant women under the age of 25, women experiencing homelessness, and women experiencing trauma, abuse, and/or mental illness.¹⁷⁰⁵

Birth for HumanKIND has a team of 35 volunteer doulas, or trained birth companions, who provide one-to-one care for women in need. Care includes pre-natal home visits, support during labour and birth, and help at home after birth. The organisation provides pregnancy education for young pregnant women, and runs information sessions for women from CALD and refugee communities to improve their understanding of the Australian maternal health system.¹⁷⁰⁶

Birth for HumanKIND recommended continuity of care for women from migrant, refugee and asylum seeker backgrounds:

Without support from a trained Birth for HumanKIND doula, many of our culturally and linguistically diverse clients would have birthed without a known support person, and without sufficient support to access and understand antenatal education and appointments.¹⁷⁰⁷

Ms Jen Branscombe, Programs Manager at Birth for HumanKIND, told the Committee at a public hearing in Melbourne:

Particularly for women from these [migrant, refugee and asylum seeker] backgrounds, continuity of care can enable better development of trust and rapport and better communication. It reduces the need for them to revisit traumatic memories and offers more time for them to discuss current concerns. It is not common, however, in the conventional maternal health model that many women from migrant, refugee and asylum seeker backgrounds experience. Research suggests that lists can lead to fragmented care provision, and the decrease in continuity of care can also lead to growing fear, distress and trauma in birthing women and the increased medicalisation and intervention-based management of birth.¹⁷⁰⁸

In Chapter Seven, the Koori Maternity Service continuity of care models were discussed as being beneficial to Aboriginal and Torres Strait Islander communities and improving perinatal and maternal outcomes. The Committee heard that women from CALD and refugee backgrounds are likely to benefit from continuity

¹⁷⁰⁵ Birth for HumanKIND, submission no. 59, p. 1.

¹⁷⁰⁶ Ibid.

¹⁷⁰⁷ Ibid., p. 3. See also: O Swan, 'Research Proposal: The experiences of doula support amongst women from refugee backgrounds in Melbourne, Australia', Birth for HumanKIND/Multicultural Centre for Women's Health, 2015, and J Sandall, H Soltani, S Gates, A Shennan and D Devane, 'Midwife-led continuity models versus other models of care for childbearing women', *Cochrane Database of Systematic Reviews*, Issue 4, 2016, Art. No.: CD004667.

¹⁷⁰⁸ Ms Jen Branscombe, Programs Manager, Birth for HumanKIND, Family and Community Development Committee public hearing – Melbourne, 16 October 2017, transcript of evidence, p. 4.

of care models and believes that women from these backgrounds should be offered continuity of care as a priority at public maternity hospitals which offer this as a model of care. Accordingly, the Committee recommends that:

RECOMMENDATION 8.6: The Victorian Government work with the Department of Health and Human Services and public maternity hospitals on developing a policy that gives priority for continuity of care models to women from culturally and linguistically diverse communities.

8.5 Cultural awareness training

The Committee heard that women from CALD and refugee backgrounds need culturally appropriate maternity care and that it was important to train the perinatal workforce in providing culturally appropriate care. Dr Murdolo told the Committee:

We really need a better trained and qualified workforce to do this kind of work when we are thinking about a third of the population of women who are using these services. We need to make sure that there is a workforce that understands the context of women's lives, particularly for mothers, and that is able to take a social model of health; it is understanding the systemic factors impacting on women. We also need a bit more training on non-discriminatory practice, because we have had reports from women that they have experienced discrimination.¹⁷⁰⁹

Dr Murdolo said that training for health professionals is 'very ad hoc':

Some health professionals do that kind of training, but there is no standard and it is not across the board. There is a whole range of different organisations offering the same kind of training that we offer, but it is not coordinated, and there are also private providers in that space as well. Yes, I think that there would be some benefit in coordinating that kind of thing and also making it either mandated or more attractive for health professionals to take part in.¹⁷¹⁰

Ms Patti Reilly, Acting Family Health Coordinator at the City of Melbourne, told the Committee that they work with Foundation House and other providers of services for CALD families to provide cultural awareness training for maternal and child health nurses.¹⁷¹¹ Ms Reilly also noted that they have training provided by the Department of Education and Training twice a year that often involves cultural awareness training.¹⁷¹²

In their submission to the Inquiry, the Australian College of Mental Health Nurses (ACMHN) recommended that the Victorian Government actively involve organisations such as the Congress of Aboriginal and Torres Strait Islander Nurses and Midwives (CATSINaM) and the Migrant and Refugee Women's Health Partnership when developing cultural safety in Victorian perinatal care services.¹⁷¹³ They note

¹⁷⁰⁹ Dr Adele Murdolo, Executive Director, Multicultural Centre for Women's Health, Family and Community Development Committee public hearing – Melbourne, 27 November 2017, transcript of evidence, p. 7. See also, Caroline Chisholm Society, submission no. 29, p. 30.

¹⁷¹⁰ Dr Adele Murdolo, Executive Director, Multicultural Centre for Women's Health, Family and Community Development Committee public hearing – Melbourne, 27 November 2017, transcript of evidence, p. 7.

¹⁷¹¹ Ms Patti Reilly, Acting Family Health Coordinator, City of Melbourne, Family and Community Development Committee public hearing – Melbourne, 18 September 2017, transcript of evidence, p. 5.

¹⁷¹² *Ibid.*, p. 3.

¹⁷¹³ Australian College of Mental Health Nurses, submission no. 48, p. 10.

that they recently provided a submission to the draft Scoping Report on cultural competence in education, training, and standard setting, which is being developed by the Migrant and Refugee Women's Health Partnership.¹⁷¹⁴

The Migrant and Refugee Women's Health Partnership is a national initiative which was formed in 2016 'in recognition that Australia's changing demographics require a response grounded in forethought and collaboration'.¹⁷¹⁵ Their report, *Overview of Cultural Competence in Professional Education, Training and Standard Setting for Clinicians*, captures the various Colleges' existing policies and practices which support health practitioners to work effectively with migrant and refugee communities.¹⁷¹⁶

The Committee heard that it is important for CALD communities to have culturally appropriate care and recognises the importance of cultural training for staff working in maternity services. The Committee is pleased that work is being done by the Migrant and Refugee Women's Health Partnership to consolidate the guidelines and approaches of specialist medical colleges, peak professional bodies of nurses and midwives, and general practice organisations. The Committee believes that the Victorian Government should consult with the Partnership and relevant peak bodies in the development of practice standards, strategies, and training programs aimed at strengthening cultural capability in healthcare. Accordingly, the Committee recommends that:

RECOMMENDATION 8.7: The Victorian Government mandate and provide funding, including the extra cost that regional hospitals will incur, to ensure maternity service staff at Victorian public hospitals receive training in cultural awareness and engagement and supporting women and their families from culturally and linguistically diverse and refugee backgrounds.

8.6 Mental health services

The Committee heard that migrant women experience many of the risk factors for developing perinatal depression and anxiety.¹⁷¹⁷ For example, migrant women may have low social support, low levels of partner support, experiences of domestic violence, socio-economic difficulties and poverty, past trauma experiences, and

1714 Ibid. See: Migrant and Refugee Women's Health Partnership, *Overview of cultural competence in professional education, training and standard setting for clinicians*, Migrant and Refugee Women's Health Partnership, Canberra, August 2017, accessed 27 April 2018, <<http://www.anzca.edu.au/documents/overview-of-cultural-competence-in-professional-ed.pdf>>.

1715 Migrant and Refugee Women's Health Partnership, *Overview of cultural competence in professional education, training and standard setting for clinicians*, Migrant and Refugee Women's Health Partnership, Canberra, August 2017, accessed 27 April 2018, <<http://www.anzca.edu.au/documents/overview-of-cultural-competence-in-professional-ed.pdf>>.

1716 For example, all specialist Medical Colleges, the peak professional and education bodies for nurses and midwives and the general practice training organisations took part, including: the Royal Australian and New Zealand College of Obstetricians and Gynaecologists, the Royal Australian and New Zealand College of Psychiatrists, Royal Australian College of General Practitioners, the Royal Australian College of Surgeons, the Australian College of Nursing, the Australian College of Mental Health Nurses, and the Australian College of Midwives. See: Migrant and Refugee Women's Health Partnership, *Overview of cultural competence in professional education, training and standard setting for clinicians*, Migrant and Refugee Women's Health Partnership, Canberra, August 2017, accessed 27 April 2018, <<http://www.anzca.edu.au/documents/overview-of-cultural-competence-in-professional-ed.pdf>>.

1717 Dr Adele Murdolo, Executive Director, Multicultural Centre for Women's Health, Family and Community Development Committee public hearing - Melbourne, 27 November 2017, transcript of evidence, p. 5.

low proficiency in the host language.¹⁷¹⁸ Furthermore, many women from refugee backgrounds have had difficult past pregnancy experiences, including pregnancy loss.¹⁷¹⁹

In their submission to the Inquiry, the Multicultural Centre for Women's Health (MCWH) cited a study of the post-childbirth experiences of women in Australia which found that women from non-English speaking backgrounds had a higher prevalence of depression, were more likely to report wanting more practical and emotional support, were more likely to have no 'time out' from looking after their baby, and were more likely to report feeling lonely and isolated.¹⁷²⁰

Dr Murdolo stated that there are strong links between social isolation, family violence (see section 8.7) and mental health for migrant women. She referred to recent cases of maternal infanticide from within migrant communities:

There have been some quite high profile cases in Victoria around maternal infanticide. Three of the women we have been having a look at in terms of those cases have been from migrant communities. The most recent case was Sofina Nikat, who was recently sentenced ... [In his sentencing remarks, Justice Lasry] made some very strong links between the woman's experience of family violence, mental health issues, social isolation and really Ms Nikat's capacity to cope in that situation. Obviously I am making no judgements or excuses, but we have a responsibility to have a look at that kind of perfect storm that is created when we see that combination of family violence, social isolation and mental health issues. Of course, like the research is showing us, all of those seem to be consistent factors across most cases, including the factor of migration from a mainly non-English-speaking country.¹⁷²¹

Professor Louise Newman AM, Director of the Royal Women's Hospital Centre for Women's Mental Health and Professor of Psychiatry at The University of Melbourne, told the Committee that they have a psychologist who works at Foundation House and is working with the Royal Women's Hospital (RWH) to assist their asylum seeker and refugee populations. She told the Committee about the high risk population groups they see at the RWH:

In terms of the general community populations we have a large group of Arabic-speaking populations from various parts of the world. We are now seeing the Syrian refugee groups, who have been rehoused in some of our areas, and we have the community detainees, who are still asylum seekers in terms of the immigration department, who are in the community receiving mental health treatment. At the moment they are women from Nauru on the whole, the majority of whom have experienced sexual assault. We have got some very high-risk populations. We have very good interpreter services and bicultural social workers, and we need to maintain that. Part of the issue is always dealing with new population groups when they come in.¹⁷²²

¹⁷¹⁸ Ibid.

¹⁷¹⁹ Ibid.

¹⁷²⁰ Multicultural Centre for Women's Health, submission no. 88, p. 2.

¹⁷²¹ Dr Adele Murdolo, Executive Director, Multicultural Centre for Women's Health, Family and Community Development Committee public hearing – Melbourne, 27 November 2017, transcript of evidence, pp. 5-6.

¹⁷²² Professor Louise Newman AM, Director, Royal Women's Hospital Centre for Women's Mental Health, Family and Community Development Committee public hearing – Melbourne, 16 October 2017, transcript of evidence, p. 11.

The Australian College of Mental Health Nurses (ACMHN) referred, in their submission, to a recent study of pregnant migrant women which found that there is a lack of cultural safety in perinatal mental health assessment tools ‘which can create challenges for identifying mental health concerns that arise during the perinatal period, due to the questions reflecting western culture and the variable quality of translated assessment tools and translator services’.¹⁷²³

IPC Health is a community health service operating in the Western suburbs of Melbourne, across six sites. Regarding perinatal mental health, IPC Health’s submission stated:

Perinatal depression can be isolating in itself but in the context of new and emerging migrant communities living within Western Suburbs with limited transport and service system infrastructure the impact is far more significant on the individual, the child and the family ...¹⁷²⁴

The submission from IPC Health stated that education in pre-pregnancy is not currently tailored to new migrant families, noting that these families often lack broader social and family supports and the role of fathers in pregnancy and parenthood is different.¹⁷²⁵ They note, in their submission, that understanding and navigating the health system is ‘an issue for new migrant families and this needs to be considered and strategies put in place’.¹⁷²⁶

Ms Jodie Ashworth told the Committee about the challenges working with different groups settling in Melbourne’s north, and how they were trying to assist those groups to build supportive relationships:

We are doing a trial at the moment with mothers groups from particular communities. We have a group of Punjabi women that come together to share stories and try and build supportive relationships ... We have just settled 2000 Syrian refugees in the northern corridor, as you are probably aware, and we are starting to see some of the challenges with that come through the door now. It is just part of investment in CALD communities and what we are going to do to, I suppose, assist and help build a healthy lifestyle for those Australians. I am not sure that we have nailed that yet and I am not sure the resources are there for us to be truly successful in the northern corridor just yet.¹⁷²⁷

The Committee heard that CALD communities are likely to have poorer mental health as they may have experienced trauma and may be socially isolated. The Committee believes that there is a real need for greater awareness of the perinatal mental services that currently do exist, so that early interventions can be achieved for women and families at risk of mental illness, particularly in the antenatal period. The Committee recognises the important contribution of organisations, such as PANDA and COPE, in supporting the mental health needs of women in the perinatal period. A government

¹⁷²³ Australian College of Mental Health Nurses, submission no. 48, p. 10. See also: R Playfair, B Salami and K Hegadoren, ‘Detecting antepartum and postpartum depression and anxiety symptoms and disorders in immigrant women: A scoping review of the literature’, *International Journal of Mental Health Nursing*, vol. 26, no. 4, 2017, pp. 314-325.

¹⁷²⁴ IPC Health, submission no. 19, p. 2.

¹⁷²⁵ *Ibid.*, p. 1.

¹⁷²⁶ *Ibid.*

¹⁷²⁷ Ms Jodie Ashworth, General Manager, Surgery, Women’s and Children’s, Operating Theatres and ICU and Chief Nursing Officer, Northern Health, Family and Community Development Committee public hearing – Melbourne, 5 February 2018, transcript of evidence, p. 6.

funded and supported public health education campaign should be based on collaboration with groups, such as PANDA and COPE, who are expert in public communication in this area.

The Committee believes that the Perinatal Mental Health Plan, outlined in Chapter Three, should include specific goals and outcomes for culturally and linguistically diverse communities, which the Committee recommended in Recommendation 3.1. These goals and outcomes should include an awareness campaign for CALD communities about mental health conditions and support available, and these communities should be provided culturally appropriate mental health resources at antenatal appointments. The Committee also makes the following recommendation about the mental health workforce:

RECOMMENDATION 8.8: The Victorian Government ensure that all mental health workers in the perinatal field are trained in cultural awareness and engagement with culturally and linguistically diverse communities.

8.7 Family violence

As discussed in Chapter Three, the Committee heard that in the perinatal period, women are more at risk of family violence than at any other time of their lives.¹⁷²⁸ Women from CALD and refugee backgrounds can be particularly vulnerable to family violence due to social isolation, language barriers, their financial circumstances, visa status, cultural expectations, and the stress and trauma of the migration experience.

Dr Murdolo told the Committee that the MCWH conducted research between 2014 and 2016 on migrant and refugee women's experiences of family violence and found that these women are more vulnerable to family violence due to structural and systemic factors:

We interviewed 46 migrant women from Victoria and Tasmania for that research in partnership with the University of Melbourne and the University of Tasmania, and one of the significant findings was that at least six of the 46 women we interviewed were in what we described as extreme socially isolating circumstances, so their only contact for many years was their immediate families — so husband or husband's family — and they had no contact with services and very little outside social contact. So that rang alarm bells for us in terms of any person's needs for social participation.¹⁷²⁹

Dr Murdolo notes that one of the difficulties that migrant women face is that they are often holders of a secondary visa:

[W]here they had come to Australia on a spousal visa or some kind of sponsorship or they were a secondary visa holder on a temporary visa and their main person and liaison between the world and their home was their husband, who was the

¹⁷²⁸ Ms Emma Sampson, Research and Policy Officer, Public Interest, Australian Psychological Society, Family and Community Development Committee public hearing – Melbourne, 5 February 2018, transcript of evidence, p. 3; Ms Patti Reilly, Acting Family Health Coordinator, City of Melbourne, Family and Community Development Committee public hearing – Melbourne, 18 September 2017, transcript of evidence, p. 3; Hume City Council, submission no. 69, p. 13.

¹⁷²⁹ Dr Adele Murdolo, Executive Director, Multicultural Centre for Women's Health, Family and Community Development Committee public hearing – Melbourne, 27 November 2017, transcript of evidence, p. 5.

perpetrator of the violence — so very, very difficult circumstances to be experiencing family violence in, and for many it was many, many years before they could escape their situation.¹⁷³⁰

Language was often a barrier for health practitioners in finding out about family violence and many practitioners found it challenging having conversations about family violence. Ms Ashworth told the Committee:

Our family violence rates are challenging. Having those conversations with women not in the presence of their husband with some of our communities is difficult because first you do not get that opportunity, and when you do get that opportunity you find that their English is so poor that it is difficult to truly understand what is going on in the home.¹⁷³¹

The Royal Commission into Family Violence Report, mentioned in Chapter Three, found that people from CALD communities are more likely than people of Anglo-Australian background to face barriers to obtaining help when experiencing family violence. The report stated:

The effects of family violence experienced by people from CALD communities, including recent arrivals, are compounded by a range of factors associated with the experience of migration and resettlement, as well as systemic barriers to seeking and obtaining help. The impact of family violence on CALD victims who do not have permanent residency is particularly severe because they have very limited or no access to support and can be at greater risk of coercion and control by sponsoring spouses and other family members.¹⁷³²

The Royal Commission noted, in their report, that both mainstream services and specialist family violence services ‘struggle to provide culturally appropriate, responsive services for CALD victims, and the services that are designed specifically for CALD victims are limited’.¹⁷³³ The Royal Commission, in their report, included several recommendations to strengthen the capacity of mainstream and specialist services to identify and respond to the needs of family violence victims from CALD communities.¹⁷³⁴

The Committee notes, as it did in Chapter Three, that it does not wish to re-prosecute the findings and recommendations of the Royal Commission. Further, the Committee notes that it supports the Royal Commission’s recommendations, particularly in the context of the perinatal period.

1730 Ibid.

1731 Ms Jodie Ashworth, General Manager, Surgery, Women’s and Children’s, Operating Theatres and ICU and Chief Nursing Officer, Northern Health, Family and Community Development Committee public hearing – Melbourne, 5 February 2018, transcript of evidence, p. 6.

1732 State of Victoria, *Royal Commission into Family Violence: Report and Recommendations*, Summary and recommendations, Parliamentary Paper No. 132, Victorian Government Printer, Melbourne, p. 34.

1733 Ibid.

1734 Ibid.

8.8 Access to services in regional areas

While the Committee discusses rural and regional perinatal services and makes recommendations in Chapter Four, the Committee heard that women from CALD and refugee backgrounds were particularly disadvantaged in rural and regional areas.¹⁷³⁵ In their submission, the Multicultural Centre for Women's Health (MCWH) stated that migrant and refugee women in rural and regional areas face multiple disadvantages accessing a range of health services compared to their metropolitan counterparts.¹⁷³⁶ They noted that women in rural areas are less likely to obtain healthcare from medical specialists and more likely to rely on hospital care and that mainstream services often do not always provide the culturally appropriate care women need.¹⁷³⁷

The Committee heard that many CALD communities settled in outer suburban and regional areas.¹⁷³⁸ Likewise, many refugees are resettled through the Australian Government's Humanitarian Settlement Program in rural and regional areas.¹⁷³⁹ The MCWH noted in their submission that while the majority of migrants and refugees live in metropolitan regions of Victoria, 'the population of new migrants living in rural areas of Victoria is growing, and in many areas, exceeding the population growth of the general population'.¹⁷⁴⁰ Their submission stated:

In the 5 years between 2006 and 2011, the average increase across Victorian rural regions of people who migrated from a non-English speaking country was 18.6%, compared with general population growth of 5.5%. At the 2011 census, the total of immigrants and refugees from non-English speaking countries living in rural and regional Victoria was 77,851, making up 5.4% of the general rural and regional populations ('Population Diversity in Victoria: 2011 Census Local Government Areas', OMAC, 2013).¹⁷⁴¹

Ms Bartlett raised concerns about refugees moving to areas that had poorer outcomes for mothers:

Whilst metropolitan Melbourne oversees the vast majority of these non-English speaking women during their perinatal journey, regional Victoria averages about 10 to 15 per cent of overall humanitarian arrival intake, yet it is within these regional areas that mothers fare the worst. Loddon, Hindmarsh, Yarriambiack, the Pyrenees and Central Goldfields round out the top 10 LGAs with the worst outcomes for mothers.¹⁷⁴²

¹⁷³⁵ Ms Rebeccah Bartlett, Nurse and Midwife, mAdapt Project, Family and Community Development Committee public hearing – Melbourne, 16 October 2017, transcript of evidence, pp. 2, 3.

¹⁷³⁶ Multicultural Centre for Women's Health, submission no. 88, p. 4.

¹⁷³⁷ Ibid.

¹⁷³⁸ Caroline Chisholm Society, submission no. 29, p. 30; Ms Rebeccah Bartlett, submission no. 6, p. 3; Ms Rebeccah Bartlett, Nurse and Midwife, mAdapt Project, Family and Community Development Committee public hearing – Melbourne, 16 October 2017, transcript of evidence, p. 2.

¹⁷³⁹ Albury Wodonga Health, submission no. 55, p. 2; Ms Rebeccah Bartlett, submission no. 6, p. 3. See also, Victorian Refugee Health Network, 'Rural & regional', accessed 18 May 2018, <<http://refugeehealthnetwork.org.au/engage/rural-regional>>.

¹⁷⁴⁰ Multicultural Centre for Women's Health, submission no. 88, p. 4.

¹⁷⁴¹ Ibid.

¹⁷⁴² Ms Rebeccah Bartlett, Nurse and Midwife, mAdapt Project, Family and Community Development Committee public hearing – Melbourne, 16 October 2017, transcript of evidence, pp. 2-3. See also: Ms Rebeccah Bartlett, submission no. 6, p. 3.

In their submission, Albury Wodonga Health drew attention to the health needs of refugees in regional areas:

With respect to increasing need for appropriate cultural services there is increasing numbers of refugees settling in regional areas and increasing numbers of women with HIV in regional areas amongst the refugee population. Cultural needs and resources required include greater access and accessibility to culturally appropriate services, linking services and an appropriately skilled workforce.¹⁷⁴³

1743 Albury Wodonga Health, submission no. 55, p. 2.

Appendix 1

List of submissions

Submission no.	Name of submitter
1.	Mr Wale Oladimeji
2.	Empowered Space
3.	Ms Lydia Morgan
4.	Centre of Perinatal Excellence (COPE)
5.	Mrs Tamlyn Kirk
6.	Ms Rebecca Bartlett
7.	Mr Jeremy Orchard / Helpers
8.	The Babes Project
9.	Confidential
10.	Mallee Track Health and Community Service
11.	East Grampians Health Service
12.	Ms Sarah van Ree
13.	Professor Martin Delatycki
14.	Jean Hailes Research Unit
15.	Dr Joe Garra
16.	Dr W Twycross
17.	Mrs Casey Wright
18.	Hospital to Home
19.	IPC Health
20.	Ms Andrea Rindt
21.	City of Melbourne
22.	Ms Kate Ravenscroft
23.	Mount Alexander Shire
24.	Ms Cassie Austin
25.	Royal Australian and New Zealand College of Psychiatrists (Victorian Branch)
26.	Hobsons Bay City Council
27.	Ms Laura Stubbings
28.	Families where a Parent has a Mental Illness (FaPMI)
29.	Caroline Chisholm Society
30.	Ms Suzanne Higgins
31.	Melbourne Children's Campus
32.	University Hospital Geelong
33.	Australian College of Midwives (Victoria Branch)
34.	Ballarat Health Services
35.	Royal Australian and New Zealand College of Obstetricians and Gynaecologists
36.	Charles Sturt University
37.	Ms Rebecca Gelsi
38.	Ms Gabrielle Sammon

39.	Yarra Valley Midwives
40.	Mercy Health
41.	Genetics in the North East
42.	Confidential
43.	Save Healesville Hospital Action Group
44.	Bendigo Health
45.	Tweddle Child and Family Health Service
46.	City of Whitehorse
47.	Council of Deans of Nursing and Midwifery (Australia & New Zealand)
48.	Australian College of Mental Health Nurses
49.	Northeast Border Mental Health Services
50.	The Kilmore & District Hospital
51.	The Midwife Collective
52.	Confidential
53.	Victorian Healthcare Association
54.	The University of Melbourne
55.	Albury Wodonga Health
56.	Ms Ofri Marton
57.	Warrnambool Breastfeeding Centre
58.	Ms Kिरily Tibb
59.	Birth for HumanKIND
60.	Ms Barbara Oh
61.	My Midwives Melbourne
62.	Dr Andrew Watkins
63.	Healesville Action Group
64.	Australian Breastfeeding Association
65.	Midwives and Mothers Australia
66.	Loddon Mallee Aboriginal Reference Group
67.	Australian Nursing and Midwifery Federation (Victorian Branch)
68.	Confidential
69.	Hume City Council
70.	South West Healthcare
71.	Royal Australasian College of Physicians
72.	Ms Hilary Skelton
73.	Dr Jan Hodgson on behalf of the steering committee for the ARC funded research project 'PeTALS – Prenatal Testing; a longitudinal study': Professor Jane Fisher, Professor Jane Halliday, Ms Chriselle Hickerton, Dr Belinda McClaren, Professor Sylvia Metcalfe, Dr Melody Menezes, A/Prof Kerry Petersen, and Ms Penelope Pitt; Professor Lynn Gillam – Clinical Ethicist, and Professor Sonia Grover – Consultant Obstetrician and Gynaecologist
74.	Mindful Centre for Training and Research in Developmental Health
75.	The Royal Women's Hospital
76.	Australian Catholic University
77.	Monash Health
78.	Maternity Consumer Network
79.	Parent-Infant Research Institute (PIRI)
80.	Australian Psychological Society

81.	Ms Elisia Marchesani
82.	Dr Graeme Dennerstein
83.	My Midwives Melbourne Parents Group
84.	Confidential
85.	Name withheld
86.	Sands Australia
87.	Gertrude Street Clinic
88.	Multicultural Centre for Women's Health
89.	Glenelg Shire Maternal and Child Health Service
90.	Ms Ruth Berkowitz
91.	Ms Tania Maxwell
92.	Dr Michael Block
93.	Dr Kimberley Sleeman
94.	Ms Alana Cooper
95.	Northern Health
96.	City of Greater Geelong Maternal and Child Health Service
97.	Dr Wendy Pollock
98.	Red Nose
99.	Dr Antoinette Mowbray
100.	Australasian Sonographers Association
101.	Australasian Society for Ultrasound in Medicine
102.	Paediatric Infant Perinatal Emergency Retrieval Service (PIPER)
103.	Confidential
104.	Ms Sarah Vincenzini

Appendix 2

Public hearings

The Committee held the following public hearings:

Date	Venue
4 September 2017	Melbourne
18 September 2017	Melbourne
11 October 2017	Warrnambool
16 October 2017	Melbourne
24 October 2017	Bendigo
25 October 2017	Wangaratta
9 November 2017	Mildura
27 November 2017	Melbourne
7 December 2017	Bairnsdale
8 December 2017	Warragul
11 December 2017	Geelong
5 February 2018	Melbourne

4 September 2017, Melbourne

Organisation	Name	Position
Australian Breastfeeding Association	Ms Susan Day	President
	Dr Susan Tawia	Manager, Breastfeeding Information and Research
Centre of Perinatal Excellence (COPE)	Dr Nicole Highet	Founder and Executive Director
	Mr Simon Troeth	Board Director
Royal Australian and New Zealand College of Obstetricians and Gynaecologists	Professor Michael Permezel	Immediate Past-President
Jean Hailes Research Unit	Professor Jane Fisher	Director
	Dr Heather Rowe	Senior Research Fellow
My Midwives Melbourne	Ms Hannah Quanchi	Owner and Director
	Ms Andrea Quanchi	Midwife and Director of Midwives
	Ms Gabrielle Sammon	Parents Group Representative
Individual	Ms Kate Ravenscroft	

18 September 2017, Melbourne

Organisation	Name	Position
Australian Nursing and Midwifery Federation (Victorian Branch)	Ms Lisa Fitzpatrick	Branch Secretary
	Ms Julianne Barclay	Maternity Services Officer
	Ms Maree Burgess	Maternal and Child Health Nurse, Branch President
Individual	Dr Andrew Watkins	Neonatologist
Melbourne Children's Campus	Associate Professor Rod Hunt	Director, Newborn Intensive Care, Royal Children's Hospital
	Professor Cheryl Jones	Stevenson Chair in Paediatrics, The University of Melbourne, and Head of Department
City of Melbourne	Ms Lynne Smith	Acting Team Leader, Family Services
	Ms Patti Reilly	Acting Family Health Coordinator
Royal Australian and New Zealand College of Psychiatrists (Victorian Branch)	Associate Professor Richard Newton	Chair
	Professor Louise Newman AM	Past President
	Dr Virginia Loftus	Committee Member, Faculty of Child and Adolescent Psychiatry
Tweddle Child and Family Health Service	Dr Nicole Milburn	Perinatal Psychologist and Chair
	Ms Kirsty Evans	Director of Clinical Services/Nursing

11 October 2017, Warrnambool

Organisation	Name	Position
South West Healthcare	Dr Liz Uren	Obstetrics and Gynaecology
South West Healthcare	Ms Rachael Lee	Practice Coordinator
	Ms Julianne Cliff	Director of Nursing
	Ms Janene Facey	Maternity Nurse Unit Manager
South West Healthcare	Mr Nicholas Place	Manager, Primary Mental Health Team
The Warrnambool Breastfeeding Centre	Ms Barbara Glare	President and Lactation Consultant
Warrnambool City Council	Ms Maryanne Purcell	Maternal and Child Health Nurse Coordinator
Individual	Ms Kerrie Donlon	
Individual	Ms Melissa Maher	
Individual	Ms Jess Stretton	
Individual	Ms Jane Perry	
Individual	Ms Alexandra Lenehan	
Individual	Ms Wren Bowie	
The University of North Carolina School of Medicine	Dr Alison Stuebe	Associate Professor, Maternal-Fetal Medicine
South West Healthcare	Ms Janene Facey	Maternity Nurse Unit Manager

16 October 2017, Melbourne

Organisation	Name	Position
Royal Women's Hospital Centre for Women's Mental Health	Professor Louise Newman AM	Director
Perinatal Anxiety and Depression Australia (PANDA)	Ms Terri Smith	Chief Executive Officer
Monash Medical Centre (Monash Health)	Associate Professor Ryan Hodges	Interim Program Director, Women's and Newborn Program, and Head of Obstetrics and Perinatal Services
Mercy Hospital for Women (Mercy Health)	Dr Michael Rasmussen	Clinical Services Director
mAdapt Project	Ms Rebekkah Bartlett	Nurse and Midwife
Birth for HumanKIND	Ms Kirstan Flannery	Chairperson and Co-Founder
	Ms Jen Branscombe	Programs Manager
	Ms Elizabeth Mazeyko	Volunteer Bicultural Doula

24 October 2017, Bendigo

Organisation	Name	Position
Bendigo Health	Ms Fiona Faulks	Deputy Director of Nursing, Women's and Children's Services
	Dr Nicola Yuen	Director of Obstetrics and Gynaecology
	Ms Amanda Hewett	Mamta Coordinator
Bendigo and District Aboriginal Co-operative	Ms Raylene Harradine	Chief Executive Officer, Bendigo and District Aboriginal Co-operative, and Chair, Loddon Mallee Aboriginal Reference Group
	Ms Christine Gibbins	Health Services Coordinator
	Ms Kate Glenie	Loddon Mallee Aboriginal Reference Group Early Years Project Worker, Mallee District Aboriginal Services
The Midwife Collective	Ms Elizabeth Murphy	Midwife
	Ms Marie-Louise Lapeyre	Midwife
	Ms Samantha Ward	Midwife
	Dr Veronica Moule	Collaborative Partner
City of Greater Bendigo	Ms Helen Lees	Maternal and Child Health Clinical Coordinator
St John of God Raphael Services	Ms Ursula Kiel	Senior Clinician
Individual	Ms Suzanne Hartney	Neonatal Nurse and Midwife
Gianna Centre	Ms Anne O'Brien	Volunteer
Remembrance Parks Central Victoria	Mr Graham Fountain	Chief Executive Officer
Individual	Ms Gabrielle Gamble	
Bendigo Positive Birthing	Ms Elizabeth Murphy	Volunteer

25 October 2017, Wangaratta

Organisation	Name	Position
Northeast Health Wangaratta	Ms Libby Fifis	Director of Clinical Services, Nursing and Midwifery
	Dr Leo Fogarty	Director of Obstetrics
	Dr John Elcock	Director of Medical Services
Rural City of Wangaratta	Ms Rebecca Sacco	Maternal and Child Health Team Leader
	Ms Liz Flamsteed	Head of Innovation Fund Project in Antenatal Engagement
Albury Wodonga Health	Ms Julie Wright	Operational Director of Women's and Children's Services
Northeast and Border Mental Health Services (NEBMHS)	Ms Jenny Ahrens	Operations Director, Northeast and Border Mental Health Services
	Ms Fiona Pilkington	Perinatal Emotional Health Clinician, Albury Wodonga Health
	Ms Kerry Dolan	Perinatal Emotional Health Clinician, Albury Wodonga Health
	Dr Sarah Hancock	GP, Benalla Carrier Street Clinic
Individual	Dr Will Twycross	Procedural GP in Obstetrics, Anaesthetics, and Accident and Emergency
Individual	Ms Cate Gemmill	Lactation Consultant, Northeast Health Wangaratta
Individual	Ms Megan Rickard	
Individual	Ms Lauren Bowie	
Australian Breastfeeding Association	Ms Alice Martin	
Individual	Ms Emma Avery	

9 November 2017, Mildura

Organisation	Name	Position
Mallee Track Health and Community Service	Ms Lois O'Callaghan	Chief Executive Officer
	Mr Grant Doxey	Program Leader, Social Work and Community Development
Mallee Family Care	Mr Jason Spratt	Manager, Family Services
Mallee District Aboriginal Services	Ms Jacinta Molloy	Manager, Early Years Services
	Ms Kate Glenie	Loddon Mallee Aboriginal Reference Group Early Years Project Worker
Mildura Base Hospital	Dr Nikhil Patravali	Director, Obstetrics and Gynaecology
	Ms Janet Hicks	Director of Nursing
	Ms Sandra Doyle	Nurse Unit Manager, Maternity Services
Mildura Rural City Council	Ms Samantha Cooke	Community Health Coordinator
Mildura O&G Clinic	Dr Kimberley Sleeman	Obstetrics and Gynaecology Specialist
	Dr Erin Kelly	GP Obstetrician
Zoe Support Australia	Ms Anne Webster	Executive Director
Individual	Ms Cheree Jukes	
Individual	Ms Kassie Hocking	

27 November 2017, Melbourne

Organisation	Name	Position
Department of Health and Human Services	Ms Kym Peake	Secretary
	Mr Terry Symonds	Deputy Secretary, Health and Wellbeing Division
Safer Care Victoria	Professor Euan Wallace	Chief Executive Officer
Sands Australia	Ms Anita Guyett	General Manager Improving Bereavement Care
	Ms Janelle Marshall	General Manager Services
Multicultural Centre for Women's Health	Dr Adele Murdolo	Executive Director
Caroline Chisholm Society	Dr Jennifer Weber	Transition Manager, Pregnancy and Support Service
Council of Deans of Nursing and Midwifery (Australia & New Zealand)	Associate Professor Phil Maude	Council Executive Member
Parent-Infant Research Institute (PIRI)	Dr Alan Gemmill	Deputy Director Research and Senior Research Fellow
	Ms Jennifer Ericksen	Coordinator, Infant Clinic
	Professor Jeannette Milgrom	Executive Director
Department of Education and Training	Ms Kim Little	Assistant Deputy Secretary, Early Childhood Portfolio
	Dr Anastasia Gabriel	Director of Prevention and Health Promotion
Individuals	Ms Ofri Marton	
	Mr Steven Kennedy	
Individual	Dr Wendy Pollock	Adult Intensive Care Nurse and Midwife
Red Nose	Ms Petra den Hartog	Bereavement Care Specialist
Individual	Ms Mary McCarthy	Midwife, Nurse and Women's Emergency Department Unit Manager
St Kilda Mums	Ms Jessica Macpherson	Chief Executive Officer

7 December 2017, Bairnsdale

Organisation	Name	Position
Bairnsdale Regional Health Service	Ms Bernadette Hammond	Director of Clinical Operations/Chief Nurse and Midwife
Gippsland Lakes Community Health	Ms Ailsa Carr	Executive Manager, Family, Youth and Children's Services
Swifts Creek Bush Nurse Centre	Ms Sue Carroll	Midwife
Individual	Ms Heather Daly	Midwife and Community Health Nurse
Gippsland & East Gippsland Aboriginal Co-Operative Ltd (GEGAC)	Ms Brianna Ellis	General Manager
Orbost Regional Health	Ms Meryn Pease	Chief Executive Officer
Individual	Dr Elizabeth Boyd	GP Obstetrician
Individuals	Dr Antoinette Mowbray	GP Obstetrician
	Dr Elizabeth Boyd	GP Obstetrician

8 December 2017, Warragul

Organisation	Name	Position
West Gippsland Healthcare Group	Ms Kathy Kinrade	Director, Clinical Operations, Nursing and Midwifery
	Ms Wilma Wallace	Maternity Unit Manager
Baw Baw Shire Maternal and Child Health Services	Ms Marilyn Humphrey	Maternal and Child Health Coordinator
Olivia's Place	Mrs Kirsten Finger	Co-Founder
	Mrs Carmel Riley	President
School of Nursing, Midwifery and Healthcare, Federation University	Ms Jan Jones	Coordinator, Graduate Diploma of Midwifery Program and Bachelor of Nursing Practice and Bachelor of Midwifery Program
Latrobe City Council Maternal and Child Health Services	Ms Nicky Lappin	Coordinator of Family Health and Development
	Ms Barb Parr	Enhanced Maternal and Child Health Nurse
Latrobe Regional Hospital	Dr Simon Fraser	Chief Medical Officer and Paediatrician
	Ms Christine Hoyne	Nurse Unit Manager, Parent and Infant Unit
	Dr Stuart Thomas	Psychiatrist

11 December 2017, Geelong

Organisation	Name	Position
University Hospital Geelong	Dr David Fuller	Clinical Director
	Ms Claire Geldard	Director of Operations, Women and Children's Directorate
City of Greater Geelong Maternal and Child Health Service	Ms Maree Crellin	Maternal and Child Health Coordinator
Wathaurong Aboriginal Cooperative	Mr Rodney Jackson	Chief Executive Officer
	Ms Mandy Miller	Midwife, Koori Maternity Service
Individuals	Ms Alyson Smith	Registered Nurse and Midwife
	Ms Kylie Cole	Registered Nurse and Midwife
Individual	Ms Suzanne Higgins	Midwife and Credentialed Mental Health Nurse
Families where a Parent has a Mental Illness (FaPMI)	Dr Ben Goodfellow	Psychiatrist
	Ms Cheree Cosgriff	Grampians Coordinator
	Ms Dawn Foster	Geelong Coordinator
	Ms Rose Cuff	State-wide Coordinator

5 February 2018, Melbourne

Organisation	Name	Position
Australian Psychological Society (APS)	Dr Emma Symes	Senior Psychologist, Centre for Women's Mental Health, Royal Women's Hospital
	Ms Viviane Lebnan	Convenor, Perinatal Interest Group
	Ms Emma Sampson	Research and Policy Officer, Public Interest
Paediatric Infant Perinatal Emergency Retrieval Service (PIPER)	Associate Professor Michael Stewart	Director
	Dr Jacqui Smith	Director Medical - Perinatal
The Babes Project	Ms Andreza Rodriguez	
	Ms Helen Parker	Director
Northern Health	Ms Jodie Ashworth	General Manager, Surgery, Women's and Children's, Operating Theatres and ICU and Chief Nursing Officer

A2

Appendix 3

Total number of women and babies, by place of birth, 2016

A3

Extract from Safer Care Victoria's *Victorian Perinatal Services Performance Indicators 2016-17* report, showing the total number of women and babies, by place of birth, in Victoria in 2016.¹⁷⁴⁴

¹⁷⁴⁴ Safer Care Victoria, *Victorian Perinatal Services Performance Indicators 2016-17*, Department of Health and Human Services, Melbourne, January 2018, pp. 95-97

Appendix 4: Total women and babies, 2016



Table 3: Total number of women and babies, by place of birth, 2016

Health service	Maternity capability level of service*	Number of women	Number of babies
The Royal Women's Hospital	6	7,596	7,749
Mercy Hospital for Women	6	5,852	5,980
Monash Medical Centre Clayton	6	4,144	4,307
Sunshine Hospital	5	5,374	5,448
The Northern Hospital	5	3,556	3,593
Frankston Hospital	5	2,881	2,909
Box Hill Hospital	5	2,687	2,709
University Hospital Geelong	5	2,442	2,466
Bendigo Health Care Group	5	1,350	1,367
Ballarat Health Services	5	1,369	1,389
Goulburn Valley Health	5	1,078	1,086
Albury Wodonga Health	5	1,594	1,617
Latrobe Regional Hospital (Traralgon)	5	812	824
Central Gippsland Health Service	4	449	457
Dandenong Hospital	4	2,677	2,677
Angliss Hospital	4	2,307	2,326
West Gippsland Healthcare Group	4	880	895
Mildura Base Hospital	4	880	885
South West Healthcare Warrnambool	4	720	731
Northeast Health Wangaratta	4	626	639
Wimmera Health Care Group	4	330	331
Mercy Werribee Hospital	4	3,725	3,750
Casey Hospital	4	2,137	2,137
Women's at Sandringham	4	1,560	1,563

Health service	Maternity capability level of service*	Number of women	Number of babies
Djerriwarrh Health Services	3	469	469
Bairnsdale Regional Health Service	3	358	359
Echuca Regional Health	3	378	383
Swan Hill District Health	3	233	234
Kilmore and District Hospital	3	303	303
Bass Coast Regional Health	3	183	184
Gippsland Southern Health Service (Leongatha)	3	209	209
Western District Health Service (Hamilton)	3	186	188
East Grampians Health Service (Ararat)	3	96	96
Benalla and District Memorial Hospital	3	74	74
South Gippsland Hospital	3	56	56
Mansfield District Hospital	3	90	90
Cohuna District Hospital	2	59	60
Terang and Mortlake Health Service	2	16	16
Colac Area Health	3	167	167
Maryborough District Health Service	2	68	68
Yarrawonga District Health Service	2	38	38
Kyneton District Health Service	2	31	31
Castlemaine Health	2	41	53
Portland District Health	2	66	66
South West Healthcare Camperdown	3	27	27
Orbost Regional Health	2	18	18
Other public hospitals		9	9



Health service	Maternity capability level of service*	Number of women	Number of babies
Hospital A	Private hospitals	3,263	3,345
Epworth Healthcare – Freemasons (East Melbourne)		3,129	3,171
St Vincents Private Hospital (Fitzroy)		2,550	2,614
Saint Frances Xavier Cabrini Hospital – Cabrini Malvern		2,091	2,118
Hospital B		1,112	1,121
Hospital C		930	937
St John of God Healthcare – Geelong		941	962
Jessie McPherson Private Hospital (Clayton)		893	951
St John of God Healthcare – Berwick		840	847
Hospital D		816	827
Hospital E		612	620
St John of God Healthcare – Ballarat		477	482
Bays Hospital, The – Mornington Campus		483	487
Hospital F		445	447
St John of God Healthcare – Bendigo		329	335
Private homebirth			255
Public hospital total		60,203	61,035
Private hospital total (n = 16)		18,911	19,264
Statewide total		79,114	80,299

Notes: Excludes babies born \leq 20 weeks' gestation, all terminations of pregnancy and birthweight \leq 150g. Babies born before arrival are counted at the hospital the mother and baby are subsequently transported to. Public hospitals with \leq 5 births are included in 'Other public hospitals'. Non-maternity public hospitals with occasional births are also included in 'Other public hospitals'.

* Maternity capability levels for period 2016–17. Capability levels for private hospitals were not determined for that period.

Appendix 4

Baby Friendly Health Initiative Ten Steps to Successful Breastfeeding

The criteria for a hospital's Baby Friendly Health Initiative accreditation include the following ten steps to successful breastfeeding referred to in Chapter Two:

1. Have a written breastfeeding policy that is routinely communicated to all health care staff.
2. Train all health care staff in the skills necessary to implement this policy.
3. Inform all pregnant women about the benefits and management of breastfeeding.
4. Help mothers initiate breastfeeding within half an hour of birth.
5. Show mothers how to breastfeed and how to maintain lactation even if they should be separated from their infants.
6. Give newborn infants no food or drink other than breast milk unless medically indicated.
7. Practise "rooming in" – allowing mothers and infants to remain together – 24 hours a day.
8. Encourage breastfeeding on demand – whenever the baby is hungry.
9. Give no artificial teats or pacifiers (also called dummies or soothers) to breastfeeding infants.
10. Foster the establishment of breastfeeding support groups and refer mothers to them on discharge from the hospital or clinic.

Appendix 5

Public Health and Wellbeing Act 2008 (Vic) extract

Extract from the *Public Health and Wellbeing Act 2008 (Vic)* section 46 describing the legislative functions of the Consultative Council on Obstetric and Paediatric Mortality and Morbidity (CCOPMM) referred to in Chapter One.

46 Functions of CCOPMM

- (a) conduct study, research and analysis into the incidence and causes in Victoria of maternal deaths, stillbirths and the deaths of children;
- (b) conduct study, research and analysis into the incidence and causes of obstetric and paediatric morbidity;
- (c) conduct a perinatal data collection unit for the purpose of—
 - (i) collecting, studying, researching and interpreting information on and in relation to births in Victoria;
 - (ii) identifying and monitoring trends in respect of perinatal health including birth defects and disabilities;
 - (iii) providing information to the Secretary on the requirements for and the planning of neonatal care units;
 - (iv) providing information for research into the epidemiology of perinatal health including birth defects and disabilities;
 - (v) establishing and maintaining a register of birth defects and disabilities;
- (d) provide to health service providers—
 - (i) information on obstetrics and paediatrics;
 - (ii) strategies to improve obstetric and paediatric care;
- (e) consider, investigate and report on any other matters in respect of obstetric and paediatric mortality and morbidity referred to CCOPMM by the Minister or the Secretary;
- (f) liaise with any other Consultative Council (whether or not prescribed) on any matter relevant to the functions of CCOPMM;
- (g) publish an annual report on the research and activities of CCOPMM;
- (h) perform any other prescribed function;
- (i) collect information for the purpose of performing its functions under this subsection.

Appendix 6

Child Wellbeing and Safety Regulations 2017 (Vic) extract

Extract from the Child Wellbeing and Safety Regulations 2017 (Vic) (SR 62/2017) providing the format for birth notifications referred to in Chapter Six.

Schedule 1

Regulation 10

NOTICE OF BIRTH UNDER SECTION 43(2) OF THE CHILD WELLBEING AND SAFETY ACT 2005

- (j) *To the Chief Executive Officer of the council of the municipal district of [*insert name of municipal district*], being the municipal district in which the mother of the child usually resides.

or

- (k) **[If (a) is not known]* To the Chief Executive Officer of the council of the municipal district of [*insert name of municipal district*], being the municipal district in which the birth occurred.

or

- (l) **[If the mother of the child usually resides outside Victoria]* To the Secretary to the Department of Education and Training.

Full name of mother:

*Any other name(s) by which the mother is known:

Home address:

Telephone number:

Gave birth to a child: *Male/*Female/*Other

*Live born/*Stillborn

*Full term/*Premature

*Singleton/*Multiple

*Aboriginal

*Torres Strait Islander

Child's full name (where known):

Child's date of birth:

Time of birth: *a.m./*p.m.

At: Postcode:
In attendance: *Doctor [*insert name of doctor*]
*Midwife [*insert name of midwife*]
Interpreter required: *Yes/*No [*if yes, please specify the language*]
Baby in special care nursery: *Yes/*No [*if yes, please specify the nursery site*]

Signature of responsible person:

Full name of responsible person:

Responsible person means—

- (a) in the case of a child born in a hospital or brought to a hospital within 24 hours after birth, the chief executive officer of the hospital; or
- (b) in any other case—
 - (iii) the doctor or midwife responsible for the professional care of the mother at the birth or a doctor who examined the body of the still-born child after the birth; or
 - (iv) if no doctor or midwife was in attendance at the birth, any other person in attendance at the birth.

* Delete if not applicable

