T R A N S C R I P T

FAMILY AND COMMUNITY DEVELOPMENT COMMITTEE

Inquiry into perinatal services

Mildura — 9 November 2017

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Witness

Ms Samantha Cooke, maternal and child health, Mildura Rural City Council.

The CHAIR — I welcome to these public hearings Ms Samantha Cooke from the maternal and child health service at Mildura Rural City Council. Thank you for attending here today. All evidence at this hearing taken by the committee is protected by parliamentary privilege as provided by the Constitution Act 1975 and is subject to the provisions of the Parliamentary Committees Act 2003 and other relevant legislation. Any comments you make outside the hearing will not be afforded such privilege. It is a contempt of Parliament to provide false evidence. These proceedings will be recorded and you will be sent a proof copy of the transcript. Welcome. I invite you to make a 10-minute contribution and then we might have a bit of a quiz.

Visual presentation.

Ms COOKE — I have brought a presentation along. I am not sure what has happened earlier today and what information you have got so it might be repeated. Can I just let you know that some of this information is quite confronting. It does have one explicit word, an expletive, in it which may be offensive to some people or it may not.

The CHAIR — Because we are pressed for time, Sam, we might just get you to do the best you can.

Ms COOKE — That's it.

The CHAIR — That was a great context to put it in, Sam. Who made the presentation?

Ms COOKE — That was done by Hands Up Mallee, which is about the collective impact that is going on in the community. A whole group of organisations have got together to become Hands Up Mallee, which started two years ago.

The CHAIR — It is certainly more confronting than a pie graph.

Ms COOKE — Yes. The song was quite confronting, too, but that is okay. I do have my other information as a presentation, if you would like it up there or I am happy to read it to you.

The CHAIR — We are happy if you read it; we are kind of time constrained.

Ms COOKE — There may be some information that you have heard already today, so I am sorry about that.

The CHAIR — No worries.

Ms COOKE — Mainly I will be speaking about maternal and child health in the Mildura Rural City Council area, which covers 22 300 square kilometres, which is approximately 10 per cent of the state. Our population is 53 000 people, and 3.8 per cent of those people are Aboriginal and Torres Strait Islander. It is culturally diverse, with 76 different nationalities officially recognised here in Mildura. Maternal and child health has 10 centres located throughout the region. The furthest we have to go is a 400-kilometre round trip to do a home visit or go to a maternal and child health centre at Murrayville. And then we come back to Underbool, which is 300 kilometres, and Ouyen, which is a 200-kilometre round trip. We provide home visits to all of those places, and we go down there on a regular basis

We provide universal and enhanced maternal and child health. We have a lactation consultant two days a week and a new parent group. Our centres are open from 8.30 until 5 o'clock, and we do have one service at a long-day care centre, which goes from 3.30 till 6.00, so we can see the families that are working in those areas.

We have on average 700 birth notifications a year. The 900 is for the hospital area; in our LGA it is 700. Last year we did almost 6000 key age and stage visits and provided 2500 flexible hours of capacity activities. Our enhanced maternal and child health nurse saw 161 clients. That included 1223 hours of maternal and child health and 237 hours of allied health services. Our new parent group was offered to 244 first-time parents, and our staff work very closely with child protection, integrated family services and out-of-home care service providers. We have quite a good relationship with those organisations. We also provide additional home visits for two and four-weekly age and stage visits for women who have had caesarean sections. Because asking them to come to a centre is difficult, we do offer that. Birth notices are received within the 48 hours that is expected, so we have got quite a good relationship with our hospital. It is very much appreciated that we get those right on time.

Our new parent group runs for seven weeks and provides information about services available in our area as well as newborn baby tips. The other service that we are currently working with is SMECC. We go to SMECC twice a month and provide maternal and child health services at SMECC, which is Sunraysia Mallee Ethnic Communities Council. We find it is much easier for the women and their families to come there than to expect them to go to one of our centres. We also work with Sunraysia community health, MDAS, Mallee Family Care, Centacare and the Mildura Base Hospital.

The question was on the impact of commonwealth funding loss for perinatal health. Maternal and child health nurses are quite skilled at screening for perinatal health and they do it on the Edinburgh postnatal depression scale on a regular basis, but I guess the impact of the commonwealth funding loss will be quite significant for our families and it will impact greatly on the family as a whole. There are three other places in Mildura that offer some perinatal emotional health, which is great, but to lose that service would be quite stressful for some of our families. That will mean they need to travel to access appropriate support, which would be both financially and emotionally straining on the whole family, so our concerns are that families will be unable to access these services and it will result in poor outcomes for all of the families.

Dealing with high-risk and premature births locally, I guess there are six organisations that offer antenatal care services in Mildura. I am sure you have heard from those today and you are aware there is no midwifery-led model of care here. Some families are unable to access the recommended antenatal care due to financial reasons, which makes it difficult for them. An example of that is an ultrasound and the cost of an ultrasound. They just cannot do it, so then their antenatal care is not that good.

Dr CARLING-JENKINS — It is compromised.

Ms COOKE — Yes, it is very compromised.

I guess the other question I have is: are all of the antenatal services providing similar care to all of the women in our community? As part of Hands Up Mallee there is work underway to develop and strengthen the partnerships and a common pathway, for the antenatal care to be similar.

The other thing I guess we find is that transport is a big issue for attending maternal and child health or attending appointments. Our public transport system is not the best. We do have one, but if you are in our Pasadena maternal and child health centre it is very difficult to catch a bus there. So we do have those issues.

On current methods to reduce incidents of maternal and child health, going back, the birth notifications and receiving them on time is great so we can then get in and make our appointments. We will ring our clients up and make the home visit appointments — the two, four, and eight-week appointments — all at once so that we can go out and see those families or they can come to our centres. Families that have to go out of town to birth, we also get notified as long as they are birthing in a Victorian hospital. So that is really quite appreciated.

The DEPUTY CHAIR — If they go to Adelaide, for example, you do not hear?

Ms COOKE — 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.

The CHAIR — What is the hurdle there?

Ms COOKE — Different state.

Dr CARLING-JENKINS — Just different rules.

Ms COOKE — Yes.

The DEPUTY CHAIR — But they would have that system in South Australia for their own.

Ms COOKE — I would say. I believe so.

The DEPUTY CHAIR — You would think it would be a matter of course. They could pop it over the border.

The CHAIR — Yes, an extra cc on an email!

Ms COOKE — Like I said previously, we work quite closely with child protection, and we are working with them at the moment to improve sharing of client information. It makes it very difficult when we are unable to share that information in the best interests of the child, so we are working with child protection as part of the shared information. We are also in the process of implementing Patchwork throughout the area. Do you know what Patchwork is? Patchwork is an IT model where we can put in who is working with the families. MAV have rolled that out in most of their maternal and child health services across Victoria, and we are trying to get that here in Mildura. That would be good.

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.

The CHAIR — How many maternal child and health care workers do you have, or nurses do you have?

Ms COOKE — I have nine permanent staff and three casual staff. Most of those staff work part-time.

The CHAIR — And just in regard to the communication of giving birth in a hospital and a hospital discharge and the MCH, we have heard in metropolitan Melbourne that even the communication there is no good, to the point where the council or the nurses are chasing their tails trying to find these people. Do you have the same experience?

Ms COOKE — No. We are very lucky. We have a great relationship with the hospital and we are notified 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.

Ms COUZENS — You talked about the travel issues, which are obviously big problems for the women. Has the council done anything about looking at what needs to change to improve the transport options?

Ms COOKE — We are looking at that as part of the Hands Up Mallee group to see what options are available. We have the same issue with kinder attendance. A couple of the local kinders actually have a bus that they go and pick up the children in. The other thing that we are doing is offering a home visit to people who do not have transport and cannot get to a centre easily.

Ms COUZENS — You mentioned you had the two, four and eight-week appointments that are scheduled before they leave the hospital; is that right?

Ms COOKE — Once they are home.

Ms COUZENS — In those visits, how is the assessment done in identifying mental health issues or other health issues?

Ms COOKE — As part of our key age and stage framework we are set with certain questions that we ask. We ask around family violence and also around postnatal depression. We do ask that question when we go to the house and do the assessment.

Ms COUZENS — If, say, in the instance of family violence, a woman does not indicate that family violence is an issue but you can pick up that it is an issue, how do you deal with that?

Ms COOKE — 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.

Ms COUZENS — Earlier we heard from the Mildura Base Hospital that the number of caesareans is quite large. Is that your experience?

Ms COOKE — Yes, we have found it has increased over the past few years.

Ms COUZENS — Do you know why that is?

Ms COOKE — No.

Ms COUZENS — Do you have a guess about why it is?

Ms COOKE — No.

Ms COUZENS — Okay. Fair enough.

Ms COOKE — I cannot tell you, sorry. But what we have found is that previously we were expecting women who had had surgery — major surgery — to go to maternal and child health centres. They are not encouraged to drive and they are not encouraged to wear seatbelts, and we were expecting them to come to a service. We were finding it was not being attended, so the easiest thing for us to do was to change it and support the women and go to their houses. So that is what we have done.

Ms COUZENS — Are you dealing directly with Aboriginal women, or are you doing it through the Aboriginal health service? How are you working in there?

Ms COOKE — 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.

We have just recently looked at the reconciliation plan that was produced here in Mildura, and part of that is for the maternal and child health service to be more culturally appropriate and inclusive. We have looked at what changes we might need to make.

Ms COUZENS — Are you doing cultural training, or have you done it? Is it about to be done? What is the plan there?

Ms COOKE — We will be doing it, yes.

Dr CARLING-JENKINS — Thank you very much for coming in. The Hands Up Mallee slide show was very good. It was very confronting. The statistics were very confronting. We have heard I guess a smattering of the social disadvantage today, but that just drove it home, with only half of the babies at three months being breastfed, the number of children who develop obesity so early and almost 10 per cent with mental health issues. I do not want to oversimplify anything — I am just conscious of the time. Prevention is always a key. There is no easy answer or solution, but if you were to pick out your top two or three priorities for mothers and their pre-born babies — so getting them really early, while they are still in the womb — what would they be? What would you be doing?

Ms COOKE — Smoking cessation and drug and alcohol use would probably be something we would love to be able to work with families on. They would be our main ones, along with improving breastfeeding outcomes.

Dr CARLING-JENKINS — So encouraging breastfeeding before the babies are even born, basically?

Ms COOKE — Yes, what we would like to see is taking away that stigma that is attached to breastfeeding and making it normal again.

Dr CARLING-JENKINS — So that is the main barrier you are seeing, that there is still a stigma?

Ms COOKE — Yes.

Dr CARLING-JENKINS — Goodness. What are you able to do in those other spaces around smoking and drug and alcohol use at the moment?

Ms COOKE — We do not see them until after they are born, so as part of our anticipatory guidance —

Dr CARLING-JENKINS — That is key, isn't it?

Ms COOKE — Yes. We do go over that stuff, but it is after the event really.

Dr CARLING-JENKINS — So you are almost seeing it too late.

Ms COOKE — Yes. We can hope that for the next child that is born and the next pregnancy we may have an impact, but for that baby there, we are not going to get that.

Dr CARLING-JENKINS — Thanks very much for your insight, Samantha. I appreciate it.

The DEPUTY CHAIR — I have just got a couple of short ones. The hospital mentioned that there were 67 nationalities represented in the area. Last time we were here I think it was not long after there was a big influx of Syrians. Have they been very open to having your services delivered in their homes or to coming to maternal and child health?

Ms COOKE — Yes, we have quite a large Burundi population, and they are very welcoming and will come to our services. What we have found is that we need to go to them, so that is why we go to SMECC and offer our maternal and child health service there on a fortnightly basis. That is where we are finding Afghani woman and other nationalities. It is in their environment — they feel safe — so we provide it there.

The DEPUTY CHAIR — So down the track they do not come in to you?

Ms COOKE — Yes, they do.

The DEPUTY CHAIR — So you build that relationship and then —

Ms COOKE — Yes, and we use the interpreter service a lot, which is very helpful. We do get to go out. We also do home visits; we go out to their homes.

The DEPUTY CHAIR — So you are confident you are capturing that group?

Ms COOKE — Yes. Whether they stay with us is sometimes difficult, because they come from places where maternal and child health is not available, so we really have to build that relationship to give them the understanding of what that is all about and what we are doing.

The DEPUTY CHAIR — In the slide show I think you had that 18 months was the average time that people stopped attending.

Ms COOKE — Yes, it drops quite significantly at 18 months, so we are trying to find other ways that we can improve. We have a program called Let's Read, which Mallee Family Care supports. We are providing books at four months and then at 12 months, and we also provide other incentives at the 18-month and two-year-old visits.

The DEPUTY CHAIR — Do you break those statistics down by demographic — that is, by the age of the women or cultural group or something like that?

Ms COOKE — No. We have that, but that was not part of that information.

The DEPUTY CHAIR — But you do have that.

Ms COOKE — We do have that, yes.

The DEPUTY CHAIR — This is my final question. Earlier Jacinta from MDAS was talking about the hospital referring to the maternal and child health workers. As you mentioned earlier, that is a really great process that happens within the 48-hour time frame. She thought it would be great if they could have a referral

to an ACCO too. Is that something that you would see you have a role in doing, or do you see that the hospital should do that directly?

Ms COOKE — That would be the hospital's role.

The DEPUTY CHAIR — I forgot to ask them.

Ms COOKE — Under the act it is the hospital's responsibility to provide that.

The DEPUTY CHAIR — But you cannot on-refer?

Ms COOKE — When people have filled out that consent form, we do share that information for those families.

The CHAIR — Sam, I have got one more question for you, and I feel a little bit vulnerable being that the only other male in the room is a gynaecologist/obstetrician.

Ms EDWARDS — Greg is here.

The CHAIR — Apart from my learned colleague, who is always the exception.

We talked about a negative stigma for breastfeeding. I am just wondering what that stigma is. Is it that formula is better for your baby and the nutrition you provide through breast milk is not as good? Or is it that more mothers are reading *Cleo* or Dolly Doctor or whatever and thinking that their body is going to change and things are going to look different after they breastfeed? What is the main reason people are not breastfeeding? Those rates are really low.

Ms COOKE — 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.

The CHAIR — We have a baby in Parliament at the moment, and it was breastfed in the lower house the other week. It was fantastic. It was great.

Ms COOKE — Great.

The CHAIR — We will cease there for the moment because we are under a bit of a time pressure, but thank you so much for coming in, Sam, and for representing the Mildura Rural City Council. Thank you for the use of your building today, by the way, if you could pass that on to the CEO.

Ms COOKE — You are welcome.

The CHAIR — Thank you so much for your time today.

Witness withdrew.