TRANSCRIPT

FAMILY AND COMMUNITY DEVELOPMENT COMMITTEE

Inquiry into perinatal services

Melbourne — 18 September 2017

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Witnesses
Associate Professor Richard Newton, Chair,
Professor Louise Newman AM, Past President, and
Dr Virginia Loftus, Committee Member, Faculty of Child and Adolescent Psychiatry, Royal Australian and New Zealand College of Psychiatrists (Victorian Branch).
The CHAIR — Welcome, and thank you for coming today.

Assoc. Prof. NEWTON — Thank you for having us.

The CHAIR — 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 copy of the transcript.

Now we have those formalities out of the way, we would love to hear from you for about 10 to 15 minutes. Then if you could take some questions from us, that would be great.

Assoc. Prof. NEWTON — Fantastic. Thank you very much, Chair. I am the chair of the Victorian branch of the college of psychiatrists, but I am not a specialist in this area so today we have Professor Newman and Dr Loftus, both of whom are specialist practitioners in the area of perinatal mental health. You have in front of you, I think, two submissions. One is a full statement to the inquiry from the college. The other is a briefer statement from today. Rather than reading through them, we are happy to take questions on those, but we might just ask Professor Newman and then Dr Loftus to speak to some of the issues that they see.

The CHAIR — Yes, sounds good.

Assoc. Prof. NEWTON — Then if there is anything that is not covered, I will have a minute at the end.

The CHAIR — Perfect.

Assoc. Prof. NEWTON — Thank you.

Prof. NEWTON — Thank you. I might start. I am Louise Newman. I am professor of women’s mental health at Melbourne University, and I run the Centre for Women’s Mental Health at the Royal Women’s Hospital. Prior to that I ran the motherbaby unit at Monash. So I have worked in this field for some time, but particularly in the area of so-called highrisk families and women within our clinical services.

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.

As you are aware, no doubt, the overarching framework that we work within is one to do with true early intervention, which literally means intervening at crucial developmental transitions for families and women, particularly during pregnancy, and being able to better identify women who are at risk during pregnancy and offer them appropriate supports. The sorts of risk factors that obviously we see within clinical services as important are going to be in two different realms. One I would say are issues in the early lives and upbringing of women themselves, so women who themselves have experienced neglect and trauma in their early life, particularly sexual abuse and exposure to conflict and violence, and women who themselves have had poor parenting experiences. We would include some of the groups that we work with in our hospital as falling into that category, but that includes some of the young mothers that we see, including adolescent mothers. At the women’s hospital we would see some of the youngest women in the state who are having babies, some of whom, in my experience since being there, are 12 years of age and upwards. So it is hugely challenging. I would also put into that category women who have had experiences of seeking refuge, women who are asylum seekers and have experienced a range of traumas and disruptions, and women affected by drug and alcohol issues and homelessness — and often of course these factors coexist, so this is quite a needy group.

Among the other current group of risk factors, we have got a lot of emphasis — particularly following the royal commission, very appropriately — on better identifying women who are at risk of or experiencing
domestic violence and other forms of current trauma, and we are well aware of the impact of those sorts of experiences on children and parenting. The women’s hospital and others are certainly interested in reorienting our services to better identify these factors and actually provide some targeted interventions. I think for that to work effectively the sorts of models we are looking at involve not just mental health services and professionals but a range of others. Legal support, social work and maternal child health nursing are hugely important and skilled workforce contributors, which I think are very well placed to be providing some of these higher risk interventions.

So I think if we look at the model overall, this focus on early intervention and ultimately what we would think of as prevention is very much the core model that we are working within. We know a lot more in terms of the research. Because I am an academic I obviously do that sort of work looking at what we understand about the significance of early life in terms of mental health outcomes, and we know a lot about the importance of prevention of trauma and a range of negative experiences for infants and young children in terms of better social outcomes, better psychosocial development and particularly the opportunity to reduce the community burden of mental illness.

From our perspective, early experience and parenting and support for families is a crucial preventive strategy in terms of the common mental health disorders that our mental health system, as you are no doubt aware, struggles with on a daily basis. Particularly things like depression and anxiety and conditions related to trauma that are sometimes called personality disorders are a real burden on all hospitals and all clinical services, and yet in terms of an overall funding approach and resource approach we have had relatively little put into supporting preventive and early intervention programs, early in life and parenting programs, relative to what we need to put into acute services. I think getting that balance right is obviously a major issue and has long been discussed in our circles and across the clinical arena.

Perinatal and infant mental health would see itself as needing to provide some leadership in terms of high risk interventions and for high risk groups. We also need to look, I think, in a clear away at the statewide distribution of services and difficulties of access. We have obviously had some investment in regional settings. There are some difficulties that we are aware of in terms of adequately staffing those units, despite the very welcome investment into those services. We also need, I think, to look at training across the professions — because we are multidisciplinary teams — for expertise in these sorts of areas, and having training positions in regional areas, if they are adequately supported, is one strategy.

I think overall we have a lack at the moment of a centralised approach to actually developing the field and bringing expertise together to actually better advise government about how we might approach some of these issues. In previous years we did have an expert committee advising on perinatal and infant services which met periodically, which was probably a useful thing. We then had obviously, as you are aware, some withdrawal of commonwealth funding for perinatal mental health. That committee was then in abeyance. I think now that we are in this very positive climate of having some funding at a state level being put into these issues and a very positive discussion that some of us are having with the department, one thing we might be able to do is actually resurrect in a formal sense that sort of planning process, maybe through the office of the chief psychiatrist, to actually have perinatal and infant mental health services represented.

There are similar processes going on. Obviously the response to the royal commission into domestic violence and mental health services has been very productive, with the multidisciplinary approach auspiced by the office of the chief psychiatrist. I think we would be very pleased to see a more formal process. There is certainly interest in looking at the quality of services as they are developed and getting some data about the utility of the mother baby specialist psychiatric units but also what is needed in a broader sense for those women who do not necessarily need that level of admission and where we have been trying to provide better services and better access to people in their local areas and their communities for their families, and reserve psychiatric beds for the few who need that — so some clearer modelling about the range of services that are needed, particularly in upskilling community services. I hope that is clear in terms of the overall framework.

**Dr LOFTUS** — I am Virginia Loftus. I am a committee member of the Faculty of Child and Adolescent Psychiatry, and I am an experienced perinatal, infant, child and adolescent psychiatrist. I am the clinical director of Raphael Services, Bendigo. Raphael Services, Bendigo, is a specialist mental health service for women and infants in the perinatal period. It is a Monday to Friday, 9 to 5 service which is part of St John of God Health Care, and my role there is to lead a multidisciplinary team. I also work at the Women’s with
Professor Newman providing a therapeutic group for women and infants, and I spend most of my week seeing women and infants and small children in regional and metropolitan settings.

I would follow on from the comments that Louise has made. I work in Kangaroo Flat two days a week, which is in Bendigo and, as I am sure some of you are aware, has one of the highest rates of teen pregnancy and social disadvantage in the country. Our service is located there to really try and meet the needs of the most vulnerable in our community. I think a really important point to follow on from that Professor Newman has made is access, and certainly it is an issue in regional Victoria. We find across the state that there is a lack of parity in mental health services for young children. We are aware that young children have mental health difficulties and that there is under-resourcing to that group, and that is across the board but particularly evident in regional areas, where there is a significant gap.

We know that early intervention is very important. Often mental health difficulties for children are not necessarily identified as being mental health difficulties. They may present with behavioural difficulties, they might be disruptive, they might not be learning well, and that might be the reason for issues being detected rather than them being picked up early on when we could provide more effective care. There really needs to be a developmental understanding of perinatal and infant mental health, and by this I mean that we need to work from a relationship based perspective in addressing health issues for mothers and young children.

We need to really think about how parents help their kids to grow up to be healthy. We know that children grow up in the context of their family relationships. When children feel that their relationships with their parents are strong, they are more likely to do better in life. This has benefits for individuals, families and the community. So it is obviously really important that we get it right. When we are thinking about mental illness in parents, it is important not just to treat mental illness in the parent but to support and create healthy family relationships. We know in particular that if a mother is suffering with mental illness in the perinatal period, it is not enough to just treat her mental illness; we need to really work on her relationships with her children as well to help her to get better.

I would also like to say that it has been fantastic that the state government has funded advanced training positions in infant psychiatry across several mental health services in Melbourne. Such training enables child psychiatrists to become more effective clinical leaders in perinatal and infant mental health and equips them with specific therapeutic skills to see children under five, which is a very subspecialised area. I was able to access funding to complete one of these training positions at the Women’s, and the skills and expertise that I gained through doing this training position have helped me enormously in my career in several ways but particularly in my leadership of Raphael Services in a regional area of Victoria.

We do need to think about training, particularly in regional areas, and this is a challenging area. Again I would say that our workforce is multidisciplinary and we need to think about how we upskill all members of our workforce. But thinking particularly about psychiatry, it is important that we upskill psychiatrists who are working regionally and that we think about succession planning and training. The STP funding for registrar positions is very limited, and unfortunately it is now so limited that we have not been able to access it in Bendigo. If we did have more opportunities to provide training for junior doctors, that would help to increase our workforce as well. Again it often comes back to the training that we can provide to other mental health clinicians and, as Professor Newman said, to maternal and child health nurses and other people working with mothers and babies to upskill them too.

It is really important that we think about how to integrate perinatal and infant health services. We need to really think about how maternity and perinatal mental health services and child and adolescent mental health services get connected, but again it is really important that these services are developmentally focused, that they are oriented around parents and families and that there is a multidisciplinary approach. Something that is also important to highlight are the gaps in services between a secondary specialist level service and a tertiary service, and that is something we see across the board but we are particularly aware of in perinatal and infant mental health.

As Professor Newman was saying, there are many women who are very unwell in the perinatal period but not necessarily unwell enough to need a hospital admission, or for many women that is not what they want. Particularly if they are from a regional area, it means they have to be far away from their families. If they have older children, they cannot bring their older children to hospital. So if we can think about how to provide more
effective outpatient treatment for these women and their families in the perinatal period and help to decrease that gap, that would be an enormous help to these families.

Assoc. Prof. NEWTON — I will finish off, if that is okay. I am the clinical director of psychiatry at Frankston, in my day job, at Peninsula Health. I have recently come there from the Austin, where I was for a decade. So I have moved from a place with a rich resource in perinatal mental health to Frankston Hospital and Peninsula Health, which has a very different level of resourcing. I think that that speaks to one of the issues for me. As a clinical director, my interest is in having a system of health care that is accessible and universally available for everybody that is at risk in the community.

In perinatal mental health we have such gaps and holes in the system across the state. In some areas there are very specialist centres of excellence providing services. In other areas — for example, next to the Austin is the Northern Hospital, which really struggles to provide the same level of service even though it is a very major centre for obstetric activity. So making sure we have a system across the state in which there is reasonably equitable access to good enough to excellent mental health services for those at risk prenatally is very important. I think at the moment that is not there.

Postnatally we have a system of screening that by and large is implemented across the state to identify mothers who are at risk of depression and anxiety in that very high risk period, but what we do not have is any coherent system to ensure that people who are at risk and are identified from that screening program actually then have a referral pathway to adequate secondary care or, if they need it, specialist tertiary care. I cannot imagine any other branch of medicine where you would ever have a screening program that was not clearly and specifically linked to a response pathway, and yet somehow in mental health that is seen as okay. And I do not think it is okay.

I think they would be my two specific contributions to this: the need for a more systematic approach to ensure that antenatally mothers and families who are at risk have better access to mental health care in order to do both primary and secondary prevention; and then to ensure that postnatally our screening program is actually linked to an adequate and wellresourced, welltrained referral pathway.

Prof. NEWMAN — I can give an example. I absolutely agree with the point that currently there is obviously a lot of very welcome emphasis on domestic violence. We know that domestic violence, for complex reasons, can increase during pregnancy. About 20 per cent of new cases of domestic violence assaults on women actually occur during pregnancy, so it is clearly a very high risk area. We have a lot of emphasis at the moment on screening and identification. We are looking at better ways and more sensitive ways of inquiring about the presence of risk factors for violence and what to do in the immediate sense to support women. However, in terms of the really crucial followup for women who are in those situations, many of whom, for complex reasons, are not in a position to leave and are not leaving quite risky relations but who clearly need support, we do not have mental health services oriented and ready to actually provide the sort of treatment and support they might need. So I think there is a real problem here with a sole emphasis on screening unless we link that to clear pathways for mental health support. So we are trying to do some of that work at the moment.

The CHAIR — That makes a lot of sense. Are you happy to take some questions based on your submission and what you have said today? I might begin. We have established obviously very early on — I think our first speaker actually mentioned it — in the perinatal period mental health and mental illness is a huge burden. Can you give us some practical advice on how we would attract more professionals out to the regional and rural areas so we can actually provide a better continuum of care and better access to mothers who are at risk?

Prof. NEWMAN — Again, in many ways it is a very longterm problem. I do not know if we have got clear solutions to it, but some of it works on two levels. There is a need for better linkages between rural and regional centres and metropolitan centres. Currently, as you know, we have got maldistribution. We have places — at some of the major hospitals and the Women’s — 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. With the existence of technology there is no reason why we could not look at systems that are adequately supported to do more of that.
The other issue is how do we get trainees who could actually be adequately supported to work in these areas. It is not that people do not want to do the work and are not interested in the field. There is huge trainee interest in the field, but because it is something that needs to be properly supervised and taught and supported, I think we need to look at better systems of supervision and support for trainees who might be on placements rather than having trainees who feel themselves to be undersupported with sometimes very, very complex and worrying clinical issues. Sometimes work with very mentally unwell mothers and babies is highly stressful work. There is always risk for the mother and for the infant. If trainees do not feel supported, then they will not stay in those positions, so I think it needs a much more coordinated approach and willingness. I think we need to work on ‘this is our responsibility’ and the willingness of the specialists in metropolitan areas to actually go out and have arrangements where we are supported to do work in those areas.

The CHAIR — That is a very common opinion amongst the people who have come in and contributed to this hearing. On the technology you mentioned, are we talking telehealth and things like that?

Prof. NEWMAN — Yes.

The CHAIR — Is there anything else in that area besides telehealth that you would recommend that is on the horizon or —

Prof. NEWMAN — That is probably the most widely used and the most accessible. It is interesting; I do supervision for groups of clinicians in Western Australia, where we might have in a vast geographical area many teams. They have actually needed to rely on that maybe more than we have, but I think there are certainly models for doing that in a more effective way.

The CHAIR — Just a second question. It is a bit of a coincidence that you are here today. I had a question during the lunchbreak from another submitter. It was something that I have never thought about, and the more I think about it, the more I think how important it is. What is your experience as far as providing services to mothers whose babies pass away and who are then discharged? Are there any followup services, or is it some sort of testing regime and then they are out? Is there followup that you know of?

Prof. NEWMAN — Yes. I do that sort of work myself. Our hospital and the major maternity hospitals have a series of supports for women who are in that situation. We also run large neonatal intensive care units of up to 67 cots, we have got at the moment, with very highrisk babies, so it is quite an issue. We have onsite support for women and families in that situation, with followup. That is a luxury of a large centre, but we have some specialist grief and loss counselling for women who have lost infants.

The mental health service will offer followup for those who might be in an extremely distressed state. We would also offer longitudinal followup, because sometimes people who have obviously lost an infant or have risk factors for losing infants can actually have multiple losses, which is a tragic situation, but they might be coming back to the hospital to try again to have a baby. I think it is very important that they get adequate followup, and we would see those as a specialist service through their pregnancy. I think the principle is that you want to be able to offer that support in an ongoing way. That is, as I said, in the metropolitan areas. I doubt that you would have the same level of support, but it would be taken up by groups like social work in other settings.

Assoc. Prof. NEWTON — I think that Louise’s answer actually also speaks to your first question, which is about how do you attract people into rural and regional centres. One of the answers is to make sure that there is adequate and equitable distribution of resources to those centres so that the services that Louise has described, which are best practice, are not isolated in the teaching centres of excellence in the middle of the city but are actually out in the growth corridors and out in rural areas where they are needed.

The challenge, obviously, as no doubt you are very aware, is about getting that balance right around what we need in terms of tertiary level services for highrisk pregnancies and people with underlying medical conditions, for example, or where we know that they are at risk of having a complex delivery and it needs specialist pregnancy care. We cannot obviously reproduce that across every centre. On the other hand, we are stressing families often by saying, ‘You need to come to a hospital like the Women’s or one of the major maternity centres for all your pregnancy care’, when they might not want that. We know that there are some people who decline that, regardless of risk, because they do not want to leave their area, their community, their family. It is very complex.
Ms McLEISH — Thank you for your presentation. Which group of mothers do you think are most at risk of developing mental health disorders? I know you mentioned earlier about the life experiences and the early childhood factors and things that come in. Have you got collectives?

Prof. NEWMAN — The difficulty is it is not one group; there are multiple risk factors that make it more likely that women will experience common mental health problems during pregnancy and after delivery — depression and anxiety being the most common — but there are certain groups that we would say are more vulnerable than others. In general women with low levels of social support are more at risk of a whole range of depression and anxiety — the very young, so the adolescent pregnancies — but then specifically we need to look at better identifying women who have a clear history of having had mental health difficulties previously. If you have had a history of depression or anxiety, coming to pregnancy is a major life challenge, and you are more likely to develop what someone will call postnatal depression or depression and anxiety during pregnancy. So that group of women are very vulnerable.

Then those who have specific risk factors such as histories of early trauma, abuse and so on are very vulnerable, because parenting is a major challenge for women with trauma backgrounds who want to parent effectively but might be very anxious about their capacity to do that, and they need specialist support. So when you look at what we do know about common mental disorders in pregnancy, there are many, many risk factors and I guess many, many different stories, but those would be the broadest categories that we see. But there are also some problems that develop where we do not know about people’s risk — so-called postnatal psychosis, or what is called puerperal psychosis, which is a rarer condition, but we certainly, in a big hospital, see women presenting with acute mental illness who do not have a history of mental illness at all. We do not fully understand that, but that is a rarer condition.

Ms McLEISH — That leads very nicely into my next question, because again the word ‘screening’ for anxiety and depression has come up. Who is the best person, or what is in place to pick that up?

Prof. NEWMAN — To identify the risk?

Ms McLEISH — The risk factors. At what point would that be picked up and by whom?

Prof. NEWMAN — I would say that the maternity hospital and maternity centres are probably very well placed to become more efficient and proficient at risk identification. That is where women come in for antenatal care. Ideally women who have risk come to us, and some do, and want to speak about what extra care or support they might need before they conceive. We like to encourage that. Midwives and others providing direct care often have very good relationships, are very skilled at discussing the issues and if adequately supported, given the pressures of very busy clinical services, are in an ideal position to do that sort of screening.

In primary care there certainly been a lot more emphasis on getting general practice and primary carers to be involved in screening, which is important, but again, like any screening, we still need to look at the referral pathways for support once we identify them. Those systems are largely operative, but I think, as Richard was saying, we have got a bit of a gap in terms of the followup that we want to do. There are also very good community organisations where people can ring for advice and so on. I think we need all of the above, but our emphasis in terms of hospital-based work needs to be on those staff members who have most contact with women in an ongoing way. We know that sometimes women who are feeling unwell or vulnerable or who might be in a high-risk situation for violence, for example, do not necessarily tell us if we just ask routine questions when we first meet them. It often needs that sort of trusting relationship; if they feel more comfortable, they might disclose later. It is very important that we keep those doorways open. So questioning should not just be a one-off, ‘We’ll ask you some questions and see if you disclose’, given the complexity of actually admitting to feeling stressed or depressed.

Ms McLEISH — So the opportunities are there, but unless you have a bit more of a relationship, some of those things are not going to be disclosed?

Prof. NEWMAN — Often, yes.

Ms McLEISH — And the people that are in those positions are skilled up enough to pick those risk factors?
Prof. NEWMAN — Yes.

Ms McLEISH — That is not a deficit anywhere?

Prof. NEWMAN — Well, it is certainly a deficit in some hospitals. At the moment there is an emphasis on trying to do training, particularly around the domestic violence issue, so we have the state’s strengthening hospital responses to domestic violence strategy, which the women’s hospital is actually leading, which is very important in that sphere, and antenatal populations will be covered there. That requires a huge amount of training rollout, which is just happening now — it has not happened to date. That is part of the response to the royal commission, obviously. There are complex issues about screening for depression and anxiety, which in some areas has been problematic, largely because of staff concerns about lack of referral pathways. I worked in New South Wales in a previous life. That was certainly the same experience there, where because of an inadequate — I think it is fair to say — mental health system’s capacity to actually deal with women who might be identified, staff were reluctant to get involved in some of the screening activities, and that led to industrial action. So these issues get very complex. Look, I understand what their concerns were. I actually think if we are going to really try and do this sort of better identification, it has to go hand in hand with better service response and better access.

Ms EDWARDS — Thanks, everyone, for coming in today. I just wanted to ask in relation to the screening process that you were talking about — and you mentioned identifying particular cohorts that are significantly at risk — do you have women who have disabilities or autism present to you as well, and what sort of processes are there for them?

Prof. NEWMAN — Again, that is going to be very patchy around the state, and I can only speak about the major metropolitan areas. We have at the women’s hospital specialist access and support services for women with disability, both physical and sometimes chronic mental disability or developmental delay, but we as a tertiary level hospital would be referred some of those complex cases. It is very important that they are linked in with adequate social work expertise, linking in obviously to service and supports but also parenting capacity assessment. There are often concerns about some of the cases we would see — about what level of safety for infants what level of support and backup services might be needed, and that needs a fairly coordinated response. The same would apply to any families — and we would see this again — with a history of involvement with child protection or previous child protection issues where children might have been placed in alternative care. We have systems within our hospitals that are flagging those cases and trying to link them. We have a fairly large social work department.

Assoc. Prof. NEWTON — And again it is not the universal system across the state. It is the case that every area and every health service that has an obstetric service will see people at very high risk and high vulnerability, with very clearcut special needs, as you are identifying, but not every service has the ability to form a high risk outpatient screen or response service in the way that Louise is describing.

Dr LOFTUS — And certainly in regional areas these are the sorts of patients who are more likely to fall through the gaps of services who may need more than a weekly appointment, who may need some crisis out of hours care but might not fit the model of tertiary level care. So, yes, certainly these are some of the most vulnerable patients.

Ms EDWARDS — So they might need things like handson parenting support?

Dr LOFTUS — Absolutely; family support, but they may well also need a complex psychiatric assessment. This is part of why we need to upskill people in tertiary services to really identify these patients.

Ms EDWARDS — Virginia, thank you for talking about the Raphael centre. I am very familiar with it, as you know, being from Bendigo. St John of God is a private hospital. I was just curious to ask a couple of questions around that. How many women and children are referred, say, per annum? How are they referred? Who refers them and on a broader scale in terms of the Raphael centre, perhaps a little bit of background about what you do? I also want to get a better understanding of how many psychiatrists we actually have, for example, in the Loddon Mallee region, and also is the Raphael service covered by Medicare?

Dr LOFTUS — Yes. Thank you, Maree. Raphael Services are part of St John of God Health Care and they are an initiative of the branch of St John of God, which is called social outreach, so a percentage of revenue
from St John of God hospitals is put towards social outreach projects. What St John of God tries to do is help
groups in the community who are considered the most vulnerable, one of those being perinatal and infant
populations.

We are largely funded through St John of God Health Care. We also have significant input from the primary
health networks, which are very important to us, but we bill through Medicare for the consultations. One of
our key aims is to improve access to services, particularly for very vulnerable members of our community. As
I mentioned, we are based in one of the areas of highest need, so there is no cost when the patients come in.
They do need to get a mental health care plan, so their GP needs to refer them, but the initial referral will
sometimes come from other health practitioners — for example, from midwives and from maternal child
health nurses. Sometimes patients even refer themselves, but they do need a mental health care plan in order to
be seen.

In terms of numbers of referrals, I can only speak for the service that I work at in Bendigo. There are other
Raphael services in Victoria — in Berwick, in Geelong and in Ballarat, so I do not know about their numbers.
But in terms of referrals to our service, it varies. We get up to about five a week, and the complexity has
certainly been increasing in the past couple of years. That does coincide with us having an inpatient perinatal
and infant health mental health unit in the region, but I think it also reflects the increasing social complexity
and vulnerability of our population.

In terms of number of psychiatrists, I work at the Raphael Service 0.4 — four sessions a week. We did have a
registrar earlier in the year, but unfortunately we no longer have that registrar as we do not have funding for
that position. I have a great multidisciplinary team of clinicians, so social workers, occupational therapists and
mental health nurses.

It is a 9 to 5 Monday to Friday service. We do have interfaces with the public mental health services and with
primary care. In terms of the number of psychiatrists in the Loddon Mallee region, I do not know the exact
number in 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. I feel it is an invaluable service that we are able to offer, but
we would be love to be able to do more.

**Ms BRITNELL** — I have just one around teen pregnancies. Is it actually growing over the last 30 years?
We have seen increases in assisting people with family planning and the money we have put into that. Are we
actually seeing an increase in teen pregnancies at a younger age? What are the trends there?

**Prof. NEWMAN** — It is complex. Overall we have probably seen a decrease, but there is some
fluctuation. At the moment we are seeing a little bit of an increase for reasons that are unclear, but what we are
seeing in terms of the young women we are seeing is increasing levels of social disadvantage and other
concurrent problems, particularly mental health and drug and alcohol problems. So there is some speculation
about the influence, obviously, of substance use.

The other factor that has become apparent is that many of these young women who end up being in longterm
inservices are actually having higher rates of repeat unplanned pregnancies and they are also much more likely
to be in violent and exploitative relationships and have great difficulties in selfprotection and extricating
themselves — and they are homeless. So there is a very hard core, if I can use that terminology, and a very
difficult group to engage and work with. With that there has obviously been a lot of emphasis in providing
advice for people who need it. Primary care does a lot of this work about contraception and so on. That
probably is not the issue for these very, very vulnerable young women. So there is a current need and current
projects. The department of housing are looking now at collaborative working with mental health and social
services around providing some accommodation for the very vulnerable substanceabusing, homeless, pregnant
young women.

**Ms BRITNELL** — That answer paints a picture of a very complex client. I am just wondering, using the
ageold analogy of the health promotion, where we are pulling people out of the river instead of getting back up
on the bridge and actually preventing them from jumping in, how do you feel about the services that you
provide? Does it feel like you are in the river pulling them out whereas you need to be back up on the bridge
and we are just not winning?
Prof. Newman — Because we only get them obviously at a certain crosssection of time, one of the issues is how do we provide a blanket of services around people who are not just going to be managed effectively by one group. So I certainly do not see these problems as purely a mental health issue; it is not even purely an antenatal or a medical issue at all. It is because we have a rather fragmented system. For these sorts of initiatives, unless we have collaboration across all the sectors, there is no point in telling a young girl who is 14 to 15 to care for herself, to stop taking drugs and stay away from dangerous people if she has nowhere to live.

Ms Britnell — So being a complex client — that is what you term them as still, I imagine. We have been working with complex clients for a long time. Are we actually achieving anything to actually ‘unpackage’ the challenge?

Prof. Newman — Certainly I think there is much greater awareness now than there has been, at least in my time, about the need to better coordinate those sorts of services. We still have very little in the way of actual social support services that would meet those needs.

Ms Britnell — From a client outcome perspective is what I meant.

Prof. Newman — Yes. We also have that group, as you would be aware, of young women who are leaving care, who have been in alternate care, and there are very high rates of unwanted, unplanned pregnancies in those young women when they are leaving state care. I think community services are very interested in working across the sectors in terms of what we can provide for those young women who feel themselves to be abandoned in some ways by state care and then reenter services but with an unwanted, unplanned pregnancy.

Ms Mcleish — Can I just follow up on that. With the unwanted, unplanned pregnancies you also mentioned that there are often multiple pregnancies. Do they just fall into the same traps over and over again and not look at trying to prevent it?

Prof. Newman — Sadly, yes, that can be a pattern in some people’s lives, I guess, of repeating or being very stuck with seemingly feeling themselves to be powerless or helpless in terms of changing their situation, and some people do make repeated mistakes. You certainly see that in and around pregnancies in maternity settings.

Ms Mcleish — Does the baby bonus make any difference to those people?

Prof. Newman — Not in my view. I think the motivation for some of these really sad repeats of a difficult situation is probably not financial.

Assoc. Prof. Newton — With regard to the people who are now complex and challenging and have multiple social disadvantages operating within their lives, there is very little service out there to help them reestablish a different paradigm for themselves. Whether it is how to parent and how to parent in a different and more effective way for their child than they received themselves, there is very little available. This is not in the clinical space, but it is in a very important space, and over the time that I have been working in Victoria those services have become less and less available.

Ms Britnell — So that is a very intensive oneononetype program. Did we ever have services like that? And where do patients’ rights or clients’ rights and the ability to help with functional activities of daily living education —

Assoc. Prof. Newton — By and large most new parents wish to be better parents than they have experienced themselves. I think that is a truth, and that still applies for this group as well. So you cannot make people want to be better, but you can support the ones that do wish to provide a better experience of parenting, and that is the vast majority.

Prof. Newman — I think importantly infants have rights. Children and babies and infants have rights to care and protection and to a whole range of experiences that they need for healthy development, and we certainly see that as a prime focus. Obviously that puts us in the situation sometimes of having to make difficult decisions about parenting capacity, the motivation of some parents to actually engage in support services even if they were readily available and the counselling that some parents do need to have about what
their child actually needs and how to prioritise that. The sorts of service models that we are looking at from my hospital for these very vulnerable teenage pregnancies need to be ones that involve housing, social support and particularly parenting programs and linkages with child protection where I guess sometimes these parents need to know that the rights of the infant are something that we are taking into account — and I think we are obliged to do that both legally and morally.

Ms EDWARDS — I just want to ask how many mother and baby psychiatric units we actually have in Victoria.

Prof. NEWMAN — The women’s hospital does not, although we see those cases — you are referring to inpatient units. We have Monash, we have Werribee and some private beds. Overall Victoria has lost a significant number of motherbaby beds. Just to give you a sense of the implications of that, the current waiting list for some of the units can vary from one to three months.

Ms EDWARDS — So we have none in regional Victoria?

Prof. NEWMAN — We have got the units that Virginia was mentioning.

Dr LOFTUS — In Traralgon in the Latrobe region there is a Monday to Friday unit, and there are also the units in Bendigo and Ballarat.

Prof. NEWMAN — Can I just clarify that the Monday to Friday model means by definition that those units are not admitting the same level of severity. So if someone needs sevendaysaweek, 24hour care, they are not often admitted. So we are still seeing women having to travel in, which is putting some more pressure on the metropolitan beds.

Ms EDWARDS — We have heard a lot about the data in relation to Aboriginal and Torres Strait Islander women and their higher risk and higher infant mortality and mortality. I just wondered if you had any particular data or if in your experience that was a similar presentation — higher numbers of women from Aboriginal and Torres Strait Islander backgrounds.

Prof. NEWMAN — Again there has been some work on trying to provide better community-based approaches to dealing with some of the risk issues for Indigenous women during pregnancy, particularly educational approaches and support around substance abuse and protection from trauma and violence. The women’s hospital has been involved in that. The major metropolitan areas would usually have some of the Koori maternity services and Indigenous midwives. From a mental health perspective we are certainly involved in educational work with those staff.

Assoc. Prof. NEUTON — There is such a history of trauma and loss for people from Aboriginal backgrounds accessing mental health services early in their parenting experience. I think it is one of the major areas that we have not quite grasped yet in terms of ensuring that people are able to access those services and feel safe in doing so.

The CHAIR — Thank you so much for coming in today. Your submission was invaluable, and it has been great to spend some time with you and have you answer our questions. I wish we had more time, but we do not.

On a personal note, Richard, it is great to know you are down in Frankston on the peninsula and looking after us.

Witnesses withdrew.