T R A N S C R I P T

FAMILY AND COMMUNITY DEVELOPMENT COMMITTEE

Inquiry into perinatal services

Geelong — 11 December 2017

Members

Mr Paul Edbrooke — Chair

Ms Cindy McLeish — Deputy Chair

Ms Roma Britnell

Dr Rachel Carling-Jenkins

Ms Chris Couzens

Ms Maree Edwards

Mr Bernie Finn

Witnesses

Dr Ben Goodfellow, Psychiatrist,

Ms Cheree Cosgriff, Grampians FaPMI Coordinator,

Ms Dawn Foster, Geelong FaPMI Coordinator,

Ms Rose Cuff, Statewide FaPMI Coordinator, Families where a Parent has a Mental Illness (FaPMI).

The CHAIR — Welcome. My name is Paul Edbrooke, I'm the Member for Frankston and the Chair of the Committee.

Ms McLEISH — Cindy McLeish, Member for Eildon and Deputy Chair.

Ms COUZENS — Chris Couzens, Member for Geelong.

Ms BRITNELL — Roma Britnell, Member for South-West Coast.

The CHAIR — Thank you very much for attending here today. I welcome Ms Cheree Cosgriff, Ms Dawn Foster, Dr Ben Goodfellow and Ms Rose Cuff.

All evidence at this hearing taken by the Committee is protected by parliamentary privilege as provided by the Constitution Act 1975 and is subject to the provisions of the Parliamentary Committees Act 2003 and other relevant legislation. Any comments you make outside the hearing will not be afforded such privilege. It is a contempt of Parliament to provide false evidence. These proceedings will be recorded, and you will be sent a proof copy of the transcript.

I would like to start by saying the whole object of us being here in Geelong today is to inform the recommendations for the inquiry and the report itself into perinatal services in Victoria and basically, we're just trying to find out as much information from you as possible. Not that you look nervous, but please don't be nervous. We invite you to start with a 10 to 15 minute presentation, tell us about the service and we might have a conversation after that and ask some questions if that is okay with you.

Ms CUFF — I will talk for about five minutes and then Ben and Cheree will add to the presentation and then we will take questions. I'm going to talk about the FaPMI program, which is Families where a Parent has a Mental Illness, which is a statewide program, so I've got a few slides here. I'm the statewide coordinator of that program, it's a state government funded program that's been around for 10 years and I'm based at the Bouverie Centre, which is a statewide family institute based in Melbourne so I'm based there.

Just a few notes about the scale of the problem, not so much about perinatal issues but really about the issue of children and young people and families where parents have a mental illness, which is a significant number of families and in adult mental health services we estimate about 25 to 30 per cent of those adults accessing the program are parents, either full time parents or part time parents. It's only been in the last 15 years that this population of families have been identified and addressed really. The last point is an important point because vulnerable 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.

The CHAIR — Just for us, those stats, just so we've got a reference, where are they cited from?

Ms CUFF — They're primarily from some research done by Darryl Maybery, which I can send you the reference from. Monash University. The family services stat is an important one because that's not necessarily cited but it's an anecdotal given that those families are bouncing around the system and not getting access to a specialist service because they don't meet the criteria.

The FaPMI Program, as I said, is funded by the Victorian state government and it's now a fully implemented state wide program across Victoria and there are FaPMI coordinators — Cheree is in Ballarat, Dawn is in Geelong and they're across all of the 22 adult mental health services and they're full time, so it's a significant resource that it's in a very good position to influence practice; it's capacity a building program.

We do core statewide work so at the centre of what we do is we try and provide some consistency and I try and support that by developing — we've got some FaPMI practice standards that we are developing and one of those is a whole of life audit tool that actually screens for pregnancy and birth and beyond. We also have a range of peer support programs so these are influencing roles trying to improve practice. That's just a snapshot. We really work with everybody who sees families so it's not just mental health but these positions, they reach into a whole range of services that are really equipped at capacity building those services so we're in a very good position, as I said, to influence change.

The next snapshot is really just to demonstrate that as a program we do two things really, we do a lot of policy and procedure development so we look at what policies are in place that address a particular area so infant

mental health and perinatal health would be one of those where a person will have a look at what policies are in place and how do they actually take into account people presenting to the service perinatally. But we also enable service delivery as well, direct service delivery, so it does all of those.

I want to just touch on some of the features and strengths of the FaPMI Program and then why we think it's in a very good place to enable some change in the perinatal space. The FaPMI coordinators are all senior clinicians, many of them come with backgrounds of working in a perinatal space, Cheree is one of them. They have a huge amount of knowledge, skills and confidence in working in this space. It's a whole of life and, importantly, it’s a protected family lens, so mothers and babies don’t often exist in isolation, they exist within a family network and community, so we think having a family approach is very important. We also worked very closely with family violence. As you know, the family violence space is changing rapidly and we are working very hard to build relationships with and work along in synergy with the family violence sector and the AOD sectors. We also adopt an important stance of utilising lived experience, so peer support workers and lived experience practitioners to work with us to inform our work and we work closely with peak bodies as well.

Some of the examples of the FaPMI Program we think are relevant to the perinatal work — as I said before, we know that peer support and peer workers play a very important role in supporting families. You've probably heard of Circle of Security so the FaPMI program has supported the delivery of the Circle of Security, we've got a supportive playgroup model that's been developed, again with a peer worker, and we also have enabled a range of peer support programs for children. Many of those families they are older children with mothers with infants as well because often these families have got older kids as well that often fall off the radar.

The other two specialist early intervention models, again which the FaPMI Program is supporting and enabling, is the Let's Talk About Children, which is an evidence based program from Finland which is coming to the end of a four-year research project, which we've been involved with, which is a structured brief intervention where the practitioner actually talks with the parents and partner about their relationship with their child and includes pregnancy. It's got different age domains and one of those is pregnancy and naught to two-year olds. It's a beautiful model because it actually has a non-blaming approach so it's not threatening for families. I think the person before was talking about they need to be very careful in engaging with families where there is trauma. It's a very important part of that model in particular and a lot of our work has been exploring how to equip workers across services to engage sensitively and carefully with vulnerable families and that model does that really well.

Some of our key concerns we will talk about a bit more is early identification through universal screening, which I'm sure you've heard a lot about. In particular, mental health services have got limited capacity, particularly adult mental health, to provide all the above because they don't have that knowledge. They’ve got lack of confidence and no resources for same. Services continue to work in silos and there is a lack of consistency across services and poor access to resources.

We will just leave that up there. The top one that is really for us one of the most important ones is really about the vast number of families in the perinatal period who don't meet the criteria for public mental health services, despite the need for coordinated specialist intervention, and there is no strategy to address this. I think Suzanne touched on that, that we feel that is really lacking, they just fall off the radar.

There needs to be clearer guidelines and KPIs regarding funding and reporting that requires and allows mental health services to prioritise perinatal and early intervention work.

We recommend the FaPMI Program have a central role in service development and integration. We've been around now for 10 years and we have a demonstrated capacity to build those structures and networks and to bring services together.

The last one is ensuring consistency of service provision whilst allowing for regional variation and flexibility.

The CHAIR — Rose, can we get a copy of this?

Ms CUFF — Yes. I might pass over to Cheree.

Ms COSGRIFF — Rose has pretty much touched on the broad aspects and obviously our submission was also very broad in terms of the work that FaPMI does because it's hard to nail it down to one specific area. As

Rose said, we've got lots of expertise around various areas within mental health. My component of that is I've got a very strong interest in perinatal mental health. I've worked in mental health for 25 years and been a midwife for 15 of those. The last 10 I've spent specifically in perinatal mental health, working in both the mental health area and maternity area, so I've been really able to see the aspects of the issues and concerns from both sides of the professional work that I do.

Reading through some of the other transcripts, I found it was really clear that the prevalence of perinatal mental health concerns has been well outlined. I know COPE talked a lot about it and so have many of the other presenters already so it's very obvious why we're here and what we need to talk about it. I just wanted to give you a snapshot. In 2011 I was already in the FaPMI role and I was still working in a clinical role as well and I was really fortunate to be able to be part of the statewide Perinatal Advisory Committee and that was actually through FaPMI that I was able to be part of that. Our aim for the Committee was to actually help to implement the recommendations and the guidelines from the Perinatal National Initiative and all the work that Beyond Blue had done with that and the department. A large part that was universal screening, which I know you've heard a lot about, and Suzanne was talking about that as well. It was fantastic to be able to be a part of developing the roll-out of some training and education for services on universal screening. I'm sure you've heard about the success that came from that and, unfortunately, I believe it was about 30 or 40 per cent of hospitals actually took up that universal screening. So there is obviously some real benefits in that and I know COPE have released some new guidelines and they've talked a lot about that too but there's lots of areas that need to be developed and really worked on before we look at rolling it out again. I was able to actually be a part of it in a professional way. I helped in our own hospital to be able to actually roll that out as well so I can talk a little bit about those challenges too if you like me to later on.

Obviously, there is no earlier intervention than the work we do antenatally so I guess the question that I would like to pose is how well equipped are services to actually be able to provide the support that is required once we've actually identified that there are issues and concerns? Again, that comes back to our screening and our service delivery once we've identified there is a need so referral pathway is obviously a really big concern as well. We invest time and effort into early intervention and we look at screening and identifying but then what do we do once we've actually been able to identify that there is a concern and what services are available to us to do that?

I know you've heard a lot about the PEHP Program, Perinatal Emotional Health Program, as well and there has been lots of variations around the state of how the funding for that has been used and Ben is going to talk a little bit more about that locally as well. Obviously, I'm from Ballarat so I've got a Ballarat perspective on that and it does vary quite a lot in different areas too.

The FaPMI program works within Area Mental Health Services and their network partners to provide consultation, education and resources to assist the work with clients who are parents. Across the state there is a consistent theme of inadequate knowledge and experience of work in the perinatal area and it has been clearly identified that despite being a vulnerable population that with appropriate supports, recovery outcomes can be improved and the impact on the children is lessened. I know Rose talked a little about that too, and that's certainly come out of a lot of the research from Maybery and we can provide you some more information about that as well.

The big issue is that mental health services are not adequately prepared to work in perinatal space either and then the flip side of that, I guess, is that maternity services — midwives have basic emotional health training through their education. They look at bonding and attachment and they certainly work a lot with parenting, but they do not have a mental health component to their training so they are obviously not adequately trained and prepared to be able to work in the perinatal mental health field either. Mental health staff generally are not trained, as I said, to work with attachment issues or adjustment to parenting, which is what we see a lot of, there's a very high prevalence of adjustment disorders that we are actually exposed to in the perinatal mental health field. So both of them are needing to work together a lot more to be upskilled and to be able to support each other in an integrated way.

FaPMI has the ability to continue to address the identified needs for the workforce and the gaps in the service delivery within each of our regions. That is obviously going to vary from region to region and that is where FaPMI is in a really unique position because we are already embedded in each of the areas of the mental health

services so we can work on what is required within our regions but in a consistent way, having an approach from a statewide level, which is very unique for us which is fantastic.

Perinatal mental health work is a unique area that until recent years has had very little notoriety and although there has been fantastic advances in the area and there are many organisations supporting professionals and consumers, this work is still very much taken in an isolated way. There need to be a national and state approaches that addresses ways to improve the use of current resources. We've put that in our recommendations, obviously. And I think that our coordinators are in an ideal position to be able to do some of this work.

Some of the examples Rose talked about, one of them is the Circle of Security. You've all heard of it; you are all nodding. It's been mentioned a few times obviously. Something that some very clever males created across the other side of the world from us but it's been rolled out here in Australia, and particularly in Victoria, in a very large way at the moment. It's been utilised in lots of different ways and lots of different services but it's something that we have found within our region and it works really well but, again, it's about funding, it's about integrating services to work together to be able to do that. Within the Ballarat region we've actually been able to work together with family services, child and infant mental health services and adult mental health services to bring together those really vulnerable families with mental health to provide that Circle of Security group. It can be used with any families, it's not specifically aimed at mental health, but we've certainly found the outcomes from that have been very valuable. There are lots of other examples, as Rose said, about the playgroups and so on as well. I might throw it over to Ben.

Dr GOODFELLOW — It’s hard to know what to add; it's such a comprehensive discussion already. So just to introduce myself in a bit more detail, I'm an infant, child and general psychiatrist. I'm the Head of Child and Youth Psychiatry here at Barwon Health in Geelong. I have a psychoanalytic practice in Melbourne and I'm also a Director on the Board of Alfred Health so they are some of the perspectives that I bring to things. I don't have any formal affiliation with FaPMI as such, other than that it’s part of the mental health service that I’m one of the senior clinicians in, although I do work very regularly and closely with Dawn in a number of programs, some of which are of key relevance to infant perinatal work as well.

I am very pleased to have the opportunity to be able to talk and I hope that at some level, or maybe more formally, it can be just the first discussion as things proceed to look to define and have a role in crafting some of the details around how these kinds of services will operate. I'm mindful of trying to say something a little useful and different, having heard from so many people. and it's good that there is a lot of common themes, you can hear something of a consensus there, but it's probably in some of the questions you have for us that there might be some of the more specific gaps and so on.

What I thought is useful is to tell something of the perinatal services in this region because how they have ebbed and flowed, if I can put it that way, is quite useful in suggesting what needs to happen at this point.

The CHAIR — That would be fantastic.

Dr GOODFELLOW — The perinatal services in Geelong began formally around five or six years ago with the PEHP Program when that was introduced by the state government in 2000. That was shortly before my time here — I have been in this role for a year but as a psychiatrist in Geelong for nearly six years now. The PEHP funding was not recurrent funding, it tended to be renewed after the budget date and it made planning extremely difficult but the service rolled on on the assumption that things would continue. There was a point where it became a bit clearer that the funding wasn't to be continued, I think while the current government clarified what they were going to do and then reinstated a much greater amount of funding but in that gap the health service here, at levels above me I should say — decided that that wouldn't be a service we can offer because the funding wasn't there and that's one of the key things that when there isn't ring fencing protected funding for things that don't cause acute concern they necessarily fall through the gaps.

The CHAIR — Ben, just in regards to that funding, have the programs under the PEHP funding model, are they back at 100 per cent or building them up, what percentage are they at and what are you missing at the moment? I’m aware that once the funding went, we had a number of services that decided they weren't going to take that risk, and fair enough. So what are we missing now?

Dr GOODFELLOW — Restarting a service, you need the right people and there is a lag between actually being able to — you can't just say open for business when you actually are unable to provide a proper service. The service offering is probably at least 12 months behind schedule here in terms of being able to offer something resembling what it did before. It was inadequate for what it was covering, it was not sufficient, like a lot of things in mental health, but it was one of the most streamlined and efficient areas of mental health that I've ever worked in. It had much less of the triaging and that sort of soft bureaucracy that can go on in mental health services sometimes. Maternity services, all feedback I had, was that they experienced the service very usefully; they would fax a referral and they had someone who knew what was going to happen and that mother would be contacted and would be seen as needed and there didn't need to be a whole lot of rigmarole to actually get through the gate.

These families still in need, they were still there even when the service closed and then had a very different structure so we were clear there was nothing to stop referrers from continuing to make that referral and that is what I encouraged because it then demonstrates a demand that my bosses have to be able to meet. But when people hear that the PEHP is closed of course they tend to stop referring.

The CHAIR — Just to clarify. You're still referring but those parents are paying private providers? It's obviously much harder for them to get the help they need because they've got a number of obstacles, that Suzanne actually raised recently, in front of them now instead of a streamlined approach.

Dr GOODFELLOW — That's right.

The CHAIR — So those families were probably more prone to be falling through the gaps.

Dr GOODFELLOW — Definitely. Some diverted to the Raphael Program and similar clinical providers, and they became quite overwhelmed, but they managed well, all things considered. One of the strengths of Geelong Mental Health Services is our Infant Mental Health Program. For historical reasons it's one of the regional centres that has been quite strong and with my particular interest in training, that is especially common to child psychiatry training generally, it’s meant that when I started here five years ago there was able to be a psychiatrist actually part of the team and all the momentum that that can bring with it. Quite a number of those referrals then were directed to the Infant Mental Health Program so we've absorbed some of those there but there is still a very large — and the question that you asked Suzanne just as I sat down, is the central question at this hearing, you said: where are people falling through the gaps and what can we do about it?

The CHAIR — Sorry for that very broad question.

Dr GOODFELLOW — It's a big question but it's rather specific and it sort of helps sharpen my focus in what I might talk about now.

The CHAIR — If you can give us an answer that would be fantastic.

Dr GOODFELLOW — I think that first recommendation, a recognition much more broadly that there is enormous struggle and suffering that goes on for many, many families who don't cause enough of a public nuisance to get mental health services. When I'm feeling a bit cynical that's what I call public mental health service is public nuisance mental health because there needs to be a degree of disturbance, distress, agitation that someone is causing to another person and the potential to cause a hazard in an emergency department that will get you in the door, and it shouldn't be like that, it should be much more of a clinical, equitable system that addresses the suffering psychopathology that's at play. If someone is able to keep those very dark struggles that they're having as a family, the excruciating ambivalence that a parent can have towards a child, the types of predicaments that not only single mothers or people in domestic violence, they're very important and in this region a very large cohort, but it's just as likely to strike the middle classes as well.

In Melbourne, at least, there are adequate private support — people who are able to work in a psychotherapeutic manner, in a family oriented, infant-focussed approach, but in Geelong there's two or three private clinicians who, from my understanding, are adequately equipped to do that and so part of when I'm talking with the maternity services and family community service organisations, because they're the groups that are seeing the overwhelming majority, they're seeing nearly all of these families. I say no matter what kind of demand you think there is, or what lack of resources you feel we have, I want you to ring me and talk about that family. We

need to expose some of this demand that's there, so that's the first thing, not just for government but mental health services as well.

Most adult psychiatry clinicians, whether they're medical or non-medical, would say this perinatal stuff, it's nice and soft and cuddly and it would good if we can help it out, but it's not serious psychiatry. It's not always psychosis, suicide, self-harm with a baby around that we're talking about, I don't think it has to be as stark and potentially horrific and high acute risk as that for it to still be serious. So, there's issues of resourcing but also of culture that we need to try and shift.

The CHAIR — I'm taking up a lot of your time here, but would I be assuming correctly if we don't pick up some of those people they can become those — —

Dr GOODFELLOW — Absolutely. You look back at a person who has been referred, at almost any age, let's say middle child, because of my extra interest and experience in infant work, I will always ask in quite some detail about how did you become a family and the circumstances during the pregnancy in those early years, how did you get along with him as a baby? Almost universally they will say, they might identify as having had post-natal depression, something as explicit as that. They will say: I had a really tough time connecting with her. Or: she had serious feeding problems. All of these things that are grounds for an infant or perinatal referral.

Ms McLEISH — Without any treatment?

Dr GOODFELLOW — Without any treatment, that's right. Or they'll just have paediatric treatment. The younger you are, the less verbal you are, so the (indistinct) through the body that emotional disturbances are manifested. In our culture in this day and age we see physical problems of an infant as being medical problems and so there is an overly paediatric lens that's put to these things, that's part of why we work on an ongoing basis in liaison with the pediatricians in the special care nursery here in Geelong. You begin by — you're not going to be intrusive in another team's way of working entirely but it's a matter of being present and being able to just wonder about some of the dynamics. I think you mentioned what happens to these people down the track.

One of the most extraordinary things in my work is that a referral of a child, say eight or 10 years or older, or individual adults, it is often ongoing psychotherapeutic work for months or years that's somewhere between necessary and useful. But in this infant perinatal work it can be just one or a handful of sessions that things can just really unlock and pivot because it's all of the dynamics between mother, father and child, those dynamics, the trajectory are still much, much more fluid than even just a few years on from that early experience.

The CHAIR — We might ask more questions.

Dr GOODFELLOW — Of course.

Ms COUZENS — Thanks for coming in today. Going back to the Commonwealth funding that was withdrawn. That was a very good service that was running at the time and it was topped up with state funding and then the Commonwealth withdrew. What happened with the state contribution that was there? Did you continue a service with that?

Dr GOODFELLOW — I have almost nothing to do with budgets.

Ms COSGRIFF — I can answer from the Grampians region. The funding was ceased completely, so the federal funding was pulled first and then 12 months following the state funding was ceased and then there was a 12 month gap between when it finished when the new funding was actually reinstated and it's actually not the same amount of funding. The EFT around the state was initially 0.5 EFT for 500 births and it's far less than that, so most regions have about half or two thirds of that funding back reinstated.

Ms COUZENS — It's only the state funding that's been reinstated?

Ms COSGRIFF — Yes.

Ms CUFF — It's very patchy how it's coming back, services are coming back. It's slow and patchy.

Ms COUZENS — But it is coming back in this region?

Dr GOODFELLOW — It is.

Ms COUZENS — Have you been involved in that?

Dr GOODFELLOW — I have.

Ms COSGRIFF — I made a couple of notes when Ben was talking before in terms of the PEHP Funding. 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.

We talk about gaps. Sorry, Ben. We talk about gaps, I think from our perspective, we can talk from Ballarat, Geelong and South-West we're all on the PHN area, the same area, South-West, but the PEHP funding for us was to actually fill gaps and to not duplicate services. So, in Ballarat where there were already some perinatal services — we had Raphael and we had some really good work happening through the area mental health service, their focus was on the more rural areas. And without that funding we actually have nothing at the top end of our region now, absolutely nothing at all, because the 1.5 EFT they've got is actually utilised just to see mums and get them admitted into the mother and family unit and that's all they’re utilising that for at the moment. They don't have any capacity to do any outreach or community based work and so there is nothing happening in the more rural areas, and it would be exactly the same, I would imagine, in the south-west as well.

Ms COUZENS — Is there any indication that the Commonwealth will provide some funding in that area?

Ms COSGRIFF — No.

Ms COUZENS — You touched on the workforce challenges of obviously getting the skilled workers. Do you have any idea on what strategies can be put in place to attract people into the field?

Dr GOODFELLOW — It's a field where there is always a lot of interest. One of the key recommendations I have that ties into that question is that perinatal services sit under a CAMHS service. I think that CAMHS is actually quite consistently structured to work from a family perspective in a way that adult clinicians and services that's not part of their training, they are much better at other things than I am and that is just one of the trade-offs. If perinatal services that in the past were more adult focused, it remains very much what are the mother's symptoms? Is she depressed, is she anxious, and a sort of CBT medication approach, but that’s sort of a decade ago thinking as opposed to seeing the whole system of the family system as a much more comprehensive thing. We've had a few CAMHS positions come up over the last two years or so and part of what we've advertised is that those people, part of their role will be infant and perinatal, family and psychotherapeutic work and we have had a lot of good candidates at each round. There was a bit of funding holdup at a high level in the hospital for us to appoint a fantastic clinician.

Ms CUFF — The peer workforce, I think it's an area that really lends itself to developing a supported workforce of people with limited experience because the stigma and vulnerability of people to actually disclose that they are experiencing difficulties in that perinatal period is enormous. I was saying to these guys I had a family member who disclosed to me recently and it came out of the blue for her, she couldn't talk about it, so that's a big movement in the mental health field is the experience of the peer workforce because it's really powerful and I think we should be looking at that in this space and how we can do that.

Ms COUZENS — We've heard quite a bit around early intervention. Do you have any ideas on how we can tackle that issue of getting that early intervention happening and trying to avoid some of the situations that are occurring?

Dr GOODFELLOW — Again, there is resourcing and cultural constraints and it's the cultural things we can address without asking to ask the treasurer for funding, which usually puts you in a better position. That’s where my ideas — I’ve see this, there is the clinical work and I see it at board level, the KPIs for mental health

are not irrelevant, they're important as far as they go, but they cover maybe one or two percent of the work that goes on in a mental health service; the subtleties of the day to day work is not reflected at all.

Mental health services are necessarily very crisis driven and even with the best of intentions, it becomes almost impossible for a mental health service to justify spending sufficient time on the preventive and early intervention work when they're barely able to cope with the crisis. So if there were mechanisms from the department where the mental health service had to report let's say what proportion of FTE, what percentage of time is spent on preventing work, that’s how you measure it, how you define it, how you capture accurate data, there is all those problems, but it's just an example of how I think the kind of much higher level KPI type changes would be needed to just require a clinical director to make sure there is a certain number of people, that's one day a week, that's what they are doing, because otherwise there are more important things in the shorter term.

Ms CUFF — Early intervention, Suzanne talked about it, it's everybody, it's all services, not just mental health services. It's how do we equip a workforce or services to have those really early conversations? And they're not easy conversations to have when someone is front of you and you think they are vulnerable. How do you raise that? You can't just expect people to do it when their level of comfort is way out of their comfort zone. So it's really prevention and early intervention. We have to go way back. How do you stat sitting with a person in a very dark space and talking with them? You can't stat that, that's not recorded.

Ms COUZENS — In mental health there are cultural issues, there's family violence, all the things that make people vulnerable.

Ms CUFF — It’s a cross vulnerability.

Dr GOODFELLOW — I think too to have senior people providing meaningful clinical support and supervision to family services workers and maternity services because they're the very large groups of people, they're the people who first hear about this distress. And they don't all need to come and see a psychiatrist or a senior mental health person straightaway, in fact that breaks something of their working relationship they already have. Again, tertiary mental health services should have a much more explicit role in the clinical governance and principles of practice of community service agencies where there's lots of conscientiousness and well-meaning intentions but not always the clinical rigor and structure that I think there should be for such important problems.

Ms BRITNELL — You mentioned before that you were involved in the primary health network and I've heard Geelong and Ballarat. Do you cover the south-west and Portland and Warrnambool perspective?

Ms COSGRIFF — Our Mother and Family Unit in Ballarat is funded to actually cover both the Grampians and the south-west region. Again, we can take referrals from south-west to the Ballarat inpatient facility but we can't provide any discharge or follow up support afterwards so that is again another problem; it then relies on the services within south-west to actually pick these women up.

Ms BRITNELL — So is CAMHS the service that you would be working with in that instance?

Ms COSGRIFF — Generally they do have a PEHP Program still in existence but when they were defunded the hospital continued their program, they continued to fund it, so they are still working quite well and we rely on them quite heavily to either complete assessments and make referrals to the Mother and Family Unit and then also to pick them up as well post discharge.

Ms BRITNELL — Or under extraordinary pressure and have a long waiting list and are finding it hard to get staff.

Ms COSGRIFF — Yes, all of those.

Ms BRITNELL — They're coping quite well, are you saying?

Ms COSGRIFF — The numbers that we're getting admitted to Ballarat are quite small so I can only speak on the numbers that we have seen. What the other work that they're doing and how it impacts I am not really sure but I know that everybody is stretched in every service so it's an ongoing problem. Otherwise it relies on the area mental health service and, as Ben mentioned, public mental health is designed to work with crisis work

and acutely unwell people so the women that we're seeing that need that support, particularly in the early stages, are not actually going to meet criteria for treatment with those services so they are going to fall through the cracks.

Ms BRITNELL — That is what we heard. Thank you.

Ms McLEISH — One of the early slides — I think I wrote down the stats properly, there were 19,000 Victorians in a family with severe mental illness. With the recommendation that you've just popped off the screen, the first slide, I think it mentioned there were 19,000 families where a parent has a severe mental illness. With the first recommendation, is that a separate group?

Ms CUFF — It's all of the above. That's more the other people that don't get seen.

Ms McLEISH — What is the 19,000? Where is the distinction?

Ms CUFF — The severe would be people that are accessing specialist mental health services that meet the criteria.

Ms McLEISH — This is a tier below that?

Ms CUFF — Yes.

Ms McLEISH — There was also the slide before, which was key concerns. The first point: the poor uptake potentially due to lack of education and training. Where does that responsibility or accountability sit?

Ms COSGRIFF — Initially it was with the department so when the department rolled out the universal screening under the guidelines and recommendations of the initiative, they rolled it out so they offered it to all services within the state, and then it was basically a train the trainer type of model and they took it back to each of their own services and then trained staff up. It was done a very different way. I'm not sure how St John of God picked up theirs, but I know the uptake was very small.

Ms McLEISH — I'm still a bit confused about where the accountability lies or future delivery.

Ms COSGRIFF — It's a really good question because that's part of the problem that we spent millions of dollars on developing these guidelines with recommendations and one of one them was to have this universal screening, which is fantastic, but we need to skill staff to be able to do it.

Ms McLEISH — Staff where?

Ms COSGRIFF — Maternity staffing.

Ms McLEISH — Hospital staff?

Ms COSGRIFF — Maternity hospital staff to do the universal screening. Exactly as Suzanne was talking about, to deliver a psychosocial tool and generally the Edinburgh was what was being used as well.

Ms McLEISH — Have you seen the tool that we were just given before, which I believe you could have access to through the clinical practice guidelines for perinatal mental health? Have you seen that tool?

Ms COSGRIFF — Yes.

Ms McLEISH — What you do think of that tool?

Ms COSGRIFF — That's good. That's a revised tool so it was a combination of a couple of tools that have been in existence for a number of years. I know St John of God have actually used a different tool, the antenatal and postnatal risk questionnaire has been something they have been using for many years, but the new guidelines through COPE is now a modified version of that. It looks very good. In Ballarat we were using a psychosocial tool anyway so we didn't actually pick up on the recommended tool because we felt that we were already covering all of that. We just implemented the Edinburgh, the mental health component was what we were missing so other than that we were picking up on family violence, drug and alcohol, all the other

vulnerable factors, but we were missing that mental health component so we introduced the Edinburgh as part of that and our screening has been working really well but many places it's not, or they haven't even tried.

Dr GOODFELLOW — Just a very brief, partly dissenting view on screening tools, is a screening tool is only one way to make sure that there is the conversation about how are things going, should we think about extra services for you. I think for certain clinical disciplines and certain settings of care a screening tool is fantastic, it's easily the most efficient way to prompt some of these things but I would be concerned if one or two or three screening tools became somehow like the secret and mandatory and these kinds of things.

Ms COSGRIFF — And that is part of the problem because in maternity, as I said, they're not mental health trained so we can train them to use a screening tool. Question 10 in the Edinburgh 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? So, it's about clinical judgment generally and if you don't have that background and that ability to make that clinical judgment you are just relying on a tool and a number.

The CHAIR — Could one of you please help me understand the relationship between the PHN health pathways and the referral pathways you use?

Dr GOODFELLOW — Yes and no. PHNs sit in the relation to the health services generally in the areas they cover, in the different places I've worked that's sort of a work in progress and a conversation in progress in those regions. It is definitely not as efficiently utilised as it could be. The Geelong region is seen as one of the better functioning PHNs in relation to the mental health service but I ask myself that same question you do: how does this work and what could be their role more assertively? One thing that makes working with GPs very difficult is essentially they are all individual solo private practitioners and that is a difficult professional model to fit in with services that are necessarily very messy and chaotic and there needs to be lots of phone calls and outreach and of all these sorts of things.

Ms CUFF — There is some work being done in the PHNs, I think you know there is a Commonwealth funded initiative called Emerging Minds, it just got some Commonwealth funding to develop a national workforce centre for child mental health, 0-12, and it's just starting out. I'm on the Board of Emerging Minds and there is a lot of work linking PHNs in with various other workforces to try and close that off a bit more so I think that will be interesting to see how that plays out in terms of state by state.

The CHAIR — So work in progress at the moment.

Ms CUFF — Yes. It's seen as not very well. It hasn't been very clear.

Ms COSGRIFF — The health pathways, I believe, was actually developed initially here in Geelong as that's why this PHN is actually leading the way. All the Medicare locals obviously had their own way of having somewhere to store that sort of information and for GPs to access it, but Geelong's was seen as being fairly worthwhile and so they've picked it up and it's still developing very, very slowly but it's something that's in progress but it doesn't talk to any other services or any other systems.

The CHAIR — Would anyone like to ask any other questions? Thank you, Ben, Rose and Cheree for your time today; we realise you are very busy people and some people call me crazy sometimes but the psychiatrist here just said that I asked the same question that he asked himself so I can't be that crazy.

Witness withdrew.