

# TRANSCRIPT

## FAMILY AND COMMUNITY DEVELOPMENT COMMITTEE

### Inquiry into perinatal services

Warragul — 8 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 Simon Fraser, chief medical officer and paediatrician,

Ms Christine Hoyne, nurse unit manager, parent-infant unit, and

Dr Stuart Thomas, psychiatrist, Latrobe Regional Hospital.

**The CHAIR** — I welcome to these public hearings Dr Simon Fraser, chief medical officer and paediatrician; Ms Christine Hoyne, nurse unit manager, parent infant unit; and Dr Stuart Thomas, psychiatrist, from LRH. Thank you for attending 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 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 guess you have a presentation. We might spend 10 to 15 minutes on the presentation. If you can tell us about what you do in your sector and agency, then we might have a discussion and ask some questions, if that is okay.

### Visual presentation

**Dr FRASER** — Thanks very much for having us join you. Christine and I will probably talk for about 10 or 15 minutes. The presentation is divided into two parts. I am talking particularly from the perspective of Latrobe Regional Hospital and perinatal services in Gippsland. Christine is going to talk about the PEHP program and also the work that we have done in the Agnes unit in relation to mother-infant health.

As a bit of background, in Gippsland last year there were 3000 births. That is not an estimate; that is the actual number, believe it or not, when we added it all up.

**The CHAIR** — Very orderly in Latrobe.

**Dr FRASER** — Yes. For Latrobe Regional Hospital year to date we have had nearly 800 births, and it will probably take us to about 860 this year. That has been fairly constant for the last four or five years. We are a little bit unusual in Gippsland given the geography and that the maternity services are really ordered along the spine of what almost looks like a feather, I guess, compared with some of your other regional hospitals which is more a hub-and-spoke concentric model. If you looked at health services such as Ballarat and Bendigo, they would have higher delivery numbers than us. But we have about 800 to 900 deliveries a year.

As far as the Latrobe Regional Hospital's capabilities are concerned, I am sure you are familiar with the maternity and newborn capability framework. We are a level 5 service, which means we will take moderate and selected high-risk deliveries down to about 32 weeks. From a neonatal perspective we are a level 4 service and care for moderately unwell, uncomplicated newborns down to 32 weeks and around 1500 grams. That includes growing preterm and convalescing newborns and infants. We can certainly accept newborns marginally under these gestations and weights in consultation with PIPER, and that is as per the capability.

Latrobe Regional Hospital has a number of models of care in relation to perinatal care. We are predominantly a specialist obstetrician-run service. We have five specialist obstetricians and one registrar. We have shared care clinics between midwives and specialist obstetricians on site. We have the midwife day assessment clinic, which runs three days a week. We have been doing this for about two or three years. We have an outreach clinic which we run in Moe, which includes a morning clinic once a week shared by two obstetricians and a midwife specifically for vulnerable women and women who may have difficulty getting to the hospital for antenatal appointments. This certainly appears to have improved access to a better antenatal care.

We have an outreach service where a midwife visits vulnerable women, and these would be defined as women with teenage pregnancy and women with mental health issues and child protection concerns. The role of this service is to facilitate the attending of appointments, scans and social supports. We have recently, in the last 12 months, developed a multidisciplinary enhanced maternity clinic for women with high BMI, which is a major problem in pregnancy in Gippsland, women with diabetes and women who smoke. This involves a midwife, dietitian, diabetes educator and HARP nurse.

**The CHAIR** — What is a HARP nurse?

**Dr FRASER** — Sorry, hospital admission risk program. Our HARP service, amongst other things, is designed to try and reduce admission or readmission to hospital. One of the components is nurses with clinical nurse expertise with respiratory illnesses, so they are highly skilled in smoking reduction —

**Ms BRITNELL** — Is this the HARP model that came out of the Austin research many years ago, on chronic illness?

**Dr FRASER** — Yes. We also have two GP obstetricians who see patients in their GP clinic. They have admitting rights to the hospital and will deliver there.

In Gippsland we also have and have had for a number of years a well-coordinated and collaborative maternity services group which meets every two months. This has representatives of all eight of the Gippsland health services providing perinatal care. Through that group, in the last two to three years we have had some good outcomes. We have developed a regional policy for BMI in terms of levels at which women can be safely delivered and where they might need to be escalated up to higher levels, including to Monash as the tertiary referral centre. We have developed a protocol for the use of our intraregional incubator, and we are just in the final throes of working on agreed referral pathways in the region for women before, during and after delivery, and for their babies.

The Latrobe Regional Hospital is very heavily involved in clinical governance, both within the hospital and also regionally. We have our own perinatal morbidity and mortality committee, which meets monthly. I chair, and the Latrobe Regional Hospital is responsible for, coordinating the Gippsland regional M and M committee, which meets every three months. The process for that is to ensure that the committee meets in each of the health services on a rotating basis so they can understand the process and contribute. Like all health services, we look at and dissect and aim to improve based on the perinatal services performance indicators, very close relationships with the consultative council on paediatric morbidity and mortality, and ongoing support of the clinical network, particularly the neonatal and maternity e-handbook. Certainly an issue that I have put in our submission is the importance — and I really underscore the importance — of legal privilege in allowing robust discussion about adverse outcomes.

Just in closing for my component, the issues I think not just for the Latrobe Regional Hospital but for the region, and as I was hearing when we came in, are major issues around obesity and BMI. I think the evidence clearly indicates that there is a very close correlation between the incidence of BMI — or inverse correlation, I guess, between BMI and socio-economic status. The smoking rate in Gippsland sits across the region at about 27 or 28 per cent, compared with the state of Victoria, which I think is half of that. Certainly for our women in the first half of pregnancy the smoking rate is very close to that; it is about 25 per cent. We are able to get that down to about 20 per cent in the second half of pregnancy. If you look at the perinatal service indicators, that is significantly greater than other health services, particularly private hospitals. That is an area that requires ongoing support. The region is involved in a lot of work being done in trying to reduce smoking rates throughout the region, particularly with support from funding following the Hazelwood mine fire.

We, I suspect like other regional and rural health settings, have issues relating to socio-economic status and all the components in relation to that in terms of access to care et cetera. An area that we think needs further work is facilitation of transfers of mothers and babies within the region. Anecdotally it does seem to be easier for PIPER, which is the transport coordinator, if they are collecting a baby or mother from Bairnsdale or Sale to bypass the Latrobe Regional Hospital and take them to Melbourne.

**The CHAIR** — Why would that be?

**Dr FRASER** — They are concerned about double transfers, where they take a sick baby to the Latrobe Regional Hospital and then they might have to come back and take them a day or two later. I have certainly raised this on behalf of the region and the regional perinatal M and M committee with PIPER. We have a very strong commitment in the region, including our referral pathways, to where we can, within the capability of the health services, to try and keep mums and babies together and in the region, rather than having them travelling long distances.

The Latrobe Regional Hospital will be increasing our special care nursery capacity in the next 12 to 18 months. We have received funding from the health department for that, for which we are very grateful. I am sure others have raised and will raise issues around workforce recruitment and retention. It is critical moving forward that we have ongoing intraregional networking and collaboration between the health services.

**Ms HOYNE** — I am Christine Hoyne. I am the nurse unit manager of the mother and baby unit at the Latrobe Regional Hospital, known as Agnes unit. We have been open for just over three years. I was also a perinatal and emotional health program clinician for four years prior to that, for Latrobe Valley. So I am going to speak on behalf of Agnes unit and the PEHP group.

**Ms McLEISH** — Does Agnes stand for anything?

**Ms HOYNE** — All the units at LRH are named after rivers in the Gippsland area. Agnes Falls is near Foster.

As Simon has already said, we have a birthrate of 3000 in the Gippsland area. Agnes unit in its three years since opening has had 486 admissions, and the PEHP — which I will go into in more detail — in the same amount of time has had 601 referrals. PEHP, which I am not sure if you have already heard about in previous submissions, is the free outreach service that goes to women. It was set up to cover the whole of the Gippsland region, and it was for families that were having emotional problems or difficulties coping. They did not need a diagnosed mental illness, and it was for anyone with infants up to 12 months of age. Of course because you are working with these families, they often have toddlers. Even though under 12 months is our remit; over 12 months we often got involved and the clinicians were often working with families with the toddlers they had concerns about as well.

Many of these families have a history of trauma, but often unacknowledged and untreated in the past. They are often well enough that they have never had any contact with any mental health service in the past. They certainly are not acute enough to have come in with the acute public mental health service. It is a very early intervention outreach service.

**Ms COUZENS** — Are those traumas usually around family violence?

**Ms HOYNE** — It ranges. It can be family violence, it can be historical family violence, it could be immediate family violence, it could be drug and alcohol related, it could have been sexual abuse or it could have been broken families spread out all over the place. The full gamut is covered. It also included people without anything like that but then a birth trauma, and a lot of layering of all those different traumas.

What has been really helpful is that there is no minimum amount of visits, except that 12 months is sort of the cut-off and then you transition out, because it can take a while to build up a relationship for people to divulge their full history and develop that therapeutic relationship. One example of that is a woman that went to see her GP. She looked beautiful, had all her make-up on and looked really good. She tried to explain that she was not that well and he said, 'You don't look that depressed'. Yet when her clinician became involved they realised that she had significant obsessive-compulsive disorder symptoms and that it took her an hour to get out of the house each day. She had lots of rituals that she was going through. She was crying and had never really had any other service be aware of that, so they were able to get in and help treat her with those sorts of things. It did not require hospitalisation, but it did require a therapeutic relationship and some really good work to be done with that.

**Ms McLEISH** — You said that after 12 months you will finish with them — and you will refer them out to where?

**Ms HOYNE** — That is one of the challenges I can talk to you about. Sessions are typically up to eight times at least, but it is tailored to the client and what they want. They work closely with their partners, if partners are interested in being involved, with the different parenting styles, the experience of being parented themselves.

The difficulty PEHP has had, which you are probably also aware of, was that initially they were funded for 3 EFT to cover the whole Gippsland area, and then when funding was reduced, somehow the hospital did not completely cut it to half and it stayed at 1.6, but really those clinicians were just in the east and south-east of Gippsland and supposedly covered the whole of Gippsland, but realistically that was not able to happen. That was around the time that the Agnes unit opened up, but it left Latrobe Valley uncovered as far as a PEHP outreach clinician was concerned, and also Warragul was not covered.

Then in February funding was reintroduced, but it was not at the time ongoing. It was still on a yearly basis, and they were able to recruit to 2.5 EFT. The funding has since been made ongoing, but it is only to 2.5. It has never been returned to the 3 EFT. The problem with it is that they have lost valuable staff. It made the community a little bit wary that you build up with people and then you lose that service, so the new clinician has had to do a bit of work getting back into the services. It is still not fully recruited. There is no backfill for PEHP clinicians; if they go on annual leave or if there is any sick leave, no-one covers them. Then it is just there. Also when it

was first started, there was initial seed funding for those initial clinicians to have some training, which is not ongoing, so clinicians have to really fund anything they want to do themselves.

**Ms COUZENS** — So that was the national funding that was cut in 2014?

**Ms HOYNE** — Yes.

**Ms BRITNELL** — How was it restored?

**Ms COUZENS** — The states funded it.

**Ms HOYNE** — The state funded it.

**Ms BRITNELL** — I did not realise that.

**Ms HOYNE** — So that is Agnes unit three years ago, before the garden grew. We are open from Monday to Friday. The parent is the admitted client, although baby obviously comes in with them. Both parents are welcome to stay, and we do have lots of couples that do stay. Since June 2015 we have been full, now we have a bit of a waitlist which fluctuates between two weeks and about four to five weeks.

It has been really well received. Initially there was a bit of a stigma that it was seen as a mental health unit, that only really sick and crazy people go to that, but we changed a few processes and now it has been embraced by the community. Certainly many of the women that come to it talk about it with other mothers and tell them and recommend that they go in, and there is also the fact that women can self-refer, ring the unit directly, refer themselves in, discuss it with a clinician. They can even come and have a walk around the unit — anything that they want — so that they feel comfortable and they can see how normal it is.

**Ms COUZENS** — Does that include other children in the family as well?

**Ms HOYNE** — We can only accommodate infants up to 12 months of age. It is a barrier that they cannot bring their other children in with them, but having said that, some of these families need to focus on the baby and it is the first time that they have had time to just spend that with baby and a lot of women have said that they have really appreciated that. So some people have not been able to come in because they have not been able to get child care for other children, but for a lot of women it has been very therapeutic to just have a short period of time to just concentrate on that infant.

**Ms McLEISH** — With the five beds, six cots, are those cots attached just to the beds, because you said the patient — or the person who is admitted — is the parent?

**Ms HOYNE** — We can have twins.

**Ms McLEISH** — That is what it is. So do all parents come in with a child?

**Ms HOYNE** — Yes. It is postnatal; it is not an antenatal service.

**Ms McLEISH** — Yes, but I mean they do not leave the baby. You know, they do not leave a six-month-old at home.

**Ms HOYNE** — No. So it is not only about treating the mother, but a high priority is given to thinking and observing the infant and infant development and to helping the parents to think about the infant and think about what their baby might be thinking and that their babies have a mind. Actually that has been a quote that mothers have said as they have been leaving a few times: ‘One of the biggest things I have learned is that my baby has a mind’ — they are not just little blobs that you do things to and because they are babies they will forget things. So when you are talking about family violence and other traumas and things like that, it has been eye-opening to a lot of women to realise that their infants have been affected by these things and some of the behaviours that the infants are displaying have probably manifested from being in disruptive family environments. They were not in the room, but they were hearing things — but some of them were in the room.

That is just a little bit more information about our unit. So mostly they come in for a two-week stay, going home for the weekend in between. Some people have asked: is that disruptive? Is it difficult to go home? But we have found that that works quite well, that they get a chance to work on some things for the first week — a little bit of

a try of things when they go home, and knowing that they are coming back for a second week is quite reassuring. It is flexible. We can stretch it to a three or four-week admission — I think there has been one person that has had a five-week admission — and they do not have to stay for two weeks. They can just do one week if that is what is best for that family, and it may be child care issues that they can only do one week for.

The diagnoses — that might not be via the DSM diagnoses, but that has been how it has been put through. They also — same as PEHP — do not need a mental health diagnosis, but they are the main things that people are coming in with.

**Ms COUZENS** — Would you be dealing with parents who have a disabled child or a child that —

**Ms HOYNE** — We have had some that have had health concerns for their infants.

**Ms COUZENS** — But that is not a specific thing that they could go into this facility for?

**Ms HOYNE** — If they were having issues with enjoying their child or excessive worry around it, they could come in to us for that, yes. We have had children that have had extreme feeding issues, almost verging on getting a tube. So there have been things like that. We have had a child that had significant hearing loss, that sort of thing.

**Ms COUZENS** — I am just thinking, I know of a few cases of children who are brain-damaged and of the challenge for the parents with that and how stressful that is, so I was just wondering whether that links into that.

**Ms HOYNE** — We have not had that specific example. We have had some children where it has been thought, ‘Is there a neurological condition with this child?’, because they have been floppy. Then once we have done the therapeutic work and done play and engaged the mother, the child becomes enlivened and no longer looks like there are spinal injuries there, which has been amazing. That has happened. But no — with specific brain traumas coming in, we have not had that come in as yet.

**Ms COUZENS** — But they would not be rejected?

**Ms HOYNE** — No. It is a low-acuity service, but they can have complex mental health needs, and as I said earlier, there is a strong focus between the parent and the infant. Our model is based on something called the Solihull model. Solihull in England — there is a model that has come across. We are the first unit in Victoria, that I am aware of, that has used this model. It is a model that is a really practical way of working with families but with a robust theoretical structure behind it. The child and youth consultant psychiatrist who gave us advice on how to set up the unit is Dr Julie Stone. She went over to Solihull and liaised with the people who developed this model and brought it back to LRH.

Some people had some training, and then they have done further training for staff in the unit. Most of our staff do not have mainstream mental health qualifications. Most of our nursing staff are midwifery-trained and have then done further training, especially in infant mental health. We have got enrolled nurses who have not got any of that extra training, and we are doing the training on the ward. The Solihull model brings together psychoanalytic theory, child development and behaviourism. It is a really good system that can be used by everybody. I also know that maternal and child nurses in the Latrobe Valley have had some education in it and are starting to use it, and they also use it as a way of thinking about their clients, using it as a discussion model.

The other thing that we use a lot is a thing called Circle of Security, which is a model you may have already heard of. That is also another really good way of working with families, using that.

We do a lot of group work with the families, and things can range from adjustment to parenting, anxiety, depression, how you feel about yourself, how you assert yourself to how you play with babies. A lot of our mums have never had a story read to them or sung nursery rhymes or just played or enjoyed things. So we do a lot of that sort of work as well.

This evaluation was done between November 2015 and October 2015, so in our first year. There were actually 129 admissions at that time. Only 90 were analysed because not all had relevant data, but it just shows where we get most of our referrals. The maternal and child health cohort are huge and we work closely with them, and the self-referrals are really large as well.

**Ms McLEISH** — How has that happened? In such a short period of time to have a third of your referral sources being self-referred — it is pretty extraordinary, I think.

**Ms HOYNE** — That was really in the first year.

**Ms McLEISH** — In a very short period of time.

**Ms HOYNE** — Yes.

**Ms McLEISH** — How?

**Ms HOYNE** — How?

**Ms McLEISH** — TV ads?

**Ms HOYNE** — I did go on local radio for one little segment — the local radio, newspaper. We put out a lot of posters in the maternal and child health rooms and in GP clinics, and we changed them. We changed the posters and we made the focus around sleep and settling and emotions with your child — you are just not enjoying anything. But we did not use the words ‘mental health’, ‘mental illness’ — any of those things. We changed a lot of the language. We stopped saying that it had to go through mental health triage — you could just ring the unit directly. We did a lot of that stuff. I went and spoke at the new mothers groups. I went and spoke to the maternal and child health nurses directly. I did a lot of presenting at different conferences where those professionals were working, so they knew that they were around. Quite a few of the GPs will ask the mums to refer themselves. They will give them the information about Agnes unit and then give it to the mums, and the mothers that are motivated enough and can do it will ring themselves.

**The CHAIR** — Well, it is working, Christine. We have heard a lot about the Agnes unit over the last couple of days. It is very well-regarded.

**Ms McLEISH** — In Bairnsdale as well.

**Ms HOYNE** — We get a lot of referrals from Bairnsdale.

**The CHAIR** — Can I just ask a quick question, because I know I will forget it later. You do not hear of many places that take self-referrals. So I was just wondering — you have accepted 31 per cent of the self-referrals — how many of the people who would front up to your doorstep be assessed and be referred to another service?

**Ms HOYNE** — Instead of being admitted?

**The CHAIR** — Yes.

**Ms HOYNE** — These were all admissions.

**Ms McLEISH** — Who would be rejected?

**Ms HOYNE** — We have not rejected.

**Ms BRITNELL** — Forwarded, I think you mean.

**Ms HOYNE** — Everybody that is a self-referral is really appropriate, so we have admitted all of the self-referrals.

**The CHAIR** — That is amazing.

**Ms HOYNE** — They are very appropriate. They want to come in, and they are motivated.

**The CHAIR** — That just seems quite incredible to me.

**Ms HOYNE** — I think it is a big cohort out there that did not have anything available to them before. They were not sick enough to access other services. They do not necessarily have the money to go to private services on a regular basis, and this service is working.

**Ms COUZENS** — I think they are desperate for it. When they hear the information, they just pounce on it. It is similar in other communities too that do not have something like this.

**Ms HOYNE** — So as I said earlier, that is our staffing profile. That is what people we have. We have quite a small EFT that actually work on the ward nursing-wise. It is usually around two staff per shift, and then we have the allied health specialist people.

**Ms McLEISH** — Is that the psychiatrist?

**Dr THOMAS** — No, it is a different psychiatrist.

**Ms HOYNE** — No, sorry. Dr Vivien Lee. Stuart provides — and I could talk about how we do support staff — clinical supervision and facilitates reflective practice for our staff. It is a really important component of how we work well as a team and how it can work with quite a demanding environment. It was put into our model that the staff were well looked after with having reflective practice on a weekly basis and also personal individual clinical supervision. That is when you get to talk about different families, but one on one with your clinical supervisor or mentor. You can talk through maybe some of the difficult feelings you are having yourself, because if you cannot think, it is very hard to help other people think and look after their children. In-house, these people — the social workers, psychologists and myself — sort of started off running all the groups, and now the nursing staff are very competent at running a lot of the therapeutic groups.

The challenge is to get the staff with the specialty qualifications. We are pretty much growing our own by bringing in the people we think have got the right attitude, and then we develop and work with them. We do the reflective practice and the clinical supervision. With the education it is more than just attending lectures, although postgrad studies are really important. You need to be able to model things, be in a room with someone and show them things, talk to patients and interview patients, and then they have a chance and you can give feedback after that. That works with the group work, and it works with individual assessments. It works with a lot of the sleep and settling work that we do. So it is quite intensive. But we have had some really good staff that have stayed, and we have had other staff that have moved on but they have taken that expertise to other areas, so it is really good capacity building in that way.

We are getting some maternal and child health nurse students. A couple of them have come and done placements with us. We are getting a few undergrad students that are coming and doing placements with us and a few postgrad mental health students that have come and done placements with us as well.

Some of the issues with accessing the services include: who do you refer to afterwards? A lot of the time the women are for the very first time engaged in a therapeutic process and they would like to continue it, and it would benefit them. So who they can go to afterwards is a difficulty in this area. There are limited specialists who can provide parent-infant dyadic work. The PEHP clinicians are fantastic. If there is anything that I can get you to take away from this is perhaps more funding for PEHP clinicians.

**The CHAIR** — That was my first question.

**Ms HOYNE** — They are very cost-effective. But they can get out there, do the work and do it in an ongoing therapeutic way. A lot of the parenting services are doing good work in the community, but they are not set up to do the mental health therapeutic dyadic work. They can do behavioural stuff, but they are not necessarily thinking about how your baby is thinking and working with that, or how you are feeling when your baby is behaving like this — that frustration and working backwards to how we can look at this. There is also just the travel factor for people to get to specialists if they have to go past the Warragul cut-off line, and even just the lack of specialist psychiatrists — there is always a lack of psychiatrists anyway, but specialised in perinatal or infant. It is hardly ever about prescribing medication. It is a lot of therapeutic work that has to be done. That is a real speciality that is required.

I have got a couple of suggestions for solutions. If we had the specialist psychiatrist hours available, we could have a video link with families throughout Gippsland. One of the hardest things for GPs is that you get a secondary consult, but it is just a verbal sort of thing. But to actually see the mother and have an interaction gives a psychiatrist or any clinician a much better idea of what is going on. There should be an increase of the EFT for the PEHP clinicians, because at the moment there are three clinicians doing 2.5 EFT for 44 000 square



kilometres. It is pretty tricky. There is also the possibility of a perinatal infant mental health nurse practitioner specialist. That would also be an adjunct to the area for that sort of stuff.

**The CHAIR** — Stuart, would you like to contribute?

**Dr THOMAS** — I do not know if you have my written submission, whether that reached you, but at any rate, I am an adult psychiatrist with an interest in psychotherapy. I supervise this excellent team. I supervise 2 hours a week. I supervise both the PEHP and also Agnes from a psychological point of view. Because PEHP do not ordinarily have access to a psychiatrist, I also help them think about purely psychiatric considerations in their patients — for instance, if a mum is anxious. I myself do not actually see the patients or the babies. I purely supervise. So I will listen to the case of an anxious mother, for instance. Does this woman reach a threshold for an anxiety diagnosis? How severe is that? Heaven forbid, does she reach a threshold for a psychotic disorder or major depression? If so, then we realise that she will need to be referred to adult mental health. Very often these women are sub-threshold. So you might say they are not strictly psychiatric because they are sub-threshold, but nonetheless there are problems — mental health symptoms and also problems between her and baby, and of course involving her husband.

So I discuss cases with the PEHP clinicians, and I come onto the Agnes ward to do supervision and reflective practice. Christine described it really well. The two examples you mentioned, Christine, really stuck out to me. The first is of a mum who had never had a fairytale read to her or who had never been sung to by her own mother. Imagine the emotionality that that brings onto the ward. It is hard enough having a baby — emotions run high; fancy that you yourself had not been looked after as a baby. So there is this very important transgenerational effect in some of these mums — real deprivation in their own babyhood — and they now have to raise a baby. So emotions can run so high.

These emotions are reported on the ward, and they spill over onto the staff, so the staff need their own space to reflect upon what that really means for them — their own lives may in some way be triggered for them — or just how as a clinician to think about what is going on in the mind.

The other thing I chimed with from what you said, Christine, was that methods and protocols are important and behaviours are important, but also you want to think about what is happening in the mind for mum and baby, and the clinicians can do that very well when they have space to reflect on that.

**The CHAIR** — Do you mind taking some questions?

**Dr THOMAS** — Happy to.

**The CHAIR** — I guess I will start. My first one is to you, Christine, and actually Simon and Stuart as well. We know that in June this year the state government funded LRH for their Perinatal Emotional Health Program (PEHP) for 3 EFT, I think it was. What does that mean for some of the other outlying services? They would not have PEHP anymore.

**Ms HOYNE** — No, I think the LRH was only funded 2.5 EFT, and that covers the whole Gippsland region.

**The CHAIR** — Okay.

**Ms HOYNE** — So the other areas maintained their 1.6, and it has grown a little bit, but they have not been able to fully recruit to it, I think, because people have been uncertain about the insecurity of the position and also the lack of expertise to the area.

**The CHAIR** — I am just reading a submission saying that that funding did not help in other rural and regional areas providing the service whose PEHP teams were forced to close in 2015.

**Ms HOYNE** — The rest of the state? Sorry, is that what you are talking about?

**The CHAIR** — Yes. Sorry, I was probably not clear enough.

**Ms HOYNE** — I do not know what the rest of the state decided.

**The CHAIR** — If it is that valuable here, I was just after a recommendation from you about what we should be doing with that program. Should the state fund it?

**Ms HOYNE** — Yes.

**The CHAIR** — Beautiful. That is all I wanted. I should have just asked that question.

**Ms McLEISH** — Are you sure you do not want to fob it off to the feds?

**The CHAIR** — I do not necessarily want to fob it off to the feds. We have heard time and time again about this being such an important program, and while I am disappointed that the federal government did defund it, I am not blaming any particular side of politics or anything like that. But if we need it, we need it, and I think it is a really valuable outcome from your contribution, and it is important that we get on record that it does so much.

**Ms HOYNE** — It does.

**The CHAIR** — And it is cost-effective and efficient.

**Dr FRASER** — Just to clarify LRH's role, I guess, in the region, although we provide services through the Latrobe Regional Hospital and a lot of our services are provided in the Latrobe Valley, Latrobe Regional Hospital does provide mental health services for the whole region, so there is a perspective that perhaps the PEHP service is only for the valley; it is not — it is for the whole region.

**Ms HOYNE** — No. But you were talking about the whole state, not just Gippsland.

**The CHAIR** — In the end I was. I was just trying to lead you somewhere so it did not seem like I was saying it, but it is out there now.

**Ms McLEISH** — I have a couple of varied questions. Are there any adults referred off to private psychiatry, or is there no private psychiatry in the immediate area?

**Dr THOMAS** — Yes, very little. We will occasionally refer. Of course we make use of private services when possible, but they are few and far between.

**Ms McLEISH** — That seems to be fairly typical — that in a lot of country areas the only psychiatry that is accessed is through the health system rather than people accessing it privately.

**Dr THOMAS** — I can think of maybe three private psychiatrists in Gippsland.

**Ms McLEISH** — Is there a need for more, or is that the demand?

**Dr THOMAS** — Yes, there is, because not infrequently — in general terms, not just speaking about these mums and dads — sometimes a patient could do well with a private psychiatrist and does not necessarily need a public service, which of course has a team and a structure. Sometimes a person could do well with a private psychiatrist, not needing a case manager, not needing assertive follow-up. And it is disappointing when we have to recommend that they try to get in with a local psychiatrist whose space is very limited, or that they have to travel to Melbourne. So, yes, some more need is there; there is more need.

**Ms McLEISH** — Simon, could you comment on PIPER? You have mentioned PIPER and their fear of double transfers, and we have heard that from others. Does it operate as well as it could? What are your comments?

**Dr FRASER** — Yes, I think you are aware that PIPER contains three components: antenatal transfers, neonatal and paediatric. It works well, I think, particularly for neonatal transfers, so when there is a very, very sick baby the ability to mobilise the team and retrieve the baby and take the baby to Melbourne is very good, although occasionally they have issues there in terms of the interface with the ambulance system. Just by way of explanation, I am not only a paediatrician but also a neonatologist, so I have a good understanding of the area.

There certainly has been for many years a very strong commitment at a state level that if there is a tiny baby that needs to be retrieved, they will retrieve that baby and they will find a bed, and it is PIPER's responsibility to do

that and they do that very well. Sometimes there can be a little bit of *Ring a Ring o' Rosie* with antenatal transfers, which is very frustrating.

So as a user of the facility if you have got, say, a woman who is 27 weeks, she is dilating, she has got threatened premature labour, from Gippsland she has to go to Melbourne, to the west, and sometimes hours are wasted trying to find a bed. The ambulance often will not take the woman until there is a destination. I think that needs to —

**Ms McLEISH** — So they do not get an hour and a half down the road first while they are looking?

**Dr FRASER** — No, that is right. I can certainly anecdotally think of a couple of cases where we have thought, 'Well, let's just get the woman on the road, and if it's going to take an hour and a half to find a bed, she'll be in Melbourne by then and you can decide where the mother's going to go'. There is very good evidence certainly from work done in Victoria that the tiny baby outcomes are better if they are born in tertiary institutions.

What I was alluding to before, and it sounds like it has clearly come up from other speakers, is better coordination of intra-regional transfers. We do have transport incubators, one at the Latrobe Regional Hospital and one at Leongatha, and they are good for mildly unwell babies that might need transfer from one hospital to another and that do not need a nursing or medical escort. It is the higher level that —

**Ms McLEISH** — Does PIPER do those intra-regional ones?

**Dr FRASER** — No.

**Ms McLEISH** — Who does those? Ambulance?

**Dr FRASER** — The ambulance, yes. So I think there needs to be a better commitment to facilitating or coordinating intra-regional transfers.

**Ms McLEISH** — I have got just another one. LRH is level 5 maternity, level 4 nursery. Roma and I visited Warragul hospital today — they presented earlier — and they are a level 4, maternity level 3. Regarding the difference in the premature babies you will have in the birth weights and BMIs, there was not a huge amount of difference. Should there be a greater difference? Should your capacity be higher?

**Dr FRASER** — That is a very good question. I guess with the eight services in the region at the moment we are the only level 5 maternity. I think there is a strategic intent with time by DHHS for Latrobe Regional Hospital to become a level 5 neonatal.

**Ms McLEISH** — I was going to ask: what would that take?

**Dr FRASER** — Basically the difference is down to 31 weeks, 1300 grams, but probably most importantly the ability to provide intravenous parental nutrition to babies until their gut is ready and able to take nasogastric feeding.

**The CHAIR** — Sorry, Simon, is that making LRH a NICU?

**Dr FRASER** — No. NICUs are level 6. What is required there would be high levels of care, education for doctors and nurses looking after babies to be able to put in percutaneous long lines — to be able to provide that.

**Ms McLEISH** — So it is the expertise of the staff. What about the resources?

**Dr FRASER** — It can be the staff resources definitely.

**Ms McLEISH** — And the equipment? Is the equipment —

**Dr FRASER** — Probably the equipment — not necessarily. The baby requiring parental nutrition needs infusion pumps et cetera, but the equipment needs are not paramount; it is more expertise of staff and having staff who are able to look after smaller babies with more complications. There is still a need if a baby requires ventilation or intensive care for them to go centrally. My opinion is that I think it needs to be and is well

concentrated in Melbourne. Again, in the submission, and I think it has been recognised, there is a need for another NICU, but not in a regional setting.

**Ms McLEISH** — But there is room for LRH, for example, to be a level 5 nursery.

**Dr FRASER** — Certainly I think strategically that would come with time.

**Ms McLEISH** — And that would assist all of the valley. I imagine when we hear about the transfers and things that would go past you in case you would have to double back — if PIPER do not come to you and then they have to move somebody a second time, if you have that —

**Dr FRASER** — That is right, and not just the valley but the whole region. I think in an ideal situation a baby who is down to 32 or 31 weeks, irrespective of whether they are born in Gippsland, down to 1500 grams, if it does not need NICU, it would be great if LRH could provide that service rather than the baby going to Melbourne. We have been working with our intraregional partners to try and develop that. Part of that will require more cots. At the moment Latrobe Regional Hospital has six. We will be increasing to 12 in the next 12 to 18 months. The advantage of concentrating that level of care is a 32 or 33-weeker might need some respiratory support for a few days. Once they are on full feeds, they can transfer back to Sale or Bairnsdale or Warragul or Leongatha for a few more weeks until they go home.

**Ms McLEISH** — But it would keep the baby in Gippsland?

**Dr FRASER** — Definitely, yes.

**Ms COUZENS** — Most of my questions have been answered, but I have one question. Really it is for Christine around the Agnes centre. Firstly, thank you for coming today, all three of you. It is greatly appreciated. I think the Agnes centre to me sounds like a great intervention to stop some of these women escalating in their situations, which is desperately needed. I am sure you probably have data on how it has progressed during the time it has been operating, like what happens when mum goes home with baby and partner. What happens after that? Do you have any way of measuring the success, I suppose?

**Ms HOYNE** — No. What we do for follow-up is every family gets a phone call two weeks later, and it is mostly around making sure that they are linked in with the services that we hoped they would be linked in with, and if there are any issues around that, we do the ringing around and just try to find out what is going on for those families. We send very detailed discharge letters. We give one to the family so they know exactly what has been written, and we send it through with their permission to all the services that they are involved with. We do, if required, multidisciplinary team meetings with other services — get other services in — but we have not actually done any ongoing survey. It has been discussed what we could do to evaluate it. People say, ‘How do we evaluate an infant’s improvement?’, and a lot of it is anecdotal. There is no actual tick box, quantitative things that you can, say, give it a score system of how it has improved.

**Ms COUZENS** — I think it would be really valuable to have that.

**Ms HOYNE** — I do have copies here of the report — that evaluation — that we did that I spoke about before if you would like those. But, yes, it should be in the next one.

**Ms COUZENS** — So you do plan to build on that?

**Ms HOYNE** — How to do it is the part that we are a little bit stuck on at this stage.

**Ms COUZENS** — It could be difficult. Okay, thank you; I think it is fantastic.

**Dr FRASER** — Just to add to what Christine said, as a paediatrician and particularly with a population of patients that is predominantly under five, the ability to refer women or parents and babies to Agnes and to see the outcome and the improvement that is made is incredible, and I will not go into anecdotal examples. I think we are very fortunate, certainly in Gippsland, to have the unit. I worked at the Mercy Hospital for Women for 12 years, and they have got a very good mother-baby unit there, but the waiting time when I was there many years ago was weeks to months. As Christine said, two to three weeks is very good.

**Ms BRITNELL** — I have just got a question for Stuart. There was talk about the need for psychiatrists. There has been a long history in Victoria of a lack of psychiatrists in the regions. I am actually not too sure about in the metropolitan areas, but it is certainly in the regions. Is it a supply and demand issue that the college is not producing enough? Is it not getting enough out into the regions because of the lack of interest in wanting to live in the regions? What do you see as the challenge? How do you see that?

**Dr THOMAS** — I am not the best person to answer your question, but I think psychiatrists are busy everywhere, including in the metropolitan area. I think that is the first issue. Then psychiatrists will come out to rural regions if there is a particular interest they have — a particular training, a particular personal link to the region. I think it is just very anecdotal in each case. But I think psychiatrists are probably busy everywhere. As for the overall numbers, I do not think I can speak to that. I think it is going to be very anecdotal for each practitioner. I, for instance, have family ties with the region, and so I am pleased to come out each week, but I think it is probably very individual.

**Ms McLEISH** — So are you based elsewhere for the majority of the time?

**Dr THOMAS** — Yes. For the rest of the time I am in the CBD doing general psychiatry and psychotherapy. It is just something I am pleased to do, but for personal reasons in addition to the interest in the program.

**Dr FRASER** — Just in terms of workforce, I have worked at Latrobe Regional Hospital for nearly eight years and, prior to that, was the medical director in Warragul for five, and certainly my observation is psychiatry is probably the last craft group where we continue to have trouble recruiting not just into the private areas, as Stuart indicated, but into the public domain. My feeling is I think we will not be able to have adequate recruitment in regional areas until metro is saturated. I have certainly seen that in other craft groups, where we are getting good clinicians now — not probably because they want to live and work in the country but because the staff jobs are all taken. The ability to set up a lucrative private practice is saturated.

With all due respect, I think for many psychiatrists the ability to earn a very good income in private practice precludes public work. We have still got a very significant reliance in the region on international medical graduates who are only able to get work in the country because of moratoria et cetera. I think it is a complex area.

**The CHAIR** — Thanks, Simon. On behalf of the committee and the Parliament of Victoria I thank you for your time today. I very much appreciate it. We understand you are very busy people and you could be in private practice, Stuart — a lot more dollars than you are right now sitting in front of us — but we certainly rely upon your opinions and your knowledge and experience today, so thank you so much. We appreciate it.

**Dr THOMAS** — Thank you very much.

**The CHAIR** — And thanks, Christine, for helping the doctors out and keeping them afloat. I will close the hearing. Thank you, Hansard; thank you, secretariat; and thanks, committee.

**Committee adjourned.**