

TRANSCRIPT

FAMILY AND COMMUNITY DEVELOPMENT COMMITTEE

Inquiry into perinatal services

Melbourne — 16 October 2017

Members

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Professor Louise Newman, director, Royal Women's Hospital Centre for Women's Mental Health and professor of psychiatry, University of Melbourne.

The CHAIR — Welcome, everyone, to this public hearing of the Family and Community Development Committee's inquiry into perinatal services in Victoria. This is the fourth hearing to be held by the committee for this inquiry in a series of hearings that will be conducted in Melbourne and in regional Victoria over the next few months. Last week the committee visited Warrnambool, and next week the committee will hold hearings in Bendigo and Wangaratta. Please see our website for details.

These proceedings today are covered by parliamentary privilege, and as such nothing that is said here today can be the subject of any action by any court. Please note that the broadcasting or recording of this hearing by anyone other than accredited media is not permitted. Today we also have the Parliament's broadcast team here, who are filming the hearing. All mobile telephones should now be turned to silent.

I welcome to this public hearing Professor Louise Newman, professor of psychiatry, University of Melbourne, and director, Royal Women's Hospital Centre for Women's Mental Health. Thank you for attending here today. All evidence taken by the committee at this hearing 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 invite you to make a 10 to 15-minute statement. You are an old hand at this.

Visual presentation.

Prof. NEWMAN — Yes. Thank you very much for having me back again. Today I would like to give an overview, as in our submission, of the work in mental health specifically that is going on at the Royal Women's Hospital, the Centre for Women's Mental Health, of which I am the director. This centre was established in 2007–08 with initial funding from the Pratt Foundation, a family that had been intimately touched by issues of postnatal depression. That was a significant contribution that actually allowed the setting up of what has now become Australia's premier centre in research, training and clinical services in the area of women's mental health. We also now have a significant international reputation, particularly in terms of our translation of research.

The centre is multidisciplinary, obviously with psychology. Our director is Lesley Stafford. We also work very closely with allied health, particularly social work and nursing. I hope to argue for the importance of having a more integrated approach to mental health within maternity services and to make some comments about possible directions. Our focus at the centre is outlined in a document which is also available, *A Mental Health Enhancement Strategy*, which we have been working on within the Women's, which essentially outlines our aims to better integrate mental health. We are very much of the opinion that there is no health without mental health and that a prevailing problem has been, if you like, the isolation or seclusion of mental health from general health services, particularly when we are thinking about women, infants and families at these crucial times. I think it is actually very important that we move beyond that and look at health in a much more holistic way. Our model is very much about integrating health into the range of medical and maternity services that we offer.

We very much see ourselves as targeting vulnerability and providing clinical services, greater expertise and advocacy for some of the very vulnerable groups of women and infants that we see. That would include women who have experienced mental health issues but also women with current issues such as domestic violence and other social factors — drug and alcohol abuse. We have specialist programs for young mothers — and by young I am saying we see some of the youngest mothers in the state, who might be 12 or 13 years of age, a particularly vulnerable group. We have a multicultural population coming to our hospital, and we see a certain percentage of the state's asylum seekers and refugees, including women from Nauru who are in the community currently as a result of needing mental health treatment. Homeless women are over-represented. We certainly offer a range of services from the acute to very focused for these vulnerable groups.

We are a training centre, which has been a very important part of our work, but we face certain challenges in advancing this sort of model. Firstly, we are seeing an increasingly complex range of mental health problems, complex social needs and overall more acute presentations. We need to be able to provide some urgent response and emergency care, and there is a limitation over all of community services — and I am including in that mental health services.

One of the prevailing issues, which I will address, is the lack, as I see it, of expertise in these issues within general adult mental health services. I can give a concrete example of a woman I saw last week who had bipolar disorder, who walked in off the street at 36 weeks pregnant. She was acutely psychotic. There was great reluctance in the adult mental health services to see this woman, largely because of concerns about the fact that she was so many weeks pregnant and obviously that needed to be cared for. The women's hospital does not have gazetted mental health beds, and no mother-baby units had any beds available to take this woman. She ended up spending about 8 hours in a very acutely psychotic state in an emergency department, which in my opinion is not adequate for a woman in that condition. Fortunately her outcome has been, with medication, quite reasonable, but she is someone who I think typifies some of the issues that we are facing.

We have those challenges, but we also have, I think, a very important role in thinking about increasing the capacity of the system to better identify those in need and to provide models for early intervention for both parents and infants. Part of the underlying philosophy of our work is that not only are we treating mothers and families affected by mental health issues and other problems but we are also thinking about the infant and infant development. Support for early parenting and transition to parenting for vulnerable women during pregnancy but also actual early parenting programs such as the ones I will mention briefly are very important. At the moment we have an overall lack of capacity in general community services to provide these sorts of programs. It is certainly not our view that these things should only be offered in hospitals. I think the very important next stage is to better integrate early intervention and evidence-based approaches into the community where people can actually have their services in their local community health settings and to work with groups such as maternal and child health nurses and other community providers in being able to provide these sorts of crucial interventions.

In terms of education, we have a model that is very much focused within hospital settings — I think this applies to all maternity services across the state — on wanting to upskill everyone in terms of the workforce in recognising and responding to mental health issues.

We think people such as midwives and direct care staff — maternity staff — have a crucial role in better identification of risk and then integrating that with a mental health service response. We offer specialist programs in our setting for mental health professionals, and we are offering some training in programs that are mentioned in our submission, particularly the NBO, or the newborn behavioural observation, which is a very accessible technique for working with new parents to teach them about the social capacity and communication strengths of their baby. The aim of those programs is to build up people's understanding of how infants communicate and to support the development of early parenting. We have now trained over 670 — I think we are up to 673 — professionals from all disciplines around Australia in that sort of approach. The women's hospital is the sponsor of NBO Australia, which is part of NBO International. We are doing research in this area as well to see whether teaching parents about infants improves relationships and helps reduce the rates of things like postnatal depression and anxiety.

The other program mentioned in the submission, which is a very large program at the moment, is Parenting with Feeling, which is a program for mothers and infants — babies from two to 12 months of age. This is a program that is now being rolled out and is the subject of a fairly large randomised controlled trial. Again this is targeting women with the sorts of risk factors I outlined. Where there are potential difficulties that a parent might face in terms of parenting, the relationship with the infant, we are offering enrolment in a program which is a 10-week group program. We can see five to six dyads, mothers and infants together, over that period of time, and we are doing some longitudinal research to see whether this improves relationships and child outcomes. I have also run this program in New South Wales, where we demonstrated in some research there a four times reduction in the involvement of child protection in some of these high-risk relationships for documented maltreatment. This is very significant data, and we are looking at replicating and being able to look at these results in more detail.

We know a lot, and I will not repeat this, around the rates of mental health problems. Our centre of course offers mental health services for a range of issues across the life span. I guess there are some particular developmental periods which are very important. I mentioned adolescent pregnancy because that certainly is an issue needing specific expertise — a difficult group sometimes to engage, so it is important that we have better approaches to forming positive relationships with young women. Again the challenge remains of looking outside of the hospital setting and what sorts of follow-ups are going to be available potentially for women with these risk factors in the general community.

The area of domestic violence and responding better to domestic violence in pregnancy is certainly something that is very important across the state and in our hospital at the moment. The Royal Women's Hospital is the lead in terms of the Strengthening Hospitals Response to Family Violence strategy. We are doing research in terms of interventions for women who are identified during pregnancy as experiencing risk or directly experiencing domestic violence. That is the Safe Mothers, Safe Babies program mentioned, which is also a group program using the sorts of approaches that we are investigating at the moment.

Multiculturalism I mentioned, particularly the needs of young women who are asylum seekers and refugees.

Our work currently is supported by Liptember and, underlying that, Chemist Warehouse. We are, to make the point, obviously grateful to them, but we are dependent on philanthropic funding for our work. I think this raises the issue of the funding of these sorts of services within general hospitals. We are technically what is known as a consultation liaison mental health service. We have some funding from the department of health for some of the medical and establishment positions, but that only covers a proportion of what we actually provide, particularly in terms of outreach and early intervention. All our research is soft money, so that is largely philanthropically funded because of the difficulties of attracting research funding in some of these areas. This is a major issue in terms of hospital budgets at the moment as we are really looking at increasing demand with funding that has remained static in terms of the hospital since the centre was established a decade ago, and the reliance on temporary staff poses some challenges in terms of forward planning.

We aim to improve our approaches to prevention and working with so-called high-risk relationships, as I outlined. We have an approach which aims at improving parents' understanding of infants' needs and basic parenting skills. There are patchy parenting programs around the general community. Ours are very much focused on some of these higher risk groups where there is a paucity of research evidence, which is what we are attempting at the moment to grow.

Our programs overall come under the umbrella of what we are calling BEAR — Building Early Attachment and Resilience — which is a large collaboration in terms of research and activity at the moment with the Mental Health Foundation of Australia, Resilience Australia, our hospitals, two universities, the Pratt Foundation and Liptember. These sorts of collaborations I think are increasingly important in the field in terms of trying to grow the evidence base. We have outcomes that we are particularly interested in, but we are focusing on infant attachment and development, child safety and a reduction in the rates of families involved with child protection for serious concerns about child maltreatment, and better experiences for parents in terms of reducing parenting stress and rates of depression. I cannot stress enough the importance obviously of getting in early with these sorts of approaches rather than needing to wait until people present in crisis. We do know a lot more about risk factors.

So the focus on infants I think is something that may be unique in our approach. We also do research about the impacts of parenting on infant stress regulation and infant brain development — that is from a science point of view. Importantly we do translational work, which means actually taking some of the science of what we know about early infant development and communication and embedding that in the programs we are developing.

These programs, it should be said, have very high rates of compliance. Parents enjoy the programs. They enjoy the focus of learning about their baby's skills. That is very acceptable, particularly for some groups who are traditionally seen as difficult to engage. Some of the young mums are very actively involved in these programs. I think we take a very non-judgemental stance and talk to women quite openly about their desire to parent effectively even in the face of adversity, and I think that is an important approach from a social policy stance to be able to adopt.

This is one of my experimental babies — a healthy, happy infant, obviously. These women have been, to give them due credit, very keen to engage and support research efforts at the university. There he is again. I always show him because he is a nice baby. He is involved in the Parenting with Feeling program as I mentioned. We use the NBO, the newborn behavioural observation technique, within that program as well and also in our Safe Mothers, Safe Babies program. That is because our approach is very much integrating hands-on parenting skills for the parents we see. Violence I mentioned.

In conclusion, I am happy to take any points of discussion. I think we face major issues in terms of better integrating across maternity and hospital services but also in the community and our mental health approaches for vulnerable mothers, babies and families. Within the hospital we need to focus on upskilling and empowering

all staff with the skills to better recognise risk in the antenatal period, as the first step, and then also postnatally. So we do not see ourselves as wanting to remain purely a reactive emergency driven response, but rather one that supports screening and identification of things like anxiety, depression, social risk factors and very importantly domestic violence and the risk of domestic violence, which is something that we are involved in at the moment.

All our maternity clinics at the Women's Hospital, and I think this is an important model to look at, should have and do have, in our setting, mental health staff actively involved in attending all those meetings, hearing about all new cases coming through where there are particular issues so as to better integrate mental health care right from the beginning — so having mental health staff not just called upon as someone else identifies a need but being an active member of all those medical teams. We also then get to advise about some of the complex and ethical dilemmas that come up where there might be concerns about the health of a mother or the health of a baby, and as a large hospital we would see women with major issues such as the diagnosis of cancer during pregnancy and so on. I think we offer that expertise. We see mental health as needing to be much better seen as not an add-on but an integral part of physical health care.

The issues then on a statewide basis I think relate to how we better have follow-on and the stage following discharge from hospital. At the moment we have limited mother-baby beds, as the committee is well aware. We have significant waiting times. Some of those units are not 24-hour, seven days-a-week units but offer a Monday to Friday service, which changes in a sense the sorts of patients and women who may use that service, who might in fact prefer to have community-based programs and not have to have an admission.

So I think there needs to be some overall review of the functioning of those units — the strategy. Obviously we do need beds for acute mental health problems, and we face the issue that public sector adult mental health services might be underskilled in terms of recognition of parenting problems and infant issues, have some reluctance in treating women with perinatal major mental disorder and not be competent in having a pregnant woman or a woman close to delivery within an adult unit. In many ways some of the adult units are not what we would ideally want, given the acuity of problems they face for a woman who is mentally disturbed. We certainly would not and do not admit babies to those units. So we have that problem.

We also have the issue of a lack of step-down or day program facilities on the whole tailor-made for the severe mental health problems, and we have patchy access across the state at the moment. We are recommending, as you might note in our submission, a strategy for actually developing a better comprehensive model for this integration that can progress the issues that were very importantly noted in the 10-year mental health plan, but at the moment we do not have a mechanism. We did have a committee previously which went into retirement for reasons that are not totally clear, but I think now that we are facing some significant challenges and we have opportunities to better integrate what we are doing, it might be very important to reconvene an expert approach.

The challenges are significant, but I should say positively that we have huge interest in the work we are doing. We have huge interest from trainees from various disciplines. It is very positive work to be engaged in. We are attracting junior trainees across the disciplines wanting to gain expertise. I think the workforce issues may be compared relative to other health areas. We have the opposite problem of not being able to provide enough places, so in terms of growing the workforce we need for a healthier community I think we have something to contribute.

The CHAIR — Thanks, Professor, for your presentation. Are we able to get a copy of the presentation?

Prof. NEWMAN — Yes, certainly. I will leave it.

The CHAIR — I would like to start with a question based upon what you have just finished talking about. You obviously recommend that the state government develop a perinatal mental health plan. Can you tell us the main facets of this plan, and also how it relates to the 10-year mental health plan?

Prof. NEWMAN — Yes, certainly. Thank you. The 10-year mental health plan certainly recognises the importance of mental health during this period and provides a case study of a woman who needed acute mental health care, so there is that recognition. However, I think in terms of progressing that, we do not at the moment have a strategic plan that looks at some key elements. One would be the spread of services that we need, the different levels of service, and how better to move maybe beyond a model that has a few very limited beds for acute issues to one that can better integrate prevention and early intervention and link that to community.

At the moment we have multiple government departments and agencies involved in providing services ranging from education for early childhood services, where maternal and child health nurses would sit, for example. We have a significant NGO sector doing a lot of the work. We do not have a body that actually looks comprehensively at how these sectors can work better together, let alone a statement of what the overall aims are.

So currently we do not have much at a state level. Certainly some national groups are looking at this, like AICAFMHA, the Australian Infant, Child, Adolescent and Family Mental Health Association. How do we better coordinate these sectors to have a true program that we can then evaluate of early intervention and prevention? We have certain project-driven processes at the moment. Domestic violence is maybe one example that I could give to clarify that. We are certainly interested, and there is a lot of work going on about screening and identification. The royal commission identified the importance of screening in pregnancy. About 20 per cent of new cases of domestic violence start in pregnancy. Anxiety and stress in pregnancy are related to very poor neonatal outcomes, including premature delivery, small babies and developmental problems. This is a really very significant and quite a good, robust finding.

However, yes, screening is one part of the issue. What we do not have at the moment is a strategy that is looking at what actual mental health and supports these women need if they find themselves in these situations, let alone what babies need if babies are born into these high-risk relationships, when there is a body of evidence that suggests that child development and outcome are very much adversely affected by exposure to violence, as one would expect. So I think the challenges are to move away from the rather fragmented approach that we have at the moment.

Our recommendation really I think is saying that without that planning process we run the risk of having very important initiatives but not integrating them into a whole that is likely to impact on what we really want to influence, which is quality of parenting, safety and the mental health needs of women, and also then neonatal outcomes and better child outcomes.

Part of the strategy that we need I think is a statewide approach to education and rolling out the evidence base across the disciplines. I am certainly not saying this is an issue purely for mental health, let alone psychiatrists; it is not. This very much needs to be grassroots, community led, using the expertise of groups that do a lot of direct work with women and with babies and families, particularly maternal and child health nursing — a very important part of the workforce — but other mental and allied health professionals in the community.

We are lagging behind in terms of training in some of the evidence-based approaches, so at the moment the sort of approach you get really depends on where you end up, what a particular service or practitioner might practise. I think we could really look at developing some clinical practice guidelines in the area of early intervention parenting approaches and doing some more critical analysis of what the evidence shows us.

If you look at the number of parenting interventions out there — a colleague of mine is keeping a running tally — we are at about 250 programs internationally, the majority of which are not targeted for some of the risk factors that we actually see in the real world and in clinical practice particularly in hospital settings, and the evidence base is rather patchy. I think if the state is going to invest in some of these programs, we need to be able to demonstrate that we have the evidence that they are actually going to lead to positive outcomes.

The CHAIR — Absolutely. Thanks, Professor.

Ms McLEISH — I must say I am so impressed with what the Centre for Women's Mental Health has done in 10 years. It is really quite remarkable.

Prof. NEWMAN — Thank you.

Ms McLEISH — I just want to follow up from what the Chair spoke about. Earlier you talked about the early intervention in the community with the mental health approaches. Can you talk to us about how you see that looking — how that would happen?

Prof. NEWMAN — Yes. Some of the work obviously has been started. We have at least over the last 10 years had a greater recognition particularly at community primary healthcare level, among general practitioners and others, particularly in the area of postnatal depression and anxiety. That has been important. I

think, though, that has been one element, so the screening and identification issue, but what we really have not had at a community level is more in the way of access to a range of family-centred but acceptable services for people who want this sort of treatment and support in their own communities. That is obviously an issue that we face around Australia.

We have certainly put a lot of emphasis on, particularly in primary care and general practice, better screening and identifying awareness programs, and some community programs that have been very helpful with what help might be available if you are suffering from or experiencing depression and anxiety. I think the missing piece of that jigsaw — again, sorry to keep re-using the word ‘integration’ — is how do we actually follow on from some of that identification so that we are offering more than maybe reassurance and medication prescription, which might be needed for some people, into actually looking at the other component, which is parenting and child development. So in terms of the parenting approaches in early intervention we actually have a rather incoherent approach to that, with some areas having some services and others not.

The other thing we need to do is to look more closely at people’s needs when they might have had some time in a hospital setting and they might need additional support in the community where that is not readily available. That is what I mean by step-down programs or potentially day-stay programs where that is the aim of those programs.

Ms McLEISH — So how is that going to happen? That is probably more the question, not what needs to happen but how do you get there.

Prof. NEWMAN — I think stage 1 would be to review the existing mother-baby units and clearly define those who were doing tertiary level mental health inpatient stays for so-called serious mental illness, where you would need psychiatric expertise. Fortunately those are not the most common disorders that we see, but we certainly need those beds. I think we have lack of clarity about maybe some of the units at the moment, where we are not clear and they are not staffed, let us say, to take that degree of acuity, but they are maybe not offering enough in the way of programs that would actually meet the need of the next tier down, which is parenting support and psychological programs to help women. That is a different level of service, if you like.

I think the other step that we also need to better integrate is where the community health services, in linking to our existing system of home visitation — maternal and child health nurses and also our very important NGO groups like PANDA — can actually work on some of the evidence-based interventions, so filling that gap in terms of better access to services for people who might not need or want any form of day stay or hospital.

I think what we have not got is the map of the service levels. That is maybe what we should look at, and we have population data that can help guide us. We have suffered in the state with a decrease in the number of mother-baby unit beds overall, and that has led to waiting lists that are frankly not manageable, where we might say to someone, ‘Well, yes, you are acutely mentally ill. You are at risk, your baby is at risk, but you might have a three-month wait’. In those situations of course we have to separate mothers and babies if it is indicated on the grounds that the mother needs urgent treatment, and that is not how we would like to be able to work.

Dr CARLING-JENKINS — Thank you, Professor, for coming in today and for the comprehensive submission that was given to the committee from the Royal Women’s. I note that a lot of this is around — you have got a real vision — systemic issues that you have identified, and there are a lot of recommendations in here that are statewide recommendations, which is very impressive.

I was kind of disturbed when you spoke in your presentation about the ad hoc parenting programs. We see this a lot in welfare, but it is quite disturbing in this particular area. I just want to ask a quick question about one of the notes you have on the side. You said something like there were infant-led interventions. I come from disability, where we use ‘person-centred’ a lot. Can you just step me through what infant-led interventions would look like? I love that term.

Prof NEWMAN — Yes. I guess it is a technical term in some ways, but I think it is trying to explain the focus of a lot of the work that we are doing, and where the evidence, in terms of the research, is heading at the moment, which really outlines how important it is for the parent to understand that babies and infants actually have their own developmental needs and agendas; they have got skills in communicating. We need to support parents in developing better understanding, at one level, of how infants communicate and how to get that relationship right with the baby, rather than the parent imposing a particular model that they might read about in

a book or learn somewhere that says, 'We must parent in this way'. Sometimes people who are anxious clearly want advice: 'How should I parent this baby? What should I do?'

Dr CARLING-JENKINS — They want a formula.

Prof NEWMAN — Yes. They like that. I mean, obviously people are looking for the right way to do things. That is understandable. But what we are trying to do is broaden out people's understanding. So the NBO, for example, very much operates in that sphere. It takes the baby and the mother together, or the parents together, and teaches them about, 'Well, your baby might be doing this. These are the capacities of babies from very young' — these are from neonates, so they are very small — 'how they communicate and what they need'.

That is generally what that term means, as opposed to interventions which are mainly behavioural interventions or educational programs: teach the parent what to do. The trouble with the teach-the-parent-what-to-do-approach is that there are many of them. No one formula suits all parents or all infants, particularly when there is vulnerability or risk factors that we work with. I think it is important to build up the more important skill about understanding infants. A lot of our work is that fine-tuned work about what babies do. We do a lot of videoing for parents of them and their baby to help them understand how babies communicate and develop their own skills, and that is part of our program.

Dr CARLING-JENKINS — Excellent. So that is best practice now in terms of research?

Prof NEWMAN — Yes.

Dr CARLING-JENKINS — Fabulous; thank you very much. I notice one of the recommendations in your submission as well was around appointing an expert reference group to advise on the implementation of a broader model and the plan that we were speaking about before. Could you just expand on who you think should be part of that kind of a group?

Prof NEWMAN — Yes. Look, at the moment we see it as a fairly broad group, in a way, to pull together some of the expertise that we do have from obviously the mental health sector, but specifically people who work in perinatal and infant mental health, so representatives from both the research point of view but also the clinicians and the major clinical units. We have our unit. We have units also doing research about parenting, like Judith Lumley, for example. We have some of the groups, such as Deakin, looking at early social and emotional development. We have Murdoch Children's Research Institute.

Those of us who do this sort of work tend to work with others across those organisations, but we actually do have in this state a huge amount of work going on and people who have done this sort of work, including some of the long-term longitudinal work about child development for many, many years. We have the longitudinal studies of child development, which are over 20 years worth of work, and yet we do not have a formal way of getting together to better offer and advise government and policy makers on the sorts of issues. That would be one component.

But more broadly than that I think it is important to look at the community sector and other professional groups, and also the NGOs working in the area, particularly when we are looking at the possibilities for training, upskilling and the introduction of more evidence-based approaches into the general community. At the moment there is no single forum that actually pulls those groups together.

Dr CARLING-JENKINS — Fantastic. Thank you very much for that recommendation; I appreciate it.

Ms EDWARDS — Thank you, Professor. Thank you very much for your submission as well and for your presentation this morning — very informative. You mentioned your funding during your presentation.

Prof NEWMAN — Yes.

Ms EDWARDS — Can you tell me where you receive funding from?

Prof NEWMAN — We have our allocation within the general hospital budget as a consultation-liaison-mental health service, which covers some of our staff establishment, but particularly our —

Ms EDWARDS — So that is from both the state and federal governments?

Prof NEWMAN — The majority of that is state. We then have philanthropic funding, which covers obviously both direct research costs, research staff and also clinicians who are providing the group programs that I am talking about. Having just looked at the figures, for the purposes of the hospital budget, about 60 to 70 per cent of our clinical activity is actually funded by philanthropy as opposed to hospital, which is an ongoing issue given the lack of certainty that we all face as researchers in terms of research dollars. That is a year-by-year proposition.

We are very keen at the moment in actually researching a model for, as I mentioned, introducing these programs into a day program, which I might be able to do if I am fortunate with philanthropic funding. But I would not be in a position to do that if I was reliant on hospital funding at the moment. This is very difficult because of the lack of capacity to do some of the more longitudinal work that we would like to do. Now, if we are fortunate, we get more research grants. That is the situation at the moment.

Ms EDWARDS — Do you receive commonwealth funding through the National Perinatal Depression Initiative?

Prof. NEWMAN — No, we do not.

Ms EDWARDS — Also, what about the perinatal psychotropic information service?

Prof. NEWMAN — That was commonwealth funding. We now have some state funding covering some of that, and so that was to the hospital. We oversaw that, and that was a very useful network to have.

Ms EDWARDS — You also mentioned a number of clinicians that you have. I just wanted to ask a little about the workforce: what types of clinicians you have there, what the length of training is and where the gaps are in service delivery.

Prof. NEWMAN — To look at government-funded positions at the moment, we have my position, which is maybe half-funded by government money and half by research funding, because I am a joint appointee — I have a full-time university role as well — and that is fairly standard. We have minimal staff establishment funding. I have one FTE clinical psychologist, and the rest of psychology money is largely research funded. I have two psychiatric registrars; they are advanced trainees in psychiatry who are in their final year of training. We have funding for two of those positions. They are largely running the acute side of a service within the hospital, so emergencies, the use of the Mental Health Act, medication and so on, so the very severe end of the spectrum. We have a consultation liaison mental health nurse — a very important role within our service — who triages and gives basic mental health advice across the system within the hospital and related community services. That is a full-time position; that is an essential position. We have some administrative time.

In terms of other positions that I have, those have been funded out of research dollars. I have a clinical psychologist working on domestic violence and mental health programs, Safe Mothers, Safe Babies. We have a joint position with sexual assault services to provide mental health advice and case consultation for women who have experienced both childhood and current sexual assault, which is a very important risk factor. We would see those women during pregnancy and in early parenting. We have a day a week of a psychiatrist looking at our women's alcohol and drug service, so some of the very high-risk women across the state, often women affected by ice use during pregnancy, with major psychiatric issues related to substance abuse and huge risks for parenting and babies. That is actually quite a low EFT to provide a backup service for them.

We have a series of some philanthropic funding looking at women with cancer. Increasingly with younger women with cancer diagnoses we are providing services for pregnant women who might either be pregnant or find that they have a cancer diagnosis during pregnancy, which is obviously very medically complex and very stressful. We are helping women who might have limited life span related cancer to deal with parenting and the whole issue of how to talk to children, particularly young children, and let them know about the diagnosis. All of that is at the moment philanthropically funded.

Ms EDWARDS — Where are the gaps in your service in terms of the workforce?

Prof. NEWMAN — Overall, to put it in a sentence, the gap is that demand is outstripping what we can actually provide.

Ms EDWARDS — Or the psychologists.

Prof. NEWMAN — Yes, largely for psychology. We need a certain amount of hours of psychiatry because some of the issues that we deal with are at that end. But I think the major gap is in psychologists, who are a very skilled workforce and very appropriate for the majority of issues that we see, but also mental health nursing. At the women's hospital, other than my triage mental health nurse position, there are no mental health staff within the general hospital. So when we have a woman who has got a postnatal issue or anxiety during pregnancy who is in the hospital, we actually have to call in external staff, which is a very expensive enterprise because they are on-call staff. Hospitals are loath to call them in, because of budgetary constraints. The general staff in maternity services as yet are not feeling that they are skilled enough to deal with some of the issues. Part of that is the drive that we have to better train and support people.

Ms BRITNELL — I have just got a question. We heard in a previous inquiry about the inclusive approach with parenting involving fathers. I am just wondering about your NBO and PWF programs. You have talked about mothers and babies. Is there a tendency to not involve the fathers, or is there the involvement of fathers?

Prof. NEWMAN — The answer is that in some cases, yes, fathers are very involved. I think the obvious point to make is that some of our most vulnerable women might be single parents, and we do not see ourselves in some of the more severe risk situations, like fathers who are involved in domestic violence or maltreatment of women. We do not offer primary services for those men. We will certainly refer them to existing services and support, so our focus in those groups is on supporting and strengthening the mother and her relationship with the infant.

NBO is used widely with families and fathers. Certainly if a father is presenting who is a primary carer of an infant, the programs are exactly the same. In neonatal intensive care and other groups like that we offer a lot of direct fathers programs for those men who want to be involved with infants.

The approaches can be used with fathers. I have certainly worked in the past with groups of adolescent fathers — not that I am recommending that. They are a very needy group, and these techniques are actually quite involving of those young men. I think the research is going to help us if we are hopefully able to roll some of this out in the general community.

Ms BRITNELL — We heard also about the improvements in treating people with mental illness, leaving their fertility intact. Are you seeing the increase in mental health issues or mental illness issues during pregnancy as a result of improved fertility in people with mental illness? Are you seeing it as a result of more drugs and alcohol in the community? Are you seeing it as a result of just more complexity? What are the challenges that you are —

Prof. NEWMAN — I think it is probably a combination. It is very difficult to quantify what percentage of complexity comes from which areas, but as you are well aware, the general hospitals at the moment are facing greater numbers of acute presentations with drug and alcohol issues, ice particularly, across the state. So that is one issue, and the fact is that the social risk factors that go along with that — homelessness, relationship breakdown, for women in particular the experience of assault or domestic violence, increased rates of sexual assault in women who are drug affected — tend to coalesce.

In terms of the mental illness factors and the embedded treatment of psychosis, we have women who are, maybe because their illness is better managed, able to make more informed decisions about pregnancy, which is probably a much better situation than in the past where people were still fertile and so mentally unwell that they could not make decisions for themselves and did not use contraception or whatever and were coming in with unwanted pregnancies. We still see a proportion of those women.

We have women walking in who have had literally no antenatal care, who are in labour and who come into our hospital and have acute mental illness. That is a very tragic situation — tragic for them, tragic for the infant who has had no care — and it is very complex. A certain proportion of those babies will be removed from their mother's care due to the severity of the illness.

Our approach, if it is at all possible, would be to better engage women with mental illness during pregnancy. We certainly offer a consultation service for women who have a mental illness who are considering pregnancy, which is the ideal time to have those conversations, as it is when women and partners can make some choices based on full information about the risk of relapse during pregnancy and after delivery, which is significant.

People want to know about the genetic risk in terms of major mental illness for their child. Most of the maternity hospitals would offer some service like that. I think that is actually very important, but again some of those referrals are dependent on mental health services actually asking women of reproductive age who have a mental illness, 'Are you actually considering or thinking about a baby? Would you like to have some information and help about that?', rather than leaving it. Again I think that is an educational strategy. We would like to do much more early and preventive work in those situations.

The CHAIR — Professor, we have kept you for a long time because you are a wealth of knowledge and we want to take advantage of that. We have got two more questions.

Prof. NEWMAN — Sure.

Ms McLEISH — You have talked quite a lot about different programs that you run. Can you tell me how you measure the outcomes?

Prof. NEWMAN — Yes. In terms of research and looking at the programs and what they actually do, we do both short-term follow-up and also some longitudinal work. Fortunately Chemist Warehouse is supporting some longitudinal work, which is marvellous.

The outcomes that we are interested in are obviously the direct impact on the mother's mental health with these sorts of programs and reduction in parenting stress. We hope to demonstrate improvements, which we are finding, in parents' sense of competence in being a parent. We video and look at the quality of interaction between parents and babies when the babies are born, and you can rate that in various ways.

Longitudinally — in the longer term work — we are looking at infant development. So we are looking at attachment and the quality of relationships at 12 and 24 months of age; some of our babies are now over two years of age. We can look at cognitive development, so our babies are having cognitive assessments, and we can also look at social and emotional development. That is going to be very important as predictors of things like successful integration into school. I think that longitudinal data is going to be very helpful.

We also want to look at the risk factors, and our model is very much one of trying to better identify risks. We are evaluating all the tools that we are using to see whether we do actually pick up the women that we want to pick up in, say, the antenatal clinic.

Ms EDWARDS — I just had a quick question around the percentage of women who use your service or who are referred to it who are from Aboriginal or Torres Strait Islander background and/or CALD backgrounds.

Prof. NEWMAN — In terms of the CALD background we have significant populations, and we have some specialist clinics. We have clinics for women from African communities because we offer pregnancy care. Those women have experienced female genital mutilation, so it is a very specialist area, and they are staffed with bicultural and bilingual workers and are linked to a whole range of supports. We have some specialist obstetricians who can deal with some of the issues that those women are facing. That is particularly important.

In terms of the general community populations we have a large group of Arabic-speaking populations from various parts of the world. We are now seeing the Syrian refugee groups, who have been rehoused in some of our areas, and we have the community detainees, who are still asylum seekers in terms of the immigration department, who are in the community receiving mental health treatment. At the moment they are women from Nauru on the whole, the majority of whom have experienced sexual assault. We have got some very high-risk populations. We have very good interpreter services and bicultural social workers, and we need to maintain that. Part of the issue is always dealing with new population groups when they come in.

In my team I have a psychologist who also works at Foundation House and who is working with us on our asylum seeker refugee populations. In terms of Aboriginal and Torres Strait Islanders the women's hospital has Koori maternity services involvement. We have Indigenous maternity staff, so we will obviously link those women who identify and seek those services to those services. We have got good links to the community agencies. At the moment that is a well-supported and ongoing program within the hospital. We have done some direct work with the department looking at issues like helping Indigenous communities think about drug and alcohol use during pregnancy.

Again, there have been similar approaches. Several communities have spoken to me about the sorts of parenting work that we are doing. We are putting emphasis on funding applications to look at whether we can actually do a version of these programs that best meets the needs of those communities and consulting with them about an approach to parenting which might be successful. That is going to be an object of work.

Ms EDWARDS — So would you see higher numbers of women from CALD backgrounds?

Prof. NEWMAN — Yes, at the moment, overall. That is partly geographical, I think.

The CHAIR — One last question: how are women referred to your services?

Prof. NEWMAN — Because we are a consultation and liaison service, women are referred who have some sort of contact with a general hospital, but anyone can make a referral from any discipline — it is not purely a medical-to-medical process — so we might see referrals from nursing on the ward, from midwifery or maternal and child health nursing, who might be involved with someone who is coming to deliver at the hospital. So it is fairly broad.

Ms McLEISH — But if they walk in off the street, are they walking into the general hospital and they refer them down to you?

Prof. NEWMAN — Some people walk in off the street, usually into the Women's emergency care department, and then it depends on the issues. We will assess them.

The CHAIR — We could ask you questions all day, Professor, but I am going to have to stop there.

Prof. NEWMAN — Thank you very much.

The CHAIR — Thank you so much for your time.

Prof. NEWMAN — My pleasure.

The CHAIR — On behalf of the committee and also the state, thank you for all the great work you do.

Witness withdrew.