

TRANSCRIPT

FAMILY AND COMMUNITY DEVELOPMENT COMMITTEE

Inquiry into perinatal services

Melbourne — 4 September 2017

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Witnesses

Dr Nicole Highet, Founder and Executive Director, and

Mr Simon Troeth, Board Director, Centre of Perinatal Excellence (COPE).

The CHAIR — I welcome to these public hearings Dr Nicole Highet, founder and executive director, and Mr Simon Troeth from the Centre of Perinatal Excellence. Thank you for attending here today. All evidence at this hearing taken by the committee is protected by parliamentary privilege as provided by the Constitution Act 1975 and is subject to the provisions of the Parliamentary Committees Act 2003 and other relevant legislation. Any comments you make outside the hearing will not be afforded such privilege. It is a contempt of Parliament to provide false evidence. These proceedings will be recorded, and you will be sent a proof of the transcript. Welcome.

Dr HIGHET — Thank you very much.

The CHAIR — Perhaps we could start with a 10 to 15-minute submission about COPE, and we will go from there.

Dr HIGHET — Lovely. Thank you very much for the opportunity to present today. My name is Nicole Highet, and I originally came from beyondblue, the national depression initiative, where I was deputy CEO and I really oversaw the National Perinatal Depression Initiative across Australia. From that experience I suppose I could see a lot of the areas and need for innovation and sustainability. So in 2013 we developed COPE, the Centre of Perinatal Excellence, to give a dedicated focus on perinatal mental health and address a lot of the areas that needed a longer term solution. I would like to introduce Simon.

Mr TROETH — Hello, and thanks to the committee. I am Simon Troeth and I am a board member at COPE. I have been with COPE I think a bit over a year, particularly working with Nicole on government relations and communications, and supporting the excellent work that Nicole and the organisation do to help pregnant women, new mums and their families.

Visual presentation.

Mr TROETH — I would just like to start with outlining the extent of the problem in terms of perinatal mental health conditions in Australia and Victoria. Perinatal mental health problems take a huge toll on women and families in Victoria. There are very significant personal, social and economic costs to the community. The perinatal period of pregnancy and the 12 months following birth is the greatest mental illness risk period for women. Mental illness is also the leading cause of maternal death and disability. The cost to the community is very significant. If left untreated, research shows that it would cost at least \$538 million nationally and the cost in Victoria, not including higher risk refugee populations, would be around \$116 million. If we reduce the national incidence of perinatal mental health conditions by just 5 per cent, we would save \$147 million. So identifying and preventing these conditions where possible means that we can reduce this terrible toll on women, families and the community. While Australia has invested in this area under the National Perinatal Depression Initiative, there still is a lot of room to improve and support a more sustainable system of screening, referral and treatment, and we want to take you through that today.

Dr HIGHET — For example, the national guidelines, which COPE is currently reviewing for the Commonwealth Government, recommend that every woman is routinely screened to identify her risk and the presence of depression and anxiety both during pregnancy and in the postnatal period. However, if we look at the approach that we have used to date, which is pen and paper screening which occurs haphazardly across the country — and we do not really do not have any idea of where screening is occurring and what the outcomes of screening are after nearly \$100 million of investment because of the approaches we are using — we really see a need to improve on that and do things or effectively and sustainably.

If we just look at Australia's perinatal journey since 2001, this started with a national research program which highlighted rates of antenatal depression — around one in 10 women are affected, and that increases to 17 per cent in the postnatal period. Rates of anxiety are much higher than this, and we know this has significant impacts on the developing foetus, the newborn baby, attachment and the mental health trajectory of not only the mother but also the child into the future. The results of that study led us to develop a national action plan to say, 'How would we put a national approach to screening together? What would that look like?', and that informed the funding and development of the National Perinatal Depression Initiative, which concluded in 2013, and then a couple of extra years of funding. It was very clear from that that we needed to develop new approaches and be more sustainable in our approaches to screening and referral, and that is why COPE was developed in 2013 — to really look at solutions around sustainability. So today we would like to just take you through some of the new solutions that we have developed to make this happen.

First of all, as I mentioned, the Commonwealth Government is funding the development of new clinical practice guidelines which will be released in October this year. These will guide us in terms of not only the importance of screening and what screening tools to use but also what treatments are safe and effective, and this includes things like the safe use of medication during pregnancy or safe use of medication when breastfeeding, as well as other evidence-based treatments.

With the release of the guidelines, as they are launched at the end of October at the Marcé Conference by the Federal Health Minister, this is a great opportunity to look at how can we really spread and promote the national guidelines within a state level so we know that every health professional is well aware of what best practice means and what they should do in terms of day-to-day care of pregnant women and new mothers.

Mr TROETH — The next priority we want to discuss is increasing awareness and understanding of perinatal mental health issues to support early identification and treatment. Our research shows that three out of four women who suffer from depression, anxiety and other perinatal mental health conditions during pregnancy and the 12 months following birth do not seek help until they reach crisis point, so 74 per cent of women. This is due to a range of factors, including low awareness and symptoms being attributed to hormones as just part of having a baby. High levels of shame and stigma are attached to seeking help. Fear of consequences and disclosure are very real — for example, women fear having their baby taken away from them — and not knowing where to go for help is a big issue. So there is clearly a critical need to ensure women have access to timely, relevant and clinically consistent information.

COPE has developed what we have called the ‘Ready to COPE’ e-newsletter. This is a free email newsletter which goes to women on an opt-in basis. They put in the date that their baby is due if they are pregnant, or the date of the baby’s birth if postnatal, and they get a fortnightly free electronic newsletter which is based on information in the guidelines. That is tailored information about emotional and mental health that is relevant to the challenges she might face at that particular time, at that particular period during her pregnancy. That information is based on the guidelines and, unlike other newsletters that women might receive in the perinatal period, does not promote any commercial products. It is also available during the postnatal period. It is obviously far more effective than hard-copy booklets as it is cheap to distribute via email.

We are currently in discussions with the Commonwealth regarding getting the ‘Ready to COPE’ newsletter translated into 10 languages — it is currently only in English — and also its adaptation for Indigenous women, which would include Koori women in Victoria. In Victoria we clearly have the opportunity to support targeted promotion of ‘Ready to COPE’ through maternal and child health clinics, digital advertising and in parent rooms at shopping centres and other venues, to maximise take-up across the state.

Dr HIGHET — The next area we would like to focus on is routine and universal screening which, as mentioned, is recommended in the guidelines as best practice. Currently we do not really know what the screening rates are, despite the significant Commonwealth and state investments to date, and we also know that screening is rarely occurring in the private sector at all. Interestingly we had a new development only a couple of weeks ago with the release of new Medicare item numbers for GPs and obstetricians, so now these health professionals will actually receive Medicare rebates to undertake screening, and this should really increase the rates of screening in the private sector.

In response to the fact that we do not have efficient, effective ways of recording screening outcomes, in our first few years of development we have developed a new digital screening platform, called iCOPE, and this is really looking at sustainability and recording and measuring screening rates over time. I would just like to very quickly now show you a little bit about iCOPE and how it works.

Video shown.

Dr HIGHET — We were very fortunate to receive funding from the Victorian Government maternal and child health innovation grant, and as a result of that we have implemented iCOPE across the municipalities of Brimbank and Melton. We also have strong interest and uptake in now increasing that across other western suburbs — Hume and Plenty, for example — and also we have been undertaking a research trial down at Monash, where we are doing it in antenatal clinics as well. There we are actually doing it with refugee clinics. One of the great benefits of the digital platform is we are also able to provide the screening in different languages.

With the innovation grant and with the refugee community we now have this translated into 13 different languages so women can actually do the screening in the woman's own language and also receive their tailored instant reports in their own language.

The importance of the clinical report for health professionals means that we have accurate data. Currently we know that there is an up to 29 per cent error rate in adding up the scores on the Edinburgh Postnatal Depression Scale, for example. So with the digital screening platform, which is doing this automatically, we have 100 per cent accuracy.

We have a lot of interest across Brimbank and Melton and other municipalities to have this rolled out, and certainly there is a great opportunity now with the new Medicare Benefits Schedule item to increase the rates of screening across GPs and across the private sector.

Mr TROETH — The fourth priority is ensuring timely, local and appropriate referral pathways are provided after screening. Services are currently using pen and paper-listed preferred providers, which is clearly unsatisfactory and very ad hoc. In many areas we do not know where perinatal expertise exists or even what constitutes having expertise in perinatal mental health. In response to this priority we are leading the development of national accreditation standards, the identification of providers with expertise and communication with health professionals and women at risk through the e-COPE directory. The e-COPE directory is a tool based on the Commonwealth's National Health Services Directory, and eventually when it is completed we will be able to search for different providers with expertise down to a postcode level. So in practical terms that means that women and their families or healthcare professionals can plug in where they live — their postcode — and this will give them a list of accredited providers at the local level. This infrastructure is already being funded by the Commonwealth and represents a great opportunity for Victoria to support the quicker population of the e-COPE directory through dedicated resources to help complete the service list across Victoria with accredited providers.

Dr HIGHER — The next area that we would like to focus on is workforce training and development. Obviously it is imperative that the health workers at the frontline are adequately trained to identify and manage perinatal mental health problems. As part of developing the national guidelines COPE is developing a free, fully accredited online training program that health professionals will have access to. We really would like to strongly support the take-up of that across Victoria. There are some health professionals who prefer not to have online training but face-to-face training. This is an important option for some healthcare providers and also that next level of care for those who are actually providing support and treatment for women with perinatal mental health problems. There needs to be a greater level of education and training, which will be in line with the national standards that we would require to be listed on the e-COPE directory discussed just previously.

Research and data collection — as we have mentioned a few times we do not have any data to indicate the uptake or outcomes of screening, and this is where we have a great opportunity, if we were to have a statewide rollout of iCOPE, to be able to actually look at that data and evaluate it and be able to identify the rates of anxiety and depression and risk factors. It could then be used to inform service needs. So for those postcodes or suburbs where help is needed the most, this can inform where service provision should take place.

Mr TROETH — Just to sum up, in the future Australia's world-leading perinatal mental health support system will be based on an integrated, innovative, sustainable and data-driven approach which is informed by the national guidelines. This will ensure that women and families are supported in their time of greatest need no matter what their income level, cultural background or whether they live in the city, a regional centre or a rural or remote area. This is a great time to support the development of this approach as the best solution for Victorian women and families, working in conjunction with all the other COPE member organisations.

We again thank the committee for the time and would be happy to answer any questions you might have.

The CHAIR — Thank you for your very thorough submission and presentation. I have got a question in regard to one of the figures that was thrown up first on the presentation — that is, that perinatal mental health issues cost us nationally \$538 million per annum. What in your opinion will be the impact of the loss of funding for the National Perinatal Depression Initiative, and have some services already been cut?

Dr HIGHER — Yes. So in response to that, certainly some services have been cut, particularly as part of the initiative.

Part of the framework of that was having health workers in each state and territory to really support the implementation, such as the implementation of screening. All of those project officer positions have been cut with the defunding of the initiative, so there is no momentum necessarily at that state level to roll out the initiative. This is where I suppose our discussion with the Commonwealth about the importance of keeping the foundation is going, so this is what has led to the development and refunding of the national guidelines. Also from the Commonwealth's perspective they are providing support through the new Medicare items as well. Those areas have been the area of focus as well as the e-COPE directory in terms of helping the pathways to care. But the Commonwealth does consider that screening, for example, is a state responsibility.

Ms COUZENS — Thank you for that presentation. You mentioned the Aboriginal and Torres Strait Islander community. Given the outcomes of the *Closing the Gap* report, which have failed to close the gap, I would be interested in hearing from you what you are doing in terms of Aboriginal and Torres Strait Islander women, and if you are not doing anything, do you think that should be a priority?

Dr HIGHET — Certainly in terms of 'Ready to COPE', the email guide, the Commonwealth has expressed interest in us looking at developing it and tailoring it for Aboriginal and Torres Strait Islander women, which we will be looking to do. We will obviously have different versions of that for those in the west and those who might be in the east, and adapting that.

In relation to the iCOPE screening platform, we work with Murdoch University in Western Australia. They have developed a special screening program for Indigenous women and men called 'Baby Coming — You Ready?'. That is going to use the iCOPE platform to put that guided assessment onto the iCOPE platform as well. That is a very different look and feel. It is more of a conversation with a health worker where they work through it together rather than asking yes/no questions or standardised scales. Certainly the iCOPE platform lends itself not only to other languages but it can be tailored as well for that population.

Ms COUZENS — Because there would be cultural issues around how that is done.

Dr HIGHET — Absolutely. So the research at Murdoch University with Baby Coming — You Ready?, that is a very specific screening tool developed particularly for the Aboriginal and Torres Strait Islander population.

Ms COUZENS — Are women with pre-existing mental health issues being picked up once the doctor knows they are pregnant, or is there any mechanism that is in place to pick up on those women who are already —

Dr HIGHET — At risk.

Ms COUZENS — experiencing mental health issues?

Dr HIGHET — That is where screening is so important. The number one risk factor, or the factor that is likely to lead you down the path of depression or anxiety, is having a previous mental health problem. So as part of the guidelines one of the first questions around psychosocial risk factors is whether you have a personal or family history of mental health problems, so straight away that is identified. In the woman's tailored iCOPE report she will receive information that she is at greater risk because of that and providing her with more information and directing her to recognising early warning signs. That is how we can really use the iCOPE platform to identify those at risk, and that is why the national guidelines recommend that that is a psychosocial risk factor that is asked about as a routine part of screening. It is built into the platform as well as monitoring for possible symptoms — anxiety and depression — at the time.

Ms COUZENS — Can you talk about what sort of support is already available for women particularly in regional and rural areas?

Dr HIGHET — In the area of treatment?

Ms COUZENS — Yes.

Dr HIGHET — That is very variable. I suppose the bottom line is that we do not really know, because it is very much based on local knowledge of referral pathways. Health professionals are keeping lists of people that they think are good to go to. This is why we want to develop national standards of accreditation so we can be confident that if we refer a woman to a particular service, she has a standard level of training.

At the moment it is very haphazard, it is based on individual lists or knowledge and the availability of the health workers at the time. That is really why we want to look at using the infrastructure of the National Health Services Directory to be able to populate it with a level of an accredited treatment provider so that they can be easily identified at the time of screening or at any other time.

Mr TROETH — We have already had strong interest from the Australian Psychological Society and other providers about assisting us and assisting the Commonwealth and state governments to get people onto that e-COPE directory as quickly as possible.

Ms BRITNELL — I am just curious as to how you have seen over the time frame, say of 20 years, where postnatal depression was spoken about a fair bit compared to this period, where you have got the iCOPE technology in digital form. How has the transition to understanding and acceptance of that been part of normal care and screening processes of a pregnant woman and postnatal care?

Dr HIGGETT — I suppose there are two different levels. There is the consumer side. Yes, we have been talking about postnatal depression a lot in the media and about community awareness and women are given booklets, but it is the time of life where women have very high expectations. They are looking at points of reference, they are looking at Huggies ads and all those things and thinking that that is the experience they are going to have. When that does not match what their experience actually is there are still huge amounts of denial, shame and feelings of failure, which prevent women getting help early and delay help seeking. Certainly that is at the community end.

In terms of health professionals, with the previous guidelines also recommending screening, Australia has always been a world leader in terms of universal screening, and we do not want that to go backwards in terms of the NPDI not being funded, but there are a lot of barriers to screening. Health professionals talk about the lack of time in the consultation, not having clear referral pathways and not having access to translators, and then there are problems around scoring errors and things like that. That is really what has led to the development of iCOPE as a solution, and we know that from our work at Brimbank and Melton that it can be done in seven minutes. We know that the woman gets tailored information relative to her own score as opposed to being given a generic booklet, about which she thinks, ‘Well, that’s not going to be relevant to me’. With the ‘Ready to COPE’ e-newsletter we are actually able to then tailor and provide information right through the different stages of pregnancy, birth and the postnatal period so that she is receiving relevant information at the time that she needs it.

So Australia is a leader in terms of screening but we have noticed a loss of momentum with the defunding of the national perinatal depression initiative, which is why we have looked at other solutions. Particularly being available in different languages, this also makes it much more inclusive, and people can access it a lot easier.

Mr TROETH — The big focus, briefly, of the ‘Ready to COPE’ newsletter is reassuring women that other women are feeling the same thing and that there is nothing wrong with them if they feel these conditions and there is help available. It provides a very rapid referral mechanism.

Ms BRITNELL — In a practical sense, as a woman attending a perinatal appointment, will iCOPE be just one of the forms she gets to fill out which will not be paper-based — it will be on the iPad? Will that be like her having a way in whatever other —

Dr HIGGETT — Yes. At the moment, for example, down at the Southern Health Service, where they do it, they actually give the woman the iPad while she is in the waiting room, and she can do the screening in that time. In maternal and child health settings, while the nurse might be weighing the baby the woman is completing the screening on the iPad in the consultation room, or it could also be done in the waiting room. It is about really replacing the pen-and-paper approach and adapting that to what suits your healthcare setting.

We are also planning to use the iCOPE platform in IVF settings now with Melbourne IVF, where we program the different tools to look at women at risk when going in for fertility treatment. As part of that we are actually doing remote screening. They want women to actually complete the screen via their own iPhone before they come to the consultation, because those women are so short on time. It can also be adapted for remote application as well.

Mr TROETH — The pilot showed that we had very, very high levels of acceptance of the screen via a tablet as well. Was it nine out of 10?

Dr HIGHET — Yes.

Mr TROETH — Around that. Women were very happy to do it. Then obviously, as Nicole said, you have the ability to get those tailored reports very soon after screening, as do the health professionals.

Ms BRITNELL — What will be the incentives for the health professionals to ensure that no-one is falling between the gaps, and what are the trigger points along the way that you will use to make sure that it gets redone and is appropriately timed?

Dr HIGHET — That is where the guidelines recommend at what time points you should be undertaking screening, and the screening can then flag in the system whether this woman is at risk. For example, she might have a history of mental health problems, she might have other risk factors. That can prompt the person to do the screening again at a later time period. Also we have found that at the maternal and child health services in Brimbank and Melton, if they were concerned about a woman from a previous screen, they would just follow up and ask the woman to complete the screen again, and the woman can actually compare her own results to see how she is travelling from the previous time because she is getting her own tailored report each time.

Mr TROETH — It is important to note that there are future plans to ensure that this syncs with the national My Health Record system as well. That is a very important part of developing a holistic health record for a pregnant woman or a new mum.

Ms BRITNELL — In the regions we have got quite a significant amount of pressure on our mental health systems. I know that in my part of the world in Warrnambool we have staffing issues, where it is hard to attract and retain staff in the regions. So they are already under enormous pressure. How can we assist by putting more people into the system, which is what this will end up probably achieving?

Dr HIGHET — This is really about identifying people early so we do not need to have women in mother and baby units and needing more intensive treatment. As mentioned, 74 per cent of women do not get help early; they wait until they reach a crisis point. The whole point of the e-newsletter is to educate people in a very effective way. The whole point of screening is to assess so we can identify who is at risk and provide treatment early so then that treatment can be provided either on an internet-based program — there is a lot of evidence-based internet prevention and early intervention programs — rather than waiting until we have a woman with a serious mental illness which requires far more intensive and costly treatment.

Mr TROETH — Having a system driven by prevention rather than crisis is the aim of this.

Ms BRITNELL — Then the GPs will be the critical element in this. What training is offered to them to be able to cope and identify early and support effectively?

Dr HIGHET — This is where the Medicare initiative is paramount to support GPs to actually undertake screening, which often does not happen. Then the online training program that COPE has developed as part of the national guidelines — GPs can apply for CPD points, and training and support was one area of providing that next level of training. There are standard mental health training programs but we need to develop national standards so we know who we can be confident to recommend and refer people to, and that is not there at the moment.

Ms EDWARDS — Thanks very much for coming in today. It is really informative what you are doing, and I believe it is quite successful where it is being currently rolled out. I did have a couple of questions in relation to self-screening and privacy. Can you just perhaps talk us through the privacy issues that might arise from someone who is doing that self-screening regarding where that information goes and who has access to it? Also, how do you encourage women who have just had a baby and who are very time poor to do that self-screening process?

Dr HIGHET — I will start with the first question around data security. All of iCOPE is based on the national privacy and data legislation, so all screening data is encrypted so it cannot be accessed. The reports for health professionals are all in a PDF format in line with privacy legislation so that they cannot be accessed.

Regarding the patient reports, which the woman requests if she wants them as part of the screening program, there is no identifying information and she can choose where she wants that report sent to. She might want it sent to a different mobile number or a different email address. It is up to her whether she wants the report and where she has that sent. Certainly any identified data that is collected is encrypted in line with the privacy legislation.

In relation to the second question, which is around self-screening, this is where as part of best practice it is put into place. So in Victoria at the moment at four weeks the maternal and child health nurse is to do screening. In the antenatal setting the guidelines recommend it is done at the first antenatal visit and then again at 30 weeks. There are time points when the health professional is doing the screening, but we are actually finding — we have found from the Brimbank and Melton trial — that when women are doing the screening between them and the iPad, they reflecting more on their experience when answering the questions rather than being asked by a health professional, who they might fear being judged by or fear what the implications of screening are. Also, if they know they have requested a copy of their report at the outset of screening, they are more likely to be honest, because that is going to impact on the quality and relevance of the information that they receive back.

Ms EDWARDS — So GPs do the screening —

Dr HIGHET — We do not really know.

Ms EDWARDS — We want them, yes. Obstetricians?

Dr HIGHET — In the private sector there is very little screening at the moment.

Ms EDWARDS — Midwives?

Dr HIGHET — It depends. The uptake of screening in antenatal settings under the NPDI was not that high but we still do not really have actual figures. The highest rates would be likely to be postnatal, but even in the Brimbank and Melton trial we found that there was a perception amongst the coordinators that screening rates were much higher than they actually were before we put the platform in place.

Ms EDWARDS — So it is mostly maternal and child health nurses in the trial.

Dr HIGHET — In the postnatal period, yes, but at Monash and the refugee clinic it is an antenatal setting.

Ms EDWARDS — How does that work then if you have a woman who does the self-assessment and the maternal and child health nurse sees that assessment and realises that there is a problem? Maternal and child health nurses do not do referrals, so where does that information go?

Dr HIGHET — That is where we are looking to get the funding from the Commonwealth around uploading it into My Health Record. If the person has done a screening with a GP, it could be uploaded straight into My Health Record. Then if she is referred to a different mental health provider, that information is available.

Ms EDWARDS — Where does it go currently with the trial?

Dr HIGHET — With the trial at the moment the woman can request the PDF copy that is produced for the health professional, and she would take that along to her health provider so she does not have to be screened again, and then the health provider can get straight on with developing a mental health care plan.

Ms EDWARDS — In terms of our CALD communities, you mentioned you have got one trial at the moment with 13 languages.

Dr HIGHET — There is Brimbank and Melton, and also the refugee clinic. Everyone is taking that up.

Ms EDWARDS — What kind of support is available currently for women from our CALD communities in relation to experiencing mental health issues in the perinatal period.

Dr HIGHET — Again it is very variable from one place to another, and it is really up to the local services —

Ms EDWARDS — You do not have any data on that either.

Dr HIGHET — No. Local services and service providers only know their local areas, and even then sometimes things are at risk of being defunded. This is where with the e-COPE directory not only are we looking at levels of accreditation and skills but we can also drill right down to whether the mental health provider speaks other languages and has access to interpreters and those other features. That is built into the e-COPE directory so that if you are doing a referral, you can really specify what you are looking for in terms of the service provider.

Mr FINN — Thank you very much to you both for coming in today. Having read your submission and heard you today, I have one statement and question. The statement is: you have sold me. The question is: how much do you need to spread this across the state?

Dr HIGHET — We put in a submission to the government in January where we outlined a proposal featuring all these different elements, and that was estimated at about \$1.9 million.

Dr CARLING-JENKINS — Would it be possible for us to get a copy of that submission for the committee?

Dr HIGHET — Yes, absolutely.

Dr CARLING-JENKINS — Thank you very much. That would be very helpful. Thank you very much for putting in such a comprehensive submission and for appearing today. I just wanted to pick up on a couple of points that Maree started to touch on around a time lapse between identification of an issue and actually offering assistance.

On page 19 of your submission you did point out very clearly that two per cent of clients said they did not currently feel safe with their current partner and eight per cent reported that they were concerned about the safety of their baby. That is quite significant. I also noted that you identified a flaw in your own study around the fact that partners may have been present when the screening occurred, which would have dropped the numbers.

I guess I would just like you to talk to the point of how you might be able to change the design so that women who are experiencing domestic violence are picked up more easily, and if you could talk to the point around that time lapse between assistance being offered to women who are in crisis.

Dr HIGHET — Certainly. I suppose this is where ‘Ready to COPE’ is so important because even at the point of screening it does not mean everyone is going to be developing the condition at that time. Staying in touch with a woman throughout that whole period of time is paramount, along with touching on the issues all the way through so that we have lots of opportunities to engage with her. That is the first thing.

In relation to the family violence question, some of the feedback from the Brimbank and Melton trial was that four weeks postnatal was too early to do the screening. Often a lot of partners are still present at those visits. What we are looking to apply at our next stage of development with iCOPE is making it compatible with My Health Record but importantly also having the opportunity to have other screens available. For example, in New South Wales we have iCOPE with Karitane parenting centres. We are wanting to develop that we have the iCOPE screening standard without the family violence question and then that question is asked separately in the room with a health professional but the results would still appear on the same report.

So that is this technology. It is a small build to develop that, but that is exactly what that is for so that we can still ask those questions. That is why we do support that the nurses, regardless of whether it is in the waiting room or in the consultation, if the partner is there, must ask it when they are on their own.

Dr CARLING-JENKINS — Okay. So just to ensure that privacy and one-on-one questioning.

Dr HIGHET — And opportunity, yes.

Dr CARLING-JENKINS — Fantastic. Thank you very much. I appreciate that.

The CHAIR — Thanks, Rachel. If there are no other questions, I would like to thank you so much for coming in today. We very much appreciate your time and your submission. It was very informative. Thank you so much.

Dr HIGHET — Thank you.

Witnesses withdrew.