

TRANSCRIPT

FAMILY AND COMMUNITY DEVELOPMENT COMMITTEE

Inquiry into perinatal services

Melbourne — 27 November 2017

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Witnesses

Dr Alan Gemmill, deputy director research and senior research fellow,

Ms Jennifer Ericksen, coordinator, infant clinic, and

Professor Jeannette Milgrom, executive director, Parent-Infant Research Institute.

The DEPUTY CHAIR — I welcome to these public hearings Dr Alan Gemmill, senior research fellow, Ms Jennifer Ericksen, coordinator, infant clinic, and Professor Jeannette Milgrom, executive director, Patient-Infant Research Institute. 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 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.

The DEPUTY CHAIR — I invite you to make a 15 to 20-minute statement and that will be followed by questions from ourselves. We have allocated 45 minutes.

Prof. MILGROM — What we thought we would do is to start off just taking you through a few PowerPoint slides which address what we really presented and are a little bit expanded in some. Dr Gemmill may make a few comments, and then we will be interested to allow plenty of time for questions, which probably are the more relevant things that you are particularly interested in.

Visual presentation.

The DEPUTY CHAIR — Are we able to get a copy of the PowerPoint presentation?

Prof. MILGROM — Absolutely, yes.

The DEPUTY CHAIR — Thank you.

Prof. MILGROM — As you know we are from the Parent-Infant Research Institute. We are a not-for-profit organisation. We have affiliations with Austin Health — we are auspiced by Austin Health — and Melbourne University through my appointment, and we have an independent board. What distinguishes us, I think, is that we are a group of clinicians and academics, so we are on the ground, hands in, we work with people, and I think that makes us pretty different from some other groups. We collaborate very widely. I could not list the wide range of people we collaborate with.

Our main mission — we have been established since 2001 — is to tackle perinatal depression and anxiety and their consequences through research and conflating research evidence to practice. That is our central mission, and you can see our logo is the importance of ‘investing in the earliest years’ — because of the impact on the infant — ‘to build a brighter future’. The core of our work is research, but because we have been active for a number of decades now we have moved into the translational area. We have been quite active. Apart from having developed a lot of evidence-based research treatments and therefore rolling some of those out as direct service provision, we also do a lot of training, and we have been involved in public health initiatives working with Beyondblue for a decade and others in screening. It just gives a little bit of our background for reference.

We were very privileged to have the opportunity to be able to comment on the parliamentary inquiry, and we felt that we could best address four of the areas that you were interested in. You are aware of those, because they are your terms, but they are the ones that we have addressed in our submission and which I will talk to a little bit more: availability, impact of funding, training — we heard the last discussion with great interest — and disparity.

Some of the key messages that we wanted to convey was the prevalence of perinatal depression and anxiety. Approximately 100 000 new parents each year struggle with depression or anxiety, and the consequences are immense for the parents and for the child. Another key message, which I will reiterate a few times, is the importance of treating antenatal depression during pregnancy. Of course nowhere more so than in the perinatal area is prevention, identification and early intervention a key part of the strategy. We now know that apart from the social and personal suffering, the failure to detect and treat perinatal depression has enormous costs, and we quote some figures from the London School of Economics which I think apply here.

So we felt we had a lot to say about increasing availability. We are researchers, we have published a lot, recently I edited an international book on the subject of identification and management. It is awful to think that only 10 per cent of depressed women end up receiving adequate care, and we know that one in 10 women will

suffer from perinatal depression and anxiety. So that is what led us down the path of e-technologies, and I will talk a little bit more about that.

With federal funding from the Department of Health we are leading a perinatal depression e-consortium. We have had the opportunity to roll out one of our programs which was developed over six years of good research and which is actually an internet depression treatment that is as close to face-to-face treatment as we could get it. I think that the internet and digital sphere is an interesting one, because there are many things that are called 'internet' and 'digital' and 'apps'. There is a large difference, I think, between those that have a sound evidence base and those that are more maybe education. For example, our MumMoodBooster treatment is a real treatment and we have had tremendous results — at least a four-fold increase in remission after treatment — for women diagnosed with a depression.

So we have been very pleased that there is now availability, but there is a lot of room for expansion there. For example, on treating men in the perinatal period, there is a huge gap there, and there is a lot we can do to also expand what we are doing internet-wise. On increasing availability of antenatal depression services in pregnancy, antenatal depression is the leading predictor of postnatal depression; we know that. Intervening in pregnancy is critical, but we also now know that it impacts on fetal development, so we have two very good reasons to make antenatal depression treatment part of standard care, which it currently is not necessarily due to identification and women not taking up treatment. Postnatally we also need to intervene early. So we can first of all intervene antenatally. We have published *Beating the Blues Before Birth*. It is a manualised treatment that can be available through better access. But there needs to be something like a place health professionals can get these things. We do not want our things sitting on the shelf. We want them out there, we want them used. Treating postnatal depression is also important early on for the mother's welfare and, again, the infant's. The mother-infant relationship unfortunately does suffer. It is very hard to engage in optimal interaction with your infant and that may influence secure attachment, so we really do need to intervene early postnatally as well.

We have developed a number of programs for the postnatal period, a very short four-session intervention, and also community intervention. We note with interest that the Victorian government funded an app for parents to play with their infants. Here we go one step further. It is about when things go wrong. It is not about 'Play with this' or 'Play with that'. It is a very challenging area — what you do when things are not going well — and to make that available and to train people.

Our face-to-face intervention for postnatal depression to treat the maternal depression to try and get that over quickly has been shown in many trials. Again, it could be rolled out through better access. It is comparable to antidepressants.

On safety and quality I will not say much, except that obviously regular reporting is important and we certainly are happy to advise on it. We have done a lot of trying to think through what is a good reporting measure and what might be worth keeping an eye on, so we are happy to advise on that.

On the end of the National Perinatal Depression Initiative funding, we were very fortunate to have been involved in that, and we also were very fortunate to have done the research that led to the NPDI funding. That was the result of 10 years screening. PIRI was responsible for the feasibility of screening in Victoria and Tasmania and the lobbying that led to this funding. So yes, it has ended. So what is the single most pressing issue? It is that figure we talked about before — the 10 per cent of women who take up treatment. The majority of cases are not even identified. There is at least some movement there about screening, but the vast majority never receive adequate treatment. So how do we help our frontline professionals move from identifying to helping women take up treatment?

While screening for prenatal depression is something we do internationally, one thing that we are trialling at the moment and have had some success with is for nurses to have an electronic decision support system to help them move on to make the appropriate decisions. But more importantly, and it will pertain to the training you are talking about to nurses — I have just returned from Canada, where I was training midwives, by the way — it is about how do you help them learn how to then make the right decisions? You can train them, but then when they are on the ground and they are busy and they have got all the other things to do, what are some prompts that can help them make a very simple management and referral ongoing plan and go to the limits of their own abilities? We believe that there is a need to increase uptake through methods such as this and through motivational interviewing training, which we have also done.

Then moving on to the next point, which is related, is an appropriately qualified workforce. There was discussion about training during the curriculum, which is critical, but also of the practitioners out in the field. We need to keep training and keep their skills. We know that stigma remains a major reason with mental health and why women do not seek help. That is one of the reasons. We have taught motivational interviewing. We need to teach it to our workforce. Jennifer Ericksen has trained every Victorian nurse a few years ago in screening and management. We need to, for example, ask the hard questions and have nurses comfortable during risk assessment. If there is any suicidal ideation on screening, we do not want a nurse to just say, 'I noticed it'. We need to make them feel comfortable, and I think it is feasible.

On disparity, we could talk a lot about that and the importance of finding ways to reach our ethnically diverse and Indigenous population. Certainly there has been some interest as to whether we could adapt, which we would be willing to, some of the internet resources as a start for reaching our Indigenous families, for example. So, to wind up, our recommendations and evidence based on specific strategy that can increase not only early identification but the uptake to effective treatment is where we need to move. The best research that we know shows that screening is only effective if it is integrated with something further down the line, so that is key.

We need to focus on protecting the developmental prospect in the perinatal area of our children and act as early as possible in pregnancy and childhood, interrupt the intergenerational transmission; and we need to keep funding ongoing research so we can identify best practice — an evidence-based approach, bring them into the real world services. We believe that in some of the areas, for example — if you go to the second dot point — to translate it, you need to really look at how you will best maximise the impact of treatment uptake and assess the cost effectiveness of depression screening. We need to have a good evidence base for that.

There are many other questions we could look at. There are still prevalence questions about anxiety and psychosocial factors and how on earth do you not increase a response burden by having this huge screening program. People say, 'You should look at this', 'You should look at that'. We need some more research to find ways of —

At the moment we focus largely on depression, and that is fantastic — we have got a great tool. It can potentially highlight some anxiety, but there are other important questions. But how do we do that without increasing the burden on nurses, GPs and women, and then the incidence of mental health disorders in men and how to reach men. There was a very moving talk where I was working by a man who said that if he had known more about perinatal mental health he might have been able to protect his wife from committing suicide. He did not know the signs and symptoms. When men suffer from depression there is no depression treatment that is easily targeted to men, so we are suggesting, as you know, a clinician portal for health professional resources guarded by researchers and research evidence and informed by clinicians of course.

We have a range of resources available. You would know, of course, of the new clinical practice guidelines which offer the best evidence-based guidance currently in the Australian context — they have just been revised — but unfortunately the state of our knowledge means that some strong evidence-based recommendations are not yet available. If you look at the guidelines, you will see there are some good practice points as opposed to evidence-based recommendations. We feel that guidelines should be updated very closely working with researchers, such as ourselves, but across a range of disciplines — ourselves and so on — so we are looking at our guidelines should have a really strong evidence base.

We conclude and open up to questions. These are the points that we have raised — about integrated identification, early intervention with mother-child, new technologies — and finish how we started.

The DEPUTY CHAIR — Thank you very much. It is a lot of information that you have covered there, and it is really great to see that research is being conducted in this field. Do you think there is a shift in the health profession to be more proactive in this area? You have been doing a lot of research in this for quite some period, but what about the general practitioner out there?

Prof. MILGROM — Just before I start, do you want to add anything to what I said, Alan?

Dr GEMMILL — No. I think you have covered it really well, but thanks.

Prof. MILGROM — All right. Sorry about that. I realised I had not asked. Okay. Thank you. I will just explain that I just stepped off the plane.

I think there has been some tremendous health promotion in the mental health area, particularly through Beyondblue and other agencies like that, in making problems with depression and anxiety more prominent. Whether in fact it has translated across the board and individual practitioners really are more aware of these problems, I would say not yet. It is increasing, but it certainly would not be across the board, and there is a lot of evidence that needs to continue to address the different groups. More recently obstetricians have become interested in this, which has been terrific, but before that there was very little in Australia, particularly on that front. So there are so many relevant professions, as you quite rightly say.

Ms ERICKSEN — But it would be fair to say that the maternal and child health nurses are definitely moving and —

Prof. MILGROM — Yes, true.

Ms ERICKSON — When we first started training we were talking about screening, and that was the new frontier. Now they are very much across that. They are interested in how to have conversations with women that can help them to help-seek, which is the motivational interviewing approach — a woman-centred approach to care. Even some of them are getting a bit more into treatment as well through the enhanced maternal and child health programs. So yes, they are moving, but we have to keep up.

Prof. MILGROM — Particularly in Victoria, I would say.

Ms ERICKSEN — Of course.

Prof. MILGROM — Victoria has been a leader, I would say.

Dr GEMMILL — I think there has been a change over the years, and it has been a positive one in terms of awareness. Postnatal depression: I think we have seen a real rise in awareness among the public and professionals. Antenatal mental health problems have been left behind a little though. I do not think it has happened quite in that area to the same extent.

The DEPUTY CHAIR — That is where I was about to go next. We have talked about postnatal with the maternal and child health nurses in particular, but during the submission you mentioned antenatal care being left behind and perhaps there is room to include antidepressant treatment through any of the screenings there. How do you see that working, and how do you see that becoming part of the care that is given to a pregnant lady?

Prof. MILGROM — We might all again have some points to say about that. The advantage of our system is that women antenatally do have contact with professionals. So that is great. There is an opportunity through shared care, through midwives and so on. Screening is now more and more recognised. There is still that problem of what happens next. There needs to be a greater awareness that it is really important to treat depression in pregnancy and, secondly, how to facilitate that conversation to help women take up appropriate treatment. I think that that is what I would say. Would either of you add anything?

Dr GEMMILL — I think you are right. I think identification needs to be linked to the prospect of an effective treatment, and that is really the whole problem, the biggest problem.

The DEPUTY CHAIR — How do you make that happen?

Prof. MILGROM — But isn't it at the policy level and the individual institutions? If at hospitals part of their policy procedures for their midwives, for example, were that you not only identify depression but you also do try to link women to care, you would need it at every level. You need systems.

The DEPUTY CHAIR — You would see then that government has a role to play in putting a policy forward to the hospitals to say, 'We want you to be involved with the screening'.

Prof. MILGROM — Totally.

The DEPUTY CHAIR — And then these services should follow?

Prof. MILGROM — Absolutely, because we know that hospitals have so many priorities. That is very important and makes it very hard for them to bring in new procedures if they are not mandated in any way.

Ms ERICKSEN — I was just going to say that in the clinical practice guidelines it talks about screening at least once during pregnancy. One of the things when we did the national postnatal depression program was that all the hospitals have different points of contact with the women who are delivering in their hospitals. It is a challenge to say, ‘Will it be at the booking-in appointment, or will it be at a different point?’. It is not a standardised way. It depends where you deliver your baby what kind of antenatal care you are going to get and how many times you might see an obstetrician or how many times you might see the midwife. That is a challenge of bringing something in, but we definitely need the hospitals to be on board at a higher level to say, ‘This is an important part of what we’re trying to do’.

Prof. MILGROM — We also have guidelines, as you say, that it should be at least once, if not twice.

Ms ERICKSEN — Preferably early, because of what we have said here. It is really important to give us time. If you find that there is a problem, we need some time to do something about it, and also we do not want the mum to be anxious and depressed while the baby is developing, because that has some ongoing effects on that fetus — so, early.

The DEPUTY CHAIR — How good are governments at picking up evidence-based research and putting it into policy?

Prof. MILGROM — I think I would have to throw that back to you. You have got yourself in a lag. The national depression initiative: in my career that was one of two which happened rather quickly where they picked up the importance of identification. But in general there is often about a seven to 10-year lag between what we really, really know and what needs to happen. So possibly not that well.

Ms EDWARDS — Thank you for your very comprehensive presentation. It is also in our submission that we received from you as well. Just a couple of things in relation to the MumMoodBooster internet treatment program: do you have any statistics around how many people are using that since it was developed?

Prof. MILGROM — Yes, there were four phases of development, which I will go through very quickly. We have figures for all of the different phases.

Ms EDWARDS — That is fine. You can just give them to us. We do not need you to talk through them.

Prof. MILGROM — Firstly, it was in a research context. It was initially developed in Australia, and we also looked at it in the American population and found it to be effective. They were relatively small numbers. We only recently had the federal minister launch, so we have some figures on that which we can provide you.

Ms EDWARDS — Yes, that would be great. Thank you.

Prof. MILGROM — But it has only been a month that it has been out.

Ms EDWARDS — You mentioned the distribution of the program to hospitals and to maternal and child health nurses. Where have you distributed it?

Prof. MILGROM — At the moment we have a tiered promotion campaign that is going to happen. We will certainly target maternal and child health nurses, hospitals, midwives and other agencies in the community and so on. It is linked with a step-down model to make it easy for women to be referred up or down if they do need to go onto traditional services. There is risk monitoring; there is assessment. We are looking at other opportunities to integrate it with GPs and GP practices. One of the things that we know will work even better is when there is a coaching component. That is not part of the current deal, but we are looking for ways that might happen. So there are lots of opportunities. The answer is: yes, we can provide you with numbers.

Ms EDWARDS — Yes, that would be great. It will be interesting to see in six months from now how many women have benefited from the program via their health professional. One of the issues we have of course in regional Victoria is access to the internet and issues with the NBN and conductivity and things like that. In rolling it out to our regional communities it is a little more challenging simply because of those reasons. A maternal and child health nurse, for example, in Swan Hill, might not have high-speed internet access to be able to utilise that kind of program.

Prof. MILGROM — Yes.

Ms EDWARDS — It is one thing to keep in mind. The other question I had was about access to treatment for women experiencing mental health issues, whether it be depression or anxiety, throughout the pregnancy. I am thinking antenatally. We have a shortage of health practitioners in regional Victoria as well, so that is really problematic when you say that they are being identified and there is no follow-up treatment. That is partly because we just do not have access to the mental health practitioners in regional communities to be able to refer women to. That complicates things in terms of the travel required to access a practitioner in the city as opposed to more locally. That is one thing I just wanted to raise with you.

The other thing was that you mentioned screening throughout pregnancy and that usually it is maybe once. A woman may not show signs of having depression until they are eight or nine months pregnant but might have been screened when they were three months pregnant. That continuity of screening throughout pregnancy, how do you see that? Is that a possibility in terms of what you have been doing with your research? And how it could work?

Prof. MILGROM — I think that ideally you would screen more than once, and you would also have a workforce who is aware of the signs and symptoms of depression so that they are not just relying on a screening instrument. We also tell women when they screen negative that it is a screening instrument. We know women fake good and some fake bad. We also know that a screening instrument gives you sometimes the wrong answer. We always tell women, ‘Look, if this doesn’t tally or if things change, do tell me’. So you probably would set up two screening points — is my reading of what the literature would be telling us — ideally, as a guideline. You probably would be encouraging the workforce to do it more often. I also want to comment on your first point as well. I do not know if you disagree, but that is what is recommended.

Ms ERICKSEN — Certainly that is what I was going to say. The relationship that the woman has with her health professional is most important, and that is where it should come up — not just as a screening, but it should be a constant thing. The antenatal care that you get is very important. Just to talk about the MumMoodBooster, we also have the antenatal Mum2BMoodBooster. It does not help if you do not have the internet, but it does help if you do have the internet because the program itself does the coaching.

Ms EDWARDS — Is that in regional communities yet?

Prof. MILGROM — It is available to whoever wants it. At the moment mothers access it themselves through a website called MumSpace, which has resources at various levels. If they just want some help with their baby crying, there are resources there, or if they need to step up because they think they have got a depression problem. So it is available to everyone. I think that there are opportunities in remote and rural communities. We know there is tele-coaching. There are other ways of reaching women. That is the direction that we are going in — looking at the range of delivery models that we can reach these women with. It is interesting with the Indigenous population, we were talking with a group about doing some work with them. So many have mobile phones. There is all sorts of connectivity that might be possible. There might be a community centre that could have a computer that has better access where women could go and use it. There are ways that we can really think about helping.

Ms EDWARDS — Do these programs offer any support with breastfeeding, or is it purely around practical —

Prof. MILGROM — Not on the MumMoodBooster, but on the MumSpace website the programs called ‘What Were We Thinking!’ and ‘Baby Steps’ talk about sleeping, breastfeeding and crying, the very common issues that really contribute to women struggling and not coping.

Ms ERICKSEN — And our parenting centres, Tweddle, O’Connell and whatever the other one is.

Prof. MILGROM — But I am talking about the internet.

Ms EDWARDS — I just have one more question in relation to ongoing and more prevalent access to these types of programs that are internet based and how that impacts on women. In regional communities a lot of women are very isolated, and the only opportunity they have to talk to other women, if you like, is through those get-togethers once a week or whatever. I guess I get a little bit nervous about women who are just sitting at home accessing programs on the internet to tell them whether they have got anxiety or depression or not and

not actually socially going out into their communities and participating. I just wondered if you had an opinion on that.

Prof. MILGROM — Totally, and I do not think it is an either/or. I think that social support and group treatment is one of the things we advocate. That is really, really important. Certainly one of the things that we would be advocating in the program is: go and build your social network. Isolation is a key to all this. The reason why we are looking for ways of trying to introduce maybe a human contact in between the internet program — coaching, funded somehow through government — is because it is good to sometimes have that extra motivation from someone. So I totally agree that it is not an either/or. The treatment program is providing treatment tools about how you tackle these thoughts that plague you, the obsessive depressive thoughts that you have all the time. That fulfils a different function than the other need, which is to be supported, to be able to talk to other people and to involve families and friends to do that. But I think both.

Ms ERICKSEN — But what we know about depressed women is that they find it very hard to go out. They are often the ones that do not go to that first-time mothers group because it is too terrible to hear about everybody else's perfect baby that sleeps and feeds. Yes, we would say it is really important to go.

Ms EDWARDS — One of my favourite shows on TV at the moment is *The Letdown*. Have you been watching that? It is great.

Ms ERICKSEN — Yes, we are certainly on board. Yes, they should go, but they are probably the ones who are not going to go. That is why treatment that comes to them that is accessible, whenever they can find the time to do it — it can be middle of the night if they want to — is going to be a first port of call, I suppose, for treatment for depression, if they are not going to get out. If they are going to go out and see a psychologist locally, fantastic, but the large majority will not.

Ms COUZENS — Thanks for coming along today. It has been really interesting. I sort of wanted to explore a bit more the idea of women accessing professional care maybe once or twice or whatever. For a lot of women, they do not, and more often than not it is just a GP. How do we get those GPs to come up to speed with identifying those triggers? Because I think they play a vital role, more so than ever now. And I do not want to sound like a dinosaur, but when I had my kids we went to an antenatal clinic every month. The professionals would explain to you about the third-day blues or whatever it was called. So you were actually brought up to speed on what to expect right from the time you were two or three months pregnant. That does not happen anymore. So I think there is that human factor in being able to go to a clinic, which was the norm to do, whereas now it has gone to maybe seeing your GP or seeing your GP once. How do we get over some of those barriers for a lot of women, particularly when it comes to that human connection and having someone to actually explain to you — without asking questions, it is all explained to you — before you go through that stage?

Ms ERICKSEN — As a fairly new grandma, I can say —

Ms EDWARDS — Congratulations.

Ms ERICKSEN — Thank you — that certainly the girls today are much more okay with a lot of things that are happening. They have it on their phone. They have apps that they are looking at, quite apart from what they are receiving through the hospital. So I think that they are one step ahead of where we were because they have a lot more at their fingertips. There have a lot of information. You might say, 'Well, is it good information?'. Well, they have a lot of information.

Ms COUZENS — Refugees and Aboriginal people do not have the same access though.

Ms ERICKSEN — No, possibly not.

Prof. MILGROM — So I agree with Jeannette, and that is what MumSpace was about — to have that sort of information on the website that mums could go to. But as you say, if they do not go anyway, they do not access anything. I do think that there are some issues about GPs and nurses working more closely together. That is really a problem. I do think that good GPs have to be masters of everything.

Ms COUZENS — That is right.

Prof. MILGROM — So it is a challenge of how you involve them. I think myself it will end up being a mixture of the professional relying on things such as MumMoodBooster — I use the example because you know what it is — so having a resource where he does not feel he has to then do all the work. Let me say that for the remote and rural communities before we did the MumMoodBooster we had self-help workbooks. We still have a very successful ‘preparation for parenthood’ one. You still can resort to some very good paper-and-pencil methods and workbooks and so on. But if you were to support GPs through training, obviously, but also make it easy for them to identify and manage, that is what our PIRIMID is — to talk to women but have other resources that they know are good and evidence based. It is not easy.

Ms COUZENS — I think for a lot of well-educated women that is fantastic, but for the lower socio-economic groups I think we need to be exploring other ways of supporting them.

Prof. MILGROM — Certainly we are totally with you, and we are totally open. It can be from talking groups to SMSs — if they have a phone — to tele-coaching, to GPs being more ready and open to deal with these things.

Ms COUZENS — Would you see those cultural groups in the community being a point of access to get that information to their communities — like the ethnic communities councils, the Aboriginal health co-ops, that sort of thing — and targeting them?

Prof. MILGROM — Yes, it makes a lot of sense.

Ms COUZENS — But it does not happen.

Prof. MILGROM — But it does not happen, no. The only good thing is that because there is such a high prevalence, at least we are trying to reach a lot. But now we are at the stage — exactly — look at all the people we are missing out on. What can we do about them, and how can we work? So it is the old story: work with people within the community to say, ‘What can we do for you?’, ‘How would you?’ — you know, focus groups et cetera. That is how we start to get our information. We do not want to make it up. We work with people.

Ms COUZENS — I think that is it; thank you.

The DEPUTY CHAIR — I have just got a couple more questions. With the apps that we have talked about, are they in many languages?

Prof. MILGROM — The apps that we are providing, not currently. Not currently, no, and I think that that is another problem, isn’t it? But even when you look at something like a screening instrument which has been translated, it has not been validated in all those other languages. So that is a huge problem.

Ms COUZENS — And cultural differences.

Prof. MILGROM — Cultural differences too. You might end up working with people within the community to do some translation, and we certainly would love to be doing things like that.

The DEPUTY CHAIR — So if they were translated, to undertake the validation work who would you see as being an appropriate group to do that type of work?

Prof. MILGROM — People like us.

The DEPUTY CHAIR — So you would be able to validate it in another language?

Prof. MILGROM — Absolutely. This is our bread and butter to look at the evidence around —

The DEPUTY CHAIR — So it would be translated and then you would re-validate it.

Prof. MILGROM — Absolutely.

The DEPUTY CHAIR — Just one more question. Can you also just talk me through the instances of postnatal depression in people that have suffered loss through stillbirth or infant death? Is that higher or lower or around the same?

Prof. MILGROM — For how we understand postnatal depression, yes. It would definitely contribute to an increased risk. There are many risks that will contribute to depression. There are about six that are big ones. They are things like family history, social support and partner support, and antenatal depression. Then there are many others — the relationship with your own mother — but that certainly would be something that would. For an individual it is factors coming together, and someone who has suffered a loss and particularly if they have not resolved it, it certainly would contribute to a risk.

Dr GEMMILL — It is a major life stress, for sure.

Prof. MILGROM — Yes. It is actually major life stress; you are right.

Dr GEMMILL — It is near the top of the list.

Prof. MILGROM — It would have to increase it. That is true.

Ms ERICKSEN — And we see increased risk with premature babies as well, don't we? With mothers who have had a preemie baby.

Prof. MILGROM — Yes, there is some. Alan is the researcher. If you want to know any research facts or findings, you have got the man sitting here.

Dr GEMMILL — Send me an email.

The DEPUTY CHAIR — We have got one more question from Maree.

Ms EDWARDS — Two actually, very quick ones. In terms of your funding, which is federal funding — because traditionally the federal government funds research — is that ongoing, recurrent funding?

Prof. MILGROM — Not currently. At the moment we are funded until June 2018. We are hoping to be able to continue it for another year, but that has not been confirmed.

Ms EDWARDS — Is that the only funding that you receive or do you have other avenues?

Prof. MILGROM — For that initiative, yes. We would also like to be able to work perhaps with primary health networks and have some funding for the coaching, for doing it there. For it to really work well there needs to be — for perinatal work in general — ongoing funding. That has been the problem with the national perinatal. You have these great initiatives that come up, but how do they continue?

Dr GEMMILL — Yes.

Prof. MILGROM — Thank you for asking that question because it is something that does keep me awake at night.

Ms EDWARDS — Yes, budget submissions are challenging.

Prof. MILGROM — It is hard to keep it going.

Ms ERICKSEN — We have had funding from a variety of things. We have had some funding through the Victorian government for the training for maternal and child health nurses. We have had philanthropic money. We have had research funding.

Dr GEMMILL — Of course.

Prof. MILGROM — A whole lot of things, so it is pieced together.

Ms EDWARDS — A lot of grants.

Dr GEMMILL — Competitive grants — NHMRC grants.

Prof. MILGROM — But that is not for the translational work; the translational work is a different paradigm, and that is a challenge. And when I talk overseas — because there is a lot of interest — that is what we are grappling with. How do we make these things sustainable?

Ms EDWARDS — So when you put your submission in, the national guidelines were being established. They have been done, haven't they?

Prof. MILGROM — Yes.

Ms EDWARDS — They have been revised.

Dr GEMMILL — Yes.

Ms EDWARDS — When did that happen?

Ms ERICKSEN — Just recently.

Dr GEMMILL — They were launched in October.

Prof. MILGROM — In October, yes, at the Marce conference.

Ms EDWARDS — I guess without elaborating too much but in terms of it being a national guideline for all services delivering perinatal mental health, what is the uptake in adherence to those national guidelines? Are they obliged to or they do not really have to, or it is just there for their own —

Dr GEMMILL — It is a recommendation.

Ms EDWARDS — It is a recommendation. Thank you; that is what I wanted to know.

Dr GEMMILL — It is not mandated, certainly not at a federal or a state level.

Ms EDWARDS — Would mandating it make a difference?

Prof. MILGROM — It would. It definitely would.

Dr GEMMILL — That is a very good question. You would think it would, yes.

Prof. MILGROM — The careful researcher — but yes, it definitely would.

Dr GEMMILL — You would need to evaluate that.

Prof. MILGROM — The national perinatal depression initiative went one step further, but that funding ceased as you know. It had a framework that was recommended, and there was some funding for it from the federal government. So that meant that — if you couple funding and the framework — it happened, but even then it happened in an uncoordinated way across Australia. So yes, you do want to see the recommendations, but as we have pointed out there are also some shortcomings of the guidelines. So there is screening, but the big problem is that that is not enough. You have got to actually integrate.

Ms ERICKSEN — You have got to have the pathways to care.

Prof. MILGROM — You have got to have the pathways to care, so just saying 'follow the guidelines' is not enough — follow the guidelines and address the major issues. So there is that and, yes, mandating that perinatal and mental health identification and management is important.

Ms EDWARDS — Thank you very much.

Ms ERICKSEN — It is vital.

The DEPUTY CHAIR — Thank you very much. The committee has greatly appreciated hearing from the Parent-Infant Research Institute. You have had a lot of great information.

Witnesses withdrew.