

TRANSCRIPT

FAMILY AND COMMUNITY DEVELOPMENT COMMITTEE

Inquiry into perinatal services

Bendigo — 24 October 2017

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Witness

Ms Ursula Kiel, senior clinician, St John of God Raphael Services.

The DEPUTY CHAIR — I now welcome to these public hearings Ms Ursula Kiel, senior clinician from St John of God Raphael Services. Thank you for attending here today. 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.

I invite you to show us your slideshow and make your statement, and then we will follow that with questions.

Visual presentation.

Ms KIEL — Thank you for inviting me to present today on behalf of the Raphael service. As I have mentioned, my name is Ursula Kiel. I am the senior mental health clinician at the Bendigo Raphael service. My background is more than 10 years in mental health services. I originally trained in occupational therapy. I have worked in public and private mental health, perinatal and infant and child and adult mental health services.

Today I am going to talk a bit about what we provide at our service and, similar to what Helen Lees has spoken about previously, some of the challenges and some of the gaps in the services for our region as I see them. Our service, as mentioned, is a perinatal and infant mental health service. We see families during pregnancy. Up until a child turns four we consider to be that postnatal period. The mother is the identified client — or at times it might be a father — rather than the child. We are located in Kangaroo Flat here in Bendigo.

There is no cost to the client in attending the service so we receive funding from a range of different areas. We report to St John of God Health Care's social outreach division — that is based in Perth. They fund the service, but we receive some additional funding from the Murray Primary Health Network — that used to be called funding; its name has changed, but it is some federal mental health funding — and Medicare, so better access to mental health for allied mental health professionals and psychiatry. Clients do not pay any out-of-pocket cost. They do not need to have had their babies or pregnancies cared for through St John of God, and they do not need to have private health insurance.

In terms of staffing, as you can see, we are a very small team. We have 2.7 FTE of clinical staff; 0.4 of that, or two days a week, is our psychiatrist, who is our clinical director, and 2.3 of that is mental health clinicians. Currently that is four staff working between two and four days per week. There are several occupational therapists, a social worker and a mental health nurse on the staff currently. At different times we have also had psychologists, depending on the staffing mix. We all provide that clinical care to clients in a mental health clinician role.

The sorts of things that we offer are a comprehensive assessment of mental health and treatment for those conditions. The main conditions we would see are perinatal depression and anxiety. That is, I guess, what our service is targeting, but as Helen touched on previously, there are times when people present to a mental health service for the first time, and they might have actually had an existing mental health problem that has not arisen, or they have not sought treatment until this perinatal period. That is not unusual with our client group. We also provide psychiatric assessment and treatment by the psychiatrists. That may include medication for some people if that is required.

Our key approach, and I guess what is different within our service compared to other public and private services, is that our focus is really on the parent-child relationship — not just on treating a mental health problem in the parent and not just on focusing on the parenting skills with their infant but really addressing both in conjunction.

We offer other types of psychotherapy — things like cognitive behavioural therapy, relaxation techniques and helping them sort of re-engage in a range of different services as well. Psychosocial support and education — we put a lot of emphasis on helping the parents themselves understand about the mental health problems they might be experiencing and helping them prevent a relapse so that I guess ideally they have that period of service with us and do not need to come back to see a service again or have a good sense of what might be the early signs of relapse, particularly if they had a future pregnancy. We also help them link in with a range of other services if they are not already engaged.

Parent skills development is thinking specifically about that parent-child relationship, but for some families, particularly if they have had a difficult early life themselves, they do not have a good, I guess, role modelling of parenting and attachment — you know, connection — with a baby, so we start with some fairly basic work with some families around just being with a baby and playing with them and things like that.

We also provide groups which again are focusing on that parent-infant relationship. One example is a program called the Circle of Security, which is an American-based program that has been really well received. They run regular training — I think at least twice a year just in Melbourne. There is a huge demand. It is basically a well-researched parenting program around improving that attachment relationship between parents and children, helping them recognise the cues that even young babies are giving them about their needs, whether that is for basic things like a feed and a change or whether it is about wanting to connect with their parents on an emotional level — and we know from research that that can be something that is more difficult if the mother is depressed particularly and that babies might start to withdraw if they are not getting that emotional connection with their mum. We think those sorts of things are really important.

In terms of service delivery, our service has been open almost five years. These are just some stats from the last financial year. In that period we received 165 referrals and we worked with 177 clients because some were from the previous year. The length of treatment averaged 13 sessions, which is more than what is funded through Medicare Better Access and also more than what the primary health network, through the ATAPS funding, would provide. That is an example, I guess, of a gap where St John of God's funding of the program just covers that cost. Approximately six months of treatment was the average length.

In terms of where our clients have come from, predominantly they are within Bendigo or the Greater Bendigo region, so outlying towns like Elmore and others, but we have also had clients coming from nine other areas. They included — some quite a distance — Buloke; Gannawarra, which is Kerang area; Moira, which is over towards the north-east; and Mount Alexander, so Castlemaine. We did have an outreach service regularly in Castlemaine up until earlier this year. Partly staff changes and partly less referrals from that area meant it was not sustainable to continue on a weekly basis, but there is an option to resume that. We have had people travel from the Swan Hill area, Loddon shire and Central Goldfields — so Maryborough area — again because I think in terms of access to this specific type of mental health care it is longer term than what is typically in the public mental health system, and there are not a lot of private providers around that can do this specific work or people cannot afford to pay for that.

We do not have a geographical boundary, but it can be difficult to sustain at least attending fortnightly if someone is travelling up to 2 hours one way to see us. If they are really keen, sometimes they might be seeing a private obstetrician in Bendigo antenatally and are able to fit their sessions with us into the same day they are visiting. Those sorts of arrangements we have been able to provide, but otherwise we really encourage people to look at whether there is something closer to home that might be more sustainable for them, particularly once their baby is born and the logistics of doing a long trip might not be as easy.

In terms of partnerships, as I said, we are co-located with Bendigo Community Health Services. They have three sites in Bendigo, but we are located with their Kangaroo Flat service. Kangaroo Flat is a suburb that is seen as an area of high disadvantage anyway, and that was part of why St John of God chose that site to partner with them. They have got a range of services that our clients may be already accessing or may benefit from. We really benefit from being able to walk up the passage and have those conversations. There are paediatricians or paediatric registrars and their allied health clinics such as autism clinics; family support services; the Cradle to Kinder program, which was mentioned earlier — their service is also located there; drug and alcohol; and they have other mental health and counselling services as well. There is also a maternal and child health centre across the car park from us, and given that we do see a fair few clients from around our local area, that can be handy as well.

Our main liaison, though, is with GPs, because they are who provide our referrals, and some private obstetricians, more so than public obstetricians. Maternal and child health services often will provide provisional referrals to us or ring for advice about families they are working with, particularly from their enhanced maternal and child health service that was spoken about earlier.

Public mental health services — we liaise both ways at different times. We are part of the parent-infant mental health working party, which has representatives from a range of agencies for the Loddon Mallee region, but particularly it is chaired by Bendigo Health CAMHS, the Child and Adolescent Mental Health Service, and

representatives from a whole range of other services working with this age group. That is a great way for us to keep in touch with what is happening in all those different agencies, to share ideas and to come up with ideas for training to run together in the region. Also we tend to touch base on things like waitlist times for the different services or staff changes. We also have close links with St John of God Bendigo Hospital, obviously, being part of the same service. Originally our service was set up under their umbrella, but earlier this year we have been realigned under the social outreach national division, as are the other Raphael services around Australia. We have an ongoing relationship with their maternity unit, so we will do face-to-face intake assessments if they are concerned about a mother on their maternity unit, or at that earlier stage of booking in for their maternity care, they might flag referrals with us. Staff from our team also go and talk at the antenatal and postnatal classes that they run. We often find that that leads to referrals to us for people that did not otherwise know that our service was out there.

Gaps — some of this information probably is not surprising, but, as Helen mentioned, there is a gap between what we can offer and what the public mental health system can offer. We are a Monday to Friday, 9 to 5 service, and we have a small EFT. We cannot provide that crisis care that some people need for at least short periods of time, so we facilitate referrals through to Bendigo Health psychiatric services if needed, or, as I said, occasionally the referrals might be outside of the Loddon Mallee region, so we would make sure that that person is accessing public mental health elsewhere if they needed it. There can also be challenges because we do not provide outreach. We are an office-based service, so if people are having difficulty with transport, finance or whatever it might be, we try to work with them as much as we can or, if they have got another agency involved, to help coordinate transport with that worker to bring them to appointments, but we cannot always be as flexible as perhaps we would like with that.

More serious or severe mental health conditions that have a longer term need for treatment like psychotic illnesses, bipolar disorder if it is at that more severe end and personality disorders generally require quite long-term treatment. We have had cases where we might provide some care to those patients if they are well enough and able to and wanting to work on the parent-child relationship, but if it was really more about them having, for example, a psychotic episode in that postnatal period, and it is not about the relationship with the baby but about them needing that specific care, that would generally be through the public mental health system.

In-patient care — not a lot of our clients need that care. They tend to be at the mild to moderate end of illness. That certainly improved with the opening of the local parent-infant unit, but there are times when the child might be over 12 months. Their cut-off is around a child that is 12 months old, or walking, and I can think of examples just in the last month where the child might be 15 months old or already walking at 11 months, and they would benefit from an admission but they are not able to be admitted there. So again, thinking about the parent and the young child, sometimes it is more that toddler age when there would be great benefit in both parent and child being admitted together to support that continuing relationship. It can be a barrier for women who probably need inpatient care to accept an admission because they do not want to be separated from their child.

Enhanced maternal and child health is a fantastic service. We have a lot of relationships with the workers on the ground. Sometimes they are holding cases that really need mental health care and the parents are not quite ready to engage. Sometimes we support them in a secondary consult way, but there can be more demand for that sort of service. People might wait quite a while to get that support, and that can be a challenge.

We generally would always have a wait of at least a couple of weeks for our first appointment, so usually around, say, two weeks, but in recent months that has been anywhere from four to six weeks. Annually we seem to have an increase of referrals around September and October. I believe certainly at St John of God Bendigo they have an increase of babies born around that time as well, so that tends to be a challenge, but it does mean that sometimes families get to that point that they feel they need the help, they go through the process of getting a referral and then they get quite disheartened with the wait time. We try and manage that as best we can, but there is never enough support.

As Helen mentioned earlier, we do ask people to get a GP referral and a mental health care plan to access our service. That is to do with obviously wanting to have a collaborative approach with the doctor, who would continue the care longer term and get that background, but it is also a funding requirement for Medicare and the primary health network. It can be a barrier to people accessing our service, but I have generally found that if

people call and inquire, we talk them through the process or sometimes send a letter to their doctor to say, 'We think this person would benefit. They are going to come and see you for an appointment'. That can help them through that process.

Probably the only other thing to mention is, as I said, our service is time limited. We do not have a specific cut-off, but it is around trying to determine at the outset what we can offer and whether it is better for them to access another service then or whether we have an agreement with the family about a specific lot of work and then looking at referral on.

We do see some fathers. That is a growing area probably of demand and interest for our service. It can be challenging in that sometimes mother and father might both be referred, and so we would not usually see both parents because we are such a small team with one psychiatrist. It creates some issues around privacy and separation of support, so wherever there have been cases where both parents are referred, we work with them to work out who we will see and who we will support to access care elsewhere.

The other thing I guess that seems to be increasing in funding federally is around telehealth, and there are going to be some increases in, I believe, Medicare funding towards those services in November, which will be good. I think as a general population approach I see some real challenges for how that could work in our sort of work, because we are wanting to see parents with their children. I am not sure how well that would work over videoconference, but it may be something that becomes part of our role and provides us with a greater outreach than what we can provide currently.

Lastly, I have got some contact details if anyone would like to follow up, and I have brought some brochures for our service too that you can read.

The DEPUTY CHAIR — Thank you very much. We will appreciate getting those. We will also get a copy of your slideshow, if it is possible?

Ms KIEL — Yes.

The DEPUTY CHAIR — Again, another comprehensive statement giving us a good idea of the services that you offer. One of the things that you mentioned towards the end was about the waitlist, and typically you have a two-week waitlist but more recently it has been four to six. Do you know why that is?

Ms KIEL — A combination of the increase in referrals around this time seems to relate to increased births around this time of year. As I said, for at least the last three years September has been the highest referral time for us. Midwives I have spoken to on the maternity unit say that something happens nine months before. That means, you know, the Christmas period perhaps. I think for us it is a combination. We have had some changes of staffing. With school holiday periods, given that in our workforce some have their own families, perhaps it is around leave at different periods. But more generally I think it is just about an increase of demand at this time of year that then does settle. In terms of looking at increasing staffing, we are hopeful there will be an increase in our clinical staffing, but there are other periods of the year that our demand is less. It is hard to make sense of.

The DEPUTY CHAIR — Do you have many no-shows?

Ms KIEL — Yes, we do. We have no-shows. We try to manage that through, where possible, offering the appointment times that best meet the client in conjunction obviously with our availability. Transport issues and things, as I mentioned earlier —

The DEPUTY CHAIR — Perhaps often a challenge with the free service as well?

Ms KIEL — Yes, I think so. Making sure that people understand that there is a demand on the service can help with that. We have got some things that have helped a bit. We have SMS reminders about appointments. If there are people who repeatedly might fail to attend, we have some processes about following up, maybe doing a reminder phone call the day before or things like that to really encourage people to attend. If they have some sort of support service involved, like family services, we might liaise with them and see if they can help that person get to their appointments — that sort of thing. But no-shows or reschedules are a challenge and, working with parents and young children, kids get sick, parents get sick, they cannot get child care — those things do all create an element of no-shows for our service.

The DEPUTY CHAIR — In terms of postnatal — days, weeks, months postnatally — what is the average referral?

Ms KIEL — In terms of at what stage postnatally they might be referred?

The DEPUTY CHAIR — Yes. When you say it is hospital staff who pick up and say, ‘Hey, listen, you need to click in here’?

Ms KIEL — Yes, they do, but I think sometimes it would be unusual for people to get to around three to four months after having their baby. I think it is a combination where if they have a partner, the partner might have a period of time off work after the baby is born and it is after they have returned to work and that readjustment period can be a trigger. I do most of the intake work for our service, so we have a phone screening of the referral with the client, and very often people will say, ‘I thought I was going okay’ or ‘I thought when I got a bit more sleep I would feel a bit better, but a month has passed and I’m not feeling better even though I’m sleeping better or my baby is sleeping better’, and things like that. Usually it is at least a couple of months after the birth, or antenatal referrals often are because they might be pregnant with a second or third child. They sort of soldiered on after having a first child and maybe got better, maybe did not, and then hear about our service antenatally and decide that they might need some support because they are anxious about how they will cope after the baby is born.

The DEPUTY CHAIR — You mentioned ante and postnatal classes. I assumed that they were group work?

Ms KIEL — Yes. The classes that we assist with are for St John of God, so they are private patients obviously through St John of God Bendigo. They have a range of antenatal classes. We go and speak at one of the three classes that they run, and our approach is more about general emotional wellbeing.

The DEPUTY CHAIR — Okay, so they are not the people who have been referred?

Ms KIEL — Sorry, yes. We do run groups for our clients as well. Typically people will always come and see us for an initial assessment first. So we have had times where we have run antenatal group programs, but we would always do our usual assessment first to exclude any concerns or need for more specific care. The antenatal programs that have run have been based on a model from the women’s hospital in Melbourne. It is around wellbeing, I guess, but it is for people who have been identified as having or being at risk of depression and anxiety during their pregnancy, helping them prepare for the birth. One of those sessions includes their partner or a support person, like a parent, to give them some education as well.

The DEPUTY CHAIR — Finally, you mentioned the referral to the Bendigo Health psychiatric services if somebody is bipolar or has psychotic episodes or things and that there is inpatient care. Are the support services for the people that need more intensive work available locally?

Ms KIEL — Not as much as we would like. I say that in my current role and having worked in that system previously. The demand for the public mental health system, I think, has grown far more than they can deliver, so their threshold for accepting a referral — someone needs to have quite an acute, urgent need for care. Sometimes we receive a referral for someone who has quite significant mental health problems, whether they have a diagnosis of bipolar or something or not — it might be depression. They might get a period of short-term, I guess, what used to be called the CAT team — crisis mental health care — but once their self-harm or suicidal thoughts, for example, resolve they might not be seen as needing the longer term case management. They are also no longer eligible for their crisis care and they might still be too complex for what we can offer in terms of a fortnightly appointment. They are examples of, I think, what Helen was referring to earlier. They do not quite fit with any of the services and sometimes it means something has to change for them to then get in at one of those services.

Ms EDWARDS — Good to see you. Thanks for coming down. We heard about Raphael services at one of our hearings in Melbourne, and we are keen to hear a little more. In terms of offering programs and services, do you have particular supports available for women in particular, I suppose, who are from other multicultural communities, like our Karen community, for example, and also from Aboriginal and Torres Strait Islander background, and do you work with BDAC in relation to some of that?

Ms KIEL — We do not have a current close partnership. I would say the diversity is not as diverse as it could be. The Bendigo region is not as diverse, certainly, as other areas of Victoria. The majority of our referrals do come from an Anglo-Saxon background, I would say. We have had increasing referrals of people where English might be a second language or they might be migrants to Australia from a range of different countries. Some might have a refugee background; some might not. But I would not say we have any specific work in those areas at the moment. It certainly was something that had been looked at some time ago. A challenge with that is that our service has restructured and we no longer have an on-site manager; we have a manager that is covering the four Victorian Raphael services. They are some of the things, I think, that are going to be challenges for us moving forward. How do we ensure that we improve and maintain some specific links in our specific region so that some of the groups that can experience even greater disadvantage or more difficulty accessing mental health care can be seen?

Ms EDWARDS — It could actually mean that the women from our CALD communities or Aboriginal and Torres Strait Islander communities are not seeking support or are unaware of the services that are available. In relation to our GPs across the region, do you think there is good identification and treatment and potentially referral when perinatal depression might exist — or anxiety?

Ms KIEL — I think it is improving, and I say that based on the variety of referrers that we are having, the phone inquiries we get from GPs and the level of detail in the referrals, but we also get some anecdotal updates from clients where they might talk about having initially approached a particular GP, whether that was their usual doctor or not, and maybe feeling that they were dismissed or that their symptoms were not recognised, and they might have decided then to go to a different doctor or they might have decided to go back after having sat with those concerns for a while. I think overall though there is an increasing interest in and knowledge of our service in our region, and quite a few GPs will ring and just say, ‘I’m not sure if this referral is appropriate. Can I talk to you about it?’. I guess we can only go by what we hear and what we see, but yes, I do think it is improving.

Ms EDWARDS — I just have one last question. We have a very high suicide rate across our region, and I just wondered if there is any breakdown that you are aware of maternal suicide in our region? We know the broad risk factors, but what are the particular risk factors that women through that perinatal period might experience?

Ms KIEL — I do not know the stats on perinatal patients. I guess I can say confidently that in the time that our service has been opened we have not had any deaths of patients of our service, but certainly it is why we are very mindful about both having that screening process at the start or liaising with public mental health — so even if we are not sure if the referral will be accepted at their end, still making those referrals and having those conversations. I think some of the increased risks can be around other diagnoses, like substance use that might be co-occurring. It can be about child protection involvement, which I guess is a double-edged sword. It might be the distress of having that involvement, but at the same time that involvement usually means there are some significant concerns with that family. Access to help in a timely manner is a big barrier as well, but I think that is improving with a range of services, public and those like ours. There is less stigma about accessing help in the perinatal period than there used to be. I think it is becoming much more accepted and known about, particularly postnatal depression. People in the general community seem to be much more aware that there is a problem and that it is okay to get help, I would say, compared to other mental health conditions at other times in life.

Ms BRITNELL — I just want to go back. You said that when they initially set up as an organisation, St John of God recognised that they wanted to begin at the lower socio-economic area of Kangaroo Flat. I do not know the area; I am repeating what you said.

Ms KIEL — Yes, that is okay.

Ms BRITNELL — We also heard from the previous person — and you have mentioned it yourself — that alcohol and drugs, mental illness and family violence were key contributors. Is the finding in your experience that it is at the lower socio-economic end of the spectrum, or is it right across the spectrum of socio-economic status that you are seeing women using your service from?

Ms KIEL — In terms of just our general population that we are seeing?

Ms BRITNELL — General, yes. What have you found? Is it because of the lower socio-economic end who are suffering more, or are we seeing it right across the spectrum?

Ms KIEL — Right across the spectrum. Our service was set up to target the socially disadvantaged groups — isolation, single-parent families, young parents, drug and alcohol co-occurring, child protection involvement et cetera — but obviously the service is open to anyone that needs it. But I would say that it does not discriminate. Currently our median age is actually more in the over-26 and under-35 groups, but in saying that we have mums attending the service from mid to late teens up to mid-40s. Whilst we perhaps have a reasonable proportion of lower socio-economic groups because of our location and our no-cost, I could not give you some exact stats, but we certainly see many people who might be from higher-education, professional backgrounds who might have never accessed mental health care before through to those with multigenerational unemployment, single-parent families, child protection involvement and everything in between.

The DEPUTY CHAIR — Finally, with regard to your comments regarding telehealth and that you would like to see parents with their children, is there any role that you can see for telehealth in your organisation and your services?

Ms KIEL — Yes. I know this will be in a transcript but do not quote me on it currently. I know there is a Raphael service in Blacktown in Sydney that does outreach to Tamworth and some other regional sites. I do believe they already have some use of telehealth. I could not tell you exactly how that works, but I believe it is more in terms of reviews of existing patients. In terms of the usual work we do in the room in the therapy with the parent and child, I do not think that would work, but in terms of maybe reviews in between periods of therapy, where there is a need to keep connected with somebody but for some reason they cannot attend, maybe there would be scope for telehealth. The other one may be in a secondary consultation role from other maternity services, say, in smaller country hospitals, where they are wanting to discuss or think about a particular patient and perhaps have some contact with that patient via the video link to determine if they would be suitable for the service — that sort of thing.

Ms EDWARDS — Sorry, I am going over time.

Ms KIEL — That is okay.

Ms EDWARDS — I was just curious in relation to support for new dads, in relation to fathers during the perinatal period, but also the support for families — parents, mothers, fathers — when there is pregnancy loss.

Ms KIEL — With dads, as I said, we have had an increasing number of referrals. When I say that, it is still small, but in my couple of years working in the service we are getting more inquiries about or referrals of dads. As I said, there are some challenges for how we can meet that if the mother is also needing care.

Ms EDWARDS — Are you seeing increasing numbers of men presenting with depression and anxiety? Is that what you are saying, as opposed to more severe mental illness?

Ms KIEL — Yes. I would say, though, it is possibly that GPs are specifying it as a perinatal depression. They are recognising that dads go through a period of anxiety, depression, adjustment, to having a child, just like mums, and that the symptoms can be sometimes different to a general depression but can be related to the stress of that time and of supporting a family. It might be around their finances and so on as well. I think meeting that need is going to be an increasing demand. We try to involve the dads right through the whole process. So from the point of intake — as I said, mothers are generally our referred client — we let them know that as part of our usual process we want to meet their baby or young children, we want to meet their partner, we want to work with them together. They come into some of the sessions, get some education and support, and it is a way of us checking in how they are going. If we identify that they need mental health care, we then work with them to access that. Yes, so I think it is a combination of the community understanding more about perinatal depression and anxiety in dads, seeing that as a specific condition and thinking about specific services for that.

The DEPUTY CHAIR — Thank you very much, Ursula.

Ms KIEL — Thank you.

Witness withdrew.