T R A N S C R I P T

FAMILY AND COMMUNITY DEVELOPMENT COMMITTEE

Inquiry into perinatal services

Warrnambool — 11 October 2017

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Mr Nicholas Place, Manager, Primary Mental Health Team, South West Healthcare.

The CHAIR — I welcome to these public hearings Mr Nicholas Place, the Manager of the Primary Mental Health Team at South West Healthcare. 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 copy of the transcript. Thanks for attending today, Nicholas. Would you like to start by giving us a brief statement for 10 or 15 minutes?

Visual presentation.

Mr PLACE — Yes, certainly. Thank you for the opportunity to present today. My name is Nicholas Place. I manage the Primary Mental Health Team that incorporates the Perinatal Emotional Health Program, which you have heard a little bit about today.

In terms of the focus of my presentation, in the written submission and in my presentation today, it was the inquiry's second term of reference that directly related to the program that I manage, but I wanted to also comment on other terms of reference — namely, 1, 5, 6 and 7. I guess the motivation behind the presentation too is that South West Healthcare, particularly Mental Health Services, has a long-established history of supporting perinatal mental health initiatives, so that was partly my motivation as well.

You have heard from some of my colleagues today, including the Director of Nursing. I included a brief slide about the hospital itself. We are a provider of acute health services but also mental health services — both inpatient and community rehab services — aged care, primary care and community services. I thought it was important just to highlight what it is that the entire hospital presents.

In terms of the Mental Health Division, we service a population of 110 000 people across the five municipalities. Mental Health Services has regional centres in Portland, Camperdown and Hamilton and clearly in Warrnambool. The Mental Health Division is separated into a number of different teams or programs: the Child and Adolescent Mental Health Services team, Adult Mental Health Services and the Aged Persons Mental Health Service. The team that I manage, the Primary Mental Health Team, incorporates the Perinatal Emotional Health Program. I have not listed there the inpatient facility. We have a 15-bed inpatient facility and an additional five beds of extended inpatient care, and we are about to commence use of the PARC facility that has been recently built.

A little bit about the Primary Mental Health Team: it is a relatively small team, 7.6 FTE, and multidisciplinary in nature. The brief of that team is to support GPs in their assessment and management of consumers with high-prevalence disorders — that being depression and anxiety. We do that through co-location in the GPs' rooms.

Specifically the Perinatal Emotional Health Program that you have heard a little bit about is 1 FTE. We have two midwives employed across that 1 FTE, both at 0.5. One of those midwives, Andrea, is present here today. She has come in from her annual leave. The brief of the Perinatal Emotional Health Program is to support women and families at risk of or experiencing perinatal mental health concerns. We have got Andrea on the right and Carly. Andrea has been with us from the inception of the team. The team was first funded in 2000, so she has been with us since then, and Carly joined us earlier this year.

I wanted to highlight a little bit about the team, specifically the funding model established by the Victorian government. This initiative too was for rural Victorian area mental health services, not for metropolitan services. The funding model was that we were allocated 1 FTE on the basis of 1000 births. So given that we had a little over 1000 births in our region, we received 1 FTE. The Perinatal Emotional Health Program is supported by, as I said, the Primary Mental Health Team and its consultant psychiatrist.

In addition to their midwifery training, Andrea and Carly have additional training — a graduate certificate in primary care, diploma of mental health nursing and masters in counselling work. So there is a level of expertise beyond their midwifery that equips them well to work in this area of perinatal mental health.

The region extends, as I mentioned, across five municipalities, 26 000 square kilometres, four birthing hospitals in that region, our own hospital here at Warrnambool and also the Camperdown campus but also Portland

District Health, the Terang and Mortlake Health Service and the Western District Health Service. Across the catchment area we have roughly 1070 births on average. This past year it has actually dropped a little. Since its inception PEHP has received on average 120 referrals a year. With a birthrate of a little over 1000 people, that represents 12 per cent of women being referred to the program. The incidence of perinatal mental health concerns is anywhere from 8 to 15 per cent, so if you compare the two figures, we are hitting the mark in terms of receipt of referrals of women in need. I guess what it says to me is that the demand for the service is definitely there, and there is also significant recognition of the program's value and the outcomes that the program provides to not only consumers but other stakeholders as well — the referring stakeholders.

I have included a graph there that demonstrates referrals since our inception. I highlight that during the past couple of years when there has been some uncertainty about the funding — and in the context of actually having a reduced FTE for at least six months of that two-year period — we in fact saw an increase in our referrals. Clearly with a quarter to go in this calendar year we will reach some significant numbers of referrals this year.

In terms of who refers, we can take a referral from anybody. The largest referrer is acute health represented by midwifery floors across the region and the Women's Health Clinic that Rachael heads up. They are both followed by referrals from GPs, consumers themselves, family support agencies, et cetera.

Are there any concerns about the referral trend? I do not believe so. I think the significant referrer being acute health — midwifery floors and the Women's Health Clinic — reflects their recognition of the need that their clients / patients have.

In terms of the interventions by the PEHP workers themselves, they perform a triage function — clearly an assessment of the consumer's needs, treatment planning and then the subsequent implementation of that plan. They undertake consultation and liaison — so on occasions they are not seeing the client but they are offering advice to stakeholders.

There is a clear care coordination role that they exercise in terms of a range of needs that their consumers might have. On many occasions they find themselves performing a very strong and passionate advocacy role in terms of addressing women's needs. They have an education and training aspect to their function, and that is to other stakeholders, other care providers. I did want to highlight as well that whilst we are very accessible to consumers when they are an inpatient — that is, on a midwifery floor as opposed to home based — our services are principally home based.

The outcomes for the PEHP: independent of our own experience, research demonstrates that women, infants, children and their families receive long-term benefits from early intervention services. We have our own data that reflects — in terms of pre and post interventions — outcomes that are positive through reduced depression, reduced anxiety and reduced stress symptoms. On our own consumer feedback — and I did include some testimonials in the written presentation — we certainly get very positive feedback from consumers themselves. I think we also see in our own observations and reported by our consumers that they experience enhanced parenting roles, enhanced mother-infant relationships and enhanced family functioning.

During the last couple of years the acuity of presentation has increased. In the last six months in particular we have seen quite a number of women that we have supported with major mental illnesses, so that client group has particularly benefited from the work that we have done in conjunction with Mental Health Services who might be case managing them. I think there are clear benefits to other stakeholders — the referring midwives, general practitioners.

The final point on that slide, I guess, is I want to highlight the cost-effective nature of this program. You have seen that in some of the former slides: 1 FTE across five municipalities, four birthing hospitals, this year taking 140 referrals. On the raw data that reflects a very cost-efficient model.

There are other programs within South West Healthcare that do provide work in this psychological space for women. Our Child and Adolescent Mental Health Services team does some Circle of Security work, and they also have newborn observation expertise. They are similarly seeing an increased acuity of presentations.

The hospital has counselling support services, and some of the activities that they perform I have noted there — responding to unexpected outcomes. So they might be birth defects, for example, or bereavement support. In the

former presentation you heard a little bit about palliative care, so they would certainly offer support to women and families around bereavement. Some pretermination counselling may be offered, and; a consumer advocacy role, particularly in relation to child protection presentations. You heard a little bit about the special care nursery today, and they find themselves doing a lot of work with families around a family's needs and infant needs. Like ourselves they offer staff support.

Healthy Mothers, Healthy Babies is a new initiative recently funded. It commenced in 2017 here at South West Healthcare. Again that is a small FTE — 1 FTE staffed by a midwife and a community worker. They are some of the activities that they undertake. That program specifically targets women who might otherwise not access optimal antenatal care. Their brief also extends to four to six weeks postpartum. I should have indicated that the brief of the Perinatal Emotional Health Program is from conception through to 12 months postpartum.

So what are the achievements? I guess we are drawing to a close. I think the Perinatal Emotional Health Program has consolidated the work that the hospital's Mental Health Services in particular have established around the routine or systematic inquiry of psychological health that all the birthing hospitals in our region exercise. So it is a routine experience that for anyone presenting for antenatal care or when birthing or postpartum, their psychological health will be inquired about. The Primary Mental Health Team initiated that back in 2004, when together with the antenatal clinic, there was the introduction of the Edinburgh Postnatal Depression Scale and some psychosocial questioning. That was roughly concurrent with Beyondblue beginning to research the efficacy of using that tool during the antenatal period.

There is significant capacity building, so this is our midwives and mental health staff in general supporting other stakeholders in their recognition and then support of women with psychological needs. I think the utilisation of PEHP clearly demonstrates a recognition of their expertise and the significant demand for services, and I think the consumer experiences will speak volumes about our achievements.

In terms of the challenges, the FTE profile of one across the region is a significant challenge. I think there is a critical mass that you need, and one FTE is not that critical mass. Covering leave and absences in itself is a challenge. With that number of referrals we need to have a demand management strategy. I guess we do that in a way that is consistent with a stepped model of care that is endorsed within both state and federal policy frameworks. The funding uncertainty has placed some strain on our services over recent times. It was very pleasing that the State Government guaranteed that funding earlier this year. We understand that they have indicated that it will be recurrent. A further challenge for us — I guess again consistent with my colleagues from the acute services — is the increasing acuity of presentations.

In terms of a take-home message I suppose I have some summary remarks for further consideration. If I could highlight that the delivery of such interventions through programs of the nature of PEHP, but not restricted to PEHP, especially in rural settings is critical for these families. Rural settings, whilst we are often challenged by a range of inhibiting factors, do boast dedicated, resourceful, creative and experienced skilled practitioners. We do things well. In terms of the current funding formula, I think it is insufficient at the present time.

I guess the final point I have noted on the slide is that despite the latter point of insufficient resources, I think we are very cost-effective.

The CHAIR — Thank you very much, Nicholas. There is a lot to think about there. Do you mind if we ask you some questions?

Mr PLACE — No, absolutely.

The CHAIR — You have talked about the cost-effectiveness and good outcomes of PEHP, but it is 1 FTE. I understand that that is putting constraints on the service. What has changed as far as the training for the PEHP staff with the withdrawal of the commonwealth funding? Even more broadly, what effect has it had?

Mr PLACE — We experienced some uncertainty. The Commonwealth indicated in some consecutive years that they were considering withdrawal of that funding. So there was some strain on teams — not only our team but the other teams across the state. When the Commonwealth did withdraw its funding, most of the teams across the state closed, with the exception of our own service and also the service at Wangaratta. I understand you will hear from that team in particular.

What I was able to do was secure the support of my director, who guaranteed funding in the absence of the Commonwealth share to ensure that we continue to function at 1 FTE. With some heightened uncertainty and some additional pressures on the overall mental health budget, there was a period of six months where our FTE reduced from one back to 0.5 — half time — so that meant we saw less clients. There were less people getting our support. There was greater strain on the existing resources at that time.

Mr FINN — I am interested to hear your views on the impact of illicit drugs on the mental health issues of women that have presented. I recall some years ago I asked a very senior practitioner in the mental health area why there was such an increase or a spike in mental health issues, and he answered in two words. He said, 'Illicit drugs'. I am just wondering if that is a major issue here in the south-west.

Mr PLACE — I would say it is an issue. I would not say it is solely attributable for the increased acuity that we are seeing in our presentations. I think there are a range of factors that impact on why someone might experience difficulty during the perinatal period. But it is definitely present. My colleague shared with me the experience of a woman that we had been supporting more recently who has a history of illicit substance use. Most likely her care of her child has been compromised — in fact, jeopardised — by her use, with Child Protection Services becoming involved in that case. There are occasions when we are working with clients who will have those experiences and who will have those challenges. There has been some commentary this morning about access to drug and alcohol services. We certainly have drug and alcohol services present in the region, and we will utilise them when and if they are required.

Mr FINN — I noticed on the slide there that you provide pretermination counselling.

Mr PLACE — No, that was one of the other teams within South West Healthcare — so the counselling support team.

Mr FINN — Does that counselling provide for women the dangers — the psychological dangers and the mental health dangers — of termination?

Mr PLACE — I am confident that it would. Knowing the staff in that team, I am confident that it would.

Mr FINN — Given that we know that abortion does quite often cause major psychological problems, do you or any of your team or other teams provide any post-abortion counselling at all for women?

Mr PLACE — No, not my team.

Mr FINN — Any other team that you are aware of?

Mr PLACE — I would have to confirm with the counselling support team. They are continuing, so they have got a pretermination counselling role, but for post-termination I would have to confirm with them. I would anticipate that there are statewide post-termination support services, and I would anticipate that consumers would at least be alerted to the existence of those services.

Your question, if I might, does draw me to some of the points highlighted by my colleagues in acute health. I wonder if I might comment on them in terms of the presentation that somebody comes to us with — obstetric complications, post-birth trauma, bereavement and the experience of domestic violence. You were inquiring yourself about the experience of domestic violence. What we know is that the experience of domestic violence actually increases during the antenatal period. So in terms of the range of experiences that women come to us with, there are significant stressors and significant histories that come to us. The experience of trauma is quite a significant one that we see.

Ms BRITNELL — Can you just elaborate on the Circle of Security work? I did not understand the context of that.

Mr PLACE — There is a program referred to as the Circle of Security that a number of staff within the South West Healthcare Mental Health Services are trained in. Child and Adolescent Mental Health Services staff are trained in that. Andrea, my PEHP colleague, is trained in that. The focus of that program is generally delivered in a group format, but it can be tailored and delivered in an individual format. The focus of that is to look at mother-infant interactions and to, I guess, make an assessment and then encourage optimal mother-infant interactions.

Ms BRITNELL — I am not sure whether you are the right person to answer this question, but regarding the decrease in birth rates, as a region are you aware of the rationale behind that? Is there any theory or has any work been done?

Mr PLACE — I am not sure that I am qualified. I made the observation myself because I guess we had been tracking the trends over the years. I think there would be a range of factors. I think we have seen over the past decade the odd year where the numbers do drop significantly. I think that happened roughly eight years back, when it dropped significantly and then jumped back up.

I imagine there are some consumers to the east of our region who are possibly tracking towards Colac. I am not sure if Bernie is aware of whether the numbers at Colac are increasing. I understand, only anecdotally, that as their services have been further enhanced, maybe the birth numbers at Colac Health have increased. At the Camperdown campus of South West Healthcare certainly some numbers have levelled this past year, but that will only account for maybe 20 or so births going out of the region.

Ms BRITNELL — So is it really more stable and just spreading between Portland and coming back, when we lost Portland and Camperdown?

Mr PLACE — The drop in birth numbers is across our whole region. So there has been a shift —

Ms BRITNELL — Indicating population.

Mr PLACE — We have seen a drop of over 100 births in South West Healthcare. Some of those births are going back to Portland, but not 100; it might be 20 or so going back to Portland. There might be some, like I said, going east towards Colac, but they will not be significant numbers in my reading of the circumstances. I think it is a year where we have simply seen a decrease in the birth numbers.

Ms BRITNELL — Can I just clarify, too: you actually said you are confident that all people in the south-west during their pregnancy would have their mental health inquired into.

Mr PLACE — Yes.

Ms BRITNELL — That is quite impressive actually. So is that why we are getting more referrals, because we are actually helping people be proactive rather than reactive?

Mr PLACE — One of the reasons, yes. As I indicated, the Primary Mental Health Team through some additional state funding had a project referred to as the Postnatal Depression Project, but it was essentially a perinatal project of 18 months duration. It was during that time back in 2003–04 that we invited all the maternity floors, or the antenatal component to their service delivery at the time, to inquire about psychological health. I had noted that Beyondblue were conducting research at that time around the efficacy of the use of the EPDS — the Edinburgh Postnatal Depression Scale — and also psychosocial questions. Western District Health Service participated in that, so a health service in our region participated in that research. Independent of that research, all the hospitals in our region agreed to the introduction of that routine inquiry.

I have not done this for a number of years, but I remember that at about four years post-introduction of that we assessed the data and there was one decline. So there were over 4000 births at that time and one decline of that inquiry, so it reflected to us that women appreciated the inquiry of their psychological health, and that has continued to be experienced during the last decade. Women routinely appreciate inquiry about that.

Ms BRITNELL — Also for clarification, so this service actually goes into the person's home a lot?

Mr PLACE — The Perinatal Emotional Health Program, yes — so some home visiting.

Ms BRITNELL — We were interested before — I am not sure if we followed that up when we had the opportunity — but how are you finding, from a staff safety perspective, the issues you are coming across, and how do you actually do the risk assessment?

Mr PLACE — There is a particular template questionnaire that South West Healthcare does require staff to complete that includes consideration of dogs and at-risk animals, but we will take consideration of any history of violence and any access to weapons on the property as well.

Ms BRITNELL — So you ask the mother these questions?

Mr PLACE — We will ask somebody at the home, generally the client, and in our program's instance that will be the woman. Also some other care providers can provide that information as well, so if we took a referral from another program within the hospital, we will inquire around the safety of home visiting.

Ms BRITNELL — So when you identify there has been a history of an aggressive partner, do you send two staff if you have only got one —

Mr PLACE — We would be less inclined to do home visits and offer that support from our administrative base.

Ms BRITNELL — Do you see that as a real challenge, given that they are probably the ones most at risk and needing more support and that they are in an aggressive family violence situation?

Mr PLACE — It is a challenge, and I did not answer your question thoroughly. There would be occasions when we would do two workers visiting.

Ms BRITNELL — Right.

Mr PLACE — Yes. We would not decline a service on the basis of the client not coming in, so we look at ways in which we could see the client. In some cases it is possibly not even a home visit; it is agreeing to meet them somewhere else. On some occasions a consumer would prefer not to be seen at home, and they would prefer to be seen somewhere else.

I guess to that end I could highlight the role of the Primary Mental Health Team as well. The Perinatal Emotional Health Program sits within the Primary Mental Health Team. On any given day Primary Mental Health Team clinicians are sitting in GP rooms seeing clients, including PEHP clients but also seeing clients with depression and anxiety. That is a very safe, non-stigmatising environment to see clients, but it also enhances the collaboration between the mental health clinician and the GP in this instance.

Ms BRITNELL — Thank you very much.

Dr CARLING-JENKINS — I will not take up too much of your time since we are running over time, but thank you very much for coming in. I also wanted to thank you for your submission. It was a great submission.

Mr PLACE — Thank you.

Dr CARLING-JENKINS — I appreciate you taking the time to do that. I am quite impressed with your service and obviously the area is as well, because you have been increasing in referrals, which you have just been speaking about — over three times in six years. That is quite impressive. And you mentioned in your slide that there is an increase in the complexities in referrals. You listed that as a challenge. Does that relate to what you were talking about with Bernie Finn's point around trauma — that the complexities are now expanding to include more domestic violence issues et cetera? Is that what you are seeing?

Mr PLACE — I think so. Maybe an additional complexity I have not spoken about is that — this was highlighted to us during the last six months — we had at one point in time two consumers that required inpatient admission; one woman was postnatal and one was antenatal. Admitting that client group to our inpatient facility is a challenge. It is a challenge for a number of reasons. It is not entirely the appropriate venue — someone being admitted with postpartum depression or psychosis with other consumers, that is non-perinatal consumers with a major mental illness requiring inpatient admission. On some occasions some of those consumers are involuntary consumers. We do have access to the Werribee Mother Baby Unit, and we would use that infrequently. It is a valuable service, but one of the challenges with an admission is the benefits sometimes are outweighed by the women being dislocated from their community — from their family — by having to travel to Werribee.

Dr CARLING-JENKINS — Disconnected.

Mr PLACE — Ballarat Health Services has established a five-day-a-week Mother Baby Unit, Monday to Friday. It has a slightly different focus. It focuses particularly around mother-infant attachment. We have had a number of consumers utilise that service as well.

Dr CARLING-JENKINS — Excellent. Very interesting. Just finally, you have mentioned there are obviously some quite huge funding issues. Having one full-time staffer — we do not need to say too much more about that. If you could be provided with the funding you needed, what would that look like for your service? What would your ideal be?

The CHAIR — And we have all got pens in our hands, Nicholas.

Dr CARLING-JENKINS — It is your opportunity to say it. What would your ideal be if the money was not an issue?

Mr PLACE — If you said you could double it, that would be gratefully appreciated. I think the demand for service reflects a funding model that is not simply based on a fixed 1 FTE per 1000 births. Even in the regions where there are 2500 births and they have 2.5 FTE, it is still relatively small for responding to significant numbers of referrals. We require a critical mass, and 1 FTE is not a critical mass. So covering annual leave, periods of unexpected absence — they are very challenging times. When we do not have that cover, consumers do not receive service or they do not receive optimal service. I think there needs to be a base critical mass, and I think that should sit at at least 2 FTE. There were some comments from Dr Uren about locating psychology within antenatal clinics. I do not disagree with that necessarily, and I think the psychology profession may take offence at what I say here, but there are range of disciplines that can offer psychological support beyond psychology — social work, occupational therapy and nursing. When we advertised the perinatal emotional positions, we opened it up to all disciplines, and the best applicants were midwives.

Dr CARLING-JENKINS — Interesting.

Mr PLACE — We did not expect that it would be midwives that would be appointed to these positions. The appointment of the two midwives that we had at the time — one of them being Andrea and the other being Clare, but since then Rachael and Carly — come with considerable expertise. We provide them with additional training. They have undertaken additional training of their own volition. Their capacity to engage with this client group is in part because they are midwives who understand that midwifery experience that the consumer has. I am not sure whether I have answered your question.

Dr CARLING-JENKINS — You have actually; that is great. Thank you.

The CHAIR — Thanks, Rachel, and thank you, Nicholas, for your time. You have definitely answered a lot of our questions, but you have also given us some questions to answer as well. So thank you for that.

Mr PLACE — Thank you. I did make extra copies of the PowerPoint if you wanted hard copies.

Dr CARLING-JENKINS — That would be great. Thank you.

The CHAIR — We would love that. Thank you so much.

Witness withdrew.