

TRANSCRIPT

FAMILY AND COMMUNITY DEVELOPMENT COMMITTEE

Inquiry into perinatal services

Melbourne — 4 September 2017

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Witnesses

Professor Jane Fisher, Director, and

Dr Heather Rowe, Senior Research Fellow, Jean Hailes Research Unit.

The CHAIR — I welcome to these public hearings Dr Heather Rowe, senior research fellow, and Professor Jane Fisher, director, from the Jean Hailes Research Unit. Thank you for your attendance 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 to have a look through. Perhaps we can start with a 10 to 15-minute statement from you.

Visual presentation.

Prof. FISHER — Thank you very much. My name is Jane Fisher and my colleague is Heather Rowe. You have already introduced us. We work at quite a unique partnership, which is a formal partnership between a not-for-profit, community-based health information and education organisation — Jean Hailes for Women's Health — and Monash University's school of public health and preventive medicine.

We are really very pleased and impressed and want to thank you for your specific interest in the mental health of women who are pregnant or who have recently given birth and their children and their families. We think that this makes an enormous contribution, that you have noted this and are affording it the attention that you are giving it. We understand that you have already had some discussion of that this morning, and we want to perhaps extend that discussion by bringing the perspectives that a public health approach to these problems can add to the more traditional psychiatric approach to understanding them.

The first point I think that is important is that it is very good that the term 'postnatal depression' is now in widespread use. It is well used among health professionals and among members of the community. But it is in fact an umbrella term — it does not describe a single condition or state of mind. In fact most of the problems that get caught under that umbrella are more accurately understood as being adjustment problems or anxiety-related problems. They are not distinct major depression, which tends to be quite a rare and very serious condition, but it is not the only mental health problem that is specific to this phase of life. So I think this provides health services with the challenges of how they respond to this more complex reality.

What we believe is really worthwhile in considering this is thinking about what a public health approach can bring. The main distinction of a public health approach is that it seeks to engage in prevention. So before the problems have become established or they have begun to have their consequences what can we do to try and prevent them? What this seeks to do is to reduce risks across the whole population, so not just for subgroups with special needs, and to strengthen the protective factors that are also available within communities. We know that this universal approach is less stigmatising, so if it is something that is offered to everybody, not just to a subgroup of people, it is more likely that it will be taken up and more likely that it will have a benefit for the whole population.

We argue that probably the best location for a universal approach to perinatal mental health promotion is within the maternal and child health nursing service in Victoria. We want to take the opportunity to introduce you to a program of research and research translation that we have led over the last 15 years that really provides a very strong example of how this could be implemented in Victoria.

We will just give you a brief background as to what has been tried worldwide to bring a universal approach to preventing mental health problems. There have been a number of very high-quality randomised trials, and they have tried things like continuity of midwifery care, an earlier than usual visit to a GP and the provision of extra information for people during pregnancy. The only one of these that worked was the one embedded within the British National Health Service, which involved intensive home visiting. On average there were six individual home visits to every woman who had given birth, which in our health service is really not a cost-effective or feasible thing to implement. In Britain where they have health visitors embedded in the National Health Service it was more feasible.

But notably none of these interventions included the father and none included the baby. We believe that contemporary approaches have to be much more respectful of whole families, including fathers and other co-parents. The other problem with them is that none really specified what risk factor they were seeking to address.

So with support from the National Health and Medical Research Council, state and federal governments and Beyondblue we have developed a program that seeks to take a new approach. It is called What Were We Thinking!, because this is the kind of language parents often use themselves. What is unique about it is that it includes partners and their babies, and it identifies very clearly risk factors that can be addressed early in the phase after someone has had a baby. The two that we have found are most crucial are how to manage dysregulated infant behaviours, especially persistent crying, dysregulated sleep and difficulties with feeding. These are big problems for up to one-half of Australian families, especially those with a first baby.

But the other is adjustments to the partner relationship, in particular finding respectful ways of renegotiating roles and responsibilities without conflict and arguments and with understanding how gender stereotypes can really pervade how couples renegotiate these things. What we have shown is that we can train maternal and child health nurses how to implement this approach within their routine care of first-time parents and that it can have a very beneficial impact on preventing mental health problems. It addresses, first of all, teaching parents how to understand and respond to infant behaviour, how to understand each other's changed needs and respond to these, and how to name and recognise gender stereotypes. I am going to hand to my colleague Dr Rowe to talk to you a little bit about what this What Were We Thinking! program involves and what research evidence we have generated about its benefits.

Dr ROWE — Good morning, everyone. Thank you for the opportunity to speak today. The What Were We Thinking! program has three components. The first is clinical care from a trained maternal and child health nurse so that she can converse with parents in her day-to-day clinical care using the terms and the concepts that are central to this program. The second is a seminar, which is conducted with groups of five or so couples and their babies, and the third is take-home materials that parents are able to refer to for further reference. I am going to focus on the seminar in the next few minutes. It is designed very specifically to fit into Victoria's first-time parent groups, which are well-established in this state. It is designed to be offered on a Saturday in order to maximise the inclusion of fathers, and it is manualised so that it is readily implemented.

We take an approach that recognises that parents have increased learning needs after the birth of a first baby, and it is based very clearly on adult learning principles with a number of different activities in an enjoyable, inclusive sort of format. There are lectures, small-group discussions, discussions among, between and within couples, and demonstrations. It is based on 15 parent worksheets which are attractively designed and have lots of images so that it reduces the need to read information. They also are designed to increase the engagement and the participation of the parents.

It is separated into two sections. The first one is about the baby. As Jane mentioned, it is about increasing knowledge as well as skills about infant development but in particular skills about how to settle a baby to sleep. The second part is about parents, which really helps parents get new knowledge, concepts and language to describe their changed needs and the different needs that they have from each other and in particular how to renegotiate the roles, responsibilities and workload in a way that feels fair.

As part of a trial, which I will come to in a moment, participants were asked to answer a number of questions anonymously after having attended the seminar. You can see here that it is regarded as very helpful and enjoyable. The handouts were praised, the facilitators were praised and the parents really valued the opportunity to have input about these new learning needs that they have. Perhaps the best endorsement is that most parents said that it would be helpful for everybody, not just themselves.

As far as evidence is concerned, we have conducted two large trials within Victoria in a number of different local government areas across the socio-economic and geographic spectrum, and we showed that there were very clear benefits for women's mental health. Women were roughly half as likely to experience moderate anxiety or adjustment problems if they had participated in the program compared to usual care. We can see that the seminar component is probably the most potent of all three. Not everybody came to the seminar, as you might expect, mostly because men were not available, although we did try hard to make that possible for them. But those who did attend or did receive all three components had the greater benefit. So we think that the seminar is an important part of it. There are also benefits to families, as Jane referred to before. There is less conflict, increased confidence and a higher likelihood of using the safe-sleeping practices that are promoted.

Some people argue that these kinds of sleeping practices that are taught in What Were We Thinking! might influence breastfeeding, but we were very careful to assess these potential adverse outcomes and we found no difference in any aspect of breastfeeding or mother-infant relationships. Importantly, we found that there were

no differences across the socio-economic spectrum, so we regard this as pretty good evidence that it is suitable for everybody.

A program like this needs multiple formats in order to increase the reach and accessibility, so we have taken specific steps all along to increase the range of options for parents. We have made a DVD for one aspect of the program, we have an interactive website where parents and professionals can fill out these worksheets online in an interactive way and we were fortunate to be funded by the Australian government under their e-mental health initiative to create some electronic resources. We have a professionally moderated What Were We Thinking! blog where parents write about their experiences. A trained maternal and child health nurse joins the discussion and uses the opportunities that arise to reinforce the What Were We Thinking! messages to the participants. The smartphone app has all the knowledge and in particular behaviour modification strategies for parents across the first six months of the baby's life. Of course the nurses who need to be trained in this are supported by a training course. I will hand back to Jane here.

Prof. FISHER — This is a very specific example, and we would be very pleased to engage in a broader conversation with you about public health approaches and strengthening primary care capability in the field of mental health promotion. We believe that what this illustrates is a bit of Victorian innovation. The intervention has been derived from very wide consultation with practitioners, with end users and with our own experience in early parenting services. It has, we believe, great potential to actually make a contribution through the prevention of the most common mild to moderate mental health problems that occur following childbirth. At the same time it advances policy objectives around the promotion of respectful family relationships. We know that this phase of life is one where there are risks of adversarial interactions between members of an intimate partnership but also between parents and children and that in particular persistent crying in babies is a known risk for maltreatment of very young children. This program has potential to reduce that.

It has been published. We have a large number of peer-reviewed articles. We have engaged in translational activities. We feel that it is something that now really merits consideration for being taken to scale across our state and then possibly more broadly. What it would involve are changes to practice so that we perhaps move beyond calling it a maternal and child health service and we think about calling it a parent and infant health service where men and other co-parents are made to feel welcome and as though care is tailored to their needs. We feel that it will involve some consideration and flexibility of opening hours so families in different circumstances are able to attend at times when they are free, and it needs consideration of extending in-service training for all practitioners. There are about 1000 maternal and child health nurses in this state, so it would be a program to be rolled out more broadly.

We believe it is a really powerful example of how academics, policymakers and knowledge translation experts have been able to work together to address a problem in quite an innovative way, and we welcome the opportunity to discuss it with you.

The CHAIR — Thank you, Jane and Heather. I have just got one question. In regard to some of our smaller communities who are grossly over-represented in perinatal statistical data, has the What Were We Thinking! program been adapted to CALD, refugee and Aboriginal and Torres Strait Islander groups? Is it accessible to them as well?

Prof. FISHER — It is an excellent question, and we have made every effort to do that within the resources that we have had available. We have had an opportunity to work with VACCHO to develop a format of it that we hope is of value to Aboriginal and Torres Strait Islander families. It is called *Yarning about Parenthood and Your Bub*. We do not have an example with us. I am sure we could give it to you. It is really beautifully illustrated, and the language and images are, we are told, useful and valuable. We have significant interest from people working in Mildura to actually test it in their community.

We have translated and culturally adapted these materials into three community languages. They are available in Vietnamese, Mandarin and Sinhala, because those are groups in our south-east Melbourne corridor who have a high proportion of families with young children. We are working with colleagues internationally to translate it into Japanese and also into Spanish. That is a somewhat slow process, but it is definitely one we are committed to.

Ms COUZENS — Just continuing on in terms of Aboriginal and Torres Strait Islander people, has there been any specific research done by your organisation in terms of culturally safe programs for Aboriginal and Torres Strait Islanders?

Dr ROWE — We have engaged, as Jane said, with VACCHO, and that project was managed by an Aboriginal woman herself who spoke to her community. The idea is to train women from within that community to offer these resources themselves. It is not specifically research, but I would regard it as translational work.

Prof. FISHER — We are obviously very keen to ensure that if it is implemented, we get the experience of users as to whether they find it relevant or useful. Very definitely we have done it in collaboration.

Ms COUZENS — You talk about the long waiting list and high occupancy rates for the residential parenting services. How long are the waiting lists?

Prof. FISHER — The one I am most familiar with is one in the private sector called the Masada Private Hospital mother-baby unit. That now has 20 beds. We have expanded from five beds to 20 beds. We thought that would take our waiting list away, but it is up again to nine weeks. We understand that in the public sector — Tweddle, the Queen Elizabeth Centre and the O’Connell Family Centre — it is up to three months. But if a family contacts one of these services, they have a need then. You do not ring up until you are feeling pretty seriously in need, so the long waiting list is, I think, a significant problem that we face.

Ms COUZENS — What are the consequences of that unmet demand?

Prof. FISHER — I think it can mean that some of the problems become quite embedded and that parents become very tired. They can become exasperated and they can become despondent. I think it contributes to an intensification of the mental health problems among the parents, and it means that the problems with the baby, which are ones that can be addressed and helped, become harder to change because they then really have got a habit of waking frequently or crying a lot. I think having a program like this available that might send things on a better trajectory — we have shown in the economic analysis that went alongside this trial that there were fewer admissions to early parenting services among the group that got this program. That does not take away all need, but it changes it.

Ms COUZENS — So are you suggesting that that residential program is a significant part of addressing problems?

Dr ROWE — The concepts in *What Were We Thinking!* were derived from work that we did in these services, and the elements that we regarded as most important to include are based on the kinds of program that women and their families will experience when they are admitted. The idea here is to teach them these concepts early on. What I did not say is that these first-time parent groups that *What Were We Thinking!* focus on happen around the time that the baby is four, five or six weeks old. So it is very early in the baby’s life, and we hope that by teaching these skills in a preventive kind of way there will be less need for admission once the problems become established.

Ms COUZENS — So are the waiting lists generally on the basis of greatest need or just who gets in first on the waiting list?

Prof. FISHER — I am most aware of the service within which I have a clinical appointment. I am a clinical psychologist there. I have been there for more than 20 years. It is done partly on the basis of intensity of need. In that service everyone is medically referred, so we have to take what the clinician says into account, so it is a constant triage balance between intensity of need and what other resources and supports are available.

I think we would hear the same from both Tweddle and the O’Connell Family Centre — that they feel that there is a much bigger need for these services than they are able to address. We know that they provide a significant part of the perinatal mental health services, but it tends not to be one that is named or identified as that, so they are different from the psychiatric mother-baby unit beds.

We did a piece of research some years ago that looked at occupancy rates and waiting lists. The occupancy rates in the psychiatric mother-baby units tend to be under one — they are not full — but in the residential early parenting services they are always over one. They always have more need than they can meet. They are

fantastic services. They are the envy of other countries in the world, but I think if we can reduce the need for people to get into that predicament, we make a bigger contribution.

Ms COUZENS — Are you aware of any regional services in the residential —

Prof. FISHER — As I understand it there are some being planned, and I think Latrobe Regional Hospital has recently opened a service of this kind. I think that some of the private hospital providers are also seeking to increase what they provide. The main regional service is provided by St John of God. They have Raphael centres, which are community-based services. I think they are in Bendigo, Ballarat, Warrnambool, Geelong —

Ms BRITNELL — Not anymore. We have lost it, Warrnambool.

Prof. FISHER — Lost it? I am sorry to hear that. I did not realise. But they have provided a very important service in this sector. It tends to be support of an individual counselling kind, not the psycho-educational support that this provides. I think the key to this is that we have shown you can train a general maternal and child health nurse to do this and it has a mental health benefit; it does not need a specialist mental health provider. That I think is a very important component of a comprehensive service.

Ms COUZENS — Thank you.

Ms BRITNELL — Thank you for your presentation. I became familiar with your service about 15 years ago, it must be, when I worked in an Aboriginal health service and was involved with the Jean Hailes foundation doing some research a long time ago. I cannot actually remember what it was about, but you showed a lot of initiative coming into the Aboriginal community and we appreciated it at the time.

It also reminds me that many, many years ago we used to admit mums and babies into a children's ward with, I think it was, inability to cope. We used to teach mum and baby how to settle and how to put a routine in place, and it was an extremely effective way of assisting families, so it is reminding me a little bit of that. I always thought it was such an important service. It was quite odd that it was in a hospital situation because it did not fit. There was no-one unwell, but it would have led to severe unwellness, which we have seen. But that is probably irrelevant to my question.

In your submission you talk about the 'postnatal depression' term being too non-specific. Why is it that you think that it is preferable to refer to the group of conditions that can arise in the perinatal period as postnatal common mental disorders? Can you explain that a little bit more please?

Prof. FISHER — It is a really good question, and we did not come up with that descriptor. It was argued about 25 years ago by a pretty influential British psychiatrist called David Goldberg that because depression and anxiety at the mild to moderate level, which is the most common severity, are actually quite difficult to distinguish from each other — and they are especially difficult in a primary care setting without a highly specialised mental health specialist — the term 'common mental disorders' is in fact a more useful umbrella term that includes depression, anxiety, adjustment disorders and trauma responses in this group of psychological states that are accompanied by some disability but to which there can be quite a common response. It probably is not crucial to distinguish this symptom pattern from that symptom pattern because what you would offer would actually be a similar response.

Ms BRITNELL — Fair point. Thank you.

Ms EDWARDS — I think that we are covering the questions that I had in my mind, but there was one question that I was interested in in relation to the seminars. Thinking along the terms of expanding them and how you do that, currently you are only focused on first babies, so I am assuming that somewhere down the track you would be looking at second and subsequent babies when women have a lot more on their plates, families are much busier and mental health issues become a lot more significant. I guess you are thinking about that.

The other thing I was thinking about was in relation to the flexibility of the program — sorry, I am referring to the What Were We Thinking! program — and expanding the maternal and child health nurses. While they are currently the model that you are utilising, what would be the potential of expanding that to particularly, I am thinking, rural and regional areas, where maternal and child health nurses are a bit light on the ground, in a cooperative, collaborative approach with other health providers or community groups like community health,

neighbourhood houses or sporting clubs where we know families like to go, where you would have a captured audience. How are you thinking about expanding, because that is what I was thinking while you were talking?

Dr ROWE — I think you have given some examples of some really creative thinking because not all services or locations are the same as each other. We have good evidence that not all first-time parent groups are run by maternal and child health nurses either. They use early childhood workers, and we are very keen to incorporate that particular workforce in this. We have some provisos in terms of professional competencies. Handling babies is something that is done by properly qualified maternal and child health nurses, and so some components of the program might need to be offered by a nurse, either on an invitation basis or in a service where she already exists. But much of it could be offered by —

Ms EDWARDS — By a travelling midwife locum.

Dr ROWE — Absolutely. But much of it could be offered by a skilled, trained person from a different profession.

The CHAIR — Great question.

Prof. FISHER — It is. I think just to take it on, there are other groups that are interested in this. Australian Rotary Health actually funded us to do the follow-up, and they said, ‘Rotary clubs exist in every community. Why aren’t you using senior women in Rotary clubs and training them to do something in their local community?’. I think what you point out is exactly what we should be thinking of.

Ms EDWARDS — Or even our friends from the ABA, who were presenting this morning and have very good grassroots links into their local communities.

Dr ROWE — Absolutely.

Mr FINN — One of the problems with being this far down the list is that you run out of questions. I will just ask one. I am very interested in hearing about postnatal depression and the PCMDs. I have always been a great believer in ‘prevention is better than cure’, and I am very keen to hear about the screening programs that you speak of. How effective are they? How could we make them more effective? What sorts of resources do you need to put them into place more widely? These are the sorts of issues that I think we probably should be looking at. I will leave it to you to elaborate.

Dr ROWE — I think it is an excellent question. I think there have been a number of barriers to implementing the screening programs more widely. I think they form an important component of a comprehensive mental health system in the perinatal period, but it is quite difficult to say broadly to everybody, ‘You’ll change your practice’ in an already very busy antenatal ward or a postpartum service who do not see people all that often. So there are training implementations; there are also the implications in terms of what does a woman do with the result, what does it mean to have a label and what sort of services are available to her to follow up? Then even where services are available, and they are certainly not available everywhere, they are not necessarily what she sees as a solution to her problem. So I think it is a multifaceted response that is needed to improve those services, focusing on training, on implementation and, most importantly, on the response that is available. I think one of the big disincentives for midwives and nurses to screen women was that, ‘Well, once I identify someone, what can I offer her in my local community?’.

Prof. FISHER — I think the prevention approach and the screening approach should not be positioned against each other. They are both important components. I think the benefit of an integrated universal program that promotes mental health is that you do not have to have a question about referring individuals somewhere else; it is just something that everybody has the opportunity to participate in. So I think the universal prevention is a great first step, and through that you might then identify who it is who needs a bit more. This gets called internationally a ‘stepped approach’ to care. You offer one thing to everybody and through that you identify who might have some further needs and then have an opportunity to refer them on.

Dr CARLING-JENKINS — I just have a couple of questions. I read some of your references last night —

Dr ROWE — Well done.

Dr CARLING-JENKINS — I used to be an academic myself, so I read your *Open* article, and before I forget, the last reference was one that is not published yet. That is the one that has been submitted to *Global Mental Health*. I would be really interested, once that has been published, if you could send us through a copy.

Dr ROWE — Will do.

Prof. FISHER — We would be very pleased to. The reviewers are a bit slow.

Dr ROWE — We can send you a copy.

Dr CARLING-JENKINS — Yes, some journals can be. If that is possible, that would be fantastic. Thank you.

So then from the *BMJ Open* article I noticed a couple of limitations that you identified, and I would just be interested in how you have then redesigned your study to accommodate those. The first one was around the women whose pregnancies were unintended and who had less education and higher baseline scores — they were less likely to provide complete data. I am wondering how you then redesigned this program to accommodate those women.

Dr ROWE — I think you are referring to two things there: the participation in the seminar itself, which was broadly attended; and participation in the research itself. The research is quite demanding of a person's time, and it is very normal — it is very usual — to have a bit of a gradient in terms of who completes research participation. They did telephone interviews when they first enrolled and then again as a six-month follow-up. They were quite comprehensive interviews, and it is very, very usual to get some kind of inequality in the attrition over that period of time. So we have not altered the program itself, because that was broadly attended, and as I said before, we do not see any differences in the benefits that were achieved across the socio-economic spectrum. But we would like advice about how to retain people of all levels of education and occupation and employment in research, because it is not that easy.

Dr CARLING-JENKINS — I completely understand. It is a challenge, isn't it? The second limitation to the study that I was interested in was a consistency with program implementation that you identified might have been varied. I wonder if you could just expand and comment on that, please.

Prof. FISHER — I am pleased to. The approach that we recommend in what we were thinking to the management of infant behaviours is quite a structured approach. It is completely congruent with safe sleeping recommendations, but it recommends that feeding and sleeping are separated from each other, so you get the baby up, feed the baby, play with the baby and then settle the baby to sleep. There are some advocates in the community who believe that feeding and sleeping should be much more closely related to each other and that you should suckle your baby to sleep. We do not champion that, but there are some within the maternal and child health workforce who do champion that.

Dr CARLING-JENKINS — Thus the variation.

Prof. FISHER — Thus the variation. I think it is something that can be addressed respectfully. We believe that our primary care colleagues need to adhere to an evidence-informed approach, not just something based on their opinion and values. We know that within the leadership of the maternal and child health workforce that is what they are very keen to achieve, but of course on the ground there are people who have different value systems and beliefs. That was what we found.

Dr CARLING-JENKINS — You are working with people!

Prof. FISHER — We are!

Dr CARLING-JENKINS — Fantastic. Thank you very much for clearing that up.

Prof. FISHER — Thanks for your question.

The CHAIR — If there are no other questions, thank you, Jane. Thank you, Heather.

Dr CARLING-JENKINS — Thank you very much.

Prof. FISHER — Thanks so much for the opportunity, and we have just a little information here, if anybody is interested, about the e-resources, if people want that.

The CHAIR — Fantastic. We will distribute that in a second. Thank you so much.

Witnesses withdrew.