

TRANSCRIPT

FAMILY AND COMMUNITY DEVELOPMENT COMMITTEE

Melbourne — 5 February 2018

Members

Mr Paul Edbrooke — Chair

Ms Cindy McLeish — Deputy Chair

Ms Roma Britnell

Dr Rachel Carling-Jenkins

Ms Chris Couzens

Ms Maree Edwards

Mr Bernie Finn

Witnesses

Dr Emma Symes, senior psychologist, Centre for Women's Mental Health, Royal Women's Hospital,
Ms Viviane Lebnan, senior psychologist, Mercy Hospital for Women, and
Ms Emma Sampson, research and policy officer, public interest, Australian Psychological Society.

The CHAIR — Welcome, everyone, to this public hearing of the Family and Community Development Committee’s inquiry into perinatal services in Victoria. This is the 12th and final public hearing by this committee for the inquiry. The committee has held hearings in Melbourne and regional Victoria and has also been conducting community forums to engage participation from as many people as possible. As today’s will be the last of the public hearings for this inquiry, I would like to take this opportunity to thank everybody who has contributed to the inquiry over the last six months.

The committee has received just under 100 submissions and heard from dozens of witnesses. The evidence the committee has received has been important and often very compelling. I sincerely thank in particular the mums who have addressed the committee at the public hearings or made submissions, and I thank them for bringing their bubs in, too — that was always fun. For those people who have shared their personal stories with the committee, this evidence has been invaluable to the committee, which has gained insights into how well perinatal services are working across Victoria.

These proceedings today are covered by parliamentary privilege and as such nothing that is said here today can be the subject of action in any court. Please note that the broadcasting or recording of this hearing by anyone other than accredited media is not permitted, and I would ask everyone in the gallery to turn their mobile phones to silent.

Welcome, Emma, Viviane and another Emma, who is from the Australian Psychological Society. 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 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 also a contempt of Parliament to provide false evidence. These proceedings will be recorded and you will be sent a proof copy of the transcript.

Now that we have got that over with, we are a fairly relaxed committee and we are talking about some very, very important things in this inquiry. We find that to get the best out of you it is best if you are relaxed and can talk freely, so please do not be nervous. We are here to help, and I would invite you to start with a 10-minute submission about the Australian Psychological Society and where you fit in perinatal services.

Visual presentation.

Ms SAMPSON — We will do our best to keep it to 10 minutes. We understood that we had a bit longer, so we will try and keep as close to 10 as possible. Thank you first of all for having us here today. We agree it is an extremely important area to look into, and we commend you on the work you have done so far.

I first would like to acknowledge the Wurundjeri and Boonwurrung people of the Kulin nation and pay our respects to their elders past and present and particularly pay our respects to Aboriginal mothers, who we know have been working and playing an important role in their communities for thousands of years. I am Emma Sampson, as you can see by my name tag, and I am going to speak with you in relation to the APS’s submission today.

The APS is the leading organisation for psychologists, representing over 22 000 members across Australia, and it is the largest of all non-medical health professional organisations in Australia. I am joined today by two key contributors (to our submission), both highly respected psychologists in the field of perinatal psychology. We have Viviane Lebnan, who is the senior psychologist of perinatal mental health at the Mercy Hospital for Women. She is also the convener of our perinatal interest group at the APS. Emma Symes is a senior psychologist at the Centre for Women’s Mental Health at the Royal Women’s Hospital. Psychologists are well aware that the perinatal period is one of joys but also one of many challenges. We acknowledge it is possibly one of the biggest transitions that a woman is likely to make in her life, and therefore she often may find herself vulnerable to mental health difficulties.

I suppose to start with we would just like to outline the context in which women are now mothering because we believe that that has a direct impact on adjustment and on mental health. For example, while the internet is available and advice now at fingertips, parents do have access to information but we are increasingly finding that they are reporting information overload in what they are trying to get help with. We see idealised discourses around mothering prevailing, leaving little room for women to admit to needing help or struggling. There are

unrealistic expectations about what it means to be a mother and these set mothers up routinely for self-blame and failure.

Despite significant changes in the role parents once played when they had a baby, traditional gender roles still prevail and mothers continue to shoulder the majority of responsibility for children and housework. Add to this the isolation many mothers experience. We are hearing a lot about families being separated by distance or by conflict, and I am sure in rural areas you probably see this more than anywhere. Mothers are left to be particularly isolated currently.

Referred to as the social determinants of health, we know as mental health professionals that aspects such as sense of community, the media, housing, flexible employment and transport can have as much impact on mental health as mental health services. Saying this, however, we know about the high incidence of maternal mental health difficulties during the perinatal period. We know postnatal depression is a commonly used term to describe an array of mental health difficulties. We are not going to go into that because we have seen that you have heard a lot about that throughout the inquiry, but we are happy to provide more information. Obviously this involves depressed mood, anxiety disorders, post-traumatic stress, and obviously of huge concern is that in the 12 months following delivery the leading cause of maternal mortality is suicide.

As per the recommendations of the perinatal mental health guidelines, perinatal services need to address the mental health difficulties faced by mothers during this time, and they should be provided from pregnancy up until three years post-birth. There need to be opportunities for multidisciplinary interventions, as you have heard throughout inquiry, and for continuity of care. Health professionals should be trained and skilled to provide this care, and this means working alongside women to develop a relationship with one or several healthcare providers throughout this period.

The APS is concerned about the lack of perinatal services in Victoria, including inadequate specialised mental health care for women and their infants and a lack of continuity care more generally, particularly in rural and regional areas. These particular areas for improvement will be discussed shortly by Viviane and Emma, but firstly I would like to highlight some gaps for three particular groups, the first of which is those who experience domestic violence. We know women are at increased risk of violence during pregnancy, with estimates suggesting up to a third of women experience domestic violence during pregnancy. Domestic violence may occur for the first time or be a trigger.

Secondly we know that Aboriginal women have been displaced as being experts in their own birthing experience, and we do recommend that the government work in partnership with Aboriginal communities to provide culturally competent care for Aboriginal women and their babies.

Thirdly we know that while there are gaps in service provision across the state, it is within rural and regional areas that services are lacking and almost non-existent in some communities, as you would have heard. We also know that the national perinatal depression initiative defunding has had more impact in rural and regional areas.

Along with more mental health services targeting women during this period, we support preventative and community-led approaches. Programs such as volunteer peer mentoring like the Doncare Angels for Women Network and Caring Mums, and gender-informed psycho-education programs such as Baby Makes 3 and What Were We Thinking! show promise and deserve further attention.

We also know that maternal and child health is an important resource and potential for preventative and early intervention work, so we would agree with other submitters in saying that work needs to be done within this service. Psychologists are well placed to inform initiatives in this area and work collaboratively to create clearer pathways for women to access psychological care. There is a personal cost, we know, with untreated mental health issues for women during this period, but there are also costs borne by infants, families, communities and governments, as you have well heard.

I will now hand over to Viviane, who will speak to the detail of service gaps for women who experience mental health difficulties and identify ways to address such gaps.

Ms LEBNAN — Thank you for the opportunity to speak today on behalf of psychologists in perinatal mental health services. I am a clinical psychologist with over 22 years of experience working across a variety of Victorian public mental health services. The observations and suggestions that I make here today with respect to

the needs and gaps in perinatal mental health services are informed mainly by the past five years that I have worked in perinatal mental health at the Mercy Hospital for Women as well as from conversations with professional peers specialising in perinatal and parent-infant mental health. These comments are not specific to the hospital where I work. They are equally applicable to most other public perinatal mental health services across Victoria.

I have two key messages today. The first is the need for more funding and resourcing to provide adequate psychological services within the public perinatal mental health system; the second is that there are many advantages and hence a greater need for psychologically based mental health treatment programs being offered within the public sector than by private mental health service providers.

To illustrate the first point, I am going to use the Mercy Hospital as an example. In an earlier hearing for this inquiry you heard from Dr Rasmussen some statistics from the 2016–17 year, suggesting that almost 2300 women received their antenatal care and delivered their babies at the Heidelberg maternity hospital. In addition to the growing demand for routine perinatal care for women in this catchment, which is the north-east growth corridors, this hospital also sees women with some of the most high-risk and complex pregnancies and deliveries statewide, as well as more of the women who have experienced multiple previous perinatal losses and traumatic births. These are women who have a greater need for mental health and psychological support, ideally in a coordinated and integrated manner, alongside their obstetric care and other allied health services which may be involved.

This hospital's NICU is one of four equipped to provide statewide tertiary services for newborns. This means caring for premature newborns at the earliest viable gestation. Again, this means having postpartum women at greater risk and vulnerability to anxiety, depression, grief, adjustment difficulties and stress, and requiring specialised psychological support. In addition, this hospital has several specialist obstetric care teams for at-risk women. This includes women with substance abuse or dependence, with often co-occurring mental health problems, also young mothers, and then the third group are women from Aboriginal and Torres Strait Islander cultures. Yet we have only one EFT of clinical psychology for this hospital. The above at-risk groups have access to either minimal or no internal psychological input due to under-resourcing. Werribee maternity services delivered 3700 babies in the same period, yet there are no outpatient perinatal psychological services there.

The result of limited access to psychological services within perinatal mental health — and again I am using the Heidelberg site as an example — is that women are often seen quite late in their pregnancies, too late to provide good psychological interventions in preparation for labour and delivery or to address their antenatal anxiety or depression or assist them in their adjustment to the postpartum period. For example, these may be women who have PTSD from previous birth trauma or women with severe and acute fear of childbirth, who would have benefited from early intervention. Another outcome is that women are often seen less frequently than therapeutically necessary because the clinic times are always booked out a month in advance.

Where women are initially assessed by the psychiatric registrars and found to require psychological treatment, they often have to be referred to private psychologists in the community, with a subsequent loss of continuity of care and integrated care. We know from experience across many services that those in most need usually drop out of treatment at this point, as they struggle with having to meet someone new, retell their story and develop yet another therapeutic and trusting relationship.

If there was an adequate number of trained specialist perinatal psychologists available in the service, there would be improved streamlining of allocations to clinicians based on need or the presenting problem and suitability of skill sets, hence better meeting the needs of each woman referred.

The benefits of an adequate psychology workforce in the public perinatal mental health sector would mean more opportunity to adhere to evidence-based best practice in perinatal service delivery. This would include, in addition to individual treatment, group therapy programs in the antenatal period, known to be effective in safeguarding against attachment disorders and reducing the risk of postnatal depression; also a postnatal group program, such as those offered next door at the Austin; and bereavement support groups, particularly for women already pregnant again or wanting but fearing further pregnancies due to unresolved grief and ongoing anxiety.

Finally, to improve and increase the psychology workforce, with specialist skills in perinatal mental health, opportunities for student placements and secondments for registered clinical psychologists already working in public mental health need to become more frequently available. For this to be achieved, there needs to be an

existing adequate staffing of perinatal psychologists already within the service, who can provide the clinical supervision and mentoring.

Now to my second point. I will keep this brief but welcome questions afterwards for elaboration. There are some highly skilled and experienced perinatal psychologists in private practice, most of whom have worked at one time or another in the public sector and may be a member of the parent-infant psychology interest group. They too would agree with me that there are many advantages to women receiving their mental health care in the public sector, especially from within the maternity hospital where they receive their antenatal obstetric care or have delivered their newborns. These include affordability. For many women, becoming pregnant occurs at a time in their lives when there is less financial security and private psychological services are simply not affordable. The second advantage is that there is no cap on the number of sessions. Mental health care in the perinatal period is not amenable to the limit of 10 sessions a year. There is a time-limited window of opportunity for effecting good outcomes for the parent and infant.

Thirdly, interpreter services. Many of the women attending the Mercy Hospital for Women who we see for obstetric services also have language barriers. Integrated care is a vital part of these women's care and simply not available to private psychologists, nor is the opportunity for coordination of care with other allied health clinicians who may be involved. Another advantage is the multidisciplinary approach that we can achieve in the public sector. This includes working alongside the psychiatrists and registrars as well as other allied health clinicians, such as social workers and physiotherapists, in providing more comprehensive and better coordinated care. And finally, also the opportunity to provide case management when that is also required. I welcome any questions later regarding those advantages. I would like to now hand over to Dr Symes.

Dr SYMES — Thank you very much for the opportunity to speak today. My name is Emma Symes, and it is a privilege to be here and represent Victorian psychologists. The committee has heard from witnesses throughout this inquiry about the need for better integration of mental health services across the perinatal sector, including services such as maternity hospitals, early parenting centres, outreach and other community services, and we are in full support of this recommendation. Mental health considerations should be an integral part of service provision to mothers, babies and families from the beginning. Mental and physical health are interconnected, and this should be reflected in the service system. Infants and their families benefit from access to integrated multidisciplinary care.

I would like to make several points. First, that psychologists have an important contribution to make to assessing and treating perinatal mental health disorders. Psychologists can provide direct care as well as secondary consultation, and they are well placed to deliver training and supervision to other professionals in the field. Psychologists have skills in evidence-based treatment of mental health disorders during pregnancy and in the postpartum — disorders such as anxiety, depression, post-traumatic stress disorder. They also have skills to identify those at risk of adjustment difficulties antenatally and can also support adjustment to motherhood in the postpartum. Psychologists can also provide interventions for the psychosocial factors known to be prevalent during this period, such as domestic violence, substance abuse, as well as support women from multicultural backgrounds — asylum seekers and refugees — and other vulnerable groups.

Psychologists with additional training in infant mental health also understand infant development and the importance of the relationship between the mother and her infant. It should not be assumed that treating mental health difficulties necessarily and automatically results in improved outcomes for infants. We tend to parent in ways which are similar to how we ourselves were parented. Thus women and men who did not have their emotional needs attended to as children are more likely to struggle to respond to the emotional needs of their infants, so of course treating mental health difficulties enables parents to be more available to their infants, and this is an important priority. But for many parents it is important to teach additional skills to help them understand the emotional needs of babies, such as how to read infant cues and consider the infant's feelings as well as explore models of parenting. It is important to support relationships between parents and their babies, thus optimising infant development.

Professor Louise Newman spoke about her group program, which is running at the Royal Women's Hospital centre for women's mental health, Parenting with Feeling, and the Raphael Centre also mentioned the Circle of Security group program, which they run as well. These are important, evidence-based programs which we encourage the committee to support within the public sector. Psychologists are well-placed to deliver these

programs alongside other health professionals, as well as provide training and professional supervision to staff running these programs in the community.

The second point that I would like to make is that there is a lack of specialised perinatal mental health services within Victoria. The withdrawal of the NPDI funding resulted in a reduction in the already small number of public sector roles for psychologists. The committee has heard from a number of services that women with mental health difficulties are presenting with higher levels of mental health disorder and more psychosocial complexity — domestic violence, substance abuse and so on.

The community would benefit from mental health facilities or services which are focused upon supporting women, babies and their families which have a specialised focus upon evidence-based approaches to supporting parenting and mental health. Such services would essentially provide a level of care a step above early parenting centres such as Tweddle, O'Connell and QEC but below the high level of acute psychiatric care provided within mother-baby units.

Mother-baby units and early parenting centres clearly have important functions; however, both are oversubscribed and unable to meet demand. With the reduction of mother-baby unit beds, early parenting centres have become the only residential alternative. However, the withdrawal of NPDI funding meant that psychology services were also lost. These facilities are supporting families with complex mental health difficulties in the absence of trained mental health staff. This increases risk and increases the burden upon families and those supporting them.

So there is a need for an intermediate level of care — a specialist, multidisciplinary perinatal mental health service that is able to provide mental health assessment, referral and evidence-based treatment as well as parenting programs and that has a multidisciplinary approach. Psychologists ought to be returned to early parenting centres. Families often enter these services in great distress, and as a result families are often more willing to engage in mental health interventions at these times. The committee has heard on numerous occasions about the importance of making the most of engaging vulnerable families, and a residential early parenting centre is such an opportunity.

In closing, we would urge the Victorian government to provide perinatal mental health care that accords with best practice as outlined in the national perinatal mental health guidelines. We also recommend that these services are integrated with opportunities for multidisciplinary care, psychology, maternal and child health, social work and psychiatry, and that services include support for infant mental health and parenting. Access to a range of supports, including psychology online, group programs for partners and home visiting where appropriate is also important.

Finally, we recommend that a social determinants model of health approach be adopted, with social and economic factors such as housing, safety and poverty considered and addressed as part of service provision in the perinatal period. Once again, thank you for this opportunity. We welcome questions.

The CHAIR — Thanks so much for that fantastic presentation and information. Do you mind if we just ask one or two questions each while we have got you here? We know you are busy people, and we will try not to keep you too long, but we are all very interested in this inquiry, so we do have a fair few questions. My first is: you talked about the loss of NPDI funding equalling less psychologists to do the job you need them to do. I just want to go back to an issue we have confronted many times in this inquiry, which is people falling through the gaps and not having access to those services at all. Obviously you agree that people are falling through the gaps before they access mental health services. I would just like to ask, with new mothers and mothers-to-be falling through these gaps with barely obvious symptoms, what would you think would be a recommendation for government to actually plug these gaps? Where are people falling through and what can we do? Just a simple question to start with!

Dr SYMES — I think the early parenting centres, as I just said, are one place. I think people are coming at times of high distress, and there is just no mental health support there. That is one place. But prior to that I think it is also in the maternity settings. You have got to meet new mums where they are. They are not often going to come easily to you — especially the ones we are talking about, with great amounts of social disadvantage.

Ms EDWARDS — And rural and regional disadvantage.

Dr SYMES — And rural and remote as well. So you kind of have to take the services, I think, to where they are and provide engagement at that point. Maternity hospitals are also, I think, another obvious place. But also maternal and child health, we have got that great platform, and I think services could also be tied to those. You have got those key age and stage visits. There are opportunities there. I think that mental health services complement maternal and child health nursing services as well. They ought to work together. We need to think about the mother, which is thinking about mental health, but we also need to consider the babies.

Ms LEBNAN — Can I just add to that that I would agree with Emma that we need to screen and identify those women antenatally through the maternity hospitals and then subsequently through maternal and child health. The problem is, though, once we have identified them, they still fall within the gaps if there are no services there to meet their needs and if they have long waiting periods before they can see someone. That is where my concern is. We need to identify them, but then we also need to provide them with something once we have.

Ms SAMPSON — I would agree with all of that. I suppose just to sum up, screening alone is possibly unethical without increasing services, because we are identifying more women, but if there is nowhere for them to go, particularly in rural areas, then we are leaving them on their own at a really vulnerable time. So screening alone is not the only solution. I suppose that would be our key message. It needs to be done concurrently with an increase in service capacity.

There is also an item under Medicare, a pregnancy support item, which is very poorly known about in the community, particularly amongst GPs. I suppose there is an opportunity to promote what is already there as well and work in with what exists. We certainly do —

Ms McLEISH — Is that something you can do? You do not need government to do that. You can do that yourself.

Ms SAMPSON — We certainly promote that to psychologists amongst our own members, of course. They are the ones there to receive referrals, but if they are not getting the referrals from GPs, that is the issue.

The CHAIR — So that is a certain amount of visits, is it?

Ms SAMPSON — It is a screening or assessment 3 visit item, but it does enable people then to access further services after that, so they can extend the better access visits with that item. So there is an opportunity to both promote what already exists, I guess is the point there, as well as develop new services to meet needs.

Ms LEBNAN — Bearing in mind that not all women are going to be able to afford the gap.

Ms SAMPSON — Correct, yes. That is right. That is only a certain group of women, isn't it?

Ms McLEISH — Thank you. Just drawing on some of the comments that you have mentioned about meeting the women where they are. I think about hospital settings and where we have outpatient clinics, for example. Even just during a pregnancy they do not see the same obstetrician twice, and they have to retell the story. How is that impacting on your confidentiality? If you have multiple psychologists, and they have to tell the same story to different ones, there are case notes that you keep. Can the next psychologist have full access to those case notes, or will the patient be required to retell their story

Ms LEBNAN — If they are seen within the service, then all the notes are in the one file — the obstetric notes and the psychology or mental health notes — so there is very clear communication within the service. The issue arises if they are referred out to private psychologists who do not then have that access, and then they have to retell their story. I am not sure if that answers your question.

Ms McLEISH — I think that does, because when you see multiple orthopaedic surgeons, for example, you might have to tell the same story again or during pregnancy, we have heard. People go and see an obstetrician and if there is something to be flagged, it is not necessarily followed up at the next visit because that is a different practitioner, and then people fall through the gaps that way or issues fall through the gaps. So I am wondering why this would be different.

Ms LEBNAN — Look, I am not sure about other services. Speaking from the Mercy, I think we do have very good communication through the file system and also face to face.

Dr SYMES — It is similar at the Women's, but the issue is that once you refer someone externally you do not always know that they have gone to the enhanced maternal and child health nursing service. I mean, you can follow that up. Or if you refer them to a private practitioner, for example, you do not actually know whether or not they have gone.

Ms McLEISH — So who should monitor that?

Dr SYMES — Well, whether it needs to be monitored, I suppose, but —

Ms McLEISH — Who should have that information?

Dr SYMES — the handover should go on, and that is good practice if it happens. Once you are in private practice those kinds of case management functions are additional; they are not funded.

Ms SAMPSON — I think it goes to Viv's point before around the need for multidisciplinary care. So if that care is provided amongst a group of professionals, then that is reduced — that need to retell the story. I think we are losing people because they are having to retell their story, and particularly where we are talking about traumatic births and those issues that do exist for new mothers, or this period of their life is triggering issues that have already been there. So I think it is a really great question, yes.

Mr FINN — I was most concerned to hear you say that there are no outreach services in Werribee.

Ms LEBNAN — Through the Werribee Mercy Hospital, yes.

Mr FINN — Yes.

Ms LEBNAN — Not psychologists anyway.

Mr FINN — Right — not psychologists. Yes, indeed. That would seem to me to be unsatisfactory to say the very least. How does that compare to other parts of Melbourne? Do other parts of Melbourne have satisfactory outreach services?

Ms LEBNAN — I am not sure what you mean by 'outreach'. I guess I am talking about outpatient, so the women come to the outpatient clinic at the hospital. As mentioned, Mercy has one EFT — I think you only have one EFT — so little or none is basically the current status.

Mr FINN — But there are none at the Mercy in Werribee?

Ms LEBNAN — That is right — not in outpatient.

Mr FINN — But not much around elsewhere either?

Ms LEBNAN — No.

Mr FINN — Well, I cannot scream too much of prejudice against the west there, but that probably will not stop me. On another matter and an issue that just horrifies me, and that is domestic violence during pregnancy and the increased prospect of that: is that domestic violence aimed at the mother or the baby, do you think?

Ms LEBNAN — It could be both.

Mr FINN — Really?

Ms LEBNAN — Yes. I guess when violence is perpetrated against a pregnant woman, often she is assaulted around the belly, so unborn babies are affected as well. Children are affected once they are born, so the violence is towards both the mother and the children.

Mr FINN — What can we do to overcome that? I would have thought myself that when a woman is pregnant she would be probably in a situation where she is the most protected, but from what you are saying it is quite the opposite.

Ms LEBNAN — No, she is actually more vulnerable during pregnancy. Sometimes the family violence commences during pregnancy, and if it preceded the pregnancy, it often increases during pregnancy. That is what the research shows.

Mr FINN — Dreadful. What can be done to prevent that? I know that is a huge issue in itself. But particularly during pregnancy, that is just horrifying.

Ms SAMPSON — I think Victoria is leading the way in terms of our royal commission, so I think we are really in a good position to link inquiries like this to the outcomes of the royal commission, working closely in collaboration with family and domestic violence services. Those services are the experts in prevention and treatment. Psychologists do have very relevant skills in assessment of family violence, and often they will be the ones to see people in those situations, particularly in pregnancy or prior to pregnancy. But there are also some emerging programs and research around prevention of domestic violence through looking at gender role expectations in relationships prior to birth and looking at the way that parents share responsibilities. So they are really quite new and emerging, but I would encourage the committee to have a look at those. I think there is one called Baby Makes 3, which has been rolled out in the eastern suburbs from what I could see.

It is obviously not one particular be-all strategy, but there is a range of options. Emma is involved in a working group. Emma, do you want to briefly mention that?

Dr SYMES — Just to add, I think it is about assessment as well, and I know that the Women's has got a lot of strategies around responding to domestic violence. Professor Newman is also looking at screening tools, because identifying domestic violence is a big issue in the first place. Then it is around interventions for things that also perpetuate domestic violence. Substance abuse, for example, is a big contributor. So it is complicated — there is not an easy solution. If we had that, we would certainly implement it.

Ms SAMPSON — And each profession, like ours, needs to take responsibility, so we are developing some guidelines for psychologists working in family violence. We are encouraging all professions, I think, to do that.

Mr FINN — Just a very quick one: we have seen a number of studies from overseas in particular, but I think from Australia as well, that have shown abortion is a major cause of psychological problems in women — post-abortion grief and depression and so forth. Do we have any post-abortion counselling services in Melbourne or in Victoria that we can speak of?

Ms LEBNAN — That is actually a good question. We do not perform terminations at the Mercy. I do remember at one point trying to identify counselling services for a woman who was going to be having a termination elsewhere, and to be honest I do not know the answer to that. I did not find any.

Dr SYMES — I am not sure. I think withholding the opportunity for abortion also has mental health consequences. It is a very complicated issue. The Women's does conduct terminations, but I am not sure about the support that is available.

Ms SAMPSON — If we could take that on notice, because we have done some recent work in the area at the APS. I would like to provide you with what we have done, because I think, as you say, it is a complex area, and it was not what we had prepared for today, so if that is okay, we will provide that to you.

The CHAIR — Happy with that, Bernie?

Mr FINN — Yes, thank you.

The CHAIR — No worries.

Ms EDWARDS — Thank you for coming in this morning. We heard in our previous inquiry that there is a shortage of psychologists in Victoria. That is clearly an issue, particularly in the perinatal period as well. I am just wondering what you see is needed to be done to address that shortage.

Ms LEBNAN — I think just to reiterate what I said earlier: the opportunity for more student placements from postgraduate students in maternity hospitals and in public perinatal mental health services. That is one way of encouraging new graduates to get into this area and develop the specialist skills required. Unfortunately

because of the lack of psychologists within the services the capacity to provide student placements and supervise them is already limited.

Ms EDWARDS — Are there enough graduates?

Ms LEBNAN — I think there would be, definitely. There is definitely an interest. It is meeting that demand that is the challenge.

Ms EDWARDS — We heard a lot particularly in relation to rural and regional women and their access to services and their experiences of birth and the public system. We heard a lot about the increasing risk that women are facing. You talked about the social determinants of health, so higher risk pregnancies in particular and more intervention during birth. Clearly I would assume — tell me if I am wrong — that there is a real correlation between that and mental health issues post birth.

I guess one of the things I was interested in was: where do you draw that fine line between increasing awareness of healthy lifestyle and preventative health measures to where we are right now, where it seems to be there are a lot more women having births with high intervention and then going on to have lots of other health issues, including mental health issues, post birth? Is it about actually treating it at that end or is it about treating it at that end?

Ms LEBNAN — I think personally, from my experience, having worked with a lot of women with anxiety during their pregnancies who then went on to have complications or not a straightforward delivery, they found the preparation really helped them with how they dealt with the actual birth experience and the complications that arose during that. I do not know if I can comment on how healthy lifestyle would affect obstetric complexity of delivery. I do not know if there is a correlation. It is probably not my area.

Ms EDWARDS — It is just that we heard about that correlation clearly in Mildura.

Ms LEBNAN — Really? Okay.

Ms EDWARDS — Yes, if I remember rightly.

The CHAIR — Absolutely.

Ms EDWARDS — Just another question in relation to the *National Maternity Services Plan*, which you mentioned in your submission, perhaps you could just briefly talk to the key elements of that and what the current status of that plan is.

Ms SAMPSON — I guess from our knowledge the plan was due to be evaluated, and in our awareness that has not happened. I suppose we saw that as a good step — having an overarching plan — and we would encourage that that evaluation take place so we can learn from what it did well across the country and particularly, obviously, for you here in Victoria.

Ms EDWARDS — Just one last question in relation to postnatal depression. I cannot remember — one of you mentioned the suicide rates of women post birth. Do you have any figures on that?

Ms SAMPSON — I think Emma did have a look at that.

Dr SYMES — Yes. There are some statistics online, and we can certainly get them for you. It is not a high incidence. But we can get the figures for you if you like.

Ms EDWARDS — That would be great. Thank you.

Ms SAMPSON — I suppose the point was that it is the leading cause of death —

Dr SYMES — That it is the leading cause.

Ms SAMPSON — for mums.

Ms EDWARDS — Post birth?

Dr SYMES — New mothers, post birth; that is right.

Ms SAMPSON — In the 12 months post birth.

Dr CARLING-JENKINS — Thank you so much for coming in this morning and for your submission — it was a very thorough submission; I appreciate that — and thank you for being so clear about a theme that is really coming out about the siloed approach. That is what is really coming out, I think, to the whole committee — that our services in this area are very siloed, and they need to be integrated. So thank you for pointing that out so clearly.

I am quite interested in just a couple of things, because I know we are limited in time. You have mentioned the specialist skills, so upskilling psychologists once they are in the field, around placements, around mentoring. I was particularly interested in your mentioning of infant mental health and models of parenting being something that you really like to focus on. I wonder where else psychologists can get this training. Is that something offered through professional development? Is that something that is advocated in undergraduate or postgraduate degrees? You are shaking your head already.

Dr SYMES — I think for psychologists there is not a great deal of material around this, but I think it is increasing — the APS interest groups are one forum. We at the Women's are looking at delivering some training. We are developing some training at the moment. There are a number of private providers that are starting to offer training in this area, and I think COPE is also one of those, and they have presented here. But I think it is a real issue — that actually these require lots of observation and thinking about mothers and thinking about babies and how they are together. It is actually somewhat specialised, but it is important.

Dr CARLING-JENKINS — Sure. It sounds very specialised.

Ms SAMPSON — I was just going to say, Viv, do you want to mention the reading groups? I think that is a really good model.

Ms LEBNAN — The parent-infant psychology interest group has a reading group, so that is a subgroup of that interest group. We meet once a month and we take it in turns to select an article. We all read it and one person presents it. We discuss it. We discuss cases in relation to that. That is for ongoing professional development of a group who already have the specialist skills.

Dr CARLING-JENKINS — Which is important as well.

Ms LEBNAN — Which is important to continue that work. There are always workshops that are provided at some point throughout the year, and training is also provided through the Austin's PIRI, but I honestly think that what psychologists need is to be immersed in the setting, in a maternity hospital setting, which is why I thought that the idea of having a position that can rotate where psychologists from other parts of the mental health service can come and work for six months or 12 months — this is similar to the registrar specialist training model, and I think we learn a lot more through being immersed in the environment rather than just attending a workshop or two.

Dr CARLING-JENKINS — Okay, so it is a hands-on placement that you are advocating for.

Ms LEBNAN — Definitely.

Dr SYMES — I just wanted to say too I also convene a mental health professionals network in the west, and that is open to mental health professionals. So it is a perinatal and infant MHPN. I think it is not just psychologists, though, that are interested in this area; my sense is that a lot of maternal and child health nurses and other disciplines are also really interested in thinking about supporting mental health. We have some really high attendance numbers at some of our meetings.

Dr CARLING-JENKINS — Thank you very much for that. Just for my last question, very quickly: I am quite disturbed about the low number of EFT. Viviane, you mentioned particularly the Mercy having one equivalent EFT, which is obviously not enough. My electorate office is actually in Werribee, so we are very aware of that baby boom that is happening, and obviously the services are just not there. Is there any formula that you have — for X number of babies born you should have one EFT? Do you have a formula?

Ms LEBNAN — Not yet.

Dr CARLING-JENKINS — Could you develop one?

The CHAIR — Just on that, and you can only go off the top of your head, but how many people should be employed — how many EFT would you require?

Ms LEBNAN — Just looking at my current workload, I came up with the figure that we could easily fully occupy another three at the Mercy, and I guess that would be my ideal — three, with one of those being that position where we get other psychologists from within Mercy mental health rotating through.

Dr SYMES — I think it is something similar at the Women's. I mean we certainly would not say no to any more either. I think the other advantage of having more than one psychologist in a service is you then start to share with one another, and there are opportunities for learning from each other, and I think that team approach is really useful.

Ms LEBNAN — It also then means that we have time to capacity build the rest of the staff at the maternity hospital.

Dr SYMES — Yes. We have been doing a little bit of consultation to the NICU at the Women's, but it is very small. There is so much need in the NICU, so much need in lots of areas of the hospital, but those sorts of services, we just do not have capacity to provide that.

Dr CARLING-JENKINS — For sure. Thank you very much.

The CHAIR — Thank you for giving us your time today. We understand you are very busy, but you can walk away knowing that what you have given us today in relation to your opinions and information go towards the recommendations we will put forward to the state government, and we will be pushing for action on them as well. So thank you so much.

Ms LEBNAN — Thank you.

Dr SYMES — Thank you very much for the opportunity.

Witnesses withdrew.