T R A N S C R I P T

FAMILY AND COMMUNITY DEVELOPMENT COMMITTEE

Inquiry into perinatal services

Geelong — 11 December 2017

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

Ms Suzanne Higgins, Midwife and Credentialed Mental Health Nurse.

The CHAIR — Welcome, Suzanne Higgins. We might recommence this hearing. Welcome, Suzanne, and 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 to have a look through

My name is Paul Edbrooke, I'm the Chair of the Committee and Member for Frankston.

Ms McLEISH — Cindy McLeish, I'm the Deputy Chair and I'm the Member for Eildon.

Ms COUZENS — Chris Couzens, Member for Geelong.

Ms BRITNELL — Roma Britnell, Member for South-West Coast.

The CHAIR — Don't be nervous, just relax. We're just trying to get as much information as possible. I know it's a bit daunting having four of us sitting in a circle like this talking to you, but it's not intended that way. If we could get you to give us a 10 to 15 minute rundown of the sector as you see it and your personal experience and then we might have a discussion and ask some questions, if that's okay with you.

Ms HIGGINS — Sounds good. Is it best if I stand?

The CHAIR — No. Whatever is comfortable for you.

Ms HIGGINS — You don't have to look at the PowerPoint presentation. I will leave it with you and hopefully it will help me speak clearly and succinctly.

The CHAIR — We will follow it.

Ms HIGGINS — Thank you very much for this opportunity to speak here. I really appreciate the opportunity to speak about what is my passion, my professional passion. What I will cover, I will tell you a little bit about my background just so you know where I'm speaking from. I will briefly talk about the Perinatal Depression Initiative in Geelong, which was known as the PEHP Program. Have you already had an overview of it?

The CHAIR — Yes.

Ms HIGGINS — Good, I don't need to do that. I will just mention a little bit about context. Screening as a door opener to people accessing services, emphasising that one size doesn't fit all, and that's why I really advocate for perinatal mental health services that are flexible and accessible, and I will speak about my practice-based evidence from Geelong.

The CHAIR — Sounds perfect.

Ms HIGGINS — So I've got a nursing background, maternal and child health and mental health, so I'm a credentialed mental health nurse and I've worked clinically in perinatal and infant mental health since July 2003, until last month. I was employed by St John of God Raphael Services and they've gone through a restructure and so the management position is no longer available.

Ms COUZENS — Sorry, did you say no longer available?

Ms HIGGINS — They've gone to a structure with a statewide manager so all the individual Raphael service manager positions have been restructured.

Ms COUZENS — So you are no longer there?

Ms HIGGINS — No. I've worked with families since 1994, predominantly in maternal and child health for that decade before Raphael. I have studied first time parent couples combining parenting and paid work for my doctoral thesis, which I graduated from in 2005. I have done a lot of study throughout my 40 year nursing career and most recently I was a member of the Expert Working Committee, I represented the Australian College of

Mental Health Nurses on reviewing the clinical practice guidelines which were launched by Federal Minister Hunt in October 2017. So that's enough about me.

I will only say about the National Perinatal Depression Initiative is that I think in Geelong it's been absolutely fabulous in reducing stigma and creating more awareness of the importance of perinatal mental health. Raphael Services worked collaborative with the PEHP Program and we often shared clients or we always got consent to discuss clients who may have accessed both services. I think that's really important because in Geelong relationships are very, very important and it's best for the community if different services do work collaboratively as much as possible. You're aware of that.

One of the examples of how we worked collaboratively but differently was that PEHP provided service to families until their infants were 12 months of age, Raphael worked with families until their infants were two years of age. Raphael services provided centre based counselling, the PEHP Program did home visiting, so depending on what suited families best we would identify the best service for them.

I'm aware that you've sat through many presentations and you probably know a lot of this information but what we know — —

Ms McLEISH — Don't assume.

Ms HIGGINS — Okay; I beg your pardon. Children don't need perfect families, they need good enough families in order to reach their potential and to reduce the risk of mental illness in later life. We know that pregnancy and early parenthood is a time of increased vulnerability for mental illness onset or actually relapse. I've just been at the Australasian Marce' conference up in Brisbane in October and increasingly we're identifying that it's often relapse; there are still new presentations of mental illness, but there is often a past history. I say perinatal mental illness affects everyone in the family — there may be one identified client but actually everybody in the family is affected, and we certainly saw that at Raphael when mum might present for some assistance but it became obvious that dad was also struggling.

Different families have different strengths and vulnerabilities and therefore one size does not fit all. I think it's really, really important that we have flexible services that are a client centred just to promote accessibility and deliver the type of care that families might need. We found at Raphael that many new parents have poor help seeking skills and by that, I mean they often had not asked for help or felt so vulnerable or in need of assistance at any time in their life and so I think it's really, really important that we support families to develop good help seeking skills for right now but also into the future and that's great role modeling for their children too. Of course, we know pregnancy and childbirth provide an opportunity for intervention, and early intervention, and most parents are highly motivated to be the best parents that they can be for their babies and children.

This was a quote from Alan Schore, that came from a lot of evidence that we are becoming more confident about: "From neuroscience: the peak interval of attachment formation overlaps the most rapid period of massive human brain growth that takes place from the last trimester of pregnancy through the end of the third year."

So, we've got these two really important life stages and they coincide. We know that attachment relationships form the foundation for how people form relationships going forth into the future, we also know that those early attachment relationships are so important in terms of brain development and reaching potential. Many factors impact optimum attachment opportunities, including the mental health of parents, but it's not the only one. But we do know that when people are mentally unwell it impacts their functioning in the workplace, their functioning in their intimate relationships, their functioning in the community, their functioning in employment, study, whatever, so mental health is just a cornerstone of functioning in many aspects of life. Again, just emphasising pregnancy and early parenting providing opportunities for this early identification and early intervention.

Just a reminder that we're not just talking about the family here, we are talking about the community because families provide the first building blocks of the community. You have healthy families, you have got healthy communities. If you've got healthy communities hopefully that supports families to be healthy families but in actual fact that we are impacting everyone, not just the family.

I am a big advocate for screening and the latest Clinical Practice Guidelines for Perinatal Mental Health advocate antenatal and postnatal screening, and again, based on some of the contextual factors that I've already

mentioned. We know there is a lot of evidence that it's very acceptable to women and to some men, and I think we are getting better at reaching men and inviting men to be part of this early parenthood life stage. A reminder about screening, it isn't diagnostic and therefore if there are positive risk factors for mental illness or risk of mental illness during this life stage, there needs to be further clinical assessment and sometimes that can happen with the GP who is often very, very busy but perinatal mental health services are in a really good position to do that further clinical assessment.

In Geelong up until about four years ago, screening only happened in the public hospital but now I'm proud to say Raphael was involved in introducing antenatal screening at St John of God through their maternity booking-in process and then very recently we were consulted by Epworth who heard from the obstetricians that women giving birth at St John of God were screened and that's an important part of making sure that they are in really good emotional shape to give birth and parent their new infants and so Epworth consulted Raphael and we assisted them in developing a process for screening when families give birth.

Around Australia, the private hospitals have been very slow to take up screening. There are some interesting relationships between who manages the care of pregnant women and with obstetricians in the private sector. It has been a little tricky getting screening in the private sector but I'm pleased to say it's on the agenda and it's certainly strongly advocated in the Clinical Practice Guidelines for Perinatal Mental Health.

Screening ideally takes place in a caring discussion. It's not just a tick box and then a care pathway that is delivered digitally. I know you have heard from Nicole Highet and she's certainly developing really good quality digital screening for services that can't provide that face to face opportunity.

I think a service model for perinatal and infant mental health services needs to have a response to positive screening responses because not everybody requires acute mental health service. I actually don't believe that they all need to employ a psychiatrist because not everybody needs to be seen by a psychiatrist. I think there are some women with complex and unstable mental illness who require ongoing care and possibly they would be best serviced by the tertiary sector with some additional support through a perinatal mental health service. Existing health professionals can provide screening if they are up skilled and we also support them because sometimes screening identifies some pretty confronting issues that can be challenging for health professionals to deal with so they do need to be adequately skilled, have opportunity for debriefing and supervision, and have the ability to escalate care if it's required because it always occurs at 4 o'clock on a Friday, that's when you get the most unwell people. We need nimble and agile service responses when care needs to be escalated and certainly there are many examples of gatekeeping or services who deal with more acute mental health issues not being available.

This is just some examples of the different tiers that I think should be part of a really good quality perinatal mental health service. For some individuals a discussion around screening is sufficient; they're able to take that information and take better care of themselves and recognise very early when they might need additional care. Sometimes the screening discussion is accompanied by takeaway literature or referral to websites that can provide further information. Sometimes there's a very simple psycho educational session that might need to be required; something as simple as if a woman doesn't cope well with sleep deprivation but before child they may be able to get their sleep needs met, that may be much more challenging when they've got an infant and they need to work around their infant. Sometimes a very simple psycho education session around how they can prioritise getting sleep and rest may be all that is required. There are E health and online courses.

Occasionally the screening results are not clear and need to be repeated but the maternity services may not have the ability to offer a repeat screening process. Sometimes significant mental illness is identified at screening so direct referral for symptom management or recovery directed care might be required. Sometimes people have lived with undiagnosed mental illness, as we all know. They have lived and functioned but it could become problematic when they have an infant. An example is somebody who lives with a degree of anxiety and they manage that through perhaps some obsessive-compulsive tendencies that get them through, but that may not be possible once baby arrives or it may trigger more serious illness.

What we have seen in Geelong is social isolation or moving away from your social support networks is not uncommon. We have had clusters of families doing a sea change leaving behind their employment in Melbourne, dad may still travel up the highway, they move down to Torquay and they're pregnant and it seemed idyllic but when baby is born they can experience cabin fever, they can feel isolated, so sometimes it's as simple as helping them develop a support network or being more realistic about what their needs might be.

The CHAIR — Suzanne, could I interrupt you. Would you be able to give me the rundown on Raphael? What is it?

Ms HIGGINS — Sure. I beg your pardon.

The CHAIR — We've heard it mentioned quite a few times and we've got a rudimentary understanding of it, but for someone who worked there it would be great to hear about it.

Ms HIGGINS — Raphael Services, there are six around Australia and they're funded out of the charity bucket of St John of God Health Care. Every division — so we've got St John of God Hospital in Geelong, that's called a division — every division has had a responsibility to run some charitable works in their own community but very recently it's been restructured so that all the charitable works, which still come out of the charity bucket, are managed by what we call outreach services in West Australia. It's still St John of God but has its own division.

Raphael services were initially set up to provide services for postnatal depression and our Geelong Raphael service was the second of the six. As I mentioned, it started in July 2003. Each Raphael service was slightly different because it was reflected on what gaps there were in the community, but generally they all provided assessment and counselling. They were Monday to Friday 9.00 to 5.00 and they were staffed by mental health clinicians. Geelong is the only one that doesn't have a psychiatrist and the reason for that is that we were very lucky — when I say they don't have a psychiatrist, they don't employ a psychiatrist on staff. And when we started, we were lucky enough to have support from some psychiatrists in private practice who provided rapid access and bulk billing to our clients. Clients don't pay. In the early days there was also no Medicare billing but now all of them require GP referral and most of the Raphael services clients are referred under Mental Health Care Plans via their GP.

The CHAIR — So covered under Medicare?

Ms HIGGINS — They still get significant funding from the charity bucket but each Raphael service is expected to generate some income through Medicare billing. In Geelong, and that was similar to the other Raphael services there was one on one counselling, there was community education, there were group programs such as managing depression and anxiety, an eight week program, there was supported playgroup, there was an attachment based group program called Circle of Security and in Geelong we also had a male counsellor and we were very successful in attracting men who came for their own mental health but we also offered some short term couple counselling. Some of the programs are being revamped.

The CHAIR — Do you mind if we just continue asking you some questions?

Ms HIGGINS — Sure.

Ms McLEISH — Thank you for explaining Raphael services because we kept hearing about it this morning and didn't have a detailed understanding. I was looking at your submission and you've probably answered this mostly but ideally when we're talking about that pregnancy period and providing the screening services, if people see their GP is it the GPs who should be doing the screening or if it's the midwife or through the public health system? You have said that screening is starting to start now at St John of God and Epworth but what about more general?

Ms HIGGINS — In Geelong, screening has occurred at Barwon Health, or University Hospital, for many years.

Ms McLEISH — Do you think they adequately screen for emotional mental health?

Ms HIGGINS — I haven't spoken to Barwon Health staff in the last 12 or 18 months since the PEHP Program folded. I know before the PEHP Program folded every woman booking in to give birth was offered screening and I know the midwives were very concerned if there was no PEHP Program, should they continue screening.

Ms McLEISH — It was put to us somewhere else that the midwives, as part of a general consultation, would do that screening at the same time. Is that feasible?

Ms HIGGINS — The organisation does need to value it and allocate enough time. So, at St John of God Maternity Services the booking-in appointment is a 45 minute appointment and 15 minutes of that is specifically for assessing emotional wellbeing. Certainly, up until I have been involved there that time was embargoed, it had full support by the CEO and the Director of Nursing. I'm assuming that it's still occurring at Barwon Health but I can't be 100 per cent sure.

Ms McLEISH — If the initial consultant is a 45 minute consult, it would happen?

Ms HIGGINS — It would, if there's enough time allocated, yes.

Ms McLEISH — What techniques do they use to screen?

Ms HIGGINS — There are two main tools that are used. One is the Edinburgh — you've possibly heard about the Edinburgh?

Ms McLEISH — Yes.

Ms HIGGINS — The other one — I did bring a copy. This is called a psychosocial assessment tool, so this is the tool that has been recommended in the expert working group and the clinical practice guidelines and that's the tool that we used at St John of God. The psychosocial assessment screening I don't believe can adequately take place electronically because if you read some of those questions they can be pretty confronting and you don't want to open the lid and then leave people without somewhere to go to talk that through.

The CHAIR — So this is the ideal?

Ms HIGGINS — Yes, that's the recommended tool through the clinical practice guidelines. That and the Edinburgh. The Edinburgh is a screening tool for depression symptoms but it also measures some anxiety symptoms as well.

Ms McLEISH — Thank you very much.

The CHAIR — Suzanne, just one more question from me. Where are most people falling through the gaps at the moment and how do we deal with it?

Ms HIGGINS — I think people fall through the gaps when screening identifies risk and then having that further clinical assessment if there are too many barriers. So if they have to go via their GP to get a Mental Health Care Plan, if they have to make a long appointment in order to ask for a Mental Health Care Plan, if they don't have a regular GP. The other area that people are falling through the gap is when they go for one or two appointments and they're not fully engaged and they don't go back, and the organisation is too busy to do a follow up, I think then they just disappear.

Ms COUZENS — Thank you for coming along today. The questionnaire you have just given us, how many questions does a person have to answer to be at risk?

Ms HIGGINS — The tool is designed to be scored and there are quite, what I think, quite complex scoring processes. How we decided to use it at St John of God — and I have discussed it with the developer of the tool, Marie-Paule Austin, who is a psychiatrist who chaired the expert working panel, we decided to use it as a discussion starter and what happens is any of those issues that are positive that are troubling for the woman they are invited to accept a referral.

Ms COUZENS — So you sort of just use it as a starting point really?

Ms HIGGINS — Yes.

Ms COUZENS — Could you outline a little bit about what else you see needs to be changed in this sort of assessment tool. Is there anything in particular you haven't already touched on?

The CHAIR — Does it come down to the bedside manner of the person applying this tool?

Ms HIGGINS — I think that's really important so we needed it to be administered with a health professional who is comfortable in dealing with whatever might come up and that comfort can be developed with support

and supervision so what we did with the midwives at St John of God was we did some training programs, there is online training beyondBlue offer, so midwives were encouraged to do the training so at least they had a good knowledge base around perinatal mental illness, and then every month we would meet with the midwives and talk to them about any tricky cases or provide follow up on people that they had referred and you saw the professional development of the health professionals. I'm not sure if that answered your question.

I think a lot of it comes down to the individual worker and their area of comfort but we have certainly seen at St John of God a change in the approach of the midwives so initially the midwives, I think it's fair to say, were a little bit scared about mental illness and the disclosure that might occur, but now they actually go looking for it. It's part of everyday conversation at the bedside.

Ms COUZENS — Early in your presentation you talked about the importance of early intervention. How early do you think that intervention needs to be occurring?

Ms HIGGINS — I think when people become pregnant mostly they have hope and positivity about that experience and throughout the pregnancy you have got nine months to consider that there's the ideal but also the real, and to do a bit of education. Again, we had input into all childbirth education classes that St John of God ran where we would have a session talking about emotional wellbeing and talk a little bit about the incidence of mental illness for both men and women because when I first started back in 2003 we didn't think that men had an increased risk of perinatal mental illness and we now know that they do. One in 10 men actually has significant symptoms of mental illness.

During pregnancy you need to alert each of them to the possibility that they may experience some emotional fragility. You don't have to necessarily talk about depression and anxiety but it's a good idea to alert them that it is a time of emotional fragility, and talk to them about how they can look out for one another and also how they can look after themselves so I think right from then.

If people came to see me at Raphael because they scored positive on either the depression screening tool or the psychosocial risks questionnaire, you then explore what might need to happen. There are clinical indicators, clinical pathway. If I know somebody has had a traumatic early childhood, in and out of foster care, perhaps don't have a great blueprint in their brain, I'm not going to go straight for that jugular and want to talk about their traumatic childhood but rather try and form a trusting relationship and explore with them how they can be aware of those ghosts in the nursery but make sure that they are not too intrusive.

Ms COUZENS — Do you think there is enough training for people working in the perinatal industry like in family violence, mental health, cultural awareness those sorts of things? Do you think it's adequately covered or do you think there needs to be more done?

Ms HIGGINS — I think all health professionals should have input during their education and their university degrees or TAFE degrees on all those issues. At the moment there is a lot of emphasis on family violence and that is really, really important, but I think there are a whole lot of issues. I personally think that somebody who has experienced childhood sexual assault or family violence or the mental illness of parents may all present with blurred blueprints on what is good parenting. So there are a lot of trigger factors which I think health professionals need to be aware of, they are all potentially traumatising and may impact on the ability to be a good enough parent. Or a good enough parent.

Ms BRITNELL — Throughout the inquiry we have been hearing about the Edinburgh scale and you have presented this one here. We have also heard consistently that screening is really important and there is a real commitment both in the antenatal phase from midwives, from GPs, from someone who is administering antenatal care. We've also been hearing that it's not one person's job, it's belonging to all the people who touch the antenatal and postnatal person and the families. We also heard in Warrnambool how the systems of IT don't talk to each in the health sector. Is there a risk that we can miss someone because we haven't got the IT streamlined and would it be a good system if we could, rather than asking the patient have you had it, someone has done it, someone else has done it, and some who are getting it five times and others not getting it at all? Is there a way that you can see that we can be more technologically mature and obviously don't want to do it just once anyway, want to do it at certain phases as the emotional challenges change in a person's life, but are you seeing a risk there of the holes that we are creating with the system not talking smoothly to each other in different parts of the sector?

Ms HIGGINS — Yes, I think there is a risk. I guess if people's medical records were available for every health service to access, that may reduce people falling through the cracks or being over-screened because there can be a fatigue if people are asked too often about their health and wellbeing that they might fob it off or not be honest about it. But, certainly I know all different organisations seem to have different IT programs that they capture their data on and so I'm not really well informed about that sort of thing.

The CHAIR — Thank you, Suzanne, for your contribution today. We would love to pick your brain for a lot longer but we are under time constraints. Thank you so much for giving us your time today.

Ms HIGGINS — It's my pleasure. Thank you for the opportunity.

Witness withdrew.