Submission to the Victorian Parliamentary Inquiry into Perinatal Services

Australian Psychological Society

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1. Summary of Recommendations

1. The APS recommends adopting a social determinants of health approach to the perinatal period, which considers the influence of broader societal, economic and political factors, including the way perinatal health services are structured and organised, and how women experience these services.

2. The APS recommends that the Victorian Government urgently address the paucity of perinatal mental health services within Victorian Maternity Hospitals, Early Parenting Centres and community health settings, through advocacy, funding and better service coordination.

3. It is recommended that the Victorian Government work with mental health service providers, with input from women and consumer groups, to provide better multidisciplinary, coordinated care within the perinatal period.

4. The APS recommends that service provision cater to the needs of women and young families, and hence that there should be a variety of opportunities for residential services, outreach programs and group programs, along with individual mental health services.

5. It is recommended that the Victorian Government adopt the core principle of continuity of care as fundamental to underpin effective mental health care and that this principle apply to all maternity care and service provision in the perinatal period.

6. The APS recommends that the Victorian Government advocate for the Federal Government to commission an independent and comprehensive evaluation of the National Maternity Services Plan, with particular reference to mental health outcomes.

7. In the absence of such an evaluation, it is recommended that the Victorian Government commission an independent evaluation regarding Victorian Hospital and Health Services' implementation of State Government commitments to the NMSP. This is in order to determine the extent to which Victorian women and families have experienced an increase in access to high quality, evidence-based models of maternity care, and to what extent these are associated with better health and mental health outcomes for women, particularly for high risk families and their infants.

8. The APS recommends that maternal child and health services strengthen their focus on mothers' health and wellbeing, and that family support and community outreach programs are supported.

9. It is recommended that the Victorian Government work in partnership with Aboriginal communities and services to provide culturally responsive perinatal mental health care to Aboriginal and Torres Strait

Islander women and their families that is in line with the Perinatal Clinical Practice Guidelines.

10. The APS recommends that the Victorian Government advocate for the re-funding of the National Perinatal Depression Initiative and other Federal funded services to women in the perinatal period.

11. The APS recommends strengthening the support available for high-risk and premature births in Victoria.

12. It is recommended that the Pregnancy Support Item be promoted to Victorian psychologists and that barriers to access be addressed.

13. The APS recommends that the Victorian Government disseminate and implement the recommendations within the Perinatal Clinical Practice Guidelines once these have been updated.

14. The APS recommends that psychologists be engaged to provide perinatal mental health training, support and mentorship to other professions that are key in the perinatal period, and that mechanisms for better coordinated, multidisciplinary care be strengthened.

15. The APS recommends that the gap between service availability and access for women and their infants in rural and regional Victoria be addressed as a matter of urgency. The Government should work with local communities to find responses that meet the needs of local women and their families where possible.

2. Introduction

The Australian Psychological Society (APS) welcomes the opportunity to make a submission to the Victorian Parliamentary Inquiry into Perinatal Services.

This submission has been developed in consultation with the Victorian section of the APS Perinatal and Infant Psychology Interest Group (PIPIG) which exists to foster the theoretical, applied and professional development of perinatal and infant psychology as a specialist field within mental health. Other members have also had input into our submission, including those employed in maternity hospitals, in private practice and experts involved in developing and reviewing the Perinatal Clinical Practice Guidelines.

Perinatal and infant mental health is an interdisciplinary field focused on the emotional health and development of parents and infants from the planning of conception through to three years postpartum. The APS supports the submission made into the current inquiry by the Centre for Perinatal Excellence (COPE), particularly the holistic and integrated solution to support the efficient implementation of perinatal mental health best practice that is espoused.

Conception heralds a period of enormous psychological change, and the perinatal period brings many gains but also losses. It follows that during this period, more than any other time in her life, a woman is vulnerable to developing mental health difficulties.

There is a high incidence of maternal mental health difficulties within the perinatal period. Postnatal depression is a commonly used term which describes an array of mental health difficulties, typically depressed mood and anxiety disorders of varying severity. Emotional difficulties associated with the adjustment to motherhood are also common. Posttraumatic stress disorder is another relatively common mental health disorder, which may have onset, or be exacerbated in the perinatal period. Figures suggest that almost one third of women experience postnatal depression and over 14% are experiencing PTSD because of birth (Boorman, Devilly, Gamble, Creedy, & Fenwich, 2014). Fifty percent of 'postpartum' major depressive episodes begin prior to delivery (DSM-5, 2013). The leading cause of perinatal mortality is suicide.

For women who feel isolated either by distance, culture or both, including Aboriginal and Torres Strait Islander women and women from culturally and linguistically diverse backgrounds, the likelihood of mental health issues may be even greater. (Beyond Blue, 2011).

There is a personal cost associated with untreated mental health issues for women, but there are also costs borne by infants, families, communities and governments. There is an increasing body of evidence from the field of infant mental health which has demonstrated the adverse effects of maternal mental illness upon infants.

In the antenatal period, maternal anxiety and depression increase the risk of adverse obstetric, foetal and neonatal outcomes. Chronic maternal stress and/or substance abuse are understood to negatively affect the developing brain. A protective family environment has the potential to support these infants, through the protective medium of a loving relationship with a caregiver. But for infants with antenatal exposure to chronic maternal stress and/or substance abuse, who are then born into families where there is mental illness, violence, neglect and trauma, the developmental outcomes are much poorer (e.g. Karr-Morse & Wiley, 2013).

Infant development occurs within the relationship with the primary care givers. Parental sensitivity and responsiveness to infant cues are important characteristics of optimal or 'good enough' infant-parent relationship. Research has demonstrated that infants who receive sensitive and responsive care are most likely to develop into children who are capable of self-regulation and are socially and emotionally competent. Conversely, it is well understood that maternal mental illness compromises the mother's capacity for sensitivity and responsiveness towards her infant. Infants whose mothers face mental health difficulties are at greater risk of insecure attachment and associated difficulties with social, cognitive and emotional development. Intervention in the early parenting years makes social and economic sense. Treating maternal mental illness and providing interventions to support sensitive and responsive parenting is the work of early intervention, and the aim of this work is to reduce or even prevent mental health difficulties within the next generation (Newman 2015).

The social context of parenting also means that women are increasingly required to navigate this important life transition in isolation. Extended families are increasingly not close by or available to assist, workplace flexibility and conditions are often inadequate to support parents during this period, and childcare is often limited in terms of accessibility, affordability and quality.

While there is arguably more information to support mothers during this period, it is difficult for parents to navigate this material and find quality, accurate resources. There are also increasing and unrealistic social expectations of mothers which add to an already stressful period.

While the provision of high quality, continued perinatal services is essential in meeting the needs of women and their babies, the APS also recommends adopting a *social determinants of health* approach which considers the influence that broader societal, economic and political factors, including the way perinatal health services are structured and organised, and how women experience these services (Commission on Social Determinants of Health, 2008; Sutherland, Yelland, & Brown, 2012).

The remainder of our submission addresses the Terms of Reference for which we have relevant evidence and expertise to offer.

3. Responding to the Terms of Reference

1. the availability, quality and safety of health services delivering services to women and their babies during the perinatal period;

The perinatal period is considered as beginning at conception and continuing through to at least 12 months after birth (Alderdice et al., 2013) and up to three years after birth. One of the aims in providing access to high quality and safe services during the perinatal period is to enhance maternal (and infant) health and wellbeing.

Perinatal wellbeing is a complex concept which has been defined as "the cognitive and or affective self-evaluation of the individual's life specific to the period before and/or after childbirth, which encompasses a multitude of elements such as physical, psychological, social, spiritual, economical and ecological" (Allan, Carrick-Sen, & Martin, 2013, p. 10).

Health professionals providing care should have appropriate training and skills, and whenever possible should work together to provide continuity of care for women and their families.

Perinatal services should span the entire perinatal period, through pregnancy to three years, particularly for high risk families who benefit most from consistent, long term care. There should be opportunities for multi-disciplinary interventions, and a clear framework for inter-agency cooperation when multiple agencies are involved.

The APS is concerned about the lack of perinatal services in Victoria, including inadequate specialised mental health care services for women and their infants, and a lack of continuity of care more generally during this period. These two particular areas for improvement will now be discussed.

Mental health care services

Mental health disorders may be pre-existing, arise antenatally or emerge following birth. The effects of untreated mental health difficulties upon the mother, her baby, her partner and other family members have been discussed above.

Antenatal Interventions
The range of services to support the mental health and wellbeing for women and their families in the antenatal period should include attention to:

- Postnatal depression and anxiety often have antenatal antecedents, and it is prudent to begin treatment antenatally rather than waiting until the baby arrives
- Domestic violence - Women are at increased risk of violence during pregnancy: estimates vary between 3-30% women subject to domestic violence during pregnancy (Tailleu, & Brownbridge, 2010). Domestic violence may occur for the first time in pregnancy, or

pregnancy may trigger exacerbation of violence. Psychologists can provide assessment of risk, as well as evidence based treatments for PTSD, depression and anxiety, which are the three most common mental health disorders associated with domestic violence. Domestic violence is also associated with adverse obstetric outcomes, and negatively affects infants (Howard, Oram, Galley, Trevillion & Feder 2013)

- Mental health interventions for women carrying high-risk pregnancies
- Fear of childbirth / anxiety– Mental health interventions for women with a fear of childbirth which may be associated with a history of previous traumatic birth, history of sexual assault. This can lead to difficulties during labour, postnatal anxiety and post-traumatic stress disorders, termination or premature labour, insistence on having a caesarean which carries its own risks.
- Women with a history of eating disorders
- Adjustment - support with adjustment / transition to motherhood, which need to include fathers/partners where applicable
- Psychological interventions for families with special needs or psychosocial difficulties impacting physical and mental health in pregnancy, including
  - Homelessness
  - Substance abuse
  - Financial stress
  - Aboriginal, CALD and refugee populations
  - Women with chronic health conditions

Postnatal Interventions

Specific areas for intervention in the postnatal period may include:

- Depression and anxiety
- The high rates of PTSD and psychological distress amongst families in Neonatal Intensive Care Units (eg. Kim et al 2015 estimated between 24-44% of parents in their study met criteria PTSD).
- PTSD as a result of traumatic birth, the stress of pregnancy and birth triggers PTSD symptoms (Grekin & O'Hara, 2014)
- Support for mother-infant relationship which may include assisting parents to read and respond appropriately to baby's cues and signals to meet the emotional needs of the infant.
- Support with the transition to motherhood – including relationship difficulties, adjusting expectations
- Paternal/partner mental health

Consultation with our membership indicates that there is a paucity of specialised mental health services for women and their infants in the perinatal period. For example, there are very few psychologists employed in Victorian maternity hospitals and state-funded Early Parenting Centres, despite these being important opportunities to provide assessment, intervention and referral within a multidisciplinary care environment.

The APS understands that psychologists working in services for Families-at-Risk tend to be burdened by high case-loads and have limited opportunities to deliver specialised therapeutic interventions; instead they tend to deal more in the assessment and management of risk.

Residential admissions to the three state-funded Early Parenting Centres in Victoria are important and necessary part of addressing difficulties in the perinatal period. Women with mental health difficulties are more likely to present with unsettled babies (e.g. McMahon et al 2001). Women are admitted with their infant, and ideally also with their partner. Referrals to EPCs are typically made to assist families with infant sleep and settling issues, other times feeding and or behavioural difficulties all of which impact on the mother-infant relationship and secure attachment. Parents can be supported to learn skills which then provide the foundation for mother-infant interactions and relationship-building, skills such as responsive settling, support with responding to challenging behaviour, feeding issues and so on.

Feedback from members indicates that access to these services is complicated by long waiting periods, and once admitted there is a lack of specialised training amongst staff to deal with the increasing complexity of families presenting to these services. In the absence of specialised community mental health programs for women in the perinatal period and with few mother-baby unit beds available throughout the state, some families present to EPCs with high levels of acute, untreated mental health difficulties. However, there is a paucity of psychological/mental health services within these facilities. Families tend to receive assistance with skills development and training, but adjunct mental health interventions for treatment, and which support the mother in the implementation of such skills, are lacking.

Such services could also provide group therapy interventions and psychological assessment and treatment, alongside skills development and training. When families are admitted to these services, this can provide an opportunity to engage fathers/partners in mental health interventions. At the close of admission, there is often a lack of services to refer to for ongoing mental health support, particularly if families do not have means to pay for a private psychologist. Better service coordination and linkages are required.

Some women with perinatal mental health disorders seek a referral to perinatal psychologists in private practice utilising Commonwealth Funding via the Better Access to Mental Health Care scheme. However many low income and higher risk families are not able to utilise these services because of the cost. Private practitioners have limited capacity to take case management duties, and for referrers, the identification of practitioners with specialised training in perinatal mental health is not always easy to discern. Women in rural and remote areas are disadvantaged by limited access to trained practitioners.

Similarly, it is acknowledged that high risk families often require multidisciplinary team approach. Access to other support services which complement mental health interventions, such as Family Support Services or Enhanced Maternal and Child Health Nursing, are often limited. These services are typically over-subscribed and manage the admission process by prioritising those families at highest risk. As a result, many have long waiting periods for service, and/or time limited involvement. In addition, there is often inadequate coordination between services and families, particularly infants who are unable to advocate for themselves, can fall through the gaps.

High risk families require more than brief episodes of care. Service delivery should be coordinated to prevent doubling up of interventions, and consistent, long-term support is necessary with families identified to be at high risk of poor outcomes. There is clear and copious research suggesting that early intervention is worthwhile; infants are most at risk and most responsive to protective interventions between birth and age three.

Provision of services via hospitals embeds the mental health support and provides a multidisciplinary approach to care. It is optimal for monitoring women and providing ongoing support throughout the perinatal period.

The APS recommends that the Victorian Government urgently address the paucity of perinatal mental health services within Victorian Maternity Hospitals, Early Parenting Centres and community health settings, through advocacy, funding and better service coordination.

It is recommended that the Victorian Government work with mental health service providers, with input from women and consumer groups, to provide better multidisciplinary, coordinated care within the perinatal period.

The APS recommends that service provision should cater to the needs of women and young families, and hence that there should be a variety of opportunities for residential services, outreach programs and group programs, along with individual mental health services.

Continuity of care during the perinatal period

While mental health services are a direct and necessary response for women who experience mental health issues, they are only part of a health system which should (in its entirety) provide optimal support for women's wellbeing and their babies during the perinatal period. The wellbeing of women during this stage is therefore influenced by, and can be enhanced at a range of points within (and outside) the health system. Psychologists for example, can do much more than provide treatment, such as promoting equity of access to services, and promoting care which enhances mental health.

In particular, there is strong evidence demonstrating that the provision of continuity of care or carer, where a woman has the opportunity to develop a relationship with a healthcare provider or a small group of providers

throughout her pregnancy, birth and postnatal period, is associated with better physical and emotional health outcomes for mothers, improved health outcomes for babies and higher maternal satisfaction (Homer, 2016; Sandall, Soltani, Gates, Shennan, & Devane, 2015; Sutherland et al., 2012; Tracy et al., 2013).

Continuity of care is one strategy to enhance women's access to safe and respectful perinatal care and to minimise women's exposure and vulnerability to health-compromising conditions, including discrimination and mistreatment by maternity service systems. Continuity of care with midwives is particularly valued by many women as it enables women to build a trusting relationship with their care provider, with greater potential to obtain holistic and individualised care (Davison, Hauck, Bayes, Kuliukas, & Wood, 2015; Newman, 2009; Prosser et al., 2013). Mental health care for women with known mental health difficulties or at high risk of mental health difficulties could be embedded in a similar way.

The inaugural Perinatal Clinical Practice Guideline in 2011 identified the provision of continuity of care or carer as a principle underpinning the provision of effective mental health care (Beyondblue, 2011). "Continuity of carer" was defined in this Guideline as "when a named professional, such as a midwife, who is known by the woman, provides all her care as appropriate, thus enabling the development of a relationship" (Beyondblue, 2011, p. 13). This principle of ensuring continuity of care where possible to underpin effective mental health care has been retained in the revised draft of the Australian Perinatal Mental Health Guideline, which is expected to be launched in late October 2017 (Centre of Perinatal Excellence, 2017).

Increasing women's access to continuity of care was a key priority of the National Maternity Action Plan (NMAP), launched in 2002 by a coalition of maternity consumer advocacy and midwifery organisations (Newman, Reiger, & Campo, 2011). The NMAP called for the reform of Australian maternity services to establish a strong primary care model where all women who wanted to could choose to access community-based continuity of care, with midwives collaborating with obstetricians and other specialists as required (Gray Jamieson, 2012; Newman et al., 2011).

After a national review of maternity services in 2008-09, the Federal, State and Territory Health Ministers all endorsed the Australian National Maternity Services Plan (NMSP) in 2010 (Commonwealth of Australia, 2011). Key government commitments to the NMSP were to increase women's access to evidence-based models of maternity care, including continuity of carer services (Commonwealth of Australia, 2011).

Continuity of care provided through midwifery carer services has found to be particularly important for improving quality of care and wellbeing outcomes for women in the perinatal period. For example, a World Health Organisation report suggests that:

- midwifery is associated with reduced maternal and neonatal morbidity, reduced interventions in labour, improved psycho-social outcomes and increased birth spacing and contraceptive use
- there were no adverse outcomes associated with midwife-led care but significant benefits, thus it is recommended that all women should be offered midwife-led continuity models of care to optimise the normal processes of childbirth and early life, and empower women to care for themselves and their families
- midwives have the potential to provide excellent quality of care but socio-cultural, economic and professional barriers must be overcome to allow them to practice to their full potential (WHO, 2017).

Beyond midwifery support, maternal and child health services are a key support during the perinatal period. While Victoria has led the way with the MC&H Service, it is important that there remains a focus on the mother, as well as issues related to infant care and parenting, including the mother's (and father's) mental and physical health and wellbeing.

APS members have suggested that many women see these services as being primarily about babies and children and therefore do not consider taking issues of concern to themselves or their relationships to the maternal and child nurse. Furthermore, it seems the nurses have little time to spend on issues of concerns for women (apart from physical recovery and the required post-natal depression screen).

Across the research on perinatal depression is recognition of the need for family support and yet there are few services available in this regard. There are a number of good examples which could be further supported and expanded including volunteer peer support and home visiting programs for young families. Programs which aim to assist parents in their transition to parenting are important, including navigating their relationship and providing identification and prevention of family violence.

Aboriginal and Torres Strait Islander women's perinatal needs and services

Aboriginal women have been displaced from being the experts of their birthing experiences through tradition, culture and experience, to being passive recipients of medicalised and institutionalised pregnancy care (Hancock, 2006). Differences may exist within Aboriginal and Torres Strait Islander contexts of the experience of mental health issues, because mental health problems may show themselves spiritually and culturally, resolution can only be achieved in the same manner (Marriott & Ferguson-Hill).

Many Aboriginal people ask that 'workers in community agencies apply an 'Aboriginal lens' and consider additional factors and approaches' when working with Aboriginal people, for example and working in collaboration with social and emotional wellbeing (SEWB) workers and Aboriginal mental health workers (AMHWs) is essential during the perinatal period.

According to the Perinatal Clinical Practice Guidelines, the following factors may assist in improving uptake of services and maternal mental health outcomes among women from Aboriginal and Torres Strait Islander communities:

- involving an Aboriginal and Torres Strait Islander health worker, Aboriginal and Torres Strait Islander liaison officer or interpreter in the maternal health care team (the role taken will depend on knowledge and experience but may include administering assessments, home visits and assisting women to access follow-up) — consulting the woman about who she would like to be involved in her care may help to ensure that internal roles within the community are not compromised (e.g. family members are not appropriate interpreters);
- acknowledging the importance of involving extended family and kin (community) in decision-making (NSW Dept Community Services 2008);
- cultural competence of health professionals (AHMAC 2004);
- providing culturally appropriate educational materials (including local adaptation of materials);
- specific birth, parenting and young mother programs (Swan & Raphael 1995);
- where possible, providing services in a setting that is comfortable for the woman (e.g. Aboriginal and Torres Strait Islander staff are employed in a range of roles and there is evidence that Aboriginal and Torres Strait Islander people are welcome); and
- acknowledging the role of traditional healers.

It is recommended that the Victorian Government adopt the core principle of continuity of care as fundamental to underpin effective mental health care and that this principle apply to all maternity care and service provision in the perinatal period.

The APS recommends that the Victorian Government advocate for the Federal Government to commission an independent and comprehensive evaluation of the National Maternity Services Plan, with particular reference to mental health outcomes.

In the absence of such an evaluation, it is recommended that the Victorian Government commission an independent evaluation regarding Victorian Hospital and Health Services' implementation of State Government commitments to the NMSP. This is in order to determine the extent to which Victorian women and families have experienced an increase in access to high quality, evidence-based models of maternity care and to what extent these are associated with better health and mental health outcomes for women, particularly for high risk families and their infants.
The APS recommends that maternal child and health services strengthen their focus on mothers' health and wellbeing, and that family support and community outreach programs are supported.

It is recommended that the Victorian Government work in partnership with Aboriginal communities and services to provide culturally responsive

perinatal mental health care to Aboriginal and Torres Strait Islander women and their families that is in line with the Perinatal Clinical Practice Guidelines.

2. the impact that the loss of Commonwealth funding (in particular, the National Perinatal Depression Initiative) will have on Victorian hospitals and medical facilities as well as on the health and wellbeing of Victorian families;

The loss of Commonwealth funding (in particular, the National Perinatal Depression Initiative) has already had a significant impact on Victorian women, their families, and the services available to them via hospitals and mental health and wellbeing services.

The withdrawal of NPDI funding has led to the cessation or reduction of mental health services provided by psychologists in many Victorian services including:

- Maternity hospitals (Inpatient and outpatient, public and private)
- Early Parenting Centres
- Community health and mental health
- Outreach and home visiting services
- Tertiary and secondary consultation.

Where psychologists and mental health services remain, there is less capacity for multidisciplinary and coordinated care resulting in a lower quality of care for women. For example, the lack of psychologists now employed at maternity hospitals has impacted on the capacity to identify, refer and support women with mental health concerns during pregnancy, which means women with mental health difficulties that could have been treated antenatally are missed, or these women present with great symptom acuity and higher levels of distress postnatally. It is also more likely that they are experiencing difficulties with the mother-infant relationship.

The defunding has resulted in an increased privatisation of the service sector. While public funding is available through Medicare via Better Access, is often inadequate for those with more serious perinatal mental illness who require more intensive support and treatment than ten sessions per calendar year. It also unaffordable for many clients, as it is not embedded with other support services such as MCHN or paediatricians. It may also be less accessible and private practitioners are less able to offer other services that may increase the quality of care, such as interpreters or case management, and because there is no provision under Better Access, fathers and partners are not able to access relationship counselling which adds to the potential for individual rather than family centred interventions. Fathers and partners have been particularly impacted by this model as there is not currently the provision for couples or relationship counselling through Better Access. There is less opportunity or willingness for psychologists in private practice to offer groups given the lower Medicare rebate. It is unfortunately not often financially viable to run group programs in the private sector.

Private practitioners are also often reluctant to offer outreach, in-home visits to families. However, for women with young families and mental health difficulties, women from particular cultural groups, and often families at higher-risk this can be a necessary way of engaging, assessing risk and initiating treatment.

The APS recommends that the Victorian Government advocate for the re-funding of the National Perinatal Depression Initiative and other Federal funded services to women in the perinatal period.

3. the adequacy of the number, location, distribution, quality and safety of health services capable of dealing with high-risk and premature births in Victoria

There is a paucity of mental health support for families dealing with high-risk and premature birth. Research suggests that there are high rates of PTSD and psychological distress amongst parents in the Neonatal Intensive Care Unit (Kim et al 2015).

Mental health support and follow up for families once they have left hospital is also lacking, yet improvements in medical technology mean that younger babies are now being saved but these babies are often sicker and are at increased risk of developmental difficulties.

The APS recommends strengthening the support available for high-risk and premature births in Victoria.

5. Access to and provision of an appropriately qualified workforce, including midwives, paediatricians, obstetricians, general practitioners, anaesthetists, maternal and child health nurses, mental health practitioners and lactation consultants across Victoria;

The lack of specialised mental health services for women in Victoria stands in stark contrast to the evidence about the importance of assisting mothers with mental health difficulties, and more generally to the adjustment of parenting during the perinatal period. This is also at odds with the understanding about the critical importance of early intervention with infants where there is parental mental illness, to prevent longer term developmental difficulties, psychopathology and other adverse outcomes (summary Newman 2015).

Perinatal psychologists have training to deliver evidence-based treatments for perinatal mental health issues, and which span the entire perinatal period. Perinatal psychologists are trained in evidence-based treatments for mental health disorders such as anxiety, depression, and PTSD. They also have the capacity to assess and treat the mother-infant relationship and consider the mental health of the infant.

Perinatal psychologists have the specialised training and skills to deliver group programs, and to support other health practitioners running these

programs. Psychologists in private practice do not run these groups because they are not financially viable due to low Medicare rebates. However, community services, early parenting centres and public mental health services are well suited to deliver such programs.

While psychologists in general and those with additional training and experience within the perinatal period are qualified to support women in the perinatal period, there is extremely limited access to them, particularly in publicly available services. One of Melbourne's largest maternity hospitals for example, has only one psychologist (P4) in the Perinatal Mental Health service employed at .8 EFT and another (P3) at .2 EFT, with no current psychologist employed in the Mother Baby unit. Feedback from these services would indicate that there is a need for at least 3 full time psychologists.

As mentioned earlier, there are extremely limited services within each of Victoria's three Early Parenting Centres (not one full-time psychologist at any of these services). Psychology roles were cut with the NPDI funding.

In terms of the private sector, there are barriers to access for women to gain a referral to a psychologist through their GP. There is specific federal funding and a system for access to a psychologist during the perinatal period (Pregnancy Support Item), which is accompanied by training and a clear referral pathway via GP's. This initiative aims to provide three non-directive, shorter sessions, but the funding is not well known about or accessed.

While many GPs and psychologists work collaboratively, for a number of reasons this step might present as a barrier, including women not wanting to disclose mental health issues, concerns about insurance, uncertainty about their ability to afford services and the additional step required to see two health professionals at such a busy stage. As mentioned earlier, the allocated sessions via Medicare's Better Access program are often not adequate during this life stage, and they need to be better integrated into the wider health system.

The APS acknowledges that lack of access to other (non-mental health) health services essential during the perinatal period, including obstetricians midwives or lactation consultants has direct implications for the mental health of women and their infants.

Furthermore, non-mental health professionals play a key role in supporting the wellbeing of women and their infants during the perinatal period. It is important that professionals such as midwives, maternal child and health nurses, GP's are provided with adequate training in mental health and that psychologists are part of multidisciplinary teams with such professionals where appropriate so the care provided can be integrated and seamless.

It is recommended that the Pregnancy Support Item be promoted to Victorian psychologists and barriers to access be addressed.

The APS recommends that psychologists be engaged to provide perinatal mental health training, support and mentorship to other professions that are key in the perinatal period, and that mechanisms for better coordinated, multidisciplinary care be strengthened.

6. Disparity in outcomes between rural and regional and metropolitan locations; and

While there are gaps in service provision across the state, it is within rural and regional areas that public (and private) perinatal mental health and other services targeted towards women's wellbeing during the perinatal period are almost non-existent. To our knowledge there are only:

- two mother and baby units in regional areas, one in Ballarat, one in Traralgon (none in rural areas)
- one Early Parenting Centre (in Koo Wee Rup)
- limited availability of Perinatal Mental Health Public Outpatient services and limited private services, mostly in regional areas

Access to continuity of care via maternity services is equally limited, impacting on the mental health and wellbeing of women in rural communities.

Feedback from members suggests that rural Victoria was particularly impacted by the defunding of the National Perinatal Depression Initiative, with the cutting of key preventative and educative health promotion programs, including home visiting approaches.

The APS recommends that the gap between service availability and access for women and their infants in rural and regional Victoria be addressed as a matter of urgency. The Government should work with local communities to find responses that meet the needs of local women and their families where possible.

7. Identification of best practice.

The Perinatal Clinical Practice Guidelines (currently being updated) represent best practice for clinical practice within the perinatal period. The Guidelines recommend an approach based on routine assessment of emotional health and wellbeing during both pregnancy and the following year that can be integrated into women's regular health checks with a midwife, maternal and child health nurse, Aboriginal and Torres Strait Islander health worker, general practitioner (GP) or obstetrician (Beyond Blue, 2011). As stated in the Guidelines:

> *Follow-up requires a pathway or 'map' by which the woman and her family can access the most appropriate care and support during the perinatal period. The pathway to care will depend on the severity of the woman's risk or symptoms, together with her preferences and social context.*

The way in which different health professionals use these Guidelines will vary depending on their knowledge, skills and role, as well as the setting in which care is provided. Whatever the setting and circumstances, perinatal mental health care should be culturally responsive and family-centred. It should involve collaborative decision-making with the woman and her significant other(s), which includes full discussion of the potential risks and benefits of any treatments offered. Health professionals providing care should have appropriate training and skills, and whenever possible should work together to provide continuity of care for women and their families.

Perinatal services should span entire perinatal period, through pregnancy to three years, particularly for high risk families who benefit most from consistent, long term care. There should be opportunities for multi-disciplinary interventions, and a clear framework for inter-agency cooperation when multiple agencies are involved Beyond Blue, 2011:VI).

The APS recommends that the Victorian Government disseminate and implement the recommendations within the Perinatal Clinical Practice Guidelines once these have been updated.

The Victorian Government is urged to provide perinatal mental health care that is culturally responsive and family-centred, and involve collaborative decision-making with the woman and her significant other(s).

As identified earlier, the APS recommends that the following principles be adopted as best practice within the perinatal period:

- Mental health services be accessible for all Victorian women, and consistent with an early intervention approach, begin during the antenatal period
- Mental health services should be provided within a multidisciplinary team, coordinated with other essential health and social services
- A range of supports should be available to women including access to a psychologist, online support, participation in a group, support for partners and home visiting where appropriate
- Continuity of care and consumer choice should be embedded in all service provision throughout the perinatal period. Women-centred care should be provided, including offering midwifery care where appropriate and safe, and support in the postnatal period that is focussed on their needs, in addition and separate to the needs of their infants
- A social determinants of health approach should be adopted, where social and economic factors such as housing, safety and poverty are considered and addressed as part of service provision in the perinatal period.

Selected References

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The Australian Psychological Society (APS) is the national professional organisation for psychologists with more than 22,000 members across Australia. Psychologists are experts in human behaviour and bring experience in understanding crucial components necessary to support people to optimise their function in the community.

A key goal of the APS is to actively contribute psychological knowledge for the promotion and enhancement of community wellbeing. Psychology in the Public Interest is the section of the APS dedicated to the communication and application of psychological knowledge to enhance community wellbeing and promote equitable and just treatment of all segments of society.