Australian Psychological Society

Submission to the Australian Health Ministers' Advisory Council's

National Strategic Approach to Maternity Services Consultation

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Australian Psychological Society

APS contact:
Heather Gridley
Manager, Public Interest
h.gridley@psychology.org.au
03 8662 3327

Level 11, 257 Collins Street
Melbourne VIC 3000
PO Box 38
Flinders Lane VIC 8009
T: (03) 8662 3300
F: (03) 9663 6177
www.psychology.org.au

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1. Introduction

The Australian Psychological Society (APS) welcomes the opportunity to make a submission to the National Strategic Approach to Maternity Services (NSAMS) consultation process, which seeks to examine the strengths and weaknesses of the current maternity services system and gain insights into key issues for pregnant women[1], mothers and other stakeholders.

The Australian Psychological Society (APS) is the largest national professional organisation for psychologists with more than 24,000 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.

We refer the Council to our recent submission to the Victorian Perinatal Services Inquiry, and to the Final Report of this inquiry, as findings from this Inquiry may inform the current consultation.

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

The APS acknowledges that conception heralds a period of enormous psychological change for women and their families, 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.

Mental health difficulties may be pre-existing, arise antenatally or emerge following birth. 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.

[1] The APS acknowledges that the use of binary gender distinctions is problematic for many gender diverse people. This submission refers to woman/women throughout, in recognition of the primary focus of maternity services, along with the safe delivery and wellbeing of infants themselves. The APS refers the consultation to a suite of APS resources on LGBTIQ+ parenting and families for further information on these concerns.

An accessible, high quality and safe maternity service system should have maternal (and infant) health and wellbeing at its core.

Our submission responds to the consultation questions based on psychological evidence and the experience of APS members and outlines the key aspects of a National Strategic Approach to Maternity Services required to deliver improved maternity services for all women and their families.

2. Overarching outcomes and values that should underpin the National Strategic Approach to Maternity Services

The following points are important to include in any outcome statement for the NSAMS:

- Maternity services enable the delivery of a connected and consistent (holistic) patient experience, providing the best care to ensure a safe and positive experience for infants and their families.
- Women and families have access to high quality, evidence-based models of maternity care, and these models are associated with better physical health and mental health outcomes for women, particularly for high risk families and their infants.
- Maternity models of care are women-centred and meet the health and wellbeing needs of mothers, their babies and families, and protect and respect their human rights throughout their contact with maternity services, regardless of personal, cultural, ability, sexuality or geographic context.
- Mothers' mental health and wellbeing are attended to throughout their contact with maternity services, and services are provided in ways that do not exacerbate mental health difficulties but prioritise these needs as central to the woman's experience.
- Perinatal and maternal morbidity and mortality indicators are measured and reported. Long-term public health impacts, such as maternal wellbeing, anxiety, depression, suicidality, maternal poverty, breastfeeding and birth rates, and rates of family violence during pregnancy and following should also be measured and reported.

Based on psychological evidence and experience, the following are important values to underpin an effective Maternity Services system:

- Continuity of access and quality of care across the different stages of the maternity services system
- Compassion: consistently acting with empathy and integrity
- Respect: for the rights, beliefs and choice of every individual and family
- Evidence-based care: provision of care based on the latest evidence, including but not limited to evidence-based mental health care
- Safety: an open, honest and safe environment, where women feel safe and patient outcome measures are reported

- Mental and physical health are viewed as interconnected – and the wellbeing of mothers, their babies and families are at the core of the maternity service system.
- Women have access to multidisciplinary approaches to care, which includes mental health services.

3. Strengths and gaps of the current maternity services system in Australia

The APS acknowledges that the following are recognised as positive features of maternity services in Australia:

- Universal (free) antenatal and birthing care is provided to everyone regardless of socio-economic status.
- Gross perinatal and maternal mortality outcomes are comparable to those of other OECD countries.
- A committed maternity workforce provides a level of personal care that makes a positive difference to many women's mental health and their transition to becoming mothers.

The APS has identified a number of key gaps or issues of concern for maternity services in Australia:

1. There is a lack of access to and provision of mental health supports and services. Very few psychologists are employed within Australian maternity hospitals, despite the evidence for the importance of assisting women in the perinatal period with mental health difficulties, and more generally in their adjustment to parenting. This is especially the case with women who experience anxiety, depression or have had a previous traumatic birth. More broadly, lack of access to an appropriately qualified, multidisciplinary workforce to provide services essential during the perinatal period, including obstetricians, midwives and lactation consultants, has direct implications for the mental health and wellbeing of women and their infants.

2. The mental health and psychology workforce within public antenatal and maternity ward settings is severely under-resourced, and the front-line workforce (midwives and obstetricians) is under-supported and under-skilled with regard to identifying perinatal mental health issues. This gap is at odds with current understandings about the critical importance of early intervention with infants where there is parental mental illness to preventing longer term developmental difficulties, psychopathology and other adverse outcomes. There is particularly a paucity of mental health support for families dealing with high-risk and premature birth despite research suggesting that there are high rates of PTSD and psychological distress amongst parents in neonatal intensive care units (Kim et al 2015).

3. A fragmented system of care means that many hospitals do not provide a 'team' or 'caseload' approach to maternal care, with the result that women often see a different midwife or obstetrician at each visit during their pregnancy. This can raise anxiety levels and contribute to mental health

issues as women are not afforded the opportunity to build a trusting relationship with a care provider. In practice this means that women with or at risk of mental health difficulties fall through the gaps and are not referred for mental health support. Young mothers, women in domestic violence situations, migrants or other vulnerable women may also have their mental health needs overlooked.

4. There is also very little coordination with post-hospital services like maternal and child health, family support services and mental health supports. Public sector psychologist roles were lost with the National Perinatal Depression Initiative, (NPDI) funding cuts in 2015. In the private sector, there is specific federal funding for these services during the perinatal period (Pregnancy Support Item), which is accompanied by training and a clear referral pathway via GPs. This initiative provides three non-directive, shorter sessions, but this option is not well known and thus is infrequently accessed.

5. Current models of care and decision-making do not place the woman at the centre of care nor the research evidence as the dominant driver of care. A social determinant of maternal health and wellbeing that is often neglected in the way in which maternity services are structured and organised (Newman, 2009; Sutherland, Yelland, & Brown, 2012) and the extent to which many women experience and are vulnerable to disrespectful and/or discriminatory health services (Reed, Sharman, & Inglis, 2017). Significant power imbalances within the maternity services system exist and there is a lack of recognition and action to reduce interpersonal and structural discrimination and disrespect towards pregnant women and mothers within the current system.

6. Many hospitals discharge mothers within 24 to 48 hours of giving birth, with some discharging in as little as 4-6 hours. Early discharge often places stress on families, impacts on the health and wellbeing of mothers and their babies, increases the workload of maternal and child health nurses, and affects breastfeeding rates. Early discharge can have a negative impact on both parents' mental health if they do not feel supported and confident in basic baby care tasks such as feeding. Women without family support are particularly vulnerable.

7. Finally, given that women are at increased risk of intimate partner violence during pregnancy, and that this violence is also associated with adverse obstetric outcomes and negatively affects infants (Howard, Oram, Galley, Trevillion & Feder 2013), there is a need for better identification and response to women and their families during this period to ensure safety is prioritised.

4. Recommended improvements in maternity services in Australia

1. Continuity of Care – the benefits to both mothers and babies of continuity of care models are now well established. The core principle of continuity of care is fundamental to effective mental health care and this principle should apply to all maternity care and service provision in the perinatal period.

2. Mental health considerations need to be embedded throughout the maternity and perinatal service system. Mental health and wellbeing should not be treated as an optional extra or a last resort at a time of crisis, but as part of a preventive strategy that enhances the wellbeing and outcomes for mothers, babies and families.

3. Increased funding for mental health services, including psychologists, in public maternity settings, public mental health services, home visiting and early parenting centres. Upskilling is also needed for the perinatal health workforce, including midwives and obstetricians, to detect perinatal mental health issues during pregnancy and in the immediate postnatal period. However, screening alone is insufficient; it must be accompanied by increased service provision to meet the needs of women who are identified with mental health difficulties.

4. The Government work with mental health and other service providers, with input from women and consumer groups, to provide better multidisciplinary, coordinated care within the perinatal period.

5. Increased initiatives to enhance workforce capacity, including provision of opportunities for provisional psychologists to gain the knowledge and skills required to work support perinatal and infant mental health.

6. Improvements in training to better manage the psychological issues arising from miscarriage, stillbirth, neonatal death, and termination, especially after a diagnosis of abnormality in the developing foetus. The sensitivities experienced by parents in these situations need to be better acknowledged and their psychological needs attended to more comprehensively (e.g., see Sands Australia Bereavement Care Guidelines, in press).

7. Similarly, the needs of families with premature and sick newborns is also an area where psychological and mental health supports for families require additional resources and investment.

8. Adoption of a social determinants of health approach to maternity services, which considers the influence of broader societal, economic and political factors on women and their babies, including safety issues and also the way maternity services are structured and organised, and how women experience these services.

9. Review discharge policies in all public hospitals with a view to ensuring that women receive postnatal support both in the hospital and in the community, which is integrated with mental health support for women and infants.

5. Strategies for rural and remote services and/or, Aboriginal and Torres Strait Islander women and/or, women from culturally and linguistically diverse backgrounds

The APS recommends that the gap between service availability and access for mothers and their infants in rural, regional and remote Australia be addressed as a matter of urgency. State, Territory and Federal Governments should work with local communities to develop responses that meet the needs of local women and their families where possible. Feedback from members suggests that rural Australia was particularly impacted by the defunding of the National Perinatal Depression Initiative, with the cutting of key preventive and educative health promotion programs, including home visiting. Restoration of this program would support rural and regional women and their families.

Aboriginal women have been displaced as the experts in their birthing experiences through tradition, culture and experience, to being passive recipients of medicalised and institutionalised pregnancy care (Hancock, 2006). It is recommended that the government promote and implement the following initiatives within the Perinatal Clinical Practice Guidelines:

- involving an Aboriginal and Torres Strait Islander health worker, Aboriginal and Torres Strait Islander liaison officer or interpreter in the maternal health care team to ensure culturally appropriate care
- cultural competence training for all health professionals involved in maternity services
- specific birth, parenting and young mother programs
- where possible, providing services in a setting that is comfortable for the woman (e.g. outreach, birthing on country, settings where Aboriginal and Torres Strait Islander staff are employed) and acknowledging the role of traditional healers
- providing perinatal mental health care to Aboriginal and Torres Strait Islander women and their families that is in line with the Perinatal Clinical Practice Guidelines
- developing career pathways for Aboriginal and Torres Strait Islander staff within maternity systems.

Similarly, the maternity service system needs to provide culturally competent care, work with community cultural organisations to ensure the system is responsive to women from all backgrounds, and ensure interpreters are funded and provided throughout the system. For example, interpreter services for CALD clients seeing psychologists are not currently funded under Translating and Interpreting Service (TIS) as they are for health practitioners such as GPs, so providing funded interpreters would

make psychological support much more accessible for CALD clients in the perinatal period.

The APS also recognises the need for maternity services to better support other marginalized groups such as families with a disability and those who identify as Lesbian, Gay, Bisexual, Transgender, Queer or Intersex (LGBTQI+). For example, LGBTQI+ people may conceive children in many different ways that are more likely to involve Assisted Reproductive Technologies. Pregnancy loss in particular is therefore likely to affect a diverse range of LGBT people. Currently most support services about pregnancy loss target heterosexual couples, even if this is mostly implicit. This can make it hard for LGBT people who experience pregnancy loss to receive adequate care, or to have a chance to hear similar stories and make connections with others. There is also very little mention of the potential for pregnancy loss in resources for LGBT people about surrogacy and other forms of reproductive technology (APS, 2018). The APS has developed a suite of resources on LGBTIQ+ parenting and families for further information on these concerns.

6. Measuring success

The APS recommends the following to ensure an accountable and transparent maternity services system that is high quality, evidence-based and better meets the needs of women and their families:

1. The establishment of measurable targets for increasing women's access to continuity of carer services, and access to psychological support and services. A more targeted approach to ensuring the maternity services workforce are equipped with the skills required to support the mental health and wellbeing of all women and their families is recommended.

2. An independent and comprehensive evaluation of the National Maternity Services Plan inform the development of the NSAMS.

3. The establishment of measurable targets for increasing women's access to continuity of carer services, and access to psychological support and services.

4. A more targeted approach to ensuring the maternity services workforce is equipped with the skills required to support the mental health and wellbeing of all women and their families in the perinatal period.

5. Strengthening the routine incorporation of consumer feedback about maternity experiences to ensure a more women-centred system.

Selected References

Australian Psychological Society (2018). LGBT Pregnancy Loss. APS: Melbourne. http://aps-stage.com.au/getmedia/9ea8dd55-7c2b-4653-8371-b1f732b70b58/LGBT_pregnancy_loss.pdf

Beyond Blue (2011). Clinical practice guidelines for depression and related disorders – anxiety, bipolar disorder and puerperal psychosis – in the perinatal period. A guideline for primary care health professionals. Melbourne: beyondblue.

Hancock, H. (2016). *Aboriginal women's perinatal needs, experiences and maternity services: A literature review to enable considerations to be made about quality indicators.* Ngaanyatjarra Health Service. *https://www.lowitja.org.au/sites/default/files/docs/Ngaanyatjarra-Health-Service-Lit-Review.pdf*

Homer, C.S.E. (2016). Models of maternity care: evidence for midwifery continuity of care. MJA 205 (8).

Howard, LM, Oram, S, Galley, H., Trevillion, K, & Feder, G. (2013). Domestic Violence and perinatal mental disorders: a systematic review and meta-analysis *PLosMed*. 2013 10(5).

Kim, W. J., Lee, E., Kim, K. R., Namkoong, K., Park, E. S. & Rha, D. (2015). Progress of PTSD symptoms following birth: a prospective study in mothers of high-risk infants*. Journal of Perinatology (35):* 575–579.

McMahon, C., Barnett, B., Kowalenko, N., Tennant, C., & Don, N. (2001). Postnatal depression, anxiety and unsettled infant behaviour. *Australian and New Zealand Journal of Psychiatry, 35*(5), 581-588.

Marriott, R. & Ferguson-Hill, S. (2014). Perinatal and Infant Mental Health and Wellbeing. In P. Dudgeon, H. Milroy & R. Walker (Eds.), *Working Together: Aboriginal and Torres Strait Islander mental health and wellbeing principles and practice.* *https://www.telethonkids.org.au/globalassets/media/documents/aboriginal-health/working-together-second-edition/wt-part-5-chapt-19-final.pdf*

Newman, L. (2009). The health care system as a social determinant of health: Qualitative insights from South Australian maternity consumers. *Australian Health Review, 33*(1), 62-71.

Reed, R., Sharman, R., & Inglis, C. (2017). Women's descriptions of childbirth trauma relating to care provider actions and interactions. *BMC Pregnancy Childbirth, 17*(1), 21. doi:10.1186/s12884-016-1197-0

Sutherland, G., Yelland, J., & Brown, S. (2012). Social inequalities in the organization of pregnancy care in a universally funded public health care system. *Maternal Child Health Journal, 16*(2), 288-296. doi:10.1007/s10995-011-0752-6