

SUPPORT FOR NEW PARENTS AND BABIES IN NEW SOUTH WALES

Organisation: The Royal Australian and New Zealand College of Psychiatrists
Name: Dr Gary Galambos
Position: Chair, RANZCP NSW Branch Committee
Date Received: 17 November 2017

17 November 2017

Mr Kevin Conolly MP
Chair
Committee on Community Services

By email to: communityservices@parliament.nsw.gov.au

Dear Mr Connolly

Re: Inquiry into support for new parents and babies in New South Wales

The NSW Branch of the Royal Australian and New Zealand College of Psychiatrists (RANZCP) welcomes the opportunity to provide a submission to this important inquiry. There are many components of multidisciplinary care that are involved in providing services for pregnant women, new parents and babies. The RANZCP NSW Branch response to the *Inquiry into support for new parents and babies in NSW* will focus on health and social service issues related to mental health.

It is encouraging to note that evidence-based policy foundations already exist in NSW to address mental health issues for pregnant women, new parents and babies, for example SAFESTART, a mandated NSW Health strategic policy directive. There are also several sets of national and international guidelines such as the 2017 Australian Clinical Practice Guideline developed by the Centre of Perinatal Excellence (COPE)¹. The NSW Branch believes that the challenges ahead relate to providing appropriate resources and leadership to apply these existing directives and guidelines across an effectively integrated system to raise mental health services for pregnant women and new parents and babies to an international best practice standard, across both private and public sectors.

Specifically, as indicated last year in the NSW Branch response to the NSW Ministry of Health proposed model of care for a public mother–baby Mental Health Unit in NSW, there is a continuing need for NSW to align with best practice and other Australian jurisdictions to provide inpatient beds in the public sector to jointly accommodate new mothers and their babies. As a complement to this but not an alternative, we believe that the NSW public health system needs to work harder on building private–public partnerships to optimally utilise the many resources currently in place in NSW.

Within the membership of the NSW Branch, there are several eminent Professors of Psychiatry in leadership roles in perinatal mental health. We would be pleased to coordinate further specialist review/feedback from these Fellows should it be required, as the inquiry proceeds.

¹ Austin M-P, Highet N & the expert working group (2017) *Mental healthcare in the perinatal period: Australian Clinical practice Guideline*. Melbourne: Centre for Perinatal Excellence.



The Royal
Australian &
New Zealand
College of
Psychiatrists

New South Wales Branch

Thank you for the opportunity to provide this submission. Please feel free to contact Penny Adams, NSW Branch Policy and Advocacy Advisor on [REDACTED] should you require any further information.

Yours sincerely



Dr Gary Galambos
Chair, RANZCP NSW Branch Committee



The Royal
Australian &
New Zealand
College of
Psychiatrists



NSW Committee on Community Services Inquiry into support for new parents and babies in New South Wales

November 2017

maximising opportunities for recovery

RANZCP NSW Branch submission

Inquiry into support for new parents and babies in New South Wales

About the Royal Australian and New Zealand College of Psychiatrists

The Royal Australian and New Zealand College of Psychiatrists (RANZCP) is a membership organisation that trains doctors to be medical specialists in the field of psychiatry, supports and enhances clinical practice, advocates for people affected by mental illness and advises governments on mental health care. The RANZCP is the peak mental health organisation representing psychiatrists bi-nationally in Australia and New Zealand and has strong ties with health associations internationally, especially in the Asia-Pacific region.

As mental health specialists, psychiatrists are well positioned to provide constructive input into improving the delivery of mental health services. This includes identifying gaps and solutions to improve service delivery for consumers, building a more effective and efficient system and attracting and retaining mental health professionals.

The RANZCP has almost 6000 members bi-nationally, including more than 4000 qualified psychiatrists and around 1400 members who are training to be psychiatrists. The RANZCP NSW Branch (NSW Branch) represents more than 1100 Fellows and 400 trainees.

General comments

There are many components of multidisciplinary care involved in providing services for new parents and babies. The RANZCP NSW Branch response to the Inquiry into support for new parents and babies in NSW will focus on health and social service issues related to the mental health of pregnant women and new parents and infants¹.

Experiences during gestation, in infancy and early childhood, especially parenting are critical in shaping a child's physical, psychological and social well-being. Health and social services for parents and children should focus on keeping infants physically healthy and safe, but also help parents to be both confident and competent in understanding and responding appropriately to their child's needs.

Some infants are at very high risk of current or future mental health difficulties. They are not hard to identify. These include: infants/children involved in the child protection system and at risk of abuse; children traumatised by family violence; those of Indigenous background; and CALD families. These infants/children and their families often require involvement with a broad range of services, including specialised mental health services, paediatric services and NGOs.

Other infants at risk can be identified if appropriate assessment and screening measures are routinely and universally applied over the perinatal period (pregnancy and 1 year postpartum). A range of clinical and sub-clinical mental health problems can be identified and addressed.

Evidence from the Black Dog Institute estimates that around 15–20% of women experience postpartum depression, with 5% of women experiencing severe depression postpartum, while more rarely postpartum psychosis – usually an affective psychosis affects around 0.2% of women². Similar or even higher percentages are reported for anxiety and related disorders over the perinatal period. The underlying, long-term issue for many women is anxiety.

¹ This response applies the definition of *infant* as between 0–24 months as per the NSW Specialist Community Perinatal Child and Youth Mental Health Services Model of Care Guideline. Please note that this definition varies in other countries; for example in the US, the definition is 0–36 months.

² Black Dog Institute (2014) What is Postnatal Depression? Available at blackdoginstitute.org.au/public/depression/inpregnancypostnatal/postnataldepressionpnd.cfm (accessed 27 Oct 2017).

The effects of perinatal mental health problems can be devastating, and without adequate management, symptoms and associated impairment of function can persist for years.

Maternal mental health problems can have very disruptive effects on families by contributing to the breakdown of parental relationships and increasing the risk of concurrent paternal depression. Furthermore, this important transitional period in family life has immense impact on the early development of relationships, parenting confidence and infant attachment.

It should be noted that fathers are also at an increased risk of experiencing mental health problems at such times and should also be supported³. Even though the number of affected fathers has been shown to be lower, paternal mental health problems have significant impacts on infants. The flow-on impacts related to productivity and financial costs can be substantial.

The adequacy of current services and structures for new parents, especially those who need extra support, to provide a safe and nurturing environment for their babies

Medically unwell and 'at risk' infants require care from more than one sector, reinforcing the need for inter-agency collaboration and coordination through a well-integrated system, including home-based interventions.

Fortunately, most antenatal and postnatal psychiatric problems can be managed with outpatient treatment, but in some cases, the illness and associated risks are severe enough to warrant admission to hospital. It is now widely accepted that women requiring inpatient treatment postpartum have better outcomes if accompanied by their babies.⁴ Admitting both mother and baby to hospital circumvents the possibility of women refusing inpatient treatment in order to avoid being separated from their children and also allows skilled staff to manage the disorder while ensuring maternal–infant bonding is promoted.

Joint admission to a dedicated unit has been demonstrated to lead to improved parenting skills and increased confidence in the mothering role. The 2017 Australian Clinical Practice Guideline for Mental Health care in the perinatal period recommends that mothers needing psychiatric admission be jointly admitted with their infant⁵ as do the UK National Institute for Health and Care Excellence (NICE) Guidelines⁶.

The NSW Branch notes that NSW does not yet have a public mother–baby mental health unit, despite the release of a NSW Ministry of Health proposed model of care in 2016, strongly highlighting this gap and advocating to address it. This remains a significant gap in NSW mental health services which places families unable to access private healthcare at serious risk.

Changes to current services and structures that could improve physical health, mental health and child protection outcomes

The NSW Branch emphasises the significance of the perinatal and early parenting period recognising that this represents an important transitional stage for women and that mental health risks increase during this phase.

³ Gutierrez-Galve L, Stein A, Hanington L, Heron J, Ramchandani P (2015) Paternal depression on the postnatal period and child development: Mediators and moderators. *Paediatrics* 135(2):339–47.

⁴ [Victorian Branch submission to the Family and Community Development Committee's Inquiry into Perinatal Services](#)

⁵ Austin M-P, Highet N & the expert working group (2017) Mental healthcare in the perinatal period: Australian Clinical practice Guideline. Melbourne: Centre for Perinatal Excellence.

⁶ National Institute for Health and Care Excellence (2014) *Antenatal and postnatal mental health: clinical management and service guidance*. Clinical Guideline 192.

The rates of risk are higher in women who are exposed to conflict and violence. This period is also of fundamental importance in establishing a healthy foundation for child development. The high levels of maternal stress and anxiety usually seen in women experiencing domestic violence are associated with poor infant development and outcomes, premature delivery, infants who are small for their gestational age, birth complications and poor infant developmental outcomes.

Women with complex psychosocial risk factors, often suffer from emotional dysregulation and borderline personality symptoms or disorder; and mothers with such symptoms are more likely to engage in maladaptive interactions with their children characterised by insensitive, overprotective, and hostile parenting. Adverse outcomes among their offspring include borderline personality disorder symptoms, internalising (including depression) and externalising problems, insecure attachment patterns and emotional dysregulation⁷.

Parenting is adversely affected when a woman is experiencing substantial psychosocial impairment including physical or emotional violence. The impact on the infant of having a highly stressed and vulnerable parent is significant, with infants experiencing anxiety, developmental problems, poor attachment and behavioural disturbances.

The NSW Branch advocates for better early detection of those who are experiencing, or at risk of experiencing violence in the antenatal and perinatal maternity care system. This requires improved systems of identifying women at risk and the establishment of specific and targeted mental health services in maternity settings.

We also support routine antenatal screening for risk factors associated with postnatal depression and serious mental illness as part of the range of health services accessed by pregnant women and after birth⁸.

Except in cases where the baby's or the mother's emotional or physical well-being may be jeopardised, it is recognised best clinical practice that mother and baby remain together during inpatient treatment, and the involvement of other parents/and or caregivers is supported. To this end, all prospective care funders should be encouraged to incorporate mother-and-baby joint admission into industry standards. Further, we believe there should be recognition by funders of the importance of mother-and-baby joint admission and adequate inpatient beds and facilities made available for this purpose.

As noted above, the NSW Branch is aware that NSW does not yet have a public mother-baby mental health unit. We strongly believe that this remains a significant gap in NSW mental health services. As a complement to this but not an alternative, we believe that the NSW public health system needs to work harder on building private-public partnerships to optimally utilise the many resources currently in place in NSW.

We believe in NSW that a state-wide secondary subspecialty perinatal network should be established to connect the complex spectrum of services involved in the mental health care of pregnant and new parents and babies. A managed multi-sectoral (health, mothercraft, housing, community services) network structure could:

1. Improve service integration by strengthening links between the Local Health Districts and services that provide mothercraft interventions (outpatient, day patient and inpatient facilities like Karitane and

⁷ Eyden J, Winsper C, Wolke D et al (2016) A systematic review of the parenting and outcomes experienced by offspring of mothers with borderline personality pathology: Potential mechanisms and clinical implications. *Clin Psychol Rev* 47: 85–105.

⁸ Austin, M. P., & Kingston, D. (2016) "Psychosocial Assessment and Depression Screening in the Perinatal Period: Benefits, Challenges and Implementation." In *Joint Care of Parents and Infants in Perinatal Psychiatry*, edited by Sutter-Dallay, A-L., Glangeaud-Freudenthal, N. M. C., Guedeney, A., & Riecher-Rössler, A. Springer International Publishing, 167-195

Tresilian), refuges for women/children experiencing domestic violence and accommodation services such as Charmain Clift Cottages in Doonside for supporting high-risk and socially disadvantaged mothers to access perinatal psychiatrists and other perinatal mental health clinicians in the private sector. Such a managed multi-sectoral network would optimise communication between health-care providers; child protection (FACS) case workers; child-care and disability service providers involved in the care of families with complex mental health and psychosocial needs. In the future if public mother–baby units are established in NSW, they should be linked into this network.

2. Improve service delivery in under-resourced areas through targeted capacity building and the use of telecommunication, such as telehealth and case conferencing.
3. Provide a centralised ‘hub’ to coordinate data collection for research and service enhancement and redesign.
4. Provide a more coordinated and equitable approach to the allocation of Advanced Training positions for 0–12 year olds across the state. Ideally a number of these positions would be NSW Health funded as they are currently only funded through the Commonwealth Department of Health on a triennial basis and thus always at risk of discontinuation.
5. Enhance the existing Perinatal Mental Health academic unit (affiliated with the University of NSW) to accommodate further research on mental health outcomes associated with admission into mother-and-baby psychiatric units, different models of universal perinatal integrated mental health care, online psychological interventions, strengthen practitioner understanding and promote evidence-based practice. It could also provide a research base on the effectiveness of the stepped-care model and the safe incorporation of this approach into mother and infant mental health care.

The RANZCP has previously advocated against the loss of the Commonwealth National Perinatal Depression initiative (NPDI 2008–2015). The NPDI enabled the provision of universal psychosocial assessment and screening for depression and related difficulties during the perinatal period, treatment and support for women at risk of experiencing anxiety and depressive disorders and training for a range of frontline medical professionals in screening and supporting the mental health needs of pregnant and new mothers. In part the NPDI was not extended due to the absence of a system to collect quality national data that would sufficiently evaluate the initiative. The RANZCP maintains that the loss of NPDI funding has led to service gaps, decreased workforce capacity building and lost opportunities for national coordination, data collection and standardisation of services.

It is encouraging to note that evidence-based foundations already exist in NSW to address mental health issues for pregnant women, new parents and babies, for example SAFE START, a mandated NSW Health strategic policy directive. There are also several sets of national and international guidelines such as the 2017 Australian Clinical Practice Guideline developed by the Centre of Perinatal Excellence (COPE)⁹. The NSW Branch believes that the challenges ahead relate to providing appropriate resources and leadership to apply these existing directives and guidelines across an effectively integrated system to raise mental health services for pregnant women and new parents and babies to an international best practice standard, across both private and public sectors.

⁹ Austin M-P, Highet N & the expert working group (2017) Mental healthcare in the perinatal period: Australian Clinical practice Guideline. Melbourne: Centre for Perinatal Excellence.

Specific areas of disadvantage or challenge in relation to health outcomes for babies

The NSW Branch believes there is inequity in the allocation of mental health resources for the perinatal and infancy periods. This limits the opportunities to address the distress and impairment that may be suffered by pregnant women, children and their families, and also misses an important opportunity for early intervention.

In particular, as discussed in the previous section, the NSW Branch is currently aware of a shortage of Advanced Training opportunities in the NSW public sector for psychiatrists to specialise in mental health care for 0–12 year olds. There appears to be an increasing focus on adolescent mental health in the public sector, while many opportunities for child and adolescent psychiatrists to specialise in babies and children are currently provided in the private or NGO sectors, outside NSW Health facilities. It is difficult for trainees wishing to take up these Commonwealth funded training positions to secure secondments from their 'home' LHDs and then return once the training term has been completed. These issues are contributing to a current workforce shortage and looming crisis in NSW psychiatrists with appropriate training for 0–12 year olds. Ideally a number of these positions would be NSW Health funded as they are currently only funded through Commonwealth Department of Health on a triennial basis and thus always at risk of discontinuation. The NSW Branch is working with the NSW Health and Education Training Institute and the NSW Ministry to address these issues.

As outlined in a recent review of the NPDI, women with severe and complex needs are less likely to have private health insurance and those living in rural and remote locations have less access to mental health services¹⁰. Both these issues speak to lack of equity and access to perinatal and infant services and underpin the arguments put forth by the NSW Branch of the RANZCP for public mother–baby units.

The NSW Branch recommends a strategy for NSW to increase access to perinatal and infant mental health psychiatrists for people living in rural and regional NSW. Innovative solutions around the use of telehealth and case conferencing are options to address this. An example is the service from St John of God Health Care Raphael Services NSW, offering face-to-face and telehealth consults to Tamworth and regional NSW.

Models of support provided in other jurisdictions to support new parents and promote the health of babies

The NSW Branch strongly believes that NSW is lagging behind other Australian jurisdictions in its continuing lack of a public sector mother–baby mental health unit. In other states, there are well established publicly funded mother–baby units, including three in Melbourne; one in Adelaide; two in Perth; and one in Queensland. The design of these units and their integration into state-wide networks to extend services into rural areas would be useful to consider for NSW.

Opportunities for new and emerging technology to enhance support for new parents and babies

The establishment of a state-wide secondary subspecialty perinatal network to care for the mental health of new parents and their babies would lay the foundations for the extension of supported and coordinated care in regional/rural and remote areas through the use of emerging technology to support telehealth and case conferencing.

¹⁰Chambers GM, Randall S, Hoang VP, Sullivan EA, Highet N, Croft M, Mihalopoulos C, Morgan V, Reilly N, Austin MP (2016) The national perinatal depression initiative (NPDI): An evaluation of access to GPs, psychologists and psychiatrists through the Medicare Benefits Schedule. *Australian and New Zealand Journal of Psychiatry* (ANZJP) Vol.50(3), pp.264-74.