Research

PERINATAL AND INFANT MENTAL HEALTH SERVICE ENHANCEMENT: COMMUNITY VIEWS

November 2014

Queensland Government

About this report

The Queensland Mental Health Commission was established to drive reform towards a more integrated, evidence-based, recovery-oriented mental health and substance misuse system[1].

One of its key functions in achieving reform is to undertake and commission research in relation to mental health and substance misuse issues (section 11(1)(f)) and to review, evaluate, report and advise on the mental health and substance misuse system (section 11(1)(d)).

This report is the second from the Commission considering the adequacy of existing services and supports for families experiencing perinatal mental health issues.

Feedback

We value the views of our readers and invite your feedback on this report. Please contact the Queensland Mental Health Commission on telephone 1300 855 945, fax (07) 3405 9780 or via email at info@qmhc.qld.gov.au.

Translation

The Queensland Government is committed to providing accessible services to Queenslanders from all culturally and linguistically diverse backgrounds. If you have difficulty in understanding the report, you can contact us on 1300 855 945 and we will arrange an interpreter to effectively communicate the report to you.

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1 Section 4 of the *Queensland Mental Health Commission Act 2013*.

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ACKNOWLEDGEMENT

We wish to pay respect to Aboriginal and Torres Strait Islander Elders, past and present, and acknowledge the important role of Aboriginal and Torres Strait Islander people, their culture and customs across Queensland.

We also acknowledge the people living with mental health and drug and alcohol problems, their families and carers. We can all contribute to a society that is inclusive and respectful, where everyone is treated with dignity and able to focus on wellness and recovery and have fulfilling lives.

COMMISSIONER'S MESSAGE

In January 2014, the Queensland Mental Health Commissioner commissioned a report on the need for enhanced services for perinatal and infant mental health (PIMH) in Queensland. The commissioning of the report arose from a state-wide consultation process conducted by the Commissioner in 2013, which culminated in a meeting of senior officials in December 2013.

The consultation process identified the PIMH service system in Queensland as underdeveloped and lagging behind other states in two distinct areas:

- The promotion, prevention and early intervention for perinatal and infant mental health issues
- Specialist treatment services for perinatal and infant mental health issues.

This was reflected in a specific concern about a reported lack of appropriate mental health beds to which a mother can be admitted for treatment, without separation from her baby.

The commissioned report, *Perinatal and Infant Mental Health Service Enhancement Discussion Paper*, while proposing enhancements to the entire PIMH service system in Queensland, placed strong emphasis on addressing the dearth of secondary and tertiary treatment services for PIMH in Queensland. The report noted, "The adequacy of investment in community support and education programs delivered by the NGO sector has not been considered in this proposal."

From August to October 2014, the report was disseminated for public consultation. Respondents were asked to comment on "both the priorities outlined in the Discussion Paper and opportunities for strengthening other services and support in the community for expectant and new mothers and their families experiencing mental health difficulties." Respondents were also invited to contribute their views on "ways to support better mental health among expectant and new mothers and their families in Aboriginal and Torres Strait Islander communities, and in culturally and linguistically diverse communities."

The current report, *Survey Responses*, provides an analysis of the 101 responses received during this public consultation process.

Ultimately, strategic enhancements to Queensland's existing perinatal and infant mental health service system informed by this consultation are expected to pay dividends in terms of improving PIMH services, reducing risk, and securing better outcomes for Queensland mothers, fathers, infants and families.

Dr Lesley van Schoubroeck
Queensland Mental Health Commissioner

"Having Postnatal Depression is like living with a body made of peat bog all day every day, like having someone stand on your heart all day every day, and like having ants build a nest in your mind all day every day. At the same time. And, oh yeh, you have a defenceless newborn (that you may or may not like) to take care of while you feel like this. This is the reality of PND. Well done for leading the way towards change."

REPORT SUMMARY

The 101 individual respondents to the Discussion Paper demonstrated a high level of understanding of perinatal and infant mental health (PIMH) and considerable knowledge of the existing PIMH service system in Queensland. Almost 70 per cent reported personal experience of perinatal and/or infant mental health difficulties, while approximately 30 per cent reported working in PIMH services. There was considerable overlap among respondent categories, which included carers and family members, workers in drug and alcohol services, workers in services for Aboriginal and Torres Strait Islander people, and workers in services for culturally and linguistically diverse groups. Submissions were also received from a number of organisations.

The consultation process identified high-risk gaps in the existing service system for perinatal and infant mental health in Queensland. Respondents provided practical solutions, grouped around three key themes:

Earlier intervention

Earlier intervention in PIMH covers the spectrum from traditional mental health promotion and prevention activities to secondary and tertiary treatment. For perinatal mental health, earlier intervention may:

- Prevent an episode of perinatal mental illness
- Reduce the severity and/or duration of perinatal mental illness
- Prevent the need for hospital admission, or shorten the admission required
- Prevent recurrence of perinatal mental illness with subsequent births
- Improve the relationship between parent and infant, foster attachment, and help prevent mental health problems for the infant.

For infant mental health (children aged 0 to 3), earlier intervention may:

- Improve the relationship between parent and infant, helping to safeguard the emotional wellbeing and mental health of both
- Prevent developmental delays and physical health problems associated with emotional and interpersonal problems in infancy
- Prevent internalising and externalising disorders in infancy escalating into childhood mental health problems, a proportion of which can persist into adolescence and adulthood causing significant distress and dysfunction.

Respondents identified a number of opportunities for earlier intervention, including mental health promotion and illness prevention. Key opportunities include:

- Community awareness
- Antenatal classes and checks
- Mothers' groups, fathers' groups, peer support groups for expecting and new parents
- In-hospital services
- Follow-up health services
- Early treatment services.

Respondents identified sustainable funding for the non-government sector as a game-changing strategy to prevent the development of PIMH problems, intervene earlier to reduce the severity and duration of such problems, and ensure that families beginning to experience PIMH problems are referred to appropriate specialist treatment services.

A number of respondents' recommendations align with priorities outlined in the National Maternity Services Plan (NMSP: Commonwealth of Australia, 2011), to which all state and territory governments have committed. Under the principle of Earlier Intervention, respondents endorsed the need for:

- Universal screening for perinatal depression (Priority Action 2.3.1)
- Access to continuity of carer models for maternity care (Priority Actions 1.2.1 and 1.2.2)
- Provision to meet the needs of specific groups of women with cultural, socioeconomic, medical and other risk factors for perinatal mental illness, including Aboriginal and Torres Strait Islander women and women living in rural and remote areas (Priority Actions 1.3, 1.4, 2.2 and 2.3.3).

Specialist treatment services

Respondents recognised that enhanced PIMH promotion and prevention activities cannot realistically prevent all PIMH problems. A "bottleneck" occurs when mental health problems are detected, but specialist treatment services are not available to enable the parent or infant to be referred and treated in a timely manner.

Respondents endorsed the needs identified in the Discussion Paper for:

- Local community-based mental health specialists who can provide evidence-based interventions for parents (perinatal mental health) and children to age 3 (infant mental health)
- Day programs as a cost-effective alternative to hospital admission
- A dedicated parent-infant mental health inpatient facility, to prevent admission of new parents to adult acute mental health units, and to minimise unnecessary separation of parent and infant.

As with Earlier Intervention, a number of responses dealing with Specialist Treatment Services aligned with the National Maternity Services Plan (NMSP: Commonwealth of Australia, 2011), in particular the need for:

- Formal referral pathways, for women experiencing perinatal mental illness, to specialist perinatal mental health services (Priority Action 2.3.2)
- Expanded options for overcoming separation of mothers from their babies when receiving mental health care (Priority Action 2.3.2).

System-wide capacity building

Respondents named groups of professionals who already have contact with pregnant and new mothers, their partners and families. These groups include:

- General practitioners
- Midwives (in the public, private and non-government sectors)
- Nurses and midwives in maternity units and birth centres
- Child Health nurses
- Lactation consultants

- Private obstetricians
- Aboriginal medical centres and health services
- Non-government organisations working in such areas as maternity services, child health and family wellbeing.

With additional training, professional development and support, some or all of these groups could play a role in:

- Detecting PIMH issues (through informal discussion and/or formal screening)
- Providing information, educational resources, discussion, advice and support
- Providing information about, and referral to, supports and services including specialist treatment services.

Some staff were identified as already having the skills to perform these functions, while others were seen as poorly-equipped to recognise and respond to PIMH needs.

Conclusion

Overall, the public consultation process endorsed the model for service enhancement proposed in the Discussion Paper, which includes:

- The development of specialist parent-infant facilities comparable to those in other states, as a high priority
- Use of available inpatient options as a short-term solution to the current lack of parent-infant beds
- Community-based specialist services, including day programs, as the most cost-effective way to provide PIMH treatment close to home
- Resourcing the primary care and NGO sectors to play a major role in mental health promotion, prevention and early intervention across the state
- Recognition of the need to co-ordinate cross-sectoral PIMH workforce development and other capacity-building.

Next steps

Functions of the Commission include reviewing, evaluation and providing advice on the mental health and substance misuse system and promoting strategies to prevent mental illness and facilitate early intervention.

It is anticipated that this report will inform the *Mental Health, Alcohol and Drug Services Plan* to be prepared by the Department of Health as agreed in Queensland's *Mental Health, Alcohol and Drug Strategic Plan 2014-2019*. In addition the Commission will continue to promote the importance of incorporating mental health in general antenatal education and reaffirm the importance of perinatal and infant mental health as an element of broader promotion and early intervention programs.

INTRODUCTION

The Perinatal and Infant Mental Health Service Enhancement Discussion Paper was commissioned to examine the validity of the perception raised in system-wide consultation undertaken by the Queensland Mental Health Commission in 2013, that provision of clinical services for mothers and babies with perinatal mental health issues (PIMH) was inadequate.

The Discussion Paper therefore focusses on the adequacy of clinical (treatment) services for mothers, fathers, infants and families experiencing PIMH issues.

Perinatal mental health problems occur for parents during the perinatal period, from conception until one year following birth. While community awareness of maternal postnatal depression is rising, there is still little awareness in the community or among healthcare providers that both depression and anxiety may be experienced to a clinically significant level during pregnancy and post-birth, by both mothers and fathers. There is also little awareness that infants aged 0 to 3 experience mental health problems, including internalising and externalising disorders, which left untreated can escalate into mental health disorders of childhood, adolescence and adulthood (Bayer at al 2009).

Perinatal and infant mental health issues can have serious negative impacts on the attachment relationship between parent and infant, on family functioning, and on the future physical and mental health of parents and children. Approximately 15 per cent of Queensland mothers and 5 per cent of Queensland fathers are likely to experience clinically significant perinatal depression and/or anxiety (beyondblue 2011; PANDA 2013). Queensland and South Australia have the highest levels of maternal postnatal depression in the country (Buist 2008).

Mothers with a genetic vulnerability to bipolar disorder may experience a first episode of this disorder during the perinatal period (beyondblue 2014), and up to 50 per cent of women with pre-existing bipolar disorder (whether diagnosed or not) are likely to experience a psychotic episode post-partum (Jones & Smith, 2009). Post-partum psychosis is a rare but extremely serious condition which almost always requires hospitalisation. Post-partum psychosis can affect any mother: it cannot be reliably predicted from the presence or absence of known risk factors (Jones & Smith 2009). Approximately 4 women in 1000 are expected to require hospitalisation for severe perinatal mental illness, including bipolar disorder and post-partum psychosis (Oates 2000). While perinatal illnesses are among the most preventable and treatable of all mental illnesses (Oates 2000, Salmon et al. 2003), Queensland lags behind other states in both prevention and treatment services. In 2009-2011, suicide was the leading cause of death for Queensland women in the year following birth, accounting for as many deaths as all obstetric causes combined (Queensland Maternal and Perinatal Quality Council 2013).

The Discussion Paper proposed short, medium and long term initiatives to enhance the PIMH service system in Queensland, with the intention of:

- Reducing immediate risks associated with service gaps in this area
- Securing better outcomes for Queensland mothers, fathers, infants and families
- Providing significant social and economic benefits for Queensland
- Positioning Queensland as one of Australia's leading states in meeting the mental health needs of mothers, fathers, young children and families.

From August to October 2014, the Perinatal and Infant Mental Health Service Enhancement Discussion Paper was posted on the Queensland Mental Health Commission website for public consultation. An online survey was provided as the primary mechanism by which respondents could provide comment. Respondents were asked to comment on "both the priorities outlined in the Discussion Paper and opportunities for strengthening other services and support in the community for expectant and new mothers and their families experiencing mental health difficulties." Respondents were also invited to contribute their views on "ways to support better mental health among expectant and new mothers and their families in Aboriginal and Torres Strait Islander communities, and in culturally and linguistically diverse communities." The survey questions are listed in **Appendix 1**.

The purpose of the current report is to provide analyses of the 101 responses received during this public consultation process. While the Discussion Paper summarized an extensive consultation process undertaken within the PIMH service system, the public consultation process has captured additional feedback from the non-government sector, and more insights from Queensland parents and families who have experienced or are experiencing the need for PIMH services.

RESPONDENT DEMOGRAPHICS

The respondent sample was considered adequately representative of the population of Queensland. While some groups were under-represented (particularly males and people under 25), other respondents demonstrated an awareness of issues relating to these groups and a desire to advocate for their needs.

The majority of respondents were female (92 per cent female, 8 per cent male). A larger response from males would have been desirable, given the importance of fathers in families, and the fact that one in twenty new fathers experience clinically significant anxiety and/or depression in the perinatal period (PANDA 2013). When asked to identify groups in the community whose PIMH needs are not being met, 6 per cent of respondents nominated fathers.

Just over half the respondents (53.5 per cent) were aged 25-44 years. Another 44.6 per cent were aged 45-64 years, while 2 per cent were aged 65 years or older. No responses were received from people under 25. Almost 13 per cent of the respondents identified parents under 25 years, and particularly under 18 years, as a group at higher risk for PIMH problems.

All respondents were based in Australia, and almost all in Queensland. The majority (72 per cent) lived in the Greater Brisbane area. Approximately 16 per cent lived in a regional city or town, 7 per cent lived in a rural area, and 4 per cent lived in a remote area.

Most respondents were non-Indigenous: 3 per cent identified as Aboriginal and none as Torres Strait Islander. According to projections from the 2011 census, 3 per cent of the Australian population and 4.3 per cent of the Queensland population are Indigenous.

Most respondents (83 per cent) did not identify as coming from a culturally or linguistically diverse background. Around 10 per cent were from an English-speaking culturally diverse background, while 7 per cent were from a non-English speaking culturally diverse background.

The vast majority of respondents (95 per cent) were parents with young families. Two respondents (5 per cent) identified as people with a disability, and 5 per cent identified as LGBTI.

Almost 70 per cent of respondents reported having first-hand experience of perinatal mental problems, either personally or among those close to them. Around one-third (33 per cent) of respondents identified as a consumer/client, 23 per cent as a carer or family member, and 32 per cent as a person working in perinatal and infant mental health services. A further 27 per cent worked in mental health, alcohol and other drugs services, 14 per cent worked in Aboriginal and Torres Strait Islander services, and 19 per cent worked in services for people from culturally and linguistically diverse backgrounds.

There was considerable overlap across categories, suggesting that respondents had experienced perinatal and infant mental health issues and services from multiple angles.

PROVISION OF INFORMATION AND SUPPORT

Questions

Respondents were asked “How well do you believe information and support is provided in the community for expectant and new mothers and their families, both to help prevent them from experiencing mental health difficulties, and to help those who do to get well and stay well at home?” Respondents were asked to provide “practical suggestions for improving such services”.

Answers

Almost 82 per cent of respondents felt that information and support is provided “Not at all well”. Almost 17 per cent felt that information and support is provided “Quite well”. Only 1 per cent felt that information and support is provided “Very well”, and 1 per cent did not know.

Thematic analysis revealed three key themes underpinning the majority of responses. While the objectives put forward by respondents, and practical strategies for achieving these objectives, differed slightly, the overall themes or goals were highly consistent:

1. Earlier intervention – active intervention as early as possible to:
    - Prevent the development of perinatal and infant mental health problems
    - Detect such problems early in their development
    - Provide supports and services to prevent the escalation of problems
    - Provide effective clinical treatment and other supports to optimise the trajectory of parent, infant and family back to functionality and wellness.
2. Specialist treatment services – establishing effective, timely, specialist clinical services for perinatal and infant mental health, which are currently lacking in Queensland
3. System-wide capacity building – providing education, training and support for a range of primary care providers and non-government services that are likely to have contact with expectant and new mothers, to build capacity to:
    - Detect nascent PIMH issues (through informal discussion and/or formal screening)
    - Provide information, educational resources, discussion, advice and support
    - Provide information about, and referral to, supports and services including specialist treatment services.

The objectives and strategies offered by respondents to fulfil these goals focussed on different stages along the family’s journey from pre-pregnancy, through the antenatal phase, to the time of birth, up to six weeks post-birth, and after six weeks post-birth. A few suggestions applied across the chronology.

Respondents identified one set of strategies for families where efforts to prevent the development of serious perinatal and infant mental health problems are successful. For these families, the provision of appropriate support and information at the right times results in the experience of no symptoms, or only mild symptoms, of perinatal and/or infant mental illness.

Respondents identified an extended set of strategies for families where symptoms of perinatal and/or infant mental illness do begin to develop. These families require specialist treatment services, as early as possible, to reduce the duration, severity and impact of symptoms.

For ease of representation, responses have been tabulated and are presented below in terms of a family's journey from preconception to post-birth. Responses having to do with specialist treatment services are presented last, because it is common for PIMH problems to be recognised at later points on the journey (particularly beyond six weeks post-birth), and for treatment responses to require a longer time-frame than prevention/ early intervention responses.

Responses are tabulated and presented in **Appendix 2**.

Strategic points of intervention for promotion / prevention / early intervention

Preconception/ community awareness

Respondents stated that "earlier intervention" begins with greater community awareness of the risk of perinatal and infant mental illness, mental health literacy (e.g. signs and symptoms of PIMH problems), and stigma reduction. If mothers, fathers, families, friends and service providers are generally aware of PIMH, they are better positioned to notice early symptoms in pregnancy and to enlist supports as needed. Respondents suggested that community education could occur via:

- Public health promotion campaigns
- Social media/ the internet
- Information in public places

  "There needs to be a public campaign to raise awareness of postnatal depression – everyone focuses on the joy of childbirth, and the mother and father are left feeling guilty about their feelings or emotions post birth."

  "Many women get their information now via the web… having more info in these places may reach more women and families."

  "Information in public places – libraries, community groups, open display of information, where possible real stories with real people to reinforce that this can happen to anyone."

Antenatal intervention

Respondents noted that expectant mothers, and to a lesser extent fathers and families, have routine contact with healthcare providers during the antenatal period in order to monitor the physical health of mother and developing infant and prepare for birth. Respondents identified many antenatal occasions on which staff trained in basic perinatal mental health awareness, and the prevention and early detection of problems, could provide support and referral to appropriate services to optimise parental emotional well-being. These opportunities include:

- Antenatal checks and appointments (GPs, midwives, nurses and allied health staff in maternity services)
- Antenatal classes (midwives, potentially supported by peer educators – women with lived experience of perinatal mental health problems)
- Mental health resources (printed, electronic or online resources provided at antenatal checks and classes, in waiting rooms, in other services)

- Provision of information and discussion (healthcare and other service providers engage expectant parents in discussion of risks, protective factors, signs and symptoms, available supports, and treatment options)
- Stigma reduction (healthcare and other service providers actively "normalise" perinatal mental health issues, educating expectant parents and others about the prevalence of perinatal mental health issues and how to seek help).

Respondents particularly emphasised the "baby blues" as a window for perinatal mental health early intervention. Up to 80 per cent of women experience an altered mood state a few days after birth (Black Dog Institute 2014). Healthcare providers currently adopt the position that "The baby blues usually clear up after a few days with no other treatment except support and understanding" (beyondblue 2014). However, the fact that this experience is likely to happen for most women provides an excellent opportunity in antenatal education to:

- "Normalise" the experience of an altered mood state in relation to pregnancy and birth, thereby reducing fear and stigma associated with a "mental health/ emotional health" issue
- Help women and their partners and families consider what supports are needed to optimise the mother's mental health and well-being before and after birth
- Help women, partners and families be alert for signs of anxiety, depression or other mental health disturbance that persist beyond the usual "baby blues" period

  "The prenatal information session provided by the private hospital at which I gave birth did not provide education on PND (or the baby blues for that matter). Mothers are taught practical tasks about how to care for their babies, but not taught how to identify the signs of mental illness. This is important, particularly for women who have a history of mental illness."

  "This information needs to be provided at the antenatal classes, or at least resources. I understand this can be difficult as mothers to be are excited, but I had a run-around when I had PND before I found the right help."

  "You get given the beyondblue PND brochure. This tells you the signs but it doesn't tell you what to do next. The midwives also skip over the PND brochure when handing the pack to you. Like PND is no biggie or a bit like 'when you have time'… who has time??"

  "Antenatal classes need to highlight baby blues and what services are available and when people should be accessing them... recent experience was that breastfeeding and videos of birthing seem to be all the info new mums and dads need."

  "Make more of a point in antenatal classes to talk about mental health difficulties, to break down negative stigma. This could be done by mental health trained professionals, along with mums who've experienced it personally."

Respondents were clear that additional training would be required to enable primary healthcare providers to undertake effective antenatal education about PIMH issues – the vast majority of these providers are not currently sufficiently aware of these issues or equipped to discuss them, detect them, or provide appropriate information to expectant parents. One respondent identified that without this training, healthcare workers can do more harm than good:

"They talked about it at our prenatal class at the Mater, but the nurse and participants made fun of the symptoms of PND that were in our book with statements like 'Better get to Belmont – ha ha'. This made out like PND is something that happens to others, to crazy people. How about normalising anxiety after birth and encouraging assistance like you would for breastfeeding? Funny, sooooo much info on breastfeeding and how serious it is, but not mental health."

Time of birth/ in-hospital

Similarly, respondents identified the time of birth (and the period most women spend in hospital post-birth) as an opportunity when screening for perinatal mental illness, discussion and information provision could readily be integrated with monitoring and optimising maternal and child physical health. Respondents varied on which groups of staff could potentially provide perinatal mental health support in this period, and whether this support requires specialist staff or greater PIMH capacity and expertise among doctors, nurses and midwives in the maternity unit:

> "More information and assessment needed during hospital stays. Allied health needed to assess home and systems environment for support – not on referral-only basis – ALL parents assessed in hospital."
>
> "Specialist nurses in the maternity wards so new mothers are given information immediately."
>
> "Child Health Nurses, not midwives… should… make hospital visits to make contact with as many as possible new parents before discharge from hospital, and all high risk mothers get visited by CHILD HEALTH NURSES not midwives for extended family support program prior to discharge from hospital."
>
> "In hospital visits from mental health practitioners post labour."

Some respondents felt that maternity units tend to discharge mothers too early. Others felt early discharge is appropriate if supported by a timely home-visiting service to check on the physical and emotional health of mother, father, infant and family:

> "Extended time in hospital following delivery."
>
> "Hospital stays are too short."
>
> "The pressure on midwifery services sees some mothers leaving hospital on day 1 or 2 after delivery. The opportunity for any education during this time is very limited."
>
> "Increase initial length of postnatal inpatient stay to at least day 3."

One respondent pointed out that all states and territories have committed to the Commonwealth government National Maternity Services Plan, an evidence-based plan which identifies continuity of midwifery care (from the antenatal period, through birth, into the postnatal period) as supporting better physical and mental health outcomes for mothers and infants.

> "To enhance perinatal wellbeing and prevent perinatal depression, one strategy is to improve women's access to continuity of midwifery care, consistent with the national Maternity Services Plan (2010-2015) which all States and Territories committed to implementing. Continuity of midwifery care models are associated with enhanced physical and emotional health outcomes for mothers and babies, yet only a very small proportion of Queensland women can access continuity of midwifery care."

Post-discharge to six weeks post-birth

As with antenatal and in-hospital services, respondents nominated a range of providers who could support the mental health and well-being of mothers, fathers, infants and families in the six weeks post-birth, through various strategies. The major strategies suggested were:

Home visiting services

Midwives, nurses, Child Health nurses, mental health nurses and allied health professionals were all suggested as staff who either do or could provide home visiting services. Respondents suggested these visits should include screening and assessment of parental psychosocial health and the quality of the attachment relationship, as well as the health and development of the infant:

> "More home visiting services should be provided to families and infants where there is a high risk of ongoing mental health issues."
>
> "Services should not be static. The mums/bubs who need the most help will have the least ability to make it into hospital outpatients/community clinic."

Clinics

Respondents considered that the same issues should form a focus of clinic visits. Child Health clinics are an important element of the existing service system for sustaining the health and development of mothers, infants and families. Several respondents suggested that clinic appointments should also be used for psychosocial screening, discussion of mental health and wellbeing, provision of information and advice, and referral to other services as necessary:

> "Drop-in clinics for first 3 months and then encouraged to make scheduled appointments in clinics."
>
> "More services from child health, primary care programs, such as drop in child health clinics."
>
> "Baby clinics to have info and check up on mother's health."
>
> "More programs run through child health clinics e.g. 'Experiences of Motherhood' groups run more extensively."
>
> "Visits to the child health services needs to be when the mother requires the services not dictated to mothers by timeframes. Widen Child Health Services to give 'normal families' opportunities for educational and emotional support facilitating early intervention. Child Health chemist services do not have the ability to support families as there is limited to no space to confidentially share important information, it is in an open shop with customers."

Continuity of care between hospital and community

Consistent with the National Maternity Services Plan, respondents saw a need for greater continuity of care, including (where possible) continuity of carer, between the hospital and community environments:

> "Better integration and communication between hospital and community services which may mean increasing expenditure in this area."
>
> "Follow-up of mothers after leaving hospital – particularly those with a history of mental illness."

Phone support services

Women's Health Queensland Wide currently provides a Midwife Check-in phone service, with a midwife calling the mother at pre-agreed times to monitor her emotional well-being. Respondents also highlighted the need for information and advice to be available by phone, potentially through existing services such as 1300 HEALTH. A phone information service that could also provide referral to a specialist service if necessary was identified as a potentially cost-effective innovation:

> "First and foremost you need a phone service that is well known to husbands/partners, so that when they sense something is not right (as they are likely to be the first to do so) and they are reaching out they can call and an expert perinatal mental health doctor or nurse will come out to the mother's home."

Parenting support groups

Respondents indicated that both "mainstream" playgroups and "specialist" support groups for parents with perinatal mental health issues could play a role in supporting emotional well-being, and that information about such groups should be provided as part of routine maternity care:

> "I am aware that in other states after having a baby you get linked in with a mothers group in your local area… I did not have this in Queensland."
>
> "Promote mother and baby groups at child health clinics. Fund the child health nurse to promote classes on motherhood etc."
>
> "Provide access to … support groups for pregnant and new mums."
>
> "Play groups are important for socialisation of families but mothers can be very good at hiding how they are actually feeling about their infants."

Expansion of the Ellen Barron Family Centre model

The Ellen Barron Family Centre is a short-term residential program for families who require support with building practical skills and confidence in parenting. The model focusses on sleep and settling, breastfeeding and feeding, child development and behaviour, and general parenting skills. While not a specialist mental health intervention, the model is seen as supporting the development of the attachment relationship between parents and infants, and therefore as an early intervention that helps prevent the development of serious perinatal and infant mental health issues.

> "There is often a close association between parenting issues (crying baby and feeding baby) and mother's emotional and mental health."

> "Expand Ellen Barron Family Centre program to other areas of Queensland."

More focus on parent-infant attachment

A number of respondents felt that the Discussion Paper did not provide a strong enough focus on interventions to promote health attachment between parents and infant, and to prevent the development of mental health problems in the infant from birth to 3 years:

> "Enhancing the early attachment will help reduce the risk of ongoing mental health issues for the infant and the costs of mental health on the community."

> "Focus on the infant more, too much for adults."

> "Contract out to specialist clinical psychologists who know what they are doing with this population; the child and youth mental health services have sadly deliberately avoided and minimised this area and are incredibly poorly skilled."

Non-government supports and services

One submission outlined a strategy for enhancing the non-government sector, and particularly peer-led services, to provide more mental health promotion, antenatal education, clinician training, and non-clinical supports in the PIMH area. This submission aligns with a recommendation from a number of respondents that the NGO sector should be resourced to provide these services more sustainably:

> "Sustain funding and increase services where they are making a difference. Not putting new services in, reviewing the services already in place and improving and supporting them to support the community."

> "More funding for NGOs that offer perinatal support – more programs generated through NGOs."

> "I think a number of services exist, it is about raising their profile and increasing links and referral pathways between health professionals and the existing services. We also need to look at ways that these services can remain viable and meet the need that exists."

Specialist treatment services

For some mothers, fathers, infants and families, the provision of advice and support is not sufficient to prevent the development of mental health symptoms. Respondents identified that Queensland currently lacks both expertise in the primary care sector to screen for and detect perinatal and infant mental health issues, and specialist treatment services to which families can be referred.

Screening

An internationally-validated set of Universal Psychosocial Screening measures is available, and training is provided through the Queensland Centre for Perinatal and Infant Mental Health. However, respondents identify that screening is not regularly undertaken throughout the antenatal and post-natal period, is generally not used in the private health sector or by GPs, is not always well understood by healthcare providers or consumers, and generally fails to lead to referral and treatment due to the current dearth of specialised PIMH treatment services:

"What is needed, though, is better screening."

"Greater screening of attachment, perinatal mental health and infant mental health and referral pathways needs to be enhanced to address the families who currently slip through the gaps and then do not receive treatment."

"Screening is (currently) generic and is a matter of process not with the purpose of taking action or providing service."

"Screening tests for anxiety and depression prior to birth and post birth. Screening to be done through obstetrician at 6 week check up, and during vaccination – opportunity to screen mother again at 4 month and 6 month vaccinations."

"Universal screening is needed via child health nurses and midwives."

"Incorporate screening procedures in prenatal period."

Referral pathways

The same lack of specialist treatment services leads to a lack of referral pathways:

"There are currently enormous gaps which need bridging eg. referral options in emergency situations."

"Stronger links between mental health services and perinatal health services. Ongoing collaboration between these two key stakeholders. There should be dedicated positions, potentially perinatal mental health to close this gap."

Early treatment clinics

One non-government organisation is currently trialling a model for an early treatment clinic for perinatal maternal depression:

"The focus of creating such access is to enable early intervention or first contact for people who recognise they are struggling with the early stages of depression to gain strategies to help them cope better… We have an operational clinic for women who are at risk or have anxiety/depression during the perinatal period. This clinic is… run 1 day/week… The broad aim is to reduce risk factors and thereby prevent development of a clinical disorder."

Community-based perinatal and infant mental health services

Between 2008 and 2013, under the National Perinatal Depression Initiative, 13 positions for community-based perinatal mental health nurses were funded across Queensland. These positions were able to provide specialist treatment for perinatal mental health problems, including home visiting services and clinics, and capacity-building within primary health and the NGO sector.

Due to a hiatus in NPDI funding in 2013/14, all but 6 of these positions were defunded. A significant percentage of respondents (nearly 12 per cent) identified the reinstatement of these community-based positions as a high priority for restoring perinatal mental health services in Queensland:

"Re-fund strategies that support public mental health services to provide early intervention, assessment and brief intervention for perinatal women… Metro South… supported GPS who are primarily managing these women… since the funding ended in July 2013 there is a major gap for perinatal women in Metro South being able to access services."

"Very practical & mobile assessment & treatment was provided very well by perinatal mental health services to southside of Brisbane by the perinatal mental health nurses based at PAH & Mater. They saw & provided early intervention for depressed mums in local community Child Health Centre."

"Reinstate the perinatal mental health clinical nurse consultant positions that were defunded on 30/06/13. Pick the best of the models of perinatal mental health service delivery that were established in that funded period 2010-2013, and orientate all funded HHS to model of care. Services should be similar across the state."

"Currently the local Health Service has no Perinatal Mental Health Service. During the Perinatal Depression Initiative it was identified that this area was under-resourced and in need for at the very least a consultation liaison position to improve services (Mackay)."

"More staff to existing services including a full multidisciplinary team of health professionals."

"Perinatal mental health nurse to target at-risk mothers and high risk families."

"Reinstate the perinatal mental health CNC position at the Cairns base hospital."

"We have previously been able to refer parents to a mental health service which is able to screen for mental health issues and provide appropriate referrals. Mental health issues and maternal health in the new mother need time to explore fully to enable the appropriate referrals. GP's are not able to spend the necessary time and can feel like parents are offered an ad hoc service where appropriate service is not provided. Early identification and appropriate treatment is vital to positive outcomes for mother and infant. The long term effects for infants cannot be dismissed. The perinatal mental health service which was provided by nurses with mental health qualification was valuable and has been sorely missed by parents. In addition the service was helpful for GP's to access and receive appropriate treatment plans."

"Child Health services are doing what they can - there needs to be more community care teams with perinatal and infant mental health workers who work in conjunction with child and family health services to close the gaps in service delivery."

Day programs

The Discussion Paper recommended the establishment of day programs as a cost-effective alternative to admission, and as a step-up/ step-down option to reduce the length of an inpatient stay. Respondents agreed with this recommendation:

"A day program was trialled [at The Prince Charles Hospital in 2009] which incorporated adult mental health, infant mental health and child health services. Although this program is resource intensive - I think if there was long term evaluation it would show that this is both cost effective and cost efficient and keep the parent at home with their baby rather than using lengthy hospital admissions."

Parent-Infant inpatient beds

Dedicated parent-infant facilities for the treatment of severe maternal mental health problems are recognised internationally as best practice. Separation of mother and baby at this critical period of development can seriously disrupt breastfeeding, attachment formation, and family function. Currently in Queensland there is only one Parent-Infant Unit, at Belmont Private Hospital, which is accessible only by women with private health insurance.

Building on extensive planning and consultation since 2010, the Discussion Paper recommended expansion of facilities including the establishment of a 12-bed state-wide Parent-Infant Unit. Respondents supported the need for additional specialised facilities within the public health system:

"Infants should at all costs be able to remain with their mothers who require inpatient stays to deal with their mental health. I think that women who need to be separated from their infants experience as very high level of guilt and feelings of failure as a parent that deters from their recovery. This way the attachment could be fostered in mother-infant wards while the mother recovers from an acute episode."

"The discussion paper appropriately identifies that there are no existing mother-baby units available for specialised care outside of the private hospital Belmont. More beds are needed, particularly for individuals who do not have private health insurance."

"More mother-baby units, for PND sufferers to get hands-on help (like Belmont Private Hospital Postnatal ward)."

Cross-cutting issues

Several respondents noted issues that cut across sectors and strategies in the PIMH service system. These issues include:

- **Rural and remote services** – raised in response to every question on the survey
- **Culturally safe and appropriate services** for diverse cultural groups across Queensland – addressed in the next section
- **Workforce training and development** – recognised in many submissions as vital for PIMH service system capacity-building
- **Research and data collection** – respondents noted a need to collect data on PIMH issues and interventions in Australia, to build an Australian evidence base for effective and cost-effective services

CULTURAL DIVERSITY

Questions

Two survey questions addressed the PIMH needs of specific cultural groups within the Queensland population:

> "How well do you believe existing perinatal and infant mental health services cater for Aboriginal and Torres Strait Islander families?"
>
> "How well do you believe existing perinatal and infant mental health services cater for families from culturally and linguistically diverse backgrounds, including refugee families?"

Respondents were asked to provide practical suggestions for improving PIMH services and supports for these groups. Responses are tabulated and presented in **Appendix 3**.

Answers

Almost 52 per cent of respondents felt that existing PIMH services cater for Aboriginal and Torres Strait Islanders "Not at all well". Almost 40 per cent of respondents "Didn't know". Almost 9 per cent felt that PIMH services are provided for Aboriginal and Torres Strait Islanders "Quite well". No respondents thought services are provided "Very well".

Almost 60 per cent of respondents felt that existing PIMH services cater for families from culturally and linguistically diverse backgrounds "Not at all well". Almost 30 per cent of respondents "Didn't know". While 5 per cent of respondents felt that existing services cater for these families "Quite well", no respondents thought services are provided "Very well".

Because there was considerable overlap in the themes identified across these questions, responses were combined for the purpose of analysis. Themes were divided into categories and subcategories, as follows:

Services that respect women's cultural values and practices

- Overall philosophy
- Promotion and prevention
- Reducing fear and stigma
- Collaboration with community representatives
- Composition of workforce
- Workforce education and support
- Specific services and strategies for Aboriginal and Torres Strait Islander families
- Specific services and strategies for families from culturally and linguistically diverse backgrounds.

Organisation and provision of services

- Closer to home (including service provision in rural areas)
- Involving peer support workers
- Clear roles for private, public and NGO providers
- Need for research.

Communication between families and healthcare providers

- Bilingual health workers and/or interpreters
- Accessible written and verbal communication

A number of other responses to these questions, including the need for universal psychosocial screening, training in PIMH for primary healthcare staff, and staffing for rural and remote areas, apply across the Queensland population and are addressed in other sections.

Services that respect women's cultural values and practices

Overall Philosophy

Several respondents made general comments about the need to ensure that services are culturally appropriate:

> "Ensure that services are culturally relevant."
>
> "Increase unconditional support and set in place achievable culturally safe aims and goals."

Promotion and Prevention

It was noted that perceptions of perinatal depression and anxiety as mental illness are culturally determined:

> "There will be cultural differences and mums from these cultures may not even think PND is a medical condition."

Respondents felt that available PIMH services could be better promoted, in more places, using inclusive resources that look and feel relevant to all cultures in society:

> "Use of resources that reflect all cultures as well as their own, to reflect that this potentially happens to everyone."
>
> "Making mental health services more visible in the community, better advertising, not in the GP clinic or community health centres they do not go there in the first place."

Reducing fear and stigma

Respondents indicated that the stigma associated with mental illness in general is particularly acute for mothers, who don't want to be seen as not coping or as not enjoying their baby. Due to historical precedent, Indigenous mothers may specifically fear losing custody of their babies, and this fear can present a significant barrier to help-seeking:

> "Remove the fear associated with seeking help means your baby will get taken off you."
>
> "I think the words 'mental health' immediately put people on their guard or create concern around 'madness' and not being mentally well… Seeking help seems to indicate failure at a time when there is so much expectation that it all happens naturally."

Collaboration with community representatives

Respondents identified a role for cultural advisors and community representatives in the design and implementation of services:

> "Need to engage with the communities and work with the elders in these specified communities to set up culturally appropriate systems for early identification and support within the community."
>
> "Have consultants from CALD and ATSI on service development proposals."

Composition of workforce

Most suggestions regarding workforce composition emphasised the roles of Aboriginal liaison officers and Indigenous Health Workers in brokering the relationship between families and healthcare providers:

> "Support more Aboriginal Liaison positions in hospitals and communities – provide them with high quality training to see and work with the mums/dads and infants."
>
> "The need for more Indigenous child and maternal health workers working as part of the multidisciplinary team should be a priority for government and NGO."
>
> Diversity within the clinical workforce, and professional career paths for Indigenous people and people from culturally and linguistically diverse backgrounds, were emphasised:
>
> "Aboriginal and Torres Strait Islander midwives."
>
> "Increase cultural diversity in midwifery and child health teams."

Workforce education and support

Respondents suggested that staff need not belong to the same culture as their clients, in order to provide culturally safe services. However, all groups of staff working with culturally diverse mothers, fathers, infants and families need to be well trained and educated in cultural issues, maternity/ perinatal issues, and PIMH:

> "Increased education on culturally and linguistically diverse birthing practices to support these families better."
>
> "There are currently Aboriginal and Torres Strait Islander support workers in the Mackay area who work with mums and bubs, however the mental health aspect of their care requires education & support."
>
> "Pairing clinicians with health workers from relevant cultures – indigenous, health workers, refugees workers, specific cultural needs workers – to work together to support each other clinically and culturally."
>
> "Provide better on the ground training for non-indigenous health professionals (not the desk type cultural training that is trotted out now)."

Services and strategies for Aboriginal and Torres Strait Islander families

Respondents identified that culturally-appropriate resources for PIMH should be used by healthcare professionals working with Aboriginal and Torres Strait Islander families:

> "Tailor targeted resources e.g. perinatal social and emotional well-being screening by Statewide Maternity and Neonatal Clinical Network for indigenous peoples."
>
> "Making resources more readily available. Hard copy resources more pictorial and less wordy."

In addition to the indigenous-specific psychosocial screening tool mentioned by one respondent, examples of such resources in Queensland include the DVDs Stay Connected, Stay Strong, Before and After Baby and Here's Looking At You, and print resources such as Love Yourself, Love Bubs and Caring for Bubs / Caring for Piccaninny.

Respondents also outlined specific principles and practices that help maintain social emotional wellness for Aboriginal and Torres Strait Islander mothers, fathers, infants and families, for example:

> "Support Birth on Country, where women can birth consistent with their cultural values, and close to their support networks/families."
>
> "Diversity of service provision should be incorporated. Individual therapy does not necessarily work with Aboriginal and Torres Strait Islander clients, involving mother, aunts, sisters, grandmother to support women with perinatal mood disorder is essential. The concepts of 'healing your dreaming' should be included. Mental Health in Aboriginal and Torres Strait Islander clients cannot be successful with just white solutions."

One respondent advocated for a state roll-out of the Australian Nurse-Family Partnership Program (ANFPP) currently being trialled at Wuchopperen Health Service in North Queensland:

> "Are they (services) backed by evidence? Are they proven to be effective? That would point directly to a STATE roll-out of ANFPP - it addresses ALL of the domains mentioned in the report - health, education, child safety, crime, drug and alcohol misuse, and future parenting. Also: it's targeted at young families; screens at multiple time points for perinatal maternal mental health issues; is father-inclusive; is focused on prevention and early detection; is culturally acceptable; AND IT WORKS!"

Services and strategies for families from culturally and linguistically diverse backgrounds

Respondents acknowledged the wide diversity of population groups in Queensland, and pointed to the need to access cultural advisors and education for healthcare workers to improve cross-cultural understandings:

> "Increased education on culturally and linguistically diverse birthing practices to support these families better."
>
> "Support via transcultural mental health."

Some respondents pointed to specific programs for working with people from diverse backgrounds:

> "I am aware of the RESPECT program that is run by Communify in Brisbane that may be a program that can be replicated for working with women from culturally and linguistically diverse backgrounds in other areas."

Others emphasised the need for best practice models of midwifery care and PIMH care for all women, noting that women from CALD backgrounds may have specific risk factors for PIMH issues:

"Offer public continuity of midwifery care programs for all women, particularly vulnerable groups, such as women from a CALD background."

Organisation and provision of services

A number of respondents indicated that changes in the way maternity/ perinatal services, including PIMH services, are organised and provided, would benefit all Queensland women and particularly higher-risk groups including Aboriginal and Torres Strait Islander families and CALD families.

Closer to home

> "Better health services within own communities so Aboriginal and Torres Strait Islander women do not have to leave kin."
>
> "Support Birth on Country, where women can birth consistent with their cultural values, and close to their support networks/families."
>
> "Having specialist CALD and Aboriginal and Torres Islander outreach workers within Perinatal teams."
>
> "Culturally appropriate day programs could support these families in their community of origin."
>
> "Having baby and mother check-up vans visit communities that have large populations with culturally diverse backgrounds."
>
> "Recommend perinatal mental health mobile service that was provided to hospital, community centres and GP information and support."

Involving peers, families, and peer support workers

> "Get young mothers together to create connected support with and overlay of skilled workers able to ask the right questions or observe the group to determine who needs more support."
>
> "I think many studies have shown that peer counselling can be very helpful."

"Individual therapy does not necessarily work with ATSI clients, involving mother, aunts, sisters, grandmother to support women with perinatal mood disorder is essential."

Clear roles for private, public and NGO providers

Several respondents were concerned that the roles of private, public and non-government providers should be clear, and that clinical responsibilities should be undertaken by clinicians:

"It is essential that health professionals be the most qualified to meet the needs of Aboriginal and Torres Strait Islander families – services should partner with Indigenous specific organisations and not provide funds for the non-government organisations to provide services."

"Provide funding to public mental health services so they can provide specialised perinatal services by experienced nurses."

"Nurse Practitioners and as needed psychiatrists so primary care staff and hospital midwives can access specialist support in providing optimal mental health care to these women."

Need for research

Some respondents identified the need to build an evidence-base for PIMH interventions in Australia, with Australian populations:

"There is a lack of research in the area in Australia so I think that developing an Australian owned evidence base will enhance service delivery for people from diverse communities."

"Generate data to identify the burden of stress so it can be adequately funded & recognised for immediate action."

Communication between families and healthcare providers

Bilingual health workers and/or interpreters

Strategies to facilitate effective communication between women and healthcare providers included greater access to interpreters and/or health workers who speak the client's language:

"Having a dedicated service with ready access to interpreters and not using family members for this purpose."

"We need to ensure access to interpreters are available to the NGO/community sector as well."

"Access to assistance from a visiting health worker who speaks the language of the client."

Accessible written and verbal communication

Tailoring of verbal and written information to be more accessible and understandable to women and families. Translation of universal screening tools into a range of languages was recommended to enhance the effectiveness of the screening process:

"The language used to describe mental health issues and provide education needs to be changed to be more accessible and understandable for Indigenous communities."

"Hard copy resources more pictorial and less wordy."

"Translation of universal screening tools into a range of languages."

OTHER GROUPS WITH HIGHER NEEDS

Questions

Respondents were asked:

> "Are you aware of any other specific group/s in the community whose needs for accessible perinatal and infant mental health services and supports are not being appropriately met by existing services?"

Answers

Around 60 per cent of respondents identified specific groups at higher risk for PIMH issues, or with higher support needs in relation to these issues. Responses are tabulated and presented in **Appendix 4**.

Several respondents reiterated that perinatal mental illness does not discriminate – becoming pregnant in itself constitutes a risk for perinatal mental health problems. These respondents asserted that all women need support for their social and emotional wellbeing during the perinatal period, regardless of their socioeconomic, cultural or other characteristics:

> "Women from all socioeconomic and cultural backgrounds."
>
> "All new mothers are vulnerable."
>
> "I think all ethnic groups need more awareness! It's not about ethnicity, it's about being a mother!"
>
> "YES! Normal, JOE BLOW Australians! Stop being caught up in the politically correct business of ticking boxes for this subgroup and that subgroup. Just make the services 'solid' for all."
>
> "I think the general population of mothers need to be better prepared, better informed and provided for."

In addition to this "universal" risk, several groups were identified as being at higher risk and/or requiring additional support, due to a range of issues. Some families may belong to more than one risk category. These categories included:

Demographic factors

- Young parents
- Women living in rural and remote areas
- Refugees
- Women experiencing social isolation or disadvantage associated with
  - experiencing domestic violence
  - being homeless
  - using drugs and alcohol
  - low socioeconomic status
  - women in prison or detention.

Personal / family history factors

- Parents with intellectual impairment or other disabilities
- Parents involved with child protection agencies
- Older mothers

- Fathers
- Infants

Medical / health system factors

- Women without private health insurance
- Women with private health insurance
- Women without access to public health services (e.g. temporary residents)
- Women reluctant to seek help due to stigma
- Women with mild to moderate perinatal anxiety and/or depression
- Women with severe perinatal mental health problems
- Women with pre-existing mental health problems
- Women experiencing "unusual" pregnancy and/or birth (e.g. unplanned pregnancy, multiple births, miscarriage, termination, stillbirth, premature birth, delivery complications, child requiring surgery in utero, and/or child born with physical or developmental problems)

The final section of this chapter demonstrates how responses regarding the PIMH needs of specific groups align with the priorities outlined in the National Maternity Services Plan (Commonwealth of Australia, 2011).

Demographic Factors

Young parents

Respondents defined "young parents" differently (under 18, under 21, under 25) but in all cases identified young parents as having specific needs. One respondent referred to the detrimental impact that dismissive or abusive treatment of young women by health services can have on their emotional health and wellbeing.

> "Young mums aged 18-25. They are just dismissed as attention seeking and 'not really depressed' and abused badly by services."

Other respondents referred to young women needing time and consistency from their healthcare provider/s to develop trusting relationships, enhance health outcomes, and reduce the risk of discriminatory or abusive treatment:

> "Indigenous support for young first time pregnant females in Napranum and Mapoon. Generally there is a midwife who is well qualified and expected to multi-task… Families need to have trust in the person/s delivering any such program – that takes time and consistency from staff…"

> "Young, economically disadvantaged women would benefit from continuity of midwifery care, because contemporary professional midwives work from a social model of health, and are able to develop trusting relationships with their clients during pregnancy, birth and postnatally."

Other respondents recommended referring young women to existing services designed specifically for young people, since some young parents are difficult to engage and retain in PIMH services:

> "Under 25s difficulties with engagement and retention in mental health services. Links with existing services such as Headspace and midwifery and child health services delivering services to this group."

> "In Caboolture there are large numbers of teenage mothers – they are difficult to engage – consider drop-in style access to PNMH services in this area."

"Young women's services e.g. MICAH (Projects, Young Mothers for Young Women program), Brisbane Youth Services, Othilla's (program)."

Women living in rural and remote areas

Respondents indicated that women living in rural and remote areas often have limited access to services which, when combined with limited social and family supports (such as partners working away for significant time periods) poses significant risks for their mental health:

"We have a large group of middle class families who do not qualify as the at-risk group e.g. CALD or A&TSI. We are rural so this added to limited social and family supports increase the risk of this middle class group with Perinatal Infant Mental Health Concerns."

"My region has a large population of mine workers. Often they are quite isolated from family. Mothers and babies are often left alone for days to weeks at a time when the husband/partner goes out to the mine to work."

"Rural/remote: We've seen a large increase in rural suicides by farmers. The wife/mother is considered the backbone of the family and is the mainstay for when the husband/farmer starts getting wobbly. Greater support needs to be available for these women to reduce their risk of suffering. When their world gets wobbly, the whole family dynamic breaks on the farm and the fail is usually highly significant."

Recommendations included providing access to an early intervention e-health clinic, enabling access to multidisciplinary teams via telehealth and other technologies, and supporting Child Health teams to employ multidisciplinary staff:

"Consider an early intervention e-health clinic to enable access to a multi-disciplinary team, such as the White Cloud Foundation model, to enable these mothers to access a holistic range of support in an efficient and effective time frame. These females don't have time to attend multiple appointments over multiple days in a far off city and hence could greatly benefit from seeing 4 allied health disciplines in the one setting via Skype/ facetime/ telephone to get the strategies and support they require to function for their family."

"Telehealth link up services with clinicians who can provide individual and group support to mothers. Our funding does not cover a lot of service delivery in this area."

Refugees

In addition to the challenges faced by CALD women in general, respondents identified that there are gaps in services for refugees who are particularly vulnerable:

"Refugee and asylum seeker groups - mental health NGO services in this area start from age 5 and there is less focus on perinatal [or infant] mental health. These groups are also less likely to refer to public mental health services."

"The refugee community are particularly vulnerable as they are often dealing with previous torture or trauma that impact on their mental health. Services need to be able to respond to both this previous trauma as well as new mental health issues associated with the perinatal period."

"Refugee clinic at Mater - could perinatal mental health services run mobile clinics run by [perinatal mental health nurses] to get quick, early mental health assessment and intervention to assist these mothers both antenatally and postnatally?"

Women experiencing social isolation or disadvantage

Respondents identified that a wide range of sociocultural influences or social determinants of health may contribute to women's poor perinatal mental health and recommended a range of services providing both practical and psychosocial support.

"Pregnant women feeling isolated, in violent relationships, homeless, substance addictions. Identify appropriate agencies and support services. Make things happen e.g. find accommodation, baby sitting, help with transport, access to services."

Women experiencing domestic violence

"Women's Health Queensland Wide is also working with domestic and family violence services to deliver support to women who are pregnant and/ or parenting and living with violence… I believe that there are programs that already exist that can support these women, for example the Midwife check-in that Women's Health Queensland Wide provides, what is required is that these programs become sustainable, that their profiles are raised and that better referral pathways are established."

Women experiencing homelessness

Those who are 'homeless' - they need their own advocates to support them and help. Health Professionals to not judge too rashly how those with a different life experience manage their lives."

Women using drugs and alcohol

Respondents identified that services currently supporting women using alcohol and drugs are quite fragmented and may have difficulty supporting women who have multiple risk factors. One respondent recommended providing Alcohol, Tobacco and Other Drugs Services (ATODS) in more accessible locations to better serve women's needs:

"In my experience, mental health problems often coexist with substance abuse. We need a service that can deal with this combined problem rather than bouncing the patient between services as occurs at present."

"Drug and alcohol clients have often started taking drugs to self-manage their mental health issues. Management of same is quite fragmented."

"ATODS is perceived as place to go to - not a good look for a pregnant woman/new mum. ATODS needs to be accessible at the places where their clients are already: antenatal clinics, community health centres etc."

Women of low socioeconomic status

Respondents identified the multiple risk factors of women with low socioeconomic status, and practical barriers to obtaining services such as lack of money for transport:

"Poor, uneducated, socially alienated women who are not married, and have children to random fathers."

"Women who do not have easy access to transport - fund transport."

Women in prisons or detention

Being in prison or detention without access to mental health services was identified as a risk factor for mothers and their babies:

"Women in prisons - what services do they get?"

Personal/ family history factors

Parents with intellectual impairment and/or other disabilities

Respondents identified that women with intellectual impairment and/or other disabilities are vulnerable and have difficulty accessing services. Recommendations included providing support workers to provide practical support and advocacy and collaboration between government and Non-Government Organisations (NGOs):

"Those with disabilities – they need their own advocates to support them and help… Health professionals to not judge too rashly how those with a different life experience manage their lives."

"Many of the parents that we see have a disability – there is a large population of parents who are deaf/blind and who have intellectual disability. These vulnerable families have often even less access to service provision.

My suggestion would be to work with the government and NGOs to look at how services are provided and look at using a multiagency approach to care."

Parents in contact with the child protection system

Families already involved with child protection agencies often have multiple risk factors, and are recognised as being at higher risk for both parental and infant mental health problems. Effective intervention during the perinatal period and/or infancy may help break the cycle of escalating problems which are costly to both the family and society:

"Child safety - 0-3 permanency placement. Too many of these infants have multiple+++ placements in the first 3 years of life."

Older mothers

The risk of perinatal maternal depression is known to increase with subsequent pregnancies, however most health services are focussed on the birth of a woman's first baby. Older mothers, whether first-time mothers or those already raising other children, may be particularly susceptible to isolation and deterioration of emotional health:

"I – as a 38 year old, ex-professional with no children or Mumma peers around me – believe antenatal coaching in real life/what to expect with a newborn should be offered."

Fathers

Expectant and new fathers were identified as requiring more support for their own mental health needs as well as being aware of how to support their partners' mental health.

"I feel that men/new fathers need more support for their mental health and practical advice/ways to monitor and care for their partners mental health as they are usually the ones who will see the changes in them first."

"Men; improvements in support, education, mantherapy, better conversation and co- ordination."

"An urgent need to provide antenatal and early parenting services to new and expectant fathers such as *www.mrdad.com.au* (run by male midwives and male social workers)."

Infants

Several respondents, answering this question and others, felt that healthcare providers fail to attend to the mental health needs of infants:

"Infants - services are focussed on (women's) perinatal mental health and lose sight of the infant's individual needs and the complexity involved in ensuring the well-being of an infant."

Medical / health system factors

Women without private health insurance

The major disadvantage identified for women without private health insurance was lack of access to inpatient Parent-Infant beds, should the mother's perinatal mental illness require inpatient care. The only dedicated mental health beds in Queensland in which a mother can be treated without separation from her infant are private beds at Belmont Private Hospital:

"Anyone who doesn't have private health insurance and even some who do aren't covered. There are so many women that need help but it's simply out of reach financially for a lot of them to go to a private facility for treatment."

"Those without private health insurance. Others need access to places like Belmont's unit."

Women with private health insurance

Conversely, respondents indicated that women birthing with private obstetricians in private hospitals are disadvantaged by the prevailing medical model. While attention to women's mental health and emotional wellbeing is described as somewhat erratic in the public system, the situation in the private system is considered even worse:

> "The prenatal information session provided by the private hospital at which I gave birth did not provide education on PND (or the baby blues for that matter)."

> "I had been through the private system and although I was under care of an obstetric psychiatrist, I needed someone to visit me at home in those first couple of weeks. The private hospital sent me the bill and a letter with the number for community child health – I was chewed up and spat out."

> "I was with a private obstetrician and she was not interested when I spoke to her about not travelling mentally well… I think more work needs to be done with private hospitals."

> "Women who are having their maternity needs met through the private sector do not routinely have EPDS for assessment for antenatal depression or anxiety [no universal psychosocial screening]. These women then miss referral or support to prevent or manage PND."

> "Many women who birth with private obstetricians and in private maternity hospitals do not have the same access to screening and referral to support services as women in the public sector."

Women without access to public health services

Respondents indicated that access to public health services is an issue for some women:

> "In my case, we were temporary residents of the country and were unable to access some public services due to a lack of Medicare. There was no option available for payment via private coverage."

Women reluctant to seek help due to stigma

Stigma associated with mental health problems was identified as a major barrier to help-seeking:

> "Middle class women who are ashamed - deal with stigma and support current groups."

> "Those who are scared to get help due to the stigma surrounding it. All of which puts children at risk or harm."

Women with mild to moderate perinatal anxiety and/or depression

The lack of treatment options for women with mild perinatal mental health issues was identified as a problem:

> "At the moment it feels very much like 'you are crazy or sane'. So either no treatment or full on hospital admission. What about the in between group who could do with support to overcome some mild negative feelings or anxiety? I don't feel this group has options they could easily explore."

Women with severe perinatal mental health problems

Similarly, due to lack of specialist treatment options, women with severe perinatal mental health problems were seen as a group greatly in need. Since severe mental health issues are a risk factor for maternal suicide, the respondents urged the establishment of services for them:

> "We need "mum & bub" facilities in mental health wards."

> "At any one time, for severe mental health issues for mother's there are only 10 beds available through BCPND at Belmont hospital."

Women with a pre-existing mental illness

One respondent felt her pre-existing diagnosis precluded her from obtaining services for her perinatal depression. Other respondents were concerned for mothers who have used all the mental health

appointments for which they are eligible under Commonwealth programs, and cannot afford further treatment for perinatal mental illness:

> "Because I'd had an episode of depression before [I was told that] I couldn't access perinatal services when I had depression while pregnant and in the year after."
>
> "Those who use the existing mental health plan via the GP and need more than the prescribed number of visits or who can't afford to go at all."

Women experiencing "unusual" pregnancy and/or birth

In one anecdote collected during the consultation process, a doctor challenged a mother's request for assistance with her postnatal depression, saying, "I don't know why you're depressed. The birth was perfectly normal." While there is work to be done in raising doctors' awareness of factors contributing to perinatal mental illness, apart from birth complications, respondents noted the stress that "unusual" pregnancy and birth journeys can impose on mothers, infants and families. "Unusual" journeys include but are not limited to unplanned pregnancy, multiple births, miscarriage, termination, stillbirth, premature birth, delivery complications, a child requiring surgery in utero, and/or a child born with physical or developmental problems:

> "The other group of women that Women's Health Queensland Wide is trying to work with are women who have an unplanned pregnancy. This may increase their risk of depression and anxiety irrespective of whether they choose to continue with the pregnancy or not."
>
> "Parents of multiple births, parents of children who were miscarried, aborted or stillborn are all higher risk for developing mental health issues."
>
> "Mothers of premature babies."
>
> "A number of the suicides in the Queensland Maternal Mortality report related to women committing suicide after termination of pregnancy. Termination of pregnancy needs to be taken out of the current legal quagmire, it needs to be regulated, legalised, monitored, with appropriate mental health resources around it."

Alignment with National Maternity Services Plan priorities

As outlined earlier, survey respondents' recommendations for services align with many of the priorities of the National Maternity Services Plan (NMSP: Commonwealth of Australia 2011). The Plan was endorsed by the Australian Health Ministers' Conference in late 2010, with the objective of enhancing health outcomes for Australian mothers and babies by providing high-quality, woman-centred maternity care. Consistent with survey respondents' suggestions, the five-year Plan aims to improve primary maternity services by increasing women's access to continuity of maternity care (and carer), and providing universal screening for perinatal depression (Priority Actions 1.2.1, 1.2.2 and 2.3.1).

The Plan also identifies groups in the population who experience significant health inequalities and social disadvantage. These groups include Aboriginal and Torres Strait Islander women, women living in rural and remote locations, and women with medical, socio-economic and other risk factors. The Plan outlines strategies to enhance perinatal outcomes for these at-risk women and their babies (Priority Actions 1.3, 1.4, 2.2.1, 2.2.3, 2.3.3). Agreed strategies include establishing formal referral pathways for women experiencing depression, and developing options to reduce separation of mothers from their babies while mothers are receiving mental health care (Priority Action 2.3.2). Alignments between survey respondents' recommendations and NMSP priorities are outlined in **Table 1**.

Table 1 Alignment of survey respondents' recommendations with NMSP priorities

Target Population	Discussion paper recommendations	NMSP Priority	Description	Sign of success
All women	Continuity of maternity care and carer	1.2.1	Australian governments facilitate increased access for public patients to continuity of carer programs	Increased numbers of women access continuity of carer programs
		1.2.2	State governments facilitate increased access to continuity of carer by enabling admitting and practice rights for eligible midwives and medical practitioners in public healthcare settings	Eligible midwives have the opportunity to access clinical privileges, admitting and practice rights in public healthcare settings
	Universal screening for perinatal depression and appropriate training for staff	2.3.1	Australian governments expand screening for perinatal depression arising from the National Perinatal Depression Initiative Australian governments ensure that training, mentoring and supervision of staff undertaking perinatal mental health screening is provided.	Universal screening is available for all women. Health professionals undertaking perinatal mental health screening are trained, mentored and supervised.
Women experiencing depression or mental illness	Formal referral pathways for women experiencing perinatal mental illness to specialist PIMH services	2.3.2	States and territories establish formal referral pathways for women experiencing depression and mental illness with perinatal mental health services States and territories develop options to overcome separation of mothers from their babies when receiving mental health care.	Women experiencing depression and mental illness have timely referral to appropriate professionals by maternity services. There are decreased rates of separation of mothers from their babies when receiving mental health care.
Aboriginal and Torres Strait Islander women	Services that respect women's cultural values and practices	2.2.1	Australian governments expand programs providing culturally competent maternity care for Aboriginal and Torres Strait Islander people (in the middle years of NMSP)	Increased numbers of Aboriginal and Torres Strait islander people have access to culturally competent maternity care.
		2.2.3	Australian governments establish birth on country programs (in the later years of NMSP)	Birthing on country programs for Aboriginal and Torres Strait Islander mothers are established.
Women living in rural areas	Improved access to services that are closer to home and/or enabled by technology.	1.3	Increase access for women and their family members in rural Australia to high-quality maternity care	Women in rural and remote Australia have increased access to outreach maternity services.
Women living in remote areas		1.4	Increase access for women and their family members in remote Australia to high-quality maternity care	An increased number of remote communities have access to community-based maternity care.
Women who are vulnerable due to demographic, sociocultural and other risk factors.	Enhanced psychosocial and practical support recognising the woman's holistic life circumstances and range of risk factors	2.3.3	Australian governments implement and expand evidence-based maternity care models for at-risk women, including: pregnant adolescents, CALD communities, women in prison, women using cigarettes, alcohol and illicit substances, older women, women experiencing domestic violence (in middle years of Plan).	Improved perinatal outcomes for at-risk women and their babies.

SUPPORT FOR EXISTING SERVICE PROVIDERS

It should be noted that respondents' comments are premised on an existing service system for perinatal and infant mental health in Queensland. Many respondents noted that, for the most part, services need to be grown and linked rather than created from scratch. Submissions received from organisations, in particular, tended to highlight aspects of the existing PIMH service system that provide a foundation for future development.

The following organisations took the opportunity to provide an overview of their roles in PIMH.

Women's Health Queensland Wide Inc. and Debbie Spink

Women's Health Queensland Wide Inc. is a non-government organisation that has been supporting women's perinatal mental health for over 20 years. The service currently offers:

- a Midwife Check-In phone service, to support mothers with a confidential "listening ear" in the early weeks post-birth
- preparation for parenthood seminars, offered face-to-face and as an online resource
- mental health promotion activities and resources, including Indigenous-specific and CALD-specific resources

Debbie Spink is a national leader in the development of consumer-led services for perinatal and infant mental health.

The joint submission offers a model for greater involvement of the non-government sector and consumer-led services in mental health promotion and prevention, and the provision of support for mothers, fathers, infants and families experiencing PIMH issues.

White Cloud Foundation

The White Cloud Foundation was created in 2011 with a mission to break down barriers to treatment for people developing anxiety and/or depression. White Cloud clinics aim to provide early intervention, through co-located multidisciplinary teams. White Cloud Foundation is currently trialling a clinic for postnatal depression, one day a week at QUT Health Clinics. Its brief intervention model is designed to reduce risk factors and prevent the development of a clinical disorder. Data is being collected during the trial, with a view to proving the effectiveness of the model and seeking sustainability for the clinic.

Queensland Centre for Perinatal and Infant Mental Health (QCPIMH)

The Queensland Centre for Perinatal and Infant Mental Health (QCPIMH), established in 2008, is Queensland's centre of PIMH expertise, which engages in cross-sectoral capacity-building for the prevention, detection and treatment of perinatal and infant mental illness. QCPIMH pursues four strategic directions:

- Promotion, prevention and early intervention
- Service development and implementation

- Workforce development and training
- Research and evaluation

The Discussion Paper identifies the need for a small enhancement to make QCPIMH sustainable. During the consultation, respondents identified a number of capacity-building activities which align with QCPIMH's existing remit, in particular:

- Training and education for the primary care and non-government sectors in early detection of PIMH issues, including the use of universal psychosocial screening tools
- The production and dissemination of psychoeducational resources (print, digital and other) for perinatal and infant mental health
- Supporting service co-ordination and integration, and reducing barriers to help-seeking
- Research and data collection to establish an Australian evidence-base for PIMH interventions, including health promotion and illness prevention

beyondblue

While no submission was received directly from *beyondblue*, the organisation and its resources were referenced by a number of respondents. *beyondblue* is a not-for-profit entity that provides national leadership to reduce the impact of depression and anxiety in the Australian community, and co-ordinates the National Perinatal Depression Initiative. *beyondblue* conducts a national community awareness campaign for perinatal mental health, entitled Just Speak Up, which some respondents noted could be adopted as the basis for a public awareness campaign in Queensland.

ISSUES AND PRIORITIES FOR STRENGTHENING SERVICES

Questions

Respondents were asked "How well do you believe the Discussion Paper has identified the issues and priorities for strengthening clinical perinatal and infant mental health services? If you wish to, please briefly outline the reasons for your answer".

This question provided respondents with the opportunity to comment on the strengths and weaknesses of the proposed service system enhancements outlined in the Discussion Paper, and to identify any gaps.

Answers

Most responses to these final quantitative questions aligned with the chronology established through the analysis of Question 2. Responses are presented in **Appendix 5**.

Two-thirds of respondents felt the Discussion Paper identified the issues and priorities for strengthening PIMH services "Very well" (12 per cent) or "Quite well" (49 per cent). Around one-quarter of respondents (24.8 per cent) "Didn't know". Some 15 per cent felt the issues and priorities were captured "Not at all well".

The two components of the Discussion Paper that attracted the most endorsement from respondents were the need to establish community-based perinatal and infant mental health positions across Queensland, and the need to establish parent-infant beds.

The two areas most consistently identified as "gaps" were prevention of perinatal and infant mental illness, and the need for more focus on infant mental health.

Community-based PIMH services

> "I like the Community Care expansion which is so desperately needed and which, quite honestly, if they are provided by perinatal mental health nurses can be the difference between life and death."
>
> "(The Discussion Paper recognises) the need for community-based teams which need to include consumers who have experienced perinatal issues. It reflects this impact on families – mums, dads, siblings."

Some respondents suggested innovative models for community-based services:

> "This is an area where innovative strategies such as providing nurse specialist positions such as Nurse Practitioners would help fill the gap and are an economically more efficient option than psychiatrists as well as being client friendly"

Others emphasised the importance of a consistent model of care, such that a family accessing community-based PIMH services in different parts of Queensland should be able to expect a similar type and level of care response:

> "I think more emphasis should be put on creating one model of care for ALL Queensland HHS. The 2010-2013 funding block yielded about 13 different models – there were similarities, of course, but there was also a LOT of variation in the way each HHS used the funding."

Parent-Infant Beds

Seven respondents commented specifically on the need for parent-infant beds, to prevent unnecessary separation of mother and baby while the mother is being treated for PIMH issues.

> "I work in Community Child Health and can see the gaps in the services for families, especially mothers with mental health problems. They have to be separated from their babies if admitted to hospital with mental health problems."
>
> "Still no mother & baby mental health beds publicly available. Yes I know that mums can continue to breastfeed in some circumstances… But can't we do better than this and have a purpose built mother and baby unit publicly like at Belmont Private? Public patients are disadvantaged with no quick mobile perinatal mental health service and no mother & baby beds in public hospitals."

While the Discussion Paper proposed short-term options for accommodating mothers with their babies in general hospitals, maternity units or adult mental health units, while parent-infant beds remain unavailable, respondents emphasised that these short-term options are less than ideal:

> "Please don't place women with PND into acute mental health wards. Most women feel like failures when PND strikes – is it helpful to be additionally subject to the stigma of being in a "psych" ward? Does this really help? Inpatient units are notorious for being unsafe place for women, as there is no gender division of wards in our public mental health wards. Is this a good environment that is conducive to healing, as opposed to providing an environment whose major purpose seems to be to contain the risk factors?"

Illness prevention

Consistent with responses to the earlier questions, this question attracted a number of comments on the need for earlier intervention. In particular, respondents emphasised the role of the non-government sector in providing illness prevention and early intervention services:

> "[The Discussion Paper recognises] the need for early intervention and prevention."
>
> "Research demonstrates that preventative strategies are the best investment of resources."
>
> "This has been done well, however there is a large gap in this work for the early intervention/prevention models that are available from the community (out of public and private hospitals who already have stretched resources and will be unable to address future demand)."

Infant mental health

Consistent with responses to earlier questions, this question attracted a number of comments on the need to attend to the mental health needs of infants in their own right, rather than focussing exclusively on the mental health of parents:

> "Infant needs more focus."
>
> "Infant Mental Health is a field in its own right with many factors impacting the mental health of the baby - perinatal mental health being only 1 factor. Families experience difficulty in the parent-infant relationship that do not necessarily relate to perinatal mental health, including reflective capacity, intergenerational issues, trauma, and social factors. Too many times the baby is lost as it is easier for services to focus on the needs of the mother excluding the needs of the infant."

GENERAL COMMENTS

Question

The final question “Are there any further comments you would like to make in response to the Discussion Paper?” provided respondents with the opportunity to make any additional points.

Answers

For the most part, respondents took this opportunity to reiterate priorities they had identified earlier, and strategies they had suggested to address these. Responses are tabulated and presented in **Appendix 5**, in combination with responses to Question 9.

One respondent took the opportunity to affirm that access to good services can prevent perinatal and infant mental health problems, even in the face of multiple risk factors:

> “A personal story. Post natal illness is preventable. In my first pregnancy I had four major risk factors: 1. A diagnosed psychotic mental illness 2. The need to come off my meds to avoid foetal damage 3. A sister who had PND with both her pregnancies 4. Due date of delivery coinciding with previous dates of personal episodes of severe illness. I had good care in my pregnancy, was encouraged to develop strategies to help myself, and did not develop PND, or any psychosis. I sailed through my second pregnancy three years later. And this was THIRTY years ago.....”

CONCLUSION

Overall, public responses to the *Perinatal and Infant Mental Health Service Enhancement Discussion Paper* were positive. A number of respondents stated that the Discussion Paper accurately represented needs and gaps in the PIMH service system in Queensland, and proposed a credible model to address these needs and gaps.

Respondents accepted the invitation to highlight the needs they saw as most urgent, and to propose specific practical solutions to current problems. Recommendations fell into three broad categories:

- **Earlier intervention** for both parent and infant mental health, including more community awareness-raising, better universal support for parent and infant mental health through the primary care sector and non-government sector, and better screening and detection of PIMH issues
- **Specialist treatment services**, particularly community-based specialist perinatal and infant mental health positions, day programs, and dedicated parent-infant inpatient mental health beds
- **System-wide capacity building**, including training for primary healthcare staff and non-government organisation staff to reduce stigma, reduce barriers to help-seeking, improve screening and detection, improve support and early intervention, and create referral pathways to specialist treatment services.

A number of recommendations aligned with priorities outlined in the National Maternity Services Plan (NMSP: Commonwealth of Australia, 2011), including:

- **Universal screening** for perinatal depression (Priority Action 2.3.1)
- **Access to continuity of carer models** for maternity care (Priority Actions 1.2.1 and 1.2.2)
- **Provision to meet the needs of specific groups of women** with cultural, socioeconomic, medical and other risk factors for perinatal mental illness, including Aboriginal and Torres Strait Islander women and women living in rural and remote areas (Priority Actions 1.3, 1.4, 2.2 and 2.3.3)
- **Formal referral pathways**, for women experiencing perinatal mental illness, to specialist perinatal mental health services (Priority Action 2.3.2)
- **Expanded options for overcoming separation of mothers from their babies** when receiving mental health care (Priority Action 2.3.2).

Respondents identified various strategies for better supporting the emotional wellbeing of mothers, fathers, infants and families of Aboriginal and Torres Strait Islander descent, and those from culturally and linguistically diverse backgrounds. These strategies were expressed in terms of three principles:

- **Services that respect women's cultural values and practices** through culturally appropriate workforce composition, education and support; culturally appropriate mental health promotion and prevention; the reduction of fear and stigma; and the adoption of strategies for culturally-specific service provision
- **Organisation and provision of services** closer to home; that involve peers, family members and peer support workers; that are evidence-based; and that specify clear roles for service providers from different sectors and with different expertise
- **Communication between families and healthcare providers** through the use of bilingual health workers and/or interpreters, and the provision of accessible written and verbal communication**.**

Respondents identified a number of other groups within the Queensland population who are at higher risk for PIMH issues and/or require higher levels of support to address these issues. These groups are at higher risk or have higher needs due to:

- **Demographic factors** such as being a young parent, living in rural and remote areas, coming from a refugee background, or experiencing social isolation or disadvantage
- **Personal or family history factors** such as having an intellectual impairment or other disability, being involved with the child protection system, or being an older mother. Respondents specifically highlighted the mental health needs of fathers and infants, in addition to mothers.
- **Medical or health system factors** such as being ineligible for public health services, being reluctant to seek help due to stigma, having a mild to moderate perinatal mental health disorder, having a severe perinatal mental health disorder, having a pre-existing mental health disorder, or experiencing an "unusual" pregnancy or birth. Respondents reported that while women without private health insurance are disadvantaged through lack of access to parent-infant beds, women in the private health sector are less likely to be screened for perinatal mental health problems at any point in the perinatal period, or to receive support for their mental health needs.

A number of respondents pointed out that strengthening the overall PIMH service system in Queensland to provide services to all mothers, fathers, infants and families will also improve services to groups with higher needs, and provide a foundation for more tailored interventions.

Not all submissions focussed on identifying problems. Submissions were received from several organisations, highlighting aspects of the existing PIMH service system that provide a foundation for future development:

- **Women's Health Queensland Wide Inc. and Debbie Spink** offered a model for greater involvement of the non-government sector and consumer-led services in mental health promotion and prevention, and the provision of support for mothers, fathers, infants and families experiencing PIMH issues
- **White Cloud Foundation** drew attention to a new pilot early intervention clinic for perinatal depression and anxiety
- **Queensland Centre for Perinatal and Infant Mental Health** (QCPIMH) reiterated its role as a state-wide cross-sector hub of expertise, helping to build the PIMH service system in the areas of:
  - Promotion, prevention and early intervention
  - Service development and implementation
  - Workforce development and training
  - Research and evaluation
- ***beyondblue*** was identified as a source of psycho-educational resources for PIMH community awareness, mental health promotion and prevention, and early intervention

Asked for their overall critique of the Discussion Paper, respondents took the opportunity to reiterate their perception of four major gaps in the Queensland PIMH service system:

- **Community-based perinatal and infant mental health positions**, to provide specialist treatment services close to home and greatly reduce the need for hospital admissions
- **Dedicated parent-infant beds**, to avoid separation of mother and baby when hospitalisation is required
- **Illness prevention** through better screening, detection, referral and early intervention, particularly involving the primary healthcare sector and the non-government sector

- **Infant mental health**, which many respondents described as poorly understood and severely lacking in services.

Overall, the public consultation process endorsed the model for service enhancement proposed in the Discussion Paper, which includes:

- The development of a specialist **parent-infant unit** comparable to those in other states, as a high priority
- Use of available **inpatient options** as a short-term solution to the current lack of parent-infant beds
- **Community-based PIMH specialist services**, including day programs, as the most cost-effective way to provide PIMH treatment close to home
- Resourcing the **primary care and NGO sectors** to play a major role in mental health promotion, prevention and early intervention across the state
- Recognition of the need to **co-ordinate** cross-sectoral PIMH workforce development and other capacity-building

Strategic enhancements to Queensland's existing service system, based on the issues and solutions identified in this report, are expected to pay dividends in terms of improving perinatal and infant mental health services, reducing risk, and securing better outcomes for Queensland mothers, fathers, infants and families.

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APPENDIX 1: SURVEY QUESTIONS

1. How well do you believe information and support is provided in the community for expectant and new mothers and families, both to help prevent them from experiencing mental health difficulties, and to help those who do to get well and stay well at home?

2. Please tell us about any practical suggestions you have for improving such services.

3. How well do you believe existing perinatal and infant mental health services cater for Aboriginal and Torres Strait Islander families?

4. How well do you believe existing perinatal and infant mental health services cater for families from culturally and linguistically diverse backgrounds, including refugee families?

5. Please tell us about any practical suggestions you have for improving perinatal and infant mental health services and supports in Aboriginal and Torres Strait Islander communities and/or for improving services and supports for expectant and new mothers from culturally and linguistically diverse backgrounds and their families?

6. Are you aware of any other specific groups in the community whose needs for accessible perinatal and infant mental health services and supports are not being appropriately met by existing services?

7. If so, please tell us which group/s and what improvements you think are needed.

8. How well do you believe the Discussion Paper has identified the issues and priorities for strengthening clinical perinatal and infant mental health services?

9. If you wish to, please briefly outline the reasons for your answer.

10. Are there any further comments you would like to make in response to the Discussion Paper?

APPENDIX 2: QUESTION 2 RESPONSES – PRACTICAL SUGGESTIONS FOR IMPROVING SERVICES

1. MENTAL HEALTH PROMOTION AND PREVENTION

Topic	Count	Text
PRECONCEPTION/ COMMUNITY AWARENESS		
Community education program	5	• A community education program that explains the risk factors and signs of postnatal disorders is of crucial importance. • Community awareness of the signs. • There needs to be a public campaign to raise awareness of postnatal depression – everyone focuses on the joy of childbirth, and the mother and father are left feeling guilty about their feelings or emotions post birth. • Clearly outlining treatment options would make it easier for those who do suffer from MH issues to come forward. Also make it clear that these are treatable conditions. • Community conversation to raise the profile of PND in both mums and dads, which assists in identifying the existing resources and pathways for co-ordinated care.
Information in public places	2	• Information in public places – libraries, community groups, open display of information, where possible real stories with real people to reinforce that this can happen to anyone. • More community awareness to destigmatise the issue.
Internet	1	• Many women get their information now via the web… having more info in these places may reach more women and families.
Education/ awareness on broader social issues	1	• These suicides also generally occurred in women who came from poverty-stricken and chaotic circumstances, with significant issues of domestic violence, poor education, intergenerational social decline and drug use. In the US, it has been recognised that completion of school, and marriage before children are important protective factors against chaos and social disruption. There are even advertisements in the New York subways telling girls that if they complete school and get married before having children, they reduce their risk of poverty by 90 per cent. We need similar education campaigns here. Marriage is highly protective for women and children, and needs to be encouraged amongst less well educated and poorer communities.
Preconception mental health services	1	• Need to have access to mental health services for women pre-conceptionally, within the public hospital setting.
TERMINATION/ MISCARRIAGE		
Termination	1	• A number of the suicides in the Queensland Maternal Mortality report related to women committing suicide after termination of pregnancy. Termination of pregnancy needs to be taken out of the current legal quagmire, it needs to be regulated, legalised, monitored, with appropriate mental health resources around it.

2. SERVICE DEVELOPMENT AND IMPLEMENTATION

ANTENATAL		
More information on both antenatal and postnatal mental health issues at antenatal classes	12	• Include sessions in antenatal classes. • More discussion in antenatal classes. • This information needs to be provided at the antenatal classes, or at least resources. I understand this can be difficult as mothers to be are excited, but I had a run-around when I had PND before I found the right help. • Despite the prenatal information session provided by the private hospital at which I gave birth did not provide education on PND (or the baby blues for that matter). Mothers are taught practical tasks about how to care for their babies, but not taught how to identify the signs of mental illness. This is important, particularly for women who have a history of mental illness. • Cover in prenatal checks and classes. • Antenatal classes need to highlight baby blues and what services are available and when people should be accessing them... recent experience was that breastfeeding and videos of birthing seem to be all the info new mums and dads need. Bring back the old antenatal classes… • Just like couples are told – and offered services – to prepare for a marriage versus a wedding, I – as a 38 year old, ex-professional with no children or Mumma peers around me – believe antenatal coaching in real life/what to expect with a newborn should be offered… not just how to birth and breastfeed. Our community is different these days… little family support… friends too busy etc. • Make more of a point in antenatal classes to talk about mental health difficulties, to break down negative stigma. This could be done by mental health trained professionals, along with mums who've experienced it personally. • Whole session dedicated to PND in antenatal classes. • This information could be included in antenatal sessions/ appointments/GP visits. • They talked about it at our prenatal class at the Mater, but the nurse and participants made fun of the symptoms of PND that were in our book with statements like 'Better get to Belmont – ha ha'. This made out like PND is something that happens to others, to crazy people. How about normalising anxiety after birth and encouraging assistance like you would for breastfeeding? Funny, sooooo much info on breastfeeding and how serious it is, but not mental health.
Provide information and discussion	9	• Discussion and information that normalises mental health difficulties for expectant and new mothers and their families, rationalise why this occurs as routine part of antenatal and postnatal care. • Early intervention – preparing women throughout pregnancy when there is a risk of postnatal depression. Discussion of mental health at all levels of the continuum of perinatal health services. We give huge attention to the physical health needs of women during pregnancy. We instruct on how to give birth and manage the birth process. But as far as I am aware, we don't discuss preparing yourself for an altered mental state. • Integrate mental health information and support as part of their pre natal care as per their physical well-being.

		• More education about signs and symptoms for expectant mothers during pregnancy. More information about services available. • Increased information on antenatal depression not just postnatal, increased information on the anxiety symptoms not just focus on depression. • This information could be included in antenatal sessions/ appointments/ GP visits. This information needs to be delivered in a way for mothers to feel comfortable seeking help if and when they need it. • Encourage GPs to make it (PMH) an important part of antenatal and postnatal checks. • Better education antenatally. • The provision of active psychoeducation to expectant mothers, their partners and families on mental health issues. This includes open discussion on top of provision of information.
Provide resources	6	• Or at least resources. • Providing brochures on services available for mental health as well as services providing coping strategies for new mums such as sleep centres. • You get given the *beyondblue* PND brochure. This tells you the signs but it doesn't tell you what to do next. The midwives also skip over the PND brochure when handing the pack to you. Like PND is no biggie or a bit like 'when you have time'… who has time?? • There should be a pamphlet given to all new mothers to take home with them in the child's red medical book. • *beyondblue*'s resources and the raisingchildren.net website are both excellent sources of information. • More mental health promotional material containing local services available in the bounty bag or during antenatal visits.
Antenatal check-ups/ appointments with a mental health professional	2	• Mums are to be seen by numerous different specialists during their pregnancy. Why not add an appointment with a counsellor or psychologist to discuss issues or concerns and provide referrals if needed. • Dedicated midwives who specialise in mental health who could monitor pregnant women. Often the mother doesn't realise she has a problem until it is very serious.
Reduce stigma	2	• There is still a lot of stigma attached to PND and mental health issues. A lot of work needs to be done to remove the stigma and encourage those who need help to seek it and for them to be able to do it unashamedly. • They talked about it at our prenatal class at the Mater, but the nurse and participants made fun of the symptoms of PND that were in our book with statements like 'Better get to Belmont – ha ha'. This made out like PND is something that happens to others, to crazy people. How about normalising anxiety after birth and encouraging assistance like you would for breastfeeding? Funny, sooooo much info on breastfeeding and how serious it is, but not mental health.
Dads	1	• An urgent need to provide antenatal and early parenting services to new and expectant fathers such as www.mrdad.com.au (run by male midwives and male social workers).

IN HOSPITAL		
Longer time in hospital post-birth	4	• Extended time in hospital following delivery. • Hospital stays are too short. • The pressure on midwifery services sees some mothers leaving hospital on day 1 or 2 after delivery. The opportunity for any education during this time is very limited. • Increase initial length of postnatal inpatient stay to at least day 3.
More information and assessment during hospital stay	2	• More information and assessment needed during hospital stays. Allied health needed to assess home and systems environment for support – not on referral-only basis – ALL parents assessed in hospital • Specialist nurses in the maternity wards so new mothers are given information immediately.
Post-birth check-up by mental health practitioner	1	• In hospital visits from mental health practitioners post labour.
Post-birth visits in hospital by child health nurse	1	• Child Health Nurses, not midwives… should... make hospital visits to make contact with as many as possible new parents before discharge from hospital, and all high risk mothers get visited by CHILD HEALTH NURSES not midwives for extended family support program prior to discharge from hospital.
POST HOSPITAL – BIRTH TO 6 WEEKS		
Re-fund/expand public community perinatal mental health services	11	• Refund strategies that support public mental health services to provide early intervention, assessment and brief intervention for perinatal women… Metro South… supported GPS who are primarily managing these women… since the funding ended in July 2013 there is a major gap in perinatal women in Metro South being able to access services. • Reinstate the perinatal mental health clinical nurse consultant positions that were defunded on 30/06/13. Pick the best of the models of perinatal mental health service delivery that were established in that funded period 2010-2013, and orientate all funded HHS to model of care. Services should be similar across the state. • PNMH CNC in Caboolture is sometimes overwhelmed with referrals – consider extra staffing in areas with higher clinical complexity and/or higher numbers of referrals to address demographic need. • Stronger links between mental health services and perinatal health services. Ongoing collaboration between these two key stakeholders. There should be dedicated positions, potentially perinatal mental health to close this gap. • Currently the local Health Service has no Perinatal Mental Health Service. During the Perinatal Depression Initiative it was identified that this area was under-resourced and in need for at the very least a consultation liaison position to improve services (Mackay). • More staff to existing services including a full multidisciplinary team of health professionals. • Perinatal mental health nurse to target at-risk mothers and high risk families. • Reinstate the perinatal mental health CNC position at the Cairns base hospital. • We have previously been able to refer parents to a mental health service which is able to screen mental health issues and provide appropriate referrals. Mental health issues and maternal health in the new mother need time to explore fully to enable the appropriate referrals. GP's are not able to spend the necessary time and can feel like parents are

		offered an ad hoc service where appropriate service is not provided. Early identification and appropriate treatment is vital to positive outcomes for mother's and the infant. The long term effects for infants cannot be dismissed. The perinatal mental health service which was provided by nurses with mental health qualification was valuable and has been sorely missed by parents. In addition the service was helpful for GP's to access and receive appropriate treatment plans. • There needs to be greater access to support services - Child Health services are doing what they can - there needs to be more community care teams with perinatal and infant mental health workers who work in conjunction with child and family health services to close the gaps in service delivery. • Very practical & mobile assessment & treatment was provided very well by perinatal mental health services to southside of Brisbane by the perinatal mental health nurses based at PAH & Mater. They saw & provided early intervention for depressed mums in local community Child Health Centre.
Link mother in with a mother's group	7	• I am aware that in other states after having a baby you get linked in with a mothers group in your local area… I did not have this in Queensland. • New baby groups. • Promote mother and baby groups at child health clinics. Fund the child health nurse to promote classes on motherhood etc. • Play groups are important for socialisation of families but mothers can be very good at hiding how they are actually feeling about their infants. • Community support groups. • Support attendance to perinatal support groups. • Provide access to … support groups for pregnant and new mums.
Home visits (professional unspecified)	6	• More home visits and education at home where possible. • Having a child health nurse or mental health check up BEFORE the six week check. I had been through the private system and although I was under care of an obstetric psychiatrist, I needed someone to visit me at home in those first couple of weeks. The private hospital sent me the bill and a letter with the number for community child health – I was chewed up and spat out. • Increase in in-home support for parents at risk, and daily/twice daily home visiting for first 10-14 days similar to Health Visitor in UK. • More home visiting services should be provided to families and infants where there is a high risk of ongoing mental health issues. • Services should not be static. The mums/bubs who need the most help will have the least ability to make it into hospital outpatients/community clinic. • Provide access to specialist counselling services … for pregnant and new mums, especially services that provide home visits. First time mums struggle to adjust to the demands of being a new mum and home visit counselling will enable mums to receive counselling in their home.

Continuity of care	5	• A woman's experience with the Acute Mental Health Team is disjointed, they are not managed by a single worker but seen by different members of the mental health team on each occasion or episode. They are managed in increasingly shorter periods of time meaning they are more likely to relapse without support or liaison with community services or GPs. • Mothers respond well to a professional Child Health Nurse who has a relationship to work in partnership with the family. • Continuity of carer. • I had 6 different home visit midwives, none of them did anything about my (in hindsight quite blatant) signs of severe PND as it gradually escalated. • To enhance perinatal wellbeing and prevent perinatal depression, one strategy is to improve women's access to continuity of midwifery care, consistent with the national Maternity Services Plan (2010-2015) which all States and Territories committed to implementing. Continuity of midwifery care models are associated with enhanced physical and emotional health outcomes for mothers and babies, yet only a very small proportion of Qld women can access continuity of midwifery care.
Child Health in general	5	• Child Health Services are disjointed across Queensland with varying qualifications (or lack of them in some cases) depending on the value placed on the service by local areas. Child Health is one service that needs to consistently remain a state-wide service with local input from the HHS. We can do a lot better for mothers and families in Queensland. • Need to strengthen both Maternity Services and Child Health services to enable early detection and early intervention. • Increase Child Health services. • More Child Health nurses. • I believe Child Health Services should be recognised (with both funding resource and with model of care enhancement) as the best placed to provide infant and perinatal mental health support to families on a continuum of wellness and within communities rather than isolating from "normal services and pathways" for families with infants. Staff (particularly nursing staff) dealing with newborn infants and their families need to be skilled with normal infant development, parent child interaction as well as mental health, to isolate between these two services do both the universal and targeted mental health populations a disservice. Imbedding any infant/perinatal enhancements within currently existing pathways and services allows for a strengths based service which provides services to families as needed within a collaborative multidisplinary team without moving families between services so that they receive conflicting and disjointed information. The resources could be so effectively managed by prioritizing child health to manage the health care of these families by a whole team of specialist clinicians from a variety of disciplines.
More community perinatal mental health services (emphasis on NGO supports/ services)	4	• More… community help. • Increase in perinatal mental health services. • Sustain funding and increase services where they are making a difference. Not putting new services in, reviewing the services already in place and improving and supporting them to support the community. • More funding for NGOs that offer perinatal support – more programs generated through NGOs.

		• I think a number of services exist, it is about raising their profile and increasing links and referral pathways between health professionals and the existing services. We also need to look at ways that these services can remain viable and meet the need that exists.
Follow-up (general)	3	• Follow-up of mothers after leaving hospital – particularly those with a history of mental illness • Compulsory doctor/midwife check at 1 and 4 weeks post partum. • Child Health Services used to be able to support these mothers (leaving hospital early) but with services decreasing for "normal" families and focusing on high risk families early intervention to pick up any "normal" mothers who are having difficulties with their interactions with their babies is limited to non-existent. • Provide access to specialist counselling services for pregnant and new mums.
Home visits by child health nurse	3	• The child health nurse role in the community is working well. They are able to make home visits and refer the client on to other services. This is an excellent service for mothers and babies in Queensland. • Child Health Nurses, not midwives should visit new mothers at home for the first few weeks. • Hospital in the home extension services (should) be abolished. Child Health Home Visiting services to replace these abolished hospital home visiting services so ongoing and early intervention can be improved by a consistent ongoing service. Home visiting services need to be once a week until the infant is 6 weeks old, longer for premature and multiple births.
Home visits by midwife	2	• 3-5 in-home midwife visits post hospital discharge. • More discussion of perinatal mental health issues during midwife visits.
Home visits by nurse (focussed on mother)	1	• I am aware that in other states after having a baby you get… a home visit from a nurse. I did not have this in Queensland.
Home visits by allied health professionals	1	• Allied health visits to homes after birth – government and NGO – not based on need/referral.
Home visits by mental health nurses	1	• You need a mental health nurse to visit every new mother in the first month and then at the third month (or similar time frames). Midwives just DO NOT cut it. Either they know something's not right and do nothing about it, or they're not sure what to do or they think it's no big deal or they are scared to raise the PND flag, or maybe it's just not a priority – they are after all there for the child not the mother. (Midwives) would ask me the PND questions, I would give them textbook (again in hindsight) PND responses, and they did nothing but counsel me on breastfeeding and anger management.
Lactation consultants	2	• More staff to existing services… including a Lactation consultant. There is a strong link between difficulties breastfeeding and postnatal depression so access to breastfeeding counsellors and lactations counsellors may assist new mums from feeling a failure and progressing into depression. • Lactation consultants are a great support for breastfeeding issues but as far as a holistic and ongoing approach for families they are limited.
Clinics	3	• Baby clinics to have info and check up on mother's health. • More programs run through child health clinics e.g. "Experiences of Motherhood" groups run more extensively. • Visits to the child health services needs to be when the mother requires the services not dictated to mothers by

		timeframes. Widen Child Health Services to give “normal families” opportunities for educational and emotional support facilitating early intervention. Child Health chemist services do not have the ability to support families as there is limited to no space to confidentially share important information, it is in an open shop with customers.
Drop-in clinics	2	• Drop-in clinics for first 3 months and then encouraged to make scheduled appointments in clinics. • More services from child health, primary care programs, such as drop in child health clinics.
Support attachment relationship	3	• Enhancing the early attachment will help reduce the risk of ongoing mental health issues for the infant and the costs of mental health on the community. • Focus on the infant more, too much for adults. • Contract out to specialist clinical psychologists who know what they are doing with this population; the child and youth mental health services have sadly deliberately avoided and minimised this area and are incredibly poorly skilled.
Integration/ co-ordination of services	2	• Better integration and communication between hospital and community services which may mean increasing expenditure in this area. • Better integration; knowledge sharing, collaboration between universal and targeted services.
Private hospitals	2	• I was with a private obstetrician and she was not interested when I spoke to her about not travelling mentally well. In the Wesley where I had my baby I didn’t fill out a Dms questionnaire. I think more work needs to be done with private hospitals. • Women who are having their maternity needs met through the private sector do not routinely have EPDS for assessment for antenatal depression or anxiety (no universal screening). These women then miss referral or support to prevent or manage PND.
GP check on mother’s mental health	2	• GPs to specifically check up. • Encourage GPs to make it (PMH) an important part of antenatal and postnatal checks.
Phone support service	1	• First and foremost you need a phone service that is well known to husbands/partners, so that when they sense something is not right (as they are likely to be the first to do so) and they are reaching out they can call and an expert perinatal mental health doctor or nurse will come out to the mother’s home… currently…calling 000 or 13HEALTH who will tell him that he needs to get that mother to hospital immediately or they will send an ambulance out…. If you had such a service I am certain detection would increase and more women would be helped.
Provide information and discussion	1	• Discussion and information that normalises mental health difficulties for expectant and new mothers and their families, rationalise why this occurs as routine part of antenatal and postnatal care.
Education for family and supporting friends	1	• It’s improving, but not certain how well the contact details for support are marketed. Having had PND I was the least able to help myself and only the contact made on my behalf by a mental health nurse made all the difference. Should we target family and supporting friends more??
Expand Ellen Barron Family Centre program	1	• Expand Ellen Barron Family Centre program to other areas of Qld.
Central assessment	1	• Central assessment e.g. Family Support Gateway and Referral Service as in WA, NSW, Tasmania.

Importance of cultural safety	1	• Build in cultural safety. If you're employing whitefellas you'll need blackfellas too.
EARLY TREATMENT (ACROSS ANTENATAL AND EARLY POSTNATAL PERIOD)		
Screening	7	• What is needed, though, is better screening. • Greater screening of attachment, perinatal mental health and infant mental health and referral pathways needs to be enhanced to address the families who currently slip through the gaps and then do not receive treatment. • Support and assessment throughout pregnancy for e.g. predisposition of mental illness. Support (mental and physical) needs to be continuous and consistent, visible and accessible, from pregnancy through to 3 years. • Screening is generic and is a matter of process not with the purpose of taking action or providing service. • Screening tests for anxiety and depression prior to birth and post birth. Screening to be done through obstetrician at 6 week check up, and during vaccination – opportunity to screen mother again at 4 month and 6 month vaccinations. • Universal screening is needed via child health nurses and midwives. • Incorporate screening procedures in prenatal period.
Referral pathways	6	• Greater… referral pathways needs to be enhanced to address the families who currently slip through the gaps and then do not receive treatment. • A more co-ordinated approach between care providers. • Stronger links between mental health services and perinatal health services. Ongoing collaboration between these two key stakeholders. There should be dedicated positions, potentially perinatal mental health to close this gap. • There are currently enormous gaps which need bridging eg. referral options in emergency situations. • To develop a co-ordinated approach between public mental health services and community health services. There is a lack of sharing of information between services working with mothers and families. Liaison between services needs to be implements. • An integrated service approach.
Specific early treatment clinics	2	• Speak to the White Cloud Foundation. They are setting up access to early treatment clinics for new and expecting mothers. I believe this is designed to be preventative rather than reactive. They are providing these free to the general public and are partnering with academic institutions throughout Australia. • Optional preventative services for women with prior cases of PND.
Inpatient perinatal mental health beds	7	• More support services needed for parents with newborns such as facilities like the Post Natal Disorder Unit at Belmont. • More inpatient beds. • The discussion paper appropriately identifies that there are no existing mother-baby units available for specialised care outside of the private hospital Belmont. More beds are needed, particularly for individuals who do not have private health insurance. Even for individuals with private health insurance the cost is high (at Belmont). While care is provided to the mother free of charge (depending on health cover), the baby is not covered and costs $70 per night. I personally know many women who cannot afford this rate.

		• More mother-baby units, for PND sufferers to get hands-on help (like Belmont Private Hospital Post Natal Ward). • Infants should at all costs be able to remain with their mothers who require inpatient stays to deal with their mental health. I think that women who need to be separated from their infants experience as very high level of guilt and feelings of failure as a parent that deters from their recovery. This way the attachment could be fostered in mother-infant wards while the mother recovers from an acute episode. • More mother and baby public inpatient mental health services. • New mums with severe depression are often turned away EVEN WHEN THERE ARE BEDS, because they are labelled as attention seekers. Staff deliberately hid it from me that there was a mum and bub bed at PCH - even when it was available! When I found out, just after my daughter became too old, I confronted staff and was told they deliberately hid it from me because according to them my depression was pre existing and therefore not "postnatal" and therefore I couldn't access any services for "postnatal depression". It didn't matter that being separated from my baby made me more depressed, they didn't care.
Day Programs	1	• A day program was trialled which incorporated adult mental health, infant mental health and child health services - although this program is resource intensive - I think if there was long term evaluation it would show that this is both cost effective and cost efficient and keep the parent at home with their baby rather than using lengthy hospital admissions.
Telehealth	3	• White Cloud… are offering the services face to face as well as e-health (tele/video conference) for rural locations. • Accessibility in rural/remote areas - telehealth??? • Telehealth link up services with clinicians who can provide individual and group support to mothers. Our funding does not cover a lot of service delivery in this area.
Public-private partnerships	1	• Gaps in early intervention could be bridged through private-public partnerships.
Affordable treatment	1	• Making mental health a Medicare priority so that seeing a psychiatrist is much less expensive.
CALD services	1	• Big gap in CALD services for perinatal mental health e.g. how do you identify culturally appropriate service, language barriers.
ANFPP		• Cairns has the ANFPP which is a targeted intervention for Aboriginal and Torres Strait Islander mothers - it is enabling Mums to be well and supported in maintaining their health AND keeping Mum and Bub together if challenges arise.
General	2	• Care for the mothers and support them unconditionally. Recognise the neurobiology of stress and how the resulting mental health issues impact intergenerationally. • More support for families when things do go wrong.

3. WORKFORCE DEVELOPMENT

WORKFORCE		
Training and support for GPs	11	• We provided specialist assessment, and advice around management – many GPs are poorly informed about issues such as risks and benefits of antidepressant use. • More training for local GP doctors to refer patients to psychologists/ psychiatrists instead of just handing out antidepressants without proper investigation into the issues the patient presents with. • Of course there's the GP but they only do so much (mine just said 'give up breast feeding, take these drugs and you'll feel better in a few weeks') – a new mum needs support NOW once she has realised there is a problem. • Many women get their information now via the web and/or GP. Having more info in these places may reach more women and families. • This (greater screening and referral) could occur through professional development to GPs and other primary health services. • Further education of nurses and doctors. • Educate GPs and midwives. Have Medicare Locals play a role in supporting evidence-based services. • Enhancing midwivery services and general practice and child health through education and support and liaison to deliver quality information re perinatal mental health and to be aware of pathways for management of women who need specialist psychiatric review. • In-service training in making appropriate referrals and the range of services available to frontline workers such as GPs. • Better education for GPs (detection is very poor). • Many new mothers rely on their GP who does not have the time or expertise to discuss how a mother is feeling or coping, they do not support new mothers well.
Training and support for other primary health providers (apart from GPs)	11	• This (greater screening and referral) could occur through professional development to GPs and other primary health services. • Further education of nurses and doctors. • Mental health trained midwives. • Educate GPs and midwives. • Enhancing midwivery services and general practice and child health through education and support and liaison to deliver quality information re perinatal mental health and to be aware of pathways for management of women who need specialist psychiatric review. • Awareness of mental illness, symptoms and support in the Mackay and districts health service are very poor. • In-service training in making appropriate referrals and the range of services available to frontline workers such as GPs, child health nurses, midwives, child care workers, helpline workers (eg. Lifeline, Parentline, Suicide Call Bank Service,

		etc). • Improved training and education for Child Health Nurses and Maternity Services. • Education for Child Health Nurses. • More support for Child Health Nurses when things do go wrong. • Informative upskilling of a practical nature to staff most likely to come in contact with especially 1st time pregnant women. E.g. Social/emotional determinants: not just about physical pregnancy but the whole interactive model - loss of single girl status to motherhood - transition, extended family expectations et al. (as in "The Motherhood Constellation" by Prof. Daniel Stern).
Staffing in rural mental health facilities	3	• Increase number of staff in rural mental health facilities. • Supporting remote services like NWHHS to have psychologists/ social workers as part of Child Health teams to pick up the mums who develop PND/anxiety or general attachment issues. Negotiate with mental health to have someone focussed on perinatal mental health. Support any NGO/Medicare Local staff by providing training and peer support for the work they are doing. • Service providers in all but particularly in rural areas.
Sustaining the workforce	1	• Sustaining the workforce.
Training at tertiary education level	1	• Incorporate more knowledge and awareness in midwifery and obstetrics and paediatrics about PIMH issues into tertiary education.

4. RESEARCH AND EVALUATION

RESEARCH AND DATA COLLECTION		
Collate prevalence data	1	GPs or midwives and obstetricians to provide stats on instances of anxiety and depression.

APPENDIX 3: QUESTION 5 RESPONSES – IMPROVING SERVICES AND SUPPORTS FOR ABORIGINAL AND TORRES STRAIT ISLANDERS AND FAMILIES FROM CULTURALLY AND LINGUISTICALLY DIVERSE BACKGROUNDS

Topic	Count	Text
SERVICES THAT RESPECT WOMEN'S CULTURAL VALUES AND PRACTICES		
Composition of workforce	14	• ATSI and CALD staff on-call if required. • Funding for culturally appropriate perinatal and infant mental health staff in primary health care services. • It is essential that health professionals be the most qualified to meet the needs of Aboriginal and Torres Strait Islander families – services should partner with Indigenous specific organisations and not provide funds for the non govt orgs to provide services. • ATSI midwives. • Increase cultural diversity in midwifery and child health teams. • More community care teams with identified positions available – teams need to work with child & family health services in these specified areas. • Involve ATSI workers with families. • Having dedicated ATSI positions to work alongside clinicians. • ATSI require an Indigenous Health Worker to work alongside the Nurse. Check the data readily available from HBCIS: what per cent of births at this HHS are by Indigenous mums? If it's 10 per cent of mums, 10 per cent of employment funding should be for IHW support. The regions will have a higher per cent than the south east corner - be prepared for >30 per cent. • Support more Aboriginal Liaison positions in hospitals and communities – provide them with high quality training to see and work with the mums/dads and infants. • The need for more Indigenous child and maternal health workers working as part of the multidisciplinary team should be a priority for government and NGO. Collaboration is the key there seems to be silo approaches which results in duplication..... • Include an A&TSI liaison service. • AA with qualified male ATSI healthcare workers involved. • Child Health services should have specific workers funded to address perinatal and infant issues and that can offer leadership from grass roots as well as add broader perspective to well established parenting programs.

Workforce Education and Support	11	• Culturally aware health staff – targeted training. • Further education for the workers!!! • CALD communities need a skilled worker in using an interpreter, an understanding of the cultural norms of client and their individual journey through immigration or being a refugee. • Education and upskilling Workers in these communities to provide support and management and provision of supervision and secondary consultation if required. • Appropriately trained people. • Increased education on culturally and linguistically diverse birthing practices to support these families better. • There are currently ATSI support workers in the Mackay area who work with mums & bubs however the mental health aspect of their care requires education & support. • More trained staff in rural areas. • Pairing clinicians with health workers from relevant cultures – indigenous, health workers, refugees workers, specific cultural needs workers – to work to gather to support each other clinically and culturally. • Provide better on the ground training for non-indigenous health professionals (not the desk type cultural training that is trotted out now). • Educate indigenous health workers.
Specific services and strategies for Aboriginal and Torres Strait Islander families	6	• Are they (services) backed by evidence? Are they proven to be effective? That would point directly to a STATE roll-out of ANFPP - it addresses ALL of the domains mentioned in the report - health, education, child safety, crime, drug and alcohol misuse, and future parenting. Also: its targeted at young families; screens at multiple time points for perinatal maternal mental health issues; father inclusive; is focused on prevention and early detection; is culturally acceptable; AND IT WORKS! • Birthing on country. • Support Birth on Country, where women can birth consistent with their cultural values, and close to their support networks/families. • Diversity of service provision should be incorporated. Individual therapy does not necessarily work with ATSI clients, involving mother, aunts, sisters, grandmother to support women with perinatal mood disorder is essential. The concepts of "healing your dreaming" should be included. Mental Health in ATSI clients cannot be successful with just white solutions. • The primary health care sector does well in relation to antenatal visits for Aboriginal and Torres Strait Islander people – this is however to address infant mortality. However I don't believe the PHC both Indigenous and non-Indigenous sector does perinatal and infant mental health well if at all. There are not Indigenous specific postnatal services and the need for more Indigenous child and maternal health workers working as part of the multidisciplinary team should be a priority for government and NGO. Collaboration is the key there seems to be silo approaches which results in duplication..... • Indigenous support for young first time pregnant females in Napranum and Mapoon. Generally there is a midwife who is

		well qualified and expected to multi-task. Apunipima may have a model in this area but I am uncertain. Families need to have trust in the person/s delivering any such programme - that takes time and consistency from staff who generally tolerate 3 years of fly in fly out or less if they are expected to live and work remote. A difficulty not easily overcome. Training in local interested staff may be another option but it needs to be done with sensitivity and with cultural advice.
Specific services and strategies for families from culturally and linguistically diverse backgrounds	5	• Support via transcultural mental health who MUST become less constrained by their dopey intake (well, anti-intake) process. • Similar issues [as for services for ATSI families] but complicated by the smaller numbers of a more diverse group. • Increased education on culturally and linguistically diverse birthing practices to support these families better. • Offer public continuity of midwifery care programs for all women, particularly vulnerable groups, such as women from a CALD background. • I am aware of the RESPECT program that is run by Communify in Brisbane that may be a program that can be replicated for working with women from culturally and linguistically diverse backgrounds in other areas.
Promotion and Prevention	4	• This is challenging as there will be cultural differences and mums from these cultures may not even think PND is a medical condition. • The language used to describe mental health issues and provide education needs to be changed to be more accessible and understandable for Indigenous communities. • Use of resources that reflect all cultures as well as their own, to reflect that this potentially happens to everyone. • Making mental health services more visible in the community, better advertising, not in the GP clinic or community health centres they do not go there in the first place.
Overall Philosophy	4	• Understanding their cultural needs. • Ensure that services are culturally relevant. • Increase unconditional support and set in place achievable culturally safe aims & goals. • Respecting women's business practices where appropriate.
Collaboration with community representatives	4	• Need to engage with the communities and work with the elders in these specified communities to set up culturally appropriate systems for early identification and support within the community. • Maybe involving more NGO that have previous experience with this in their communities could lead the way in informing and helping families, with government $$. • Have consultants from CALD and ATSI on service development proposals. • Having a respected cultural advisor – respecting women's business practices where appropriate.
Reducing fear and stigma	2	• Remove the stigma associated with mental health. Remove the fear associated with seeking help means your baby will get taken off you. • I think the words "Mental Health" immediately put people on their guard or create concern around "madness" and not being mentally well. I'm not sure what words we use, but it needs to be presented as something different. Perhaps child

		care or motherhood support, but get young mothers together to create connected support with and overlay of skilled workers able to ask the right questions or observe the group to determine who needs more support. Seeking help seems to indicate failure at a time when there is so much expectation that is all happens naturally.
ORGANISATION AND PROVISION OF SERVICES		
Closer to home (including service provision in rural areas)	9	• Better health services within own communities so ATSI do not have to leave kin. • Birthing on country. • Support Birth on Country, where women can birth consistent with their cultural values, and close to their support networks/families. • Having specialist CALD and Aboriginal and Torres Islander outreach workers within perinatal teams. • Greater range of community outreach models targeting specific communities. • Culturally appropriate day programs could support these families in their community of origin. • Community outreach models targeting specific communities. • Having baby and mother check-up vans visit communities that have large populations with culturally diverse backgrounds. • Recommend perinatal mental health mobile service that was provided to both hospital, community centres & GP information and support.
Clear roles for private, public and NGO providers	8	• Gatekeeper training of community Elders and leaders in identifying and referring women with mental health issues in the perinatal period. • It is essential that health professionals be the most qualified to meet the needs of Aboriginal and Torres Strait Islander families – services should partner with Indigenous specific organisations and not provide funds for the non govt orgs to provide services. • A lot of drop in clinics and support groups have been set up but A&TSI families are not accessing these. Some Aboriginal medical centres do not support or run these services. • Have people from these communities specifically educate and consult with mothers throughout pregnancy and postnatally.
Involving peers, families and peer support workers	3	• Get young mothers together to create connected support with and overlay of skilled workers able to ask the right questions or observe the group to determine who needs more support. Seeking help seems to indicate failure at a time when there is so much expectation that is all happens. • I think many studies have shown that peer counselling can be very helpful. • Individual therapy does not necessarily work with ATSI clients, involving mother, aunts, sisters, grandmother to support women with perinatal mood disorder is essential.
Need for research	2	• I also think that there is a lack of research in the area in Australia so I think that developing an Australian owned evidence base will enhance service delivery for people from diverse communities.

		• Generate data to identify the burden of stress so it can be adequately funded & recognised for immediate action.
COMMUNICATION BETWEEN FAMILIES AND HEALTHCARE PROVIDERS		
Accessible written and verbal communication	7	• Greater range of translated information targeting specific communities. • Provide translated written information on perinatal mental health. • Making resources more readily available. Hard copy resources more pictorial and less wordy. • Changing language use to assure understanding e.g. no complex metalevel language. • Translation of universal screening tools into a range of languages. • The language used to describe mental health issues and provide education needs to be changed to be more accessible and understandable for Indigenous communities.
Bilingual health workers and/or interpreters	6	• We may need to ensure access to interpreters are available to the NGO/community sector as well. • Provide 24 hr interpreter service. • Access to assistance from a visiting health worker who speaks the language of the client. • More education needs to be done with interpreters to enable them to better understand the impact of mental health on the infant and parents. • CALD communities need a skilled worker in using an interpreter. • Having a dedicated service with ready access to interpreters and not using family members for this purpose.
OTHER ISSUES		
More funding for services (including allocation of funding)	10	• I think the health services and NGOs provide good services to the CALD, refugee and ATSI communities but the limits of funding in the area limits the number of people who can receive support. • The discussion paper has been a step in the right direction, but to continue momentum there needs to be an investment of funds to see what models work and allow them to evolve to find the best model of care for each population group. • Provide funding to public mental health services so they can provide specialised perinatal services by experienced nurses. • Nurse Practitioners and as needed psychiatrists so primary care staff and hospital midwives can access specialist support in providing optimal mental health care to these women. • Get serious about the services offered. • Service provision of these services. Currently there is no service provider in Central Queensland for this service. Accommodation is not good in communities also having more vehicles for existing health workers on the ground to be able to do their job properly. • Funding for culturally appropriate perinatal and infant mental health staff in primary health care services. • More funding needs to be provided to transcultural mental health services. • Make mental health services more widely available.

		• Child Health services should have specific workers funded to address perinatal and infant issues and that can offer leadership from grass roots as well as add broader perspective to well established parenting programs. • The QCPIMH funding should be reallocated to child health services (including ATSI specific services) to allow for these supports to be provided in a culturally specific and supportive way. • Check the data readily available from HBCIS: what per cent of births at this HHS are by Indigenous mums? If it's 10 per cent of mums, 10 per cent of employment funding should be for IHW support. The regions will have a higher per cent than the south east corner - be prepared for >30 per cent.
Screening	5	• Have a child health nurse or mental health check up BEFORE the six week check. • Mental health checks to be done for all mothers throughout the first 12 months? Linked to Centrelink, so that people are forced to get check ups in order to claim benefits? • Tailor targeted resources e.g. perinatal social and emotional well-being screening by Statewide maternity and neonatal clinical network for indigenous peoples. • Translation of universal screening tools into a range of languages. • Screening currently does not trigger a response, ability to respond, refer, risk assess and act is lacking.
Modification and delivery of existing services	3	• There is an array of information available to these groups however I think a lot of its uptake and effectiveness comes down to its delivery. • Mapping of existing services needs to be completed with more vigour. Many of the organisations presently offering services could with some moderate training have programs amended/tweaked to offer and incorporate interventions that will enhance perinatal and infant work. • Find a model that is efficient, effective and gets major bang for the patient's buck (excuse the term) and customise it for Aboriginal and Torres Strait Islander communities and perinatal women from culturally and linguistically diverse background and their families. Flexibility and a willingness to change models of care rather then belligerently bulldozing ahead with models that are not specific to these groups. What works for one group won't always work for another however customising and developing existing models to address these other groups is a step in the right direction to finding what model will work best for them.
Training and support for primary health care workers (including GPs)	2	• To incorporate skills & knowledge in workforce to enable recognition of issues in infant mental health & capacity to provide appropriate information, intervention and referral early. • GPs providing care for infants should be more attuned to the mother's wellbeing.
Length of Hospital stay	1	• Perhaps stop kicking people out of hospital so early! Everyone knows breast feeding isn't established until milk comes in which is day 4 - ironically same day as baby blues! More support is needed around this.
Rural	1	• More trained staff in rural areas.
General	1	• I don't believe the PHC both indigenous and non-indigenous sector does perinatal and infant mental health well if at all.

APPENDIX 4: QUESTION 7 RESPONSES – SPECIFIC GROUPS WITH HIGHER NEEDS FOR PIMH SERVICES

Topic	Count	Text
ALL PREGNANT WOMEN AND MOTHERS NEED SUPPORT		
Overall	7	• I think all ethnic groups need more awareness! It's not about ethnicity, it's about being a mother! • YES! Normal, JOE BLOW Australians! Stop being so caught up in the politically correct business of ticking boxes for this subgroup and that subgroup. Just make the services 'solid' for all. • All new mothers are vulnerable. • I think the general population of mothers need to be better prepared, better informed and provided for. Additionally GPs providing care for infants should be more attuned to the mother's well-being. • Pretty much every family, regardless of group. • "Normal" families are slipping through the services as they are seen to be OK but can without appropriate support and education can become a high needs family through mental health issues that they or their families may not pick up in a timely manner and there is damage done to the infant attachment with ongoing issues. • Women from all socioeconomic and cultural backgrounds.
DEMOGRAPHIC FACTORS		
Young parents	13	• Parents under 25yrs. • Young, economically disadvantaged women would benefit from continuity of midwifery care as well, because contemporary professional midwives work from a social model of health, and are able to develop trusting relationships with their clients during pregnancy, birth and postnatally. • I think there is a lack of services available for young parents in the community. Once again the services that do the work are doing it well but young parents need more support for their particular developmental age. • Under 25s difficulties with engagement and retention in mental health services. Links with existing services such as Headspace and midwifery and child health services delivering services to this group. • Young parents. • Young mums - specialist services. • Young women (under 21). • In Caboolture there are large numbers of teenage mothers - they are difficult to engage - consider drop-in style access to PNMH services in this area.

		• Pregnant women under the age of 18. • Young mums aged 18-25. They are just dismissed as attention seeking and "not really depressed" and abused badly by services. • Young women's services e.g. MICAH, Brisbane Youth Service, Othilithas (Stones Corner group). • Indigenous support for young first time pregnant females in Napranum and Mapoon. Generally there is a midwife who is well qualified and expected to multi-task. Apunipima may have a model in this area but I am uncertain. Families need to have trust in the person/s delivering any such programme - that takes time and consistency from staff who generally tolerate 3 years of fly in fly out or less if they are expected to live and work remote. A difficulty not easily overcome. Training local interested staff may be another option but it needs to be done with sensitivity and with cultural advice. • Young mothers under 20 years old.
Women living in rural/remote areas	5	• Women living in rural, regional and remote Queensland often don't have their needs met in this area. • Rural/remote: We've seen a large increase in rural suicides by farmers. The wife/mother is considered the backbone of the family and is the mainstay for when the husband/farmer starts getting wobbly. Greater support needs to be available for these women to reduce their risk of suffering. When their world gets wobbly, the whole family dynamic breaks on the farm and the fall is usually highly significant. Consider an early intervention e-health clinic to enable access to a multi-disciplinary team, such as the White Cloud Foundation model, to enable these Mothers to access a holistic range of support in an efficient and effective time frame. These females don't have time to attend multiple appointments over multiple days in a far off city and hence could greatly benefit from seeing 4 allied health disciplines in the one setting via Skype/facetime/telephone to get the strategies and support they require to function for their family. • We have a large group of middle class families who do not qualify as the at-risk group e.g. CALD or A&TSI. We are rural so this added to limited social and family supports increases the risk of this middle class group with Perinatal and Infant Mental Health concerns. • Women who are part of fly-in fly-out families face unique needs as well. • My region has a large population of mine workers. Often they are quite isolated from family. Mothers and babies are often left alone for days to weeks at a time when the husband/partner goes out to the mine to work.
Refugees	4	• Refugee & asylum seeker groups - mental health NGO services in this area start from age 5 and there is less focus on perinatal mental health. These groups are also less likely to refer to public mental health services. • Refugee clinic at Mater - could perinatal mental health services run mobile clinics run by (perinatal health nurses) to get quick, early mental health assessment and intervention to assist these mothers both A/N and postnatally? • The refugee community are particularly vulnerable as they are often dealing with previous torture or trauma that impact on their mental health. Services need to be able to respond to both this previous trauma as well as an new mental health issues associated with the perinatal period. • Refugee / CALD / trauma.

WOMEN EXPERIENCING SOCIAL ISOLATION OR DISADVANTAGE		
Women using drugs and alcohol	6	• ATODS is perceived as place to go to - not a good look for a pregnant woman/new mum. ATODS needs to be accessible at the places where their clients are already: antenatal clinics, community health centres etc. • Alcohol and drug affected parents. • Pregnant women feeling isolated, in violent relationships, homeless, substance. addictions. Identify appropriate agencies & support services Make things happen eg find accommodation, baby sitting, help with transport, access to services. • Drug and alcohol users-have specialist services. • In my experience, mental health problems often coexist with substance abuse. We need a service that can deal with this combined problem rather than bouncing the patient between services as occurs at present. • Drug and alcohol clients have often started taking drugs to self manage their mental health issues. Management of same is quite fragmented.
Women of low socio-economic status	3	• Poor, uneducated, socially alienated women who are not married, and have children to random fathers. These suicides are clustered in outer metropolitan areas, and regional areas of Queensland, where health resources are also most stretched. • Those who use the existing mental health plan via the GP and need more than the prescribed number of visits or who can't afford to go at all. • Women who do not have easy access to transport- fund transport.
Women experiencing domestic violence	2	• Women's Health Queensland Wide is also working with domestic and family violence services to deliver support to women who are pregnant and/ or parenting and living with violence. We believe this is another group with unmet needs. I believe that there are programs that already exist that can support these women, for example the Midwife check-in that Women's Health Queensland Wide provides, what is required is that these programs become sustainable, that their profiles are raised and that better referral pathways are established. I believe we need to ensure an ongoing commitment to prevention and mental health promotion. If we don't do this then we will face ongoing costs as we will need to spend money in the secondary and tertiary treatment arenas. • Pregnant women feeling isolated, in violent relationships, homeless, substance addictions. Identify appropriate agencies & support services. Make things happen e.g. find accommodation, baby sitting, help with transport, access to services.
Women experiencing homeless	2	• Those who are "homeless" - they need their own advocates to support them and help Health Professionals to not judge too rashly how those with a different life experience manage their lives. • Pregnant women feeling isolated, in violent relationships, homeless, substance addictions. Identify appropriate agencies & support services. Make things happen e.g. find accommodation, baby sitting, help with transport, access to services.
Women in prison or detention	1	• Women in prisons - what services do they get?

PERSONAL/FAMILY HISTORY FACTORS		
Parents with an intellectual impairment and/or other disabilities	8	• Those with disabilities - they need their own advocates to support them and help Health Professionals to not judge too rashly how those with a different life experience manage their lives. • Parents who are involved with child protection agencies- such as unborn risks and those parents with disability. • Parents with a disability particularly one involving communication disorders where the parent is unlikely to engage or participate due to unidentified language disorder or resulting literacy difficulties. • Many of the parents that we see have a disability- there is a large population of parents who are deaf/ blind and who have intellectual disability. These vulnerable families have often even less access to service provision- My suggestion would be to work with the government and NGO's to look at how services are provided and look at using a multiagency approach to care. • Women with intellectual disorders. • Mothers with intellectual disability or low IQs. They are vulnerable and often unable to start to prepare their child for learning and school which results in bullying and or failure. • Intellectual impairment / disability sector. • Intellectual Impairment/Disabilities.
Fathers	6	• Men; improvements in support, education, mantherapy, better conversation and co ordination. • Expectant fathers. • I feel that men/new fathers need more support for their mental health and practical advice/ways to monitor and care for their partners mental health as they are usually the ones who will see the changes in them first. • Perinatal mood disorder in the father. Community Development project looking at how father feels once they become a "dad". • Fathers. • Fathers.
Parents in contact with child protection system	3	• Parents who are involved with child protection agencies - such as unborn risks and those parents with disability. • Child safety - 0-3 permanency placement too many of these infants have multiple+++ placements in the first 3 years of life. • Families involved in the child protection system.
Older mothers	1	• I – as a 38 year old, ex-professional with no children or Mumma peers around me – believe antenatal coaching in real life/what to expect with a newborn should be offered.
Infants	1	• Infants – services are focussed on perinatal mental health and lose sight of the infant's individual needs and the complexity involved in ensuring the well-being of an infant.

MEDICAL/HEALTH SYSTEM FACTORS		
Women without private health insurance	5	• Anyone who doesn't have private health insurance and even some who do who aren't covered. There are so many women that need help but it's simply out of reach financially for a lot of them to go to a private facility for treatment. • Mothers who do not have private health insurance. • Those without private health cover. • Those who are not covered by private health. • Those without private health insurance. Others need access to places like Belmont's unit.
Women with private health insurance, birthing with private obstetricians in private hospitals	6	• Women with private health insurance may benefit from continuity with Medicare eligible private midwives credentialled with Hospitals (another priority of the National Maternity Services Plan), because private obstetric care does not necessarily address women's holistic health needs. • Many women who birth with private obstetricians and in private maternity hospitals do not have the same access to screening and referral to support services as women in the public sector so we believe these women are also a group with unmet needs. • Despite the prenatal information session provided by the private hospital at which I gave birth did not provide education on PND (or the baby blues for that matter). Mothers are taught practical tasks about how to care for their babies, but not taught how to identify the signs of mental illness. This is important, particularly for women who have a history of mental illness. • I had been through the private system and although I was under care of an obstetric psychiatrist, I needed someone to visit me at home in those first couple of weeks. The private hospital sent me the bill and a letter with the number for community child health – I was chewed up and spat out. • I was with a private obstetrician and she was not interested when I spoke to her about not travelling mentally well. In the (private hospital) where I had my baby I didn't fill out a DMS questionnaire. I think more work needs to be done with private hospitals. • Women who are having their maternity needs met through the private sector do not routinely have EPDS for assessment for antenatal depression or anxiety (no universal screening). These women then miss referral or support to prevent or manage PND.
Women experiencing "unusual" pregnancy and/or birth	3	• The other group of women that Women's Health Queensland Wide is trying to work with are women who have an unplanned pregnancy. This may increase their risk of depression and anxiety irrespective of whether they choose to continue with the pregnancy or not. • Parents of multiple births, parents of children who were miscarried, aborted or stillborn are all higher risk for developing mental health issues. • Mothers of premature babies.
Women waiting or without access to public services (e.g. temporary residents)	2	• In my case, we were temporary residents of the country and were unable to access some public services due to a lack of Medicare. There was no option available for payment via private coverage.

		• Those who are on wait lists to see a mental health centre.
Women who are reluctant to seek help due to stigma	2	• Middle class women who are ashamed – deal with stigma and support current groups. • Those who are scared to get help due to the stigma surrounding it. All of which puts children at risk or harm.
Women with severe perinatal mental health problems	2	• We need "mum & bub" facilities in mental health wards. • At any one time, for severe mental health issues for mother's there are only 10 beds available through BCPND at Belmont hospital.
Women with mild-moderate anxiety & depression	1	• At the moment it feels very much like 'you are crazy or sane'. So either no treatment or full-on hospital admission. What about the in between group who could do with support to overcome some mild negative feelings or anxiety? I don't feel this group has options they could easily explore.
Women with pre-existing mental illness	1	• Those who use the existing mental health plan via the GP and need more than the prescribed number of visits or who can't afford to go at all.
OTHER ISSUES		
Workforce education and support	1	• I do not believe maternal health workers are educated enough in mental health also they need to do more follow-up.
Ongoing commitment to prevention and mental health promotion	1	• I believe that there are programs that already exist that can support these women, for example the Midwife Check-in that Women's Health Queensland Wide provides, what is required is that these programs become sustainable, that their profiles are raised and that better referral pathways are established. I believe we need to ensure an ongoing commitment to prevention and mental health promotion. If we don't do this then we will face ongoing costs as we will need to spend money in the secondary and tertiary treatment arenas.
Postnatal support	1	• CHN - runs parenting for new parents - these groups often address stress in the perinatal period - this could be formalised and put to better use. Mental Health clinicians have been involved with supporting CHN and community groups such as Pathways to Care & Mission Australia - this needs to be made a sustainable activity as it is a useful forum for early mental health intervention and often a venue women feel comfortable in.

APPENDIX 5: QUESTIONS 9 & 10 RESPONSES – DISCUSSION PAPER CRITIQUE AND FINAL COMMENTS

Topic	Count	Text
POSITIVE RESPONSES TO DISCUSSION PAPER		
	16	• I'd like to extend congratulations to QMHC for putting some focus on this population group. Some hard questions, which are sensitive, are being asked by the right people which will hopefully create greater access, support and funding for mothers. Well done!! • The paper presents the issues in this area well and appears to identify the gaps in current service delivery. • It (the Discussion Paper) was very informative. • Please ensure the paper does not just remain a Discussion Paper. • Succinctly provided case for improvement of services. • It was a very informative paper. • The paper identifies gaps and has proposed solutions that have been implemented in other states. • Proposes a good model but misses a few issues. • Excellent document. • It is a very comprehensive stocktake of the clinical perinatal and infant mental health services across Queensland. The data is mind-blowing and should make any politician wish to invest. • Congratulations QMHC for producing a high quality discussion paper in an area that requires greater focus and attention. From an overall perspective we recognise and agree with the statements made in relation to public and private mental health hospital providers. • This has been well done. • I agree with most of it. • I think the paper has identified the important gaps in the area. • The need for early intervention and prevention is recognised. • The proposed service enhancements would revolutionise the way Queensland families experiencing PMI recovery and receive support, in turn improving short and long term outcomes for the children of these families. The Options Paper has highlighted the extraordinary lack of services currently available in Queensland. Comparatively with other states, Queensland is dramatically behind.
NEGATIVE RESPONSES TO DISCUSSION PAPER		
	2	• I [don't] believe there is any support for this service at a local hospital or government level. • I am appalled that the services that are the most well-resourced already get increased services first. The whole thing is A JOKE!

1. MENTAL HEALTH PROMOTION AND PREVENTION

Topic	Count	Text
PRECONCEPTION/ COMMUNITY AWARENESS		
Prevention in general	9	• Prevention and Early Intervention are key, NOT a crisis-based model (e.g. like child protection). • Please support current evidence-based interventions offered in the community at a primary care level. • Our work with pregnant and parenting women and current research have identified the importance of the following: - the mother-baby bond, enhanced by breast feeding and other parenting skills and - pregnant and parenting women are very receptive to health promotion messages and actions at this life stage. Most women want to do the best they can for their babies. • More strategy around how to stop these women getting to the point that they need to be hospitalised. • (The Discussion Paper recognises) the need for early intervention and prevention. • Research demonstrates that preventative strategies are the best investment of resources. • Not enough emphasis on early intervention. Pregnancy doesn't have to turn into severe depression after birth. Not enough emphasis on reducing the risk, too much on providing services after the event (which is needed, but how about preventing?) • Need to address prevention during pregnancy.
Information in public places	1	• Information on available services is not publicly available.
Termination	1	• Needs to address prevention… around termination of pregnancy.

2. SERVICE DEVELOPMENT AND IMPLEMENTATION

Topic	Count	Text
IN HOSPITAL		
Longer time in hospital post-birth	1	• Am not sure if the service gaps are around policy and priorities or resources. Currently system processes revolving around funding such as early discharge following delivery are not discussed.
POST HOSPITAL – BIRTH TO 6 WEEKS		
Re-fund/expand public community perinatal mental health services	8	• The need for secondary and tertiary services in the public sector in Qld is made clear. • There appears to be an emphasis on infant mental health to the point of poor understanding of the need to provide specialist mental health services to perinatal women which is usually the domain of adult mental health clinicians. This is an area where innovative strategies such as providing nurse specialist positions such as Nurse Practitioners would help fill the gap and are an economically more efficient option than psychiatrists as well as being client friendly. • I cannot see anywhere there has been identification of the major inability of some public health services to sustain

		perinatal mental health. • As a priority, unfortunately Community Care Perinatal Team and Extended Community Care Programs are not proposed for a number of years. • I like the Community Care expansion which is so desperately needed and which, quite honestly, if they are provided by perinatal mental health nurses can be the difference between life and death. • (The Discussion Paper recognises) the need for community-based teams which need to include consumers who have experienced perinatal issues. It reflects this impact on families – mums, dads, siblings. • The paper talks about strengthening community teams which is needed. • Queensland Government needs to refund early intervention and assessment services that perinatal women can access easily as well as their treating GPs. Most of this expertise is within public mental health. The services of the appropriately qualified and experienced clinicians could be contracted out to primary care for example. Why is there such a difference in response to perinatal women in terms of services on the north side of Brisbane where they retained their perinatal mental health nurses as compared to the south side where the service was cut and not replaced with anything?
Infant Mental Health in its own right	7	• Infant needs more focus. • The discussion paper focuses on Perinatal Mental Health with infant mental health, fathers and families appearing to be included for politically correct purposes. Although the evidence shows direct intervention for infant is important (as noted in the paper), the enhancements are purely based on MATERNAL Perinatal concerns - Where is the infant in this? This paper appears to use words rather than actions to enhance the mental health of infants. Infant Mental Health is a field in its own right with many factors impacting the mental health of the baby - perinatal mental health being only 1 factor. Families experience difficulty in the parent-infant relationship that do not necessarily relate to perinatal mental health, including reflective capacity, intergenerational issues, trauma, and social factors. Too many times the baby is lost as it is easier for services to focus on the needs of the mother excluding the needs of the infant (and father and family) as evidenced in this discussion paper. More emphasis needs to be placed on direct specialist interventions for the infant in the context of their complex needs (see areas of omission above) rather than purely focussing on perinatal mental health as the sole factor that with ensure the wellbeing of an infant. I am VERY disappointed that the infant has been excluded to this extent. • Infant mental health is lost to perinatal issues ALL THE TIME, focus is always on perinatal with the infant and/or father being excluded or put into the too-hard basket by people who drive the processMore focus on direct intervention for the infant across a variety of settings, stop only focussing on the mothers. • More focus on direct intervention for the infant across a variety of settings, stop only focussing on the mothers. • When will services focus on the INFANT???? After all this is what the early intervention is about. This paper should be named Perinatal Mental Health only as the baby in this context appears to be a token gesture. • I have previously commented on the paper highlighting my concerns that this paper is purely focussed on PERINATAL mental health intervention to the exclusion of specific targeted INFANT mental health intervention… I think the statement “Your feedback on ways to support good mental health among expectant and new mothers and their families

		is very important to use" highlights my point precisely… EXPECTANT AND NEW MOTHERS????????? WHERE IS THE INFANT??????? The paper has completely lost sight of the infant which is insulting to the baby and professionals working in the field of INFANT mental health. Who is going to give the most vulnerable of all, the baby, a voice – certainly not this paper, the people writing it, or the mental health commission! What a wasted opportunity to support vulnerable infants who yet again are lost to the needs of the adults (or in this case only mothers with perinatal mental health concerns) around them. When will the infant have a right to effective and timely intervention in their own right (and yes I do recognise that intervention occurs in the context of relationship but many factors influence this relationship NOT just perinatal mental health). • Assessment of prep and pre-prep students should give some indication of need or issues that need to be addressed ASAP to prevent ongoing issues in a challenging school environment.
More community perinatal mental health services (emphasis on NGO supports/ services)	2	• This has been done well, however there is a large gap in this work for the early intervention/prevention models that are available from the community (out of public and private hospitals who already have stretched resources and will be unable to address future demand). • Page 9 first paragraph and page 12, first dot point under Section 7.1 both mention improving links across sectors and referral pathways. I think this needs to be strengthened in the document. As the manager of a non-government organisation one of the difficulties we have is in establishing and maintaining links and referral pathways with clinical services. When we meet with health professionals they all agree that our services would be of benefit to their clients but we have to drive this relationship building and consistently follow up to maintain this relationship to ensure support can be provided to women and their families. it is imperative that clinical services take some of this responsibility and begin to drive this relationship maintenance. On page 9 where you discuss what the non-government community sector is currently able to provide, I don't believe this list truly reflects the breadth and depth of services and supports that are available. This sector also undertakes universal mental health promotion activities; we also deliver primary prevention and early intervention support programs for families; we deliver programs that have been demonstrated to improve women's confidence to parent, increases their connectedness to their community, raises their awareness of good mental and emotional health and where to seek help if things aren't going well. There is a lot of research currently that identifies the importance of breast feeding to reduce women's risk of anxiety and depression and also about the life long benefits to the child. Perhaps on pages 11 and 12, promotion of breast feeding could be included as part of the service planning principles.
Child Health in general	2	• I don't believe that there should be extra services set up in addition to child health services – any additional funding should be allocated to adding a tier to service delivery for child health and improving the collaboration between adult and child health services. • What is working well is the role of the child health nurses, who are able to refer mothers to other services. However, this is often reliant on the individual child health nurse. Information on available services is not publicly available.
Midwife in general	1	• What we see missing from a number of service delivery models is the importance that the midwife can bring to these discussions and the development of service models. There is often a close association between parenting issues (crying baby and feeding baby) and mother's emotional and mental health. A midwife can be well placed to work with the

		mother on the issue that is causing her most concern and yet also identify and intervene to improve emotional and mental health and wellbeing. We are aware of a number of service delivery models that include a social worker, a counsellor/ psychologist and a mental health nurse but not a midwife. Yet most of the women we talk to have concerns about feeding and settling their baby. I believe it is imperative to include the role of the midwife in any service delivery models.
Child Development/ Developmental Health services	1	• Perhaps include health-related services which are targeting indicated and at-risk populations such as Child Development programs or Developmental Health programs.
Parent aide programs	1	• It was only through a referral that I became aware of the possibility of having a parent aide assist two hours each week in my home. This was something I urgently would have needed in the weeks after the birth. It may have prevented a 6-week admission to Belmont. Early identification and support services are key.
Home visits (professional unspecified)	1	• More in-home services
Group therapy	1	• Having been treated for PND both in Canada and Australia I can speak to the power of group based therapy which offers childcare services for mothers. In my case in West Vancouver, British Columbia, I attended a government-funded weekly group which was facilitated by a psychologist and supported by a nurse. Childcare was offered so mothers could focus on the therapy group. The services offered at the Belmont Hospital in Brisbane are one of a kind however the separation from my other child was difficult. We resided in Townsville at that time.
Integration/ co-ordination of services	1	• I am currently seeing a mother with a significant mental health history and episodes of psychosis (one during this pregnancy). She has been managed by a psychiatrist privately but had her baby in a public hospital. The plan was for her to stay for 2 weeks postnatally as she was at such a high risk or puerperal psychosis. The maternity hospital did not support this plan and the woman was discharged prior to the 2 week planned stay. I would suggest better collaboration between private and public services. Improved co-ordination between services such as housing, child safety, maternity services, child health and mental health services.
Consistent model for community perinatal mental health services	1	• I think more emphasis should be put on creating one model of care for ALL Queensland HHS. The 2010-2013 funding block yielded about 13 different models – there were similarities, of course, but there was a LOT of variation in the way each HHS used the funding.
Continuity of care	1	• I think if we want to enhance perinatal well-being, we need to look at the broader societal influences on women's wellbeing, and the structure of maternity services provided to most women in Queensland is not conducive to supporting and enhancing their holistic health needs. Providing continuity of midwifery care, with professionals working from a social model of health would go some way towards preventing the incidence of perinatal depression.
Private hospitals	1	• I was hospitalised in Belmont BCPND for 9 weeks. My FULL private hospital cover enabled me to stay by paying only my excess... my baby staying cost over $7,000 and I was supply ALL Formula, Nappies, Wipes, Bathing Products etc. This was a great contributor to our already difficult financial situation AND - I have no doubt - my prolonged stay in the ward.
Broader societal issues	1	• Given the results of the Australian Human Rights Commission's report into employment discrimination against pregnant women and mothers, we also need to consider the way women are being treated in their paid work during the perinatal period, and this is an area that is often neglected in interventions preventing or treating perinatal mental health issues.

Importance of physical health checks to mental health	1	• Research highlights better mental health outcomes for women who have their physical health needs asked about and addressed during pregnancy. The non-government sector delivers programs to address women's physical health and wellbeing and maybe this relationship could be better addressed in the paper and/or included in the section on what the non-government sector can provide.
Importance of feeding and settling issues for mothers' mental health	1	• There is often a close association between parenting issues (crying baby and feeding baby) and mother's emotional and mental health.
EARLY TREATMENT (ACROSS ANTENATAL AND EARLY POSTNATAL PERIOD)		
Inpatient perinatal mental health beds	7	• Appropriately identifies the need for more mother-baby units/ beds. • There is a definitive need for inpatient treatment (mums and bubs) but no delineation of funding save the exploration of public/private partnerships. Safety in supporting at risk mums in the community situation is fraught while that debate is not settled and funding not established. • Still no mother & baby mental health beds publicly available. Yes I know that mums can continue to breastfeed in some circumstances with family help to transport babies up to big mental health facilities e.g. PAH. But can't we do better than this and have a purpose built mother and baby unit publicly like at Belmont Private? Public patients are disadvantaged with no quick mobile perinatal mental health service and no mother & baby beds in public hospitals. • Please don't place women with PND into acute mental health wards. Most women feel like failures when PND strikes – is it helpful to be additionally subject to the stigma of being in a "psych" ward? Does this really help? Inpatient units are notorious for being unsafe place for women, as there is no gender division of wards in our public mental health wards. Is this a good environment that is conducive to healing, as opposed to providing an environment whose major purpose seems to be to contain the risk factors? • I agree there should be more inpatient beds for perinatal and infant mental health. • I work in Community Child Health and can see the gaps in the services for families, especially mothers with mental health problems. They have to be separated from their babies if admitted to hospital with mental health problems. • The paper identifies building on existing inpatient services. I would think there needs to be more than one specialised parent-infant unit built in a state the size of Queensland. It is really difficult at present, with access to perinatal beds almost impossible for families unless they have good private health insurance.
Day Programs	1	• The Extended Community Care Programs is a worry for me as a consumer (and taxpayer) as it creates an environment for community-based organisations to become opportunistic to obtain funding without providing high standard service.
Referral pathways	1	• I work in children protection. Staff currently report maternal mental health to child protection services as a last resort when nothing else is available. This does not help. A good mental health service as described should prevent many of these referrals.
"Build on existing capacity and models in public inpatient facilities"	1	• The extra hospital beds is good, but is a low-hanging fruit policy open… it should not take the place of what is severely lacking in the options paper, and that is preventing women ending up in need of a hospital bed.

RURAL AND REMOTE SERVICES		
Staffing in rural mental health facilities	3	• Interestingly, while not substantially different from a few years ago, there is more sureness now about the issues. Sadly the priorities will always go to the numbers. I have watched the people of Mt Isa struggled with a lack of choice of high quality health services – general and perinatal mental health – and this will continue with this plan too. The remote (and it is remote) area will continue to have poorer health outcomes because of distance and lack of resources. • I cannot see anywhere there has been identification of the HUGE IMBALANCE between services in rural and remote centres versus city centres. • Regional cities and towns also require additional services, this need (not?) to only include an institutional setting as a difficult stigma is attached.
Telehealth	1	• Section 7.5 begins by saying that 'It is difficult to design and deliver a cost-effective community-based service for perinatal and infant mental health in those HHS with small and highly dispersed populations and low birth rates.' We recently attended both a health expo and a baby expo in Mt Isa and from these recruited approximately 70 pregnant and parenting women to our Midwife check-in program. While this program works from a primary prevention and early intervention perspective and doesn't provide high end secondary and tertiary interventions or peer support we are able to do this for the cost of approx. $10,000 for the 2 trips (we also delivered community health education programs while in Mt Isa), the wages of a midwife (at community sector rates, not nursing award rates) and the cost of phone calls. My point is that there are programs that are available for women from these HHS that are cost-effective and community-based, they just need to be supported to be sustainable and the referral pathways from clinicians to the non-government sector needs to be improved so that health professionals are aware of their existence and regularly refer to them.
CULTURALLY AND LINGUISTICALLY DIVERSE FAMILIES		
CALD services	2	• More detailed planning for CALD communities. • CALD and trauma and the impact on the infant.
INDIGENOUS FAMILIES		
General	1	• Of all the resources where are the Aboriginal and Torres Strait Islander specific resources? Given we have higher rates of teenage pregnancy than non-indigenous Queenslanders, higher rates of children removed through child protection and population 0-17 years is estimated to grow by 17 per cent over the next decade.
SERVICES IN CENTRAL BRISBANE AREA		
	1	• I think there is a need for more services in the Brisbane Central area. It is a high density area that seems to require more mental health services for parents and infants.
MOTHERS WITH COMBINED MENTAL HEALTH/SUBSTANCE USE PROBLEMS		
	1	• Need facility for the combined mental health/drug addiction group of mothers who are rejected by both at the moment.
MOTHERS WITH TRAUMA ISSUES		
	1	• Impact of trauma on the infant.

MOTHERS WITH INTELLECTUAL IMPAIRMENT		
	1	• Intellectual impairment and impact on the infant, child safety.
FAMILIES FROM LOW SOCIOECONOMIC BACKGROUNDS		
	1	• Needs to address prevention at the level of socioeconomically deprived young people.
YOUNG MOTHERS		
	1	• Needs to address prevention at the level of socioeconomically deprived young people.
QCPIMH		
	1	• I like the idea of the QCPIMH.
IMPORTANCE OF COMMUNITY CONNECTIONS		
	1	• There seems to be such an increase in community stress levels, family stress levels and decreasing support for families. Families seem to more isolated from each other by global issues, economy, employment situations, and not knowing what is around to support them until it is too late. Many years ago I could see that the more supported families were the less issues they seemed to have as they transitioned into the next family stages. They had confidence. The internet has increased people's stress levels because people try to identify what is wrong through "Dr Google and Yahoo". Strong community connections with families is so important from a social, emotional level knowing that there is support available when you need it. Bring back the focus on supporting mothers, fathers and families to establish infant connections that will last a lifetime.
DISCUSSION PAPER (WITHOUT APPENDIX) DOESN'T PROVIDE ENOUGH DETAIL ON WHERE AND HOW THE PROPOSED ENHANCEMENTS ARE TO BE FUNDED		
	5	• The copy of the paper I downloaded didn't have Appendix I attached so I would like to see what is being proposed for the State-wide Perinatal and Infant Mental Health Service. • The report speaks of a "co-ordinated cross-sectoral state-wide service system supporting perinatal and infant mental health" with the "proposed conceptual structure for the new PIMH service system". Neither of which talk specifically to preventative strategies which research demonstrates is the best investment of resources. • Still much to accomplish – intent alone will not suffice. Issues to be dealt with are often transgenerational and deep-seated that need unconditional and meaningful commitment. • The needs are well documented and there is a lot of evidence so I would be surprised if the Centre was unable to articulate need. However they have not been as specific as should have been in terms of what type of diagnosis they are anticipating the services will treat and more detail on service criteria required. • There was no mention of cost of service e.g. inpatient services and ambulatory services and how the funding may be sourced in a significantly budget-constrained mental health service that is looking at budget cuts rather than the expansion of services.
POSTNATAL MENTAL ILLNESS IS PREVENTABLE THROUGH GOOD CARE		
	1	• A personal story. Post natal illness is preventable. In my first pregnancy I had four major risk factors: 1. A diagnosed

		psychotic mental illness 2. The need to come off my meds to avoid foetal damage 3. A sister who had PND with both her pregnancies 4. Due date of delivery coinciding with previous dates of personal episodes of severe illness. I had good care in my pregnancy, was encouraged to develop strategies to help myself, and did not develop PND, or any psychosis. I sailed through my second pregnancy three years later. And this was THIRTY years ago.....
EXPERIENCE OF PERINATAL MENTAL ILLNESS		
	1	• I think it's great you are doing this. Having PND is like living with a body made of peat bog all day everyday, like having someone stand on your heart all day everyday, and like having ants build a nest in your mind all day everyday. At the same time. And, oh yeh, you have a defenceless newborn (that you may or may not like) to take care of while you feel like this. This is the reality of PND. Well done for leading the way towards change.

3. WORKFORCE DEVELOPMENT

Topic	Count	Text
PARENT-INFANT UNIT AS TEACHING HOSPITAL		
	1	• My ideal would be developing a place of excellence which builds specialist training within a cutting edge unit. Staff secondments (3 months, say) where they become actively involved in the culture and professional practical/theoretical underpinnings of what QH wants to run out through the state. Staff could then adapt that model according to remote need. training to postgraduate level but the expectation of peer support/ongoing solution finding in remote situations and the discussion of appropriate scaffolding in theory and practice at times comes down to our own judgement. Seeing, practicing and consulting back to that centre of excellence could then be reinforced, monitored and researched in a more comprehensive way. This could help standardize and facilitate homogeneity around the State in terms of quality, purpose and aim.

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