Caroline Chisholm Society

Pregnancy and family support service

Submission to the

Royal Commission into Victoria's Mental Health System

July 2019

Contents

Introduction

Founded in 1969, for the last 50 years the Caroline Chisholm Society (CCS) has supported mothers, babies, toddlers and families during the perinatal period. CCS has aimed to be available for them from the time they learn of their pregnancy until their youngest child is school age.

In the 2017–18 financial year[1], CCS helped over 1448 clients, mostly (1214) with welfare appointments for pregnancy counselling and supports in accessing supports for homelessness, family violence and financial difficulties.

CCS also provided longer term support to 234 families in its family services or homelessness programs. CCS works with these families over a 12 month period to establish goals for themselves and working on outcomes to achieve these goals.

The critical issues that clients CCS provides long term support for are related to family violence, mental health, homelessness, and isolation. The top issue facing families is perinatal mental health. Approximately 40% of those visited for family support were born in a country other than Australia, 17% were from Asia, 8% from Africa and 4% from the Middle East.

Inquiry into Perinatal Services

CCS made a submission[2] to the Inquiry into Perinatal Services (the Inquiry) conducted by the Family and Community Development Committee of the Legislative Council of Victoria from 16 September 2015 to 20 June 2018. Dr Jennifer Weber gave evidence to the Inquiry at a hearing on 27 November 2017.[3]

In its representations to the Inquiry CCS focussed on key recommendations relating to perinatal mental health arising from its extensive contact with mothers and their children during the first 1000 days of life.

[1] Caroline Chisholm Society, *Annual Report 2018*. Available at: https://caroline.org.au/wp-content/uploads/2018/10/CCS-Annual-Report-2018.pdf

[2] Available at: https://www.parliament.vic.gov.au/images/stories/committees/fcdc/inquiries/58th/Perinatal/Submissions/S029_Caroline_Chisholm_Society.pdf

[3] Transcript of evidence is available at: https://www.parliament.vic.gov.au/images/stories/committees/fcdc/inquiries/58th/Perinatal/Transcripts/T064_Caroline_Chisholm_Society.pdf

These recommendations included:

- improving perinatal mental health through a coordinated health and community service response and significant investment for women, infants, children and other family members during and after pregnancy;
- increasing funds for perinatal mental health services to meet the needs of expectant and new mothers and their babies;
- establishing better protocols and referral pathways for mental health treatment and support during the perinatal period, especially for expectant mothers with a pre-existing mental health diagnosis;
- improving access to therapeutic programs on a more widely accessible basis to provide a means of strengthening family relationships and health and wellbeing as an early intervention service, preventing the emergence of complex issues and behaviours later in life; and
- implementing policies aligned with the World Association for Infant Mental Health's statement on the Rights of the Infant[4].

In its report[5], tabled in the Legislative Council on 20 June 2018, the Inquiry made the following ten substantial recommendations in relation to perinatal mental health:

> *3.1: The Victorian Government create a Perinatal Mental Health Plan, as an adjunct to the 10-year Mental Health Plan, as a matter of priority to address the perinatal mental health needs of mothers, fathers and families.*
>
> *The Perinatal Mental Health Plan will include as a key element a public awareness campaign, created in collaboration with key stakeholders, to promote perinatal mental health, and services.*
>
> *The Plan will include specific goals and outcomes for Aboriginal and Torres Strait Islander communities and culturally and linguistically diverse communities.*
>
> *3.2: The Victorian Government establish a taskforce of key stakeholders to consult with relevant health professionals and implement a state-wide program that ensures that all pregnant women will be screened for anxiety and depression by a health professional throughout pregnancy, as envisioned in the Australian Clinical Practice Guideline for Mental Health Care in the Perinatal Period.*
>
> *Screening to be conducted using a standard assessment tool.*
>
> *Screening to be repeated throughout the pregnancy.*
>
> *The taskforce to investigate and recommend action to ensure that all health professionals have available clear referral pathways and services for treatment for*

[4] World Association for Infant Mental Health, *WAIMH Position Paper on the Rights of Infants*, 2016. Available at: https://perspectives.waimh.org/wp-content/uploads/sites/9/2017/05/PositionPaperRightsInfants_-May_13_2016_1-2_Perspectives_IMH_corr.pdf

[5] Family and Community Development Committee, Legislative Council of Victoria, *Inquiry into Perinatal Services: final report*, June 2018. Available at: https://www.parliament.vic.gov.au/images/stories/committees/fcdc/inquiries/58th/Perinatal/Inquiry_into_Perinatal_Services_.pdf

women and families who are identified as having, or at risk of having, perinatal mental health issues.

The program include a state level accountability process.

3.3: The Victorian Government work with key stakeholders to ensure that the perinatal health workforce has the training and assessment tools to conduct perinatal mental health screening during pregnancy.

3.4: The Victorian Government engage with Victorian hospitals, key providers and stakeholders to develop a training package on bereavement care for health practitioners.

3.5: The Victorian Government work with and support the organisations that support families grieving pregnancy loss or newborn death, including creating linkages between health services and those organisations.

3.6: The Victorian Government evaluate the demand for Early Parenting Centres across the state with a view to expanding this service to provide effective coverage for mothers, babies and families.

3.7: The Victorian Government evaluate the demand for mother baby units across the state with a view to expanding this service to meet the current level of unmet demand.

3.8: The Victorian Government provide ongoing funding for the existing Perinatal Emotional Health Programs (PEHP), and fund the expansion of the program state-wide to be delivered as a key element of supporting women at risk of, or experiencing, mental health illness in the perinatal period.

3.9: The Victorian Government use its position on the Council of Australian Governments (COAG) to continue to advocate for the reestablishment of Commonwealth National Perinatal Depression Initiative (NPDI) funding.

3.10: The Victorian Government fund the expansion of perinatal mental health programs for fathers.

The Department of Health and Human Services collaborate with key stakeholders and service providers to identify and develop best practice programs to support the mental health of fathers in the perinatal period.

CCS strongly supports each of these ten recommendations that emerged from a thorough and well-conducted parliamentary inquiry.

CCS notes that in its response to the inquiry issued in February 2019[6] the Victorian State Government, rather than responding directly to the Inquiry's detailed recommendations

[6] Victorian Government, *Safe and high-quality care for Victorian women, their babies and families: response to the Inquiry into perinatal services,* February 2019, Available at: https://www.parliament.vic.gov.au/images/stories/committees/fcdc/inquiries/58th/Perinatal/Inquiry_into_Perinatal_Services_-_Government_Response_-_Final_Submission.pdf

regarding perinatal mental health stated, in a single paragraph addressing perinatal mental health:

> *About one in 10 women experience mental illness during the perinatal period, and for a very small number of women, this experience is one of serious and acute mental illness. The critical role of early sensitive care for women experiencing mental health problems during the perinatal period was highlighted by the Consultative Council on Obstetric and Paediatric Mortality and Morbidity (CCOPMM) in the Victoria's Mothers, Babies and Children 2016 report. The 2017–18 State Budget secured approximately $6 million ongoing funding for perinatal mental health services in Victoria. This investment is providing more women and their families with the mental health care and support they need during pregnancy and in the months that follow. It also means that Victorian women can more easily access the care coordination services provided by Perinatal Anxiety and Depression Australia (PANDA); however, there is more to do. Preparation for the Royal Commission into Mental Health is well underway, and a commitment to implement its recommendations will improve mental health care and support for all Victorians.*

It therefore falls to the Royal Commission into Mental Health to consider the findings and the ten detailed recommendations in relation to perinatal mental health made by the Inquiry into Perinatal Services and to make recommendations to government, hopefully including endorsement of the Inquiry's recommendation for a comprehensive perinatal mental health plan.

Comments on the terms of reference

This submission will now address some of the terms of reference of the Royal Commission.

1. ***How to most effectively prevent mental illness and suicide, and support people to recover from mental illness, early in life, early in illness and early in episode, through Victoria's mental health system, and in close partnership with other services.***

The perinatal period is a key period for prevention of mental illness. This includes prevention of, or at least early detection and treatment of, problems for mothers through universal screening as recommended (3.1) by the Inquiry into Perinatal Services and expanded programs to support the mental health of fathers in the perinatal period (Inquiry, recommendation 3.10).

According to the Royal Women's Hospital, 15 per cent of women will experience depression or anxiety during pregnancy and even a more significant numbers appear during the postnatal period.[7]

[7] https://www.thewomens.org.au/health-information/pregnancy-and-birth/mental-health-pregnancy

Based on a commissioned Deloitte Access Economics *The cost of perinatal depression in Australia Report* (2012), Perinatal Anxiety and Depression Australia (PANDA) identifies that up to 1 in 10 women and 1 in 20 men experience antenatal depression.[8]

The most effective approach to the prevention of long term mental health issues for children at risk is through better services to mothers and fathers in the perinatal period.

> *As well as affecting a woman's emotional welfare and happiness, mental health conditions affect her experience of pregnancy and parenting, are associated with a degree of increased risk of obstetric and neonatal complications and can profoundly affect a woman's ability to bond with her baby and the infant's psychological adaptation over the longer term. Fetal exposure to an untreated maternal mental health condition can also have a negative impact on the infant's wellbeing.*[9]
>
> *[P]oor quality early father-child relationships have been associated with an increased likelihood of mental health disorders such as depression, bipolar, anxiety disorders and phobias (regardless of socio-economic status and perceived quality of childhood maternal relationship) in later life* [while] *fathers who model positive behaviours such as accessibility, engagement and responsibility contribute to: better psychosocial adjustment; better social competence and maturity; and more positive child/ adolescent-father relationships.*[10]

2. How to deliver the best mental health outcomes and improve access to and the navigation of Victoria's mental health system for people of all ages, including through:

2.1. best practice treatment and care models that are safe and person-centred;

Based on decades of experience in working with at risk groups of mothers, CCS advocates that, while a child protection and out of home care safety net is needed, families where possible need to be supported to establish and maintain healthy relationships and stay together. Where children are taken into care, especially when very young, not only is the health and wellbeing of the child impacted upon but so too is that of the mother. Prevention through supporting healthy relationships and enhanced parenting skills not only leads to more resilient healthy adults but minimises the cost of associated mental health and child protection services.

Attachment theory[11] is now widely accepted through research as a key factor in the health and wellbeing of mothers and infants. A number of local and overseas teams have developed therapeutic models of practice that strengthen maternal and child bonds from infancy as the basis for developing healthy and well adults.

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[8] https://www.panda.org.au/images/resources/Resources-Factsheets/Anxiety-And-Depression-In-Early-Parenthood-And-Pregnancy.pdf

[9] Centre of Perinatal Excellence, *Mental Health Care in the Perinatal Period: Australian Clinical Practice Guideline*, October 2017, p. 6. Available at: https://cope.org.au/wp-content/uploads/2017/10/Final-COPE-Perinatal-Mental-Health-Guideline.pdf

[10] Centre for Community Child Health, The first thousand days: an evidence paper, September 2017, p. 33. Available at: https://www.eciavic.org.au/documents/item/1404

[11] John Bowlby, *A Secure Base: Clinical Applications of Attachment Theory,* Taylor & Francis, 2005

Group programs based on the accredited United States program *Circle of Security*[12] are widely delivered across Australian with many early years professionals trained and accredited in its delivery.

Similarly, an Australian based therapeutic program Tuning into Toddlers[13] is designed to achieve positive health outcomes for very young children and their families.

Bringing up Great Kids – The early years[14] is another that focusses on mindfulness techniques. The programs provide a play group type environment that enables trained group leaders to work collectively and with individual mother-baby dyads on positive parenting and parenting skill development using positive reinforcement of mother-child interaction to develop the family bond. Secondarily program leaders often identify other family issues through the development of a trusted relationship with a family.

In 2017 CCS was a leading agency to bring together a consortium approach to address the need to support mothers and young children early to overcome the impact of trauma due to family violence improve developmental outcomes for children. This consortium approach brought together the combined expertise and experience of a range of organizations with a strong track record in providing family violence supports, crisis response services, housing, material aid and case management services. This resulted in establishing the *Children and Mothers in Mind: a two generation approach*[15] as a therapeutic intervention to support young women and children under the age of four, as victims of family violence.

Literature suggests that family violence is an attack on the mother-child relationship[16]. Most mothers who experience family violence also experience significant difficulties in their parenting role, greater parenting stress and compromised parenting. Mental health conditions such as depression, anxiety, low self-esteem, and post-traumatic stress are also highly attributed to women who have experienced family violence. It is not uncommon for women who have experienced family violence to lose confidence in their ability to parent effectively, particularly if their parenting is or has been undermined or criticised by an abusive current or former partner, leading to isolation and unhealthy coping mechanisms.

Many of these programs are not readily or universally accessible and as community based programs are not state-wide.

Broad access to such group programs could help provide an effective support for women diagnosed with postnatal depression.

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[12] https://www.circleofsecurityinternational.com/

[13] https://www.tuningintokids.org.au/

[14] https://professionals.childhood.org.au/bringing-up-great-kids/

[15] https://www.childdevelop.ca/mothersinmind/about-mim

[16] Humphreys, C (2007) *Talking to my mum: strengthening relationships between mothers and children in the aftermath of family violence*, Developing Practice: The Child Youth and Family Work Journal, 19 (Winter/Spring), 12-15

2.2. ***strategies to attract, train, develop and retain a highly skilled mental health workforce, including peer support workers;***

As well as training a highly skilled mental health workforce there is a need for programs to ensure a better level of mental health awareness, including training to identify signs of risk, for all community and education workers who have contact with mothers and infants.

2.3. ***strengthened pathways and interfaces between Victoria's mental health system and other services;***

CCS supports the establishment of better protocols and referral pathways for mental health treatment and support during the perinatal period, especially for expectant mothers with a pre-existing mental health diagnosis. All community and education workers who have contact with mothers and infants should have ready access to referral pathways for their clients who are identified by them as at risk of mental health problems.

2.4. ***better service and infrastructure planning, governance, accountability, funding, commissioning and information sharing arrangements; and***

2.5. ***improved data collection and research strategies to advance continuity of care and monitor the impact of any reforms.***

3. How to best support the needs of family members and carers of people living with mental illness.

Help for fathers is essential when mothers are experiencing perinatal depression or anxiety. Men are more likely to develop perinatal anxiety or depression if their partner is also suffering from perinatal anxiety or depression. In any case fathers in these circumstances face the dual challenge of supporting the mother through her depression and anxiety, which he needs to be helped to understand and respond to constructively and ensuring that the needs of the child are attended to.

In this context, CCS draws attention to Recommendation 3.7 of the Inquiry That "The Victorian Government evaluate the demand for mother baby units across the state with a view to expanding this service to meet the current level of unmet demand" and notes that such units should also provide for the father to stay when possible so that treatment and support is provided to the whole family unit.

CCS would also advocate for improved respite care services to be established to provide time out for mothers and their young children in settings with greater focus on prevention and early intervention. Respite care provides a setting for both mother and her child/ren as a temporary relief, as well as a time of stability and opportunity to focus on the social and emotional needs of both mother and child.

While important work is underway to support mothers through early parenting centres, there is a gap in service provision for mothers during pregnancy and postpartum where they are able to receive specialized support and care beyond the immediate transition period to parenting.

At critical stages of parenting, CCS can report mothers engage with the Society in seeking out assistance to be able to mitigate the social pressures on them to be able to be engaged and connected with their young children. CCS would advocate for building on current mother and baby residential stay programs to broaden the scope to provide mother and child respite care centres in offering rest and care for both mother and child during which time mothers are connected to professional staff to work on care plans, with a focus on attachment, improving mental and physical health and improving parenting skills.

4. How to improve mental health outcomes, taking into account best practice and person-centred treatment and care models, for those in the Victorian community, especially those at greater risk of experiencing poor mental health, including but not limited to people:

CCS recommends that "mothers and fathers during the perinatal period" should be included in the list of "those at greatest risk of experiencing poor mental health", especially when combined with other risk factors in the "social determinants of health": risk of homelessness, immigrant/refugee issues, family violence, drug and alcohol use.

4.1. from Aboriginal and Torres Strait Islander backgrounds;

CCS notes that part of Recommendation 3.1 of the Inquiry is that the proposed perinatal mental health plan "include specific goals and outcomes for Aboriginal and Torres Strait Islander communities and culturally and linguistically diverse communities".

In 2017-18 some 14% of those clients we assisted who were experiencing issues with homelessness identified as Aboriginal or Torres Strait Islander and a further 22% were born outside Australia.

4.2. living with a mental illness and other co-occurring illnesses, disabilities, multiple diagnoses or dual disabilities;

4.3. from rural and regional communities; and

As a provider of family services in the Goulburn Valley to families at risk, CCS is acutely aware of the lack of adequate mental health services in regional Victoria.

In its submission to the Inquiry, CCS called for evidence based therapeutic programs to be delivered in regional centres, including Warrnambool, Horsham, Mildura, Wodonga, Shepparton, Bendigo, Geelong, Ballarat and Gippsland (Latrobe Valley).

Early intervention programs of this kind offered through strong trusted networks could reduce reliance on higher secondary or tertiary care requirements in those centres, enable prompt community response if service escalation is required and ensure that families can be readily supported where they live.

4.4. in contact, or at greater risk of contact, with the forensic mental health system and the justice system.

5. ***How to best support those in the Victorian community who are living with both mental illness and problematic alcohol and drug use, including through evidence-based harm minimisation approaches.***

CCS has dealt with complex cases involving mothers with young children who have a history of substance abuse. While the welfare of the child always remains the paramount concern, it is worth noting that motherhood presents some women with a substance abuse history with an opportunity and a strong motivation to get free of substance abuse in order to provide a better future for their child. Intensive family service support is needed to assist mothers in this situation identify this as a goal and implement steps to achieve it.

6. ***Any other matters necessary to satisfactorily resolve the matters set out in paragraphs 1-5.***

Responses to questions

1. ***What are your suggestions to improve the Victorian community's understanding of mental illness and reduce stigma and discrimination?***

Broad community education campaigns about anxiety and depression, such as RUOK Day, have been successful in starting the conversation in the community about these mental health issues, reducing stigma and creating a changed environment in which persons struggling with depression or anxiety are more likely to seek help.

Perinatal mental health needs to be addressed in similar campaigns to help make it easier for women to express their feelings. CALD and indigenous groups need specific campaigns tailored to their concerns.

CCS notes that part of Recommendation 3.1 of the Inquiry is that "*The Perinatal Mental Health Plan include as a key element a public awareness campaign, created in collaboration with key stakeholders, to promote perinatal mental health, and services.*"

2. ***What is already working well and what can be done better to prevent mental illness and to support people to get early treatment and support?***

See comments under Terms of Reference 2.1 above regarding groups and programs offering therapeutic models of practice, based on attachment theory, that strengthen maternal and child bonds from infancy as the basis for developing healthy and well adults. The groups and programs need to be more readily accessible throughout Victoria.

3. ***What is already working well and what can be done better to prevent suicide?***

According to data collated by the Australian Institute of Health and Welfare there were 20 maternal deaths by suicide between 2006 and 2016.[17] Five of these occurred in 2016 alone.[18]

Of the 12 maternal deaths by suicide between 2008 and 2012, three occurred during pregnancy, six occurred during the postnatal period, and two occurred after a termination of pregnancy.[19]

Of these 12 deaths in 8 cases the woman was known to have a prior mental health illness but in only 5 of the 8 cases was she known to have a current mental health contact and been receiving treatment.[20]

Universal screening during pregnancy for depression, anxiety and other mental health disorders, and particular care for mothers known to have a prior mental health illness, could prevent some of these suicides. The Royal Commission should adopt Recommendation 3.2 from the Inquiry as an urgent priority for government.

Regarding maternal suicide after termination of pregnancy, abortion has been found in population wide studies in Finland and California to be associated with a significantly increased risk of suicide (between 1.54 and 6).

A paper published in the European Journal of Public Health[21] found that compared with women who have not been pregnant in the prior year, deaths from suicide, accidents and homicide are 248% higher in the year following an abortion, according to a new 13-year study of the entire population of women in Finland.

The study also found that a majority of the extra deaths among women who had abortions were due to suicide. The suicide rate among women who had abortions was six times higher than that of women who had given birth in the prior year and double that of women who had miscarriages.

In addition, researchers examining death records linked to medical payments for birth and abortion for 173,000 California women found[22] that aborting women were 62 percent more likely to die than delivering women over the eight year period examined. That study also found that the increase risk of death was most prominent from suicides and accidents, with

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[17] Australian Institute of Health and Welfare, *Maternal Deaths in Australia 2016,* 17 December 2018, Table on p.3. Available at: https://www.aihw.gov.au/getmedia/558ae883-a888-406a-b48f-71f562db3918/aihw-per-99-printable-PDF-of-web-report.pdf.aspx

[18] Ibid., See table on page 1

[19] Australian Institute for Health and Welfare*, Maternal deaths in Australia 2008-2012*, Available at: https://www.aihw.gov.au/getmedia/07bba8de-0413-4980-b553-7592089c4c8c/18796.pdf.aspx

[20] Ibid. p. 33

[21] M. Gissler et. al., "Injury deaths, suicides and homicides associated with pregnancy, Finland 1987-2000," *European Journal of Public Health*, 2005; 15(5):459-63.

[22] DC Reardon et. al., "Deaths Associated With Pregnancy Outcome: A Record Linkage Study of Low Income Women," *Southern Medical Journal*, 2002; 95(8):834-41.

a 154 percent higher risk of death from suicide and an 82 percent higher risk of death from accidental injuries.

Longitudinal studies in New Zealand have found a more general association of abortion with subsequent mental health problems.

In 2006 David Fergusson and colleagues using data from the longitudinal Christchurch Health and Development Study reported that women who had an abortion before age 25 were at 1.49-1.72 times the risk of experiencing mental health problems than women who had not got pregnant or who had become pregnant and not had an abortion. Those having an abortion had elevated rates of depression, anxiety, suicidal behaviors and substance use disorders.[23]

In 2008 Fergusson and colleagues reported that exposure to abortion was associated by age 30 with a 1.3 relative risk of mental health problems while carrying an unwanted pregnancy to term was not a risk factor for mental health problems.[24]

In 2009 Fergusson and colleagues reported that over 85% of women who had an abortion reported at least one negative reaction to the abortion (sorrow, sadness, guilt, grief/loss, regret, disappointment) with 34.6% of women who had an abortion reporting five or six of these negative reactions. For those women with moderate negative reactions (1-3) to abortion this was associated with a 1.43 relative risk of subsequent mental health problems compared to women who did not have an abortion.

For those with stronger negative reactions (4-6) the relative risk of subsequent mental health problems was 1.64-1.81.[25]

Fergusson concludes that for this population (women under 30) abortion is responsible for approximately 5% of all mental health problems. He suggests that as "*no review to date has found that abortion is associated with a reduction in mental health risks*" there is a case for reviewing laws and practices that justify abortion on the grounds of preventing a serious danger to the woman's mental health.

Coleman and her colleagues found on the basis of an US national comorbidity survey that abortion was "related to an increased risk for a variety of mental health problems (panic attacks, panic disorder, agoraphobia, PTSD, bipolar disorder, major depression with and without hierarchy), and substance abuse disorders" and that it accounted for between "4.3% and 16.6% of the incidence of these disorders".[26]

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[23] D Fergusson, L Horwood and E Ridder, "Abortion in young women and subsequent mental health", *Journal of Child Psychology & Psychiatry*, 2006; 47(1): 16-24.

[24] D Fergusson. L Horwood and J Boden, "Abortion and mental health disorders: evidence from a 30-year longitudinal study", *British Journal of Psychiatry* 2008; 193: 444–51.

[25] D Fergusson. L Horwood and J Boden, "Reactions to abortion and subsequent mental health", *British Journal of Psychiatry* 2009; 195: 420–26.

[26] P Coleman et al., "Induced abortion and anxiety, mood, and substance abuse disorders: isolating the effects of abortion in the national comorbidity survey", *Journal of Psychiatric Research*, 2009; 43(8):770-6.

In the light of this evidence perinatal screening programs should include sensitive exploration about the outcome of all past pregnancies, including those ended by termination. More broadly, mental health awareness should include the acknowledgement that for a not insignificant percentage of women, termination of pregnancy is a risk factor for adverse mental health outcomes.

4. ***What makes it hard for people to experience good mental health and what can be done to improve this? This may include how people find, access and experience mental health treatment and support and how services link with each other.***

As discussed above under Terms of the Reference 2.2 and 2.3, well as training a highly skilled mental health workforce there is a need for programs to ensure a better level of mental health awareness, including training to identify signs of risk, for all community and education workers who have contact with mothers and infants.

Better protocols and referral pathways for mental health treatment and support during the perinatal period, especially for expectant mothers with a pre-existing mental health diagnosis, need to be established and clearly understood. All community and education workers who have contact with mothers and infants should have ready access to referral pathways for their clients who are identified by them as at risk of mental health problems.

Greater integration of programs within existing services and agencies would improve in mitigating the risks of mental health issues for mothers and their children that don't place additional burdens for how mothers are expected to navigate existing services.

CCS notes the disadvantage for smaller and specialized agencies not receiving funds for therapeutic work including family violence. This greatly reduces the capacity of service providers to respond to the client in the first instance with referrals out to other agencies creating further stress for a mother in managing mental health concerns as she is placed on a waitlist for appropriate interventions. With referrals required to other agencies, mothers are then having to renavigate through other service providers including retelling their stories and providing information to meet the intake and assessment requirements of other agencies.

Such pressures are also further exacerbated when mothers are referred to service providers with extensive waitlists.

5. What are the drivers behind some communities in Victoria experiencing poorer mental health outcomes and what needs to be done to address this?

The range of risk factors women and families present with is significant. From 50 years of experience in helping mothers and their children, as well as reviewing the relevant literature CCS considers the following to be some of the key social determinants of health, including mental health, for mothers and their children.

1. Homelessness and poverty both short and long term
2. Family violence
3. Cultural and linguistic diversity, such as coming from emerging communities including recent
migrants and refugees
4. Aboriginal families

5. Substance abuse
6. Families where other health factors impact upon health and parenting capacity such as long term chronic conditions.
7. Families where children and infants have special needs such as chronic illness or a disability.
8. Families where fathers are ill-equipped and missing the opportunity for change presented at
the time of becoming a parent.
9. Pre-existing maternal mental health issues impacting on maternal and child health perinatally.

The breadth of these factors that link to the social determinants of health is significant. Each of these areas requires specialist expertise that may be clinical or medical or expertise in addressing welfare, work and psycho-social issues. The key and most pressing area to address now is family mental health to ensure long term benefit to the individual, the family and the broader community.

Mental health issues commonly co-present with other risk factors listed above. Specialist help in addressing issues face by families will necessarily need partnerships to mental health supports.

Implementing a detailed perinatal mental health plan as recommended by the Inquiry would help significantly in addressing these challenges.

CCS urges the Royal Commission to address the impact of homelessness and the need for improved social housing for mothers and children. The Housing First model, that is provide housing in the first instance as a priority and provide the services and community supports to address the complex needs of the client.

The principle of the Housing First model is to quickly respond with safe and secure housing and is not conditional upon addressing the health and wellbeing issues a client may be presenting with. [27] It is crucial to address the shortage in affordable, safe and secure housing options to stabilise the foundations for at-risk and vulnerable mothers and their children. There is strong evidence of the threat of and impact of homelessness on the mental health of mothers struggling to establish or maintain safe and secure housing for their families.

Such interventions are critical in addressing the additional burden on mental health services.

6. What are the needs of family members and carers and what can be done better to support them?

See our comments above in response to Term of Reference 3 about support for fathers when the mother is experiencing postnatal depression or anxiety and the need for more mother-baby units, including provision for fathers to stay with the family unit.

9. Thinking about what Victoria's mental health system should ideally look like, tell us what areas and reform ideas you would like the Royal Commission to prioritise for change?

[27] https://www.ahuri.edu.au/policy/ahuri-briefs/what-is-the-housing-first-model

CCS urges the Royal Commission to adopt all ten recommendations on perinatal mental health put forward in Chapter 3 of the Report of the Inquiry into Perinatal Services and as set out earlier in this submission.

If we can get perinatal mental health right we will improve the wellbeing of every Victorian child during the critical first 1000 days of life and thereby significantly prevent many problems that lead to poor mental health throughout life.

Conclusion

CCS appreciates the opportunity to make this submission and is ready to assist the Royal Commission by providing further evidence in writing or in person if required.

CCS hopes that the excellent work done by the Inquiry into Perinatal Services on perinatal mental health is carried forward by the Royal Commission in its recommendations to government.

Appendix 1. Caroline Chisholm Society

The Caroline Chisholm Society (CCS) is unique as a specialist perinatal service in the community service sector. It is a leading integrated family services (IFS) provider in Victoria, particularly in Melbourne's west and western urban fringe and in Goulburn Valley.

CCS offers support from the moment a woman learns of her pregnancy to the time her youngest

child goes to school. In addition to the Department of Health and Human Services (DHHS) funded

Integrated Family Service, CCS is also funded to offer homelessness support and has received some Department of Education funding to run supported playgroups.

The agency's priority is early intervention for vulnerable families. It seeks to minimise out of home care and support for children and operates a service system that is premised upon both the application of the social determinants of health and the application of evidence -based practice. In particular, CCS delivers programs based upon the critical; importance of the mother/infant relationship and its importance in the achievement of long term health and wellbeing – attachment based models of practice.

CCS is funded to provide services for the catchments of Brimbank and Melton and Western Melbourne which includes the local government areas of Wyndham, Hobsons Bay, Moonee Valley, Maribyrnong, and Melbourne. It also provides specialist support for parents in the perinatal period from Goulburn Valley, based in Shepparton. CCS's mission is to deliver a range of pregnancy and family support services that respond to the needs of families and support them to achieve and maintain a safe and nurturing environment for themselves and their children. CCS does this by offering support to women (and children) who are:

- linked to clinical supports for their pregnancy and are in need of additional supports to ensure family safety and wellbeing
- not already linked to health or social services and need pregnancy and early parenting support
- vulnerable and present with one or more risk factors that impact on the best interest of the child(ren) and the parent.

The CCS team provides:

- stable trusted and continuous relationships with clients
- assistance and support to navigate the health and community service systems as needs and priorities change over to time
- one-off appointments for counselling and support to empower families
- ongoing case management work to support good
- parenting while at risk of or facing homelessness, family violence and mental health issues
- group work and volunteer support and mentoring
- day to day maternal and child welfare – goods needed to care for an infant and the mother and other young children

Demand for CCS is much higher than currently funded service targets. The service strives to meet the demand by all initial client consults including a risk assessment as well as advice, leveraging other agency capacity, working in partnership to increase reach, donations and through the tireless work of volunteers.

CCS sees over 1000 clients per year (1400 in FY17-18). This varies depending on funds and complexity of client needs. The CCS practitioners, support staff and team of volunteers are the Society's greatest asset, working tirelessly each day to make a difference in the lives of mothers and their children.

Appendix 2. World Association for Infant Mental Health Recommendations

To ensure optimal health and development of an individual we seek the development and implementation of policies that:

1. support adequate parental leave so that parents can provide optimal care for their infants during the crucial early years of life.

2. minimise changes in caregiver during the early years of development.

3. promote the provision of informational support to parents regarding the health and developmental needs of their infants and young children.

4. recognise the importance of facilitating emotional support for mothers, fathers, and caregivers, as an important component of fostering the optimal development and wellbeing of the infant.

5. promote access to evaluation and treatment of risks to development by trained professionals

who are culturally sensitive and knowledgeable about early development and emotional health.

6. provide infants with life-limiting conditions access to palliative services.

7. ensure the provision of adequate circumstances, including time for mothers, fathers, caregivers to get to know their infants and become skilled in providing for their infant's care and comfort, throughout the support of their family and community.

8. The right for parental leave, and its duration, should be valorised by the society, in a way that fits its contextual reality.

9. ensure the provision of access to relevant early educational and psychological opportunities and programs that promote good-enough relationship experiences and thus, enhance cognitive and socio-emotional development.

10. ensure the provision of prompt access to effective mental health treatment for mothers, fathers, and caregivers that alleviates infants' suffering and insure optimal development for the child.

11. allocate resources for training and supervision for caregivers in babies' institutions, foster care professionals and foster parents, as well as resources for assessing and treating foster care infant's emotional and developmental status.