Royal Commission into
Victoria's Mental Health System

Formal submission cover sheet

Make a formal submission to the Royal Commission into Victoria's mental health system
The terms of reference for the Royal Commission ask us to consider some important themes relating to Victoria's mental health system. In line with this, please consider the questions below. Your responses, including the insights, views and suggestions you share, will help us to prepare our reports.

This is not the only way you can contribute. You may prefer to provide brief comments here instead, or as well. The brief comments cover some of the same questions, but they may be more convenient and quicker for you to complete.

For individuals

Written submissions made online or by post, may be published on the Commission's website or referred to in the Commission's reports, at the discretion of the Commission.

You can request anonymity or confidentiality, but we strongly encourage you to allow your submission to be public - this will help to ensure the Commission's work is transparent and that the community is fully informed.

Audio and video submissions will not be published on the Commission's website. However, they may be referred to in the Commission's reports, subject to any preferences you have nominated.

For organisations

Written submissions made online or by post, may be published on the Commission's website or referred to in the Commissions reports, at the discretion of the Commission. Audio and video submissions will not be published on the Commission's website. However, they may be referred to in the Commission's reports.

Because of the importance of transparency and openness for the Commission's work, organisations will need to show compelling reasons for their submissions to remain confidential.

Should you wish to make a formal submission, please consider the questions below, noting that you do not have to respond to all of the questions, instead you may choose to respond to only some of them. If you would like to contribute and require assistance to be able to do so, please contact the Royal Commission on 1800 00 11 34.

Your information	
Title	**Dr**
First name	**Sue**
Surname	**Matthews**
Email Address	[redacted]
Preferred Contact Number	[redacted]
Postcode	[redacted]
Preferred method of contact	☒ Email ☒ Telephone
Gender	[redacted]
Age	[redacted]
Do you identify as a member of any of the following groups? Please select all that apply	☐ People of Aboriginal and Torres Strait Islander origins ☐ People of non-English speaking (culturally and linguistically diverse) backgrounds ☐ People from the Lesbian, Gay, Bisexual, Transgender, Intersex, Asexual and Queer community ☐ People who are experiencing or have experienced family violence or homelessness ☐ People with disability ☐ People living in rural or regional communities ☐ People who are engaged in preventing, responding to and treating mental illness ☐ Prefer not to say
Type of submission	☐ Individual ☒ Organisation Please state which organisation: **The Royal Women's Hospital** Please state your position at the organisation: **CEO** Please state whether you have authority from that organisation to make this submission on its behalf: ☒ Yes ☐ No ☐ Group How many people does your submission represent?

Personal information about others	Does your submission include information which would allow another individual who has experienced mental illness to be identified? ☐ Yes ☒ No
	If yes, are you authorised to provide that information on their behalf, on the basis set out in the document ☐ Yes ☐ No
	Prior to publication, does the submission require redaction to deidentify individuals, apart from the author, to which the submission refers ☐ Yes ☒ No
Please indicate which of the following best represents you or the organisation/body you represent. Please select all that apply	☐ Person living with mental illness ☐ Engagement with mental health services in the past five years ☐ Carer / family member / friend of someone living with mental illness ☐ Support worker ☐ Individual service provider ☐ Individual advocate ☒ Service provider organisation; Please specify type of provider: **The Royal Women's Hospital** ☐ Peak body or advocacy group ☐ Researcher, academic, commentator ☐ Government agency ☐ Interested member of the public ☐ Other; Please specify:
Please select the main Terms of Reference topics that are covered in your brief comments. Please select all that apply	☒ Access to Victoria's mental health services ☒ Navigation of Victoria's mental health services ☒ Best practice treatment and care models that are safe and person-centred ☒ Family and carer support needs ☐ Suicide prevention ☒ Mental illness prevention ☒ Mental health workforce ☒ Pathways and interfaces between Victoria's mental health services and other services ☒ Infrastructure, governance, accountability, funding, commissioning and information-sharing arrangements ☒ Data collection and research strategies to advance and monitor reforms ☒ Aboriginal and Torres Islander communities ☒ People living with mental illness and other co-occurring illnesses, disabilities, multiple or dual disabilities ☐ Rural and regional communities ☒ People in contact, or at greater risk of contact, with the forensic mental health system and the justice system ☒ People living with both mental illness and problematic drug and alcohol use

For individuals only

Please identify whether this submission is to be treated as public, anonymous or restricted

While you can request anonymity or confidentiality below, we strongly encourage your formal submission to be public - this will help to ensure the Commission's work is transparent and the community is fully informed

Please tick one box	
☒ Public	My submission may be published or referred to in any public document prepared by the Royal Commission. There is no need to anonymise this submission.
☐ Anonymous	My submission may only be published or referred to in any public document prepared by the Royal Commission if it is anonymised (i.e. all information identifying or which could reasonably be expected to identify the author is redacted). If you do not specify the information which you would like to be removed, reasonable efforts will be made to remove all personal information (such as your name, address and other contact details) and other information which could reasonably be expected to identify you.
☐ Restricted	My submission is confidential. My submission and its contents must not be published or referred to in any public document prepared by the Royal Commission. Please include a short explanation as to why you would like your submission restricted.

Please note:

- This cover sheet is required for all formal submissions, whether in writing or by audio or video file. Written submissions made online or by post, may be published on the Commission's website (at the discretion of the Commission) subject to your nominated preferences.
- Audio and video submissions will not be published on the Commission's website. However, they may be referred to in the Commissions reports subject to any preferences nominated.
- While the Commission will take into account your preference, the Commission may redact any part of any submission for privacy, legal or other reasons.

Your contribution

Should you wish to make a formal submission, please consider the questions below, noting that you do not have to respond to all of the questions, instead you may choose to respond to only some of them.

1. 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?

The Royal Women's Hospital (the Women's) is Australia's first and largest specialist hospital dedicated to improving the health of women and newborns. As a specialist hospital, the Women's plays a pivotal role in Victoria's health system providing specialist tertiary services for women and newborns across the state. In addition, the Women's conducts ground breaking research and advocates on specific women's health issues, including women's and newborn mental health.

The Women's operates a unit called the Centre for Women's Mental Health (CWMH), in partnership with the University of Melbourne (the University). The Centre is headed by a senior psychiatrist and has funding for 2 EFT psychiatrists, 2 registrars, and other mental health clinicians. The Centre provides training for Women's staff and external psychiatrists, psychologists and other clinicians working in the area. The Women's is an accredited training site in mother baby health for the Royal Australian and New Zealand College of Psychiatrists (RANZCP) and the Australian Psychological Society. Research activities, conducted in partnership with the University's Department of Psychiatry, focus on innovations in clinical interventions and approaches to support women experiencing perinatal mood disorder, the impact of trauma and family violence and early parenting difficulties.

The Women's provides national leadership in several aspects of women's mental health, with specific expertise in two important areas:

- the development and evaluation of early parenting interventions, and
- models of trauma-focused care for vulnerable women.

Based on the Women's expertise and experience, the responses in this submission focus on opportunities to specifically improve mental health outcomes for women and infants. The imperative to consider gender issues as part of the Royal Commission into Victoria's mental health system is discussed in greater detail in section 6 of this document.

WHAT IS WORKING WELL

THE WOMEN'S EXPERTISE

Early identification and access to mental health services for women and infants

There is an increasing body of evidence on the favourable impact of quality early parenting and infant development on later mental health outcomes and on the negative impact of factors such as maternal stress, anxiety and depression. Early identification of risk factors by maternity health services is an important strategy in improving mental health outcomes for women and infants, particularly where there may be barriers to the disclosure of these risk factors, such as in instances of women experiencing family violence and abuse. Similarly, primary care and maternal child health nursing services have an essential role in the early identification and intervention in a range of women's and infants' mental health issues in the community setting.

Research has contributed to the development of programs offered by the Women's, aimed at early intervention for perinatal and postnatal women and infants, including better access to treatment of common issues such as depression and anxiety. Families with an increased risk of mental illness, substance abuse or family violence are identified in the antenatal period and offered comprehensive multidisciplinary support. This early intervention is an essential component of a comprehensive maternity model of care focussed on population level mental health outcomes.

Examples of the Women's Expertise – What we are already doing

The services currently provided by the CWMH at the Women's provide an example of what is working well in a mental health service system that does not always respond adequately or appropriately to the specific needs of women. Most specifically, this includes women in maternity services and women from vulnerable communities. All the services detailed here have a demonstrated impact and we would be pleased to provide more detail of the outcomes to the Commission.

1. BEAR (Building Early Attachment Resilience) Program

BEAR provides a ten-week group program for mothers and infants from two months of age. The attachment-based program is specifically designed for vulnerable mothers with parenting and mental health risk factors including early trauma, depression, substance abuse issues, social exclusion and experiences of family violence. The program focuses on each mother's development of their:

- capacity to be a consistent attachment figure;
- increased understanding of infant communication and how to respond;
- coping strategies for the demands of early parenting and managing emotions;
- dealing with past trauma.

The program is trauma-focussed and incorporates current understanding of the importance of early interaction for infant development. The approach was developed by Professor Louise Newman AM, with findings showing that participants report greater parenting competence, reduced stress, improved understanding of infant developmental needs and strengthened self-perception as a parenting figure.

Fathers, partners and significant others involved with a woman and infant are able to attend the BEAR group parenting programs and currently partners with an infant in the Neonatal Intensive Care Unit are supported by a mental health support group on a weekly basis.

BEAR is currently being trialled in a community outreach model and subject to funding availability, will be conducted in poorly resourced regional settings in Victoria.

2. Newborn Behavioural Observations

The Newborn Behavioural Observations (NBO) program originated in the United States. It is a simple and innovative clinical tool that builds parents' understanding of the social capacities and emotional needs of their newborn. This in turn leads to an improved ability by parents to form a mutually-rewarding relationship that supports infant development. Sessions involve collaborations with new parents that provide education through direct demonstration of their infant's ability to engage and to communicate their needs.

Multi-disciplinary professionals can use the NBO as a brief intervention in multiple

settings and with diverse families. The NBO session can be provided universally on the postnatal ward or in a clinic, can be integrated into individual and group therapeutic programs, or offered as part of intensive home-visiting programs for high risk families. This is an exciting new alternative to information-based parenting education. To date, over 600 staff have been trained around Australia to deliver the NBO program and a research project is currently evaluating the efficacy of NBO in mothers experiencing depression in the postnatal period.

3. *Mind Baby Body*

The Mind Baby Body group is a five-week program of mindfulness techniques for stress management, preparation for birth and exercises that promote women to think about their relationship with their infant. Evidence shows the importance of supporting vulnerable parents in preparation for parenthood, managing anxiety and other mental health issues and promoting understanding of the parental role and early needs of the infant. Parents are keen to engage with these issues, with high retention rates and positive evaluations of the group. Research on the impact of this program has found that engagement by women has had a positive effect on anxiety and depressive symptoms in pregnancy. Current research at the Women's is examining the outcomes from this program, in terms of infant attachment and development, through a randomised control trial.

4. *Antenatal screening*

Identifying women experiencing depression, anxiety or mental illness during pregnancy allows early engagement with mental health services to support the psychological transition to parenthood and provision of treatment as needed. This is a key strategy to increase the likelihood of achieving the best possible start to a child's early years. This is particularly critical for women with a history of trauma, current exposure to conflict and violence in relationships, and drug and alcohol dependency.

Antenatal mental health screening is an effective early intervention strategy that was recommended by the Victorian Perinatal Mental Health Services Inquiry. Perinatal depression is thought to affect up to 20 percent of women. Significant numbers of women with pre-existing psychiatric disorders will have difficulties during pregnancy and the rate of relapse of their illness in the post delivery period ranges from 30 - 40 percent compared to the usual population with even higher rates for serious psychotic disorders.

The Women's has piloted a psychosocial screening tool for mental health, family violence, and drug and alcohol use. This program is a direct response to recommendation 96 of the Royal Commission into Family Violence, which requires family violence screening in public maternity services. This universal mental health screening pilot for women during the perinatal period provides clear referral pathways and services for treatment for women and families who are identified as having, or at risk of having, perinatal mental health issues. The Women's has developed a suite of antenatal resources for psychosocial screening. The Strengthening Hospital Responses to Family Violence Project, led by the Women's with Bendigo Health, is now operational across 88 Victorian hospitals, providing the service system infrastructure to embed mental health early intervention, identification and response to patients and staff. With additional funding, the Women's can provide similar whole of sector support for antenatal screening by tailoring and helping to embed the Women's evidence-based antenatal screening resources for other public maternity hospitals across the state.

WHAT CAN BE DONE BETTER?

What the Women's could further develop

Mental health services at the Women's have developed over time in response to both structural and service gaps in Victoria's mental health system.

The Women's mental health services are designed to better enable women and infants to receive early treatment and support, as part of the normal process of pregnancy and birth. Recommended actions to address this are discussed in section 5 of this submission.

The areas of service delivery that can be improved include the following:

Acute maternal mental health services - access to Mother Baby Psychiatric Units

A key strategy that would improve access to the Victorian mental health system is to undertake a state-wide review of access and availability of Mother Baby Psychiatric Units. A small number of these residential units currently exist. The adequacy of bed numbers requires review, together with a review of specialised step-down services closer to where women and their babies live. The current limitations on timely access to these residential units is impacting on women who have significant mental illness and risk factors, such as psychosis and severe trauma-related disorders. Such a review needs to consider how to build service coordination pathways with community programs and general acute psychiatric services for the management of pregnant and postnatal women, as well as a review of maternity hospital capacity for mental health admissions for women needing an extended stay. The Women's is well placed to lead this work or partner with other organisations to improve this vital area of need.

Enhanced psychology services

Enhancement of psychology services within the public hospital sector could also improve the management of depression and anxiety among women who are in recovery from illness or as part of the maternity episode of care. If this was coupled with better integration between hospital and community services, women would have continuity of care, closer to home. At the moment the cost of accessing private psychological care is prohibitive for many women but often is the only way women can continue their care with a specialised provider who is skilled in women's mental health. While the Commonwealth Government's Better Access initiative aims to improve consumer's access to psychology services, it has not necessarily done so for many women.

A review of the Mental Health Treatment Plan scheme is required to improve accessibility for those most in need. The rising cost of seeing a private psychologist results in many consumers having to pay significant costs despite the rebate. Community based publically funded, and therefore affordable services, are hindered by limited clinical mental health positions in the primary care sector. This situation forces practitioners into private practice and consumers into fee paying services. This problem is further exacerbated in rural and regional Victoria, where there are fewer, accessible clinical mental health practitioners. Increased public funding would provide equitable access to clinical mental health practitioners within community hospitals and primary care settings.

In summary, the Women's recommends:

A1. That a state-wide review be undertaken into the access and availability of Mother Baby Psychiatric Units. The terms of reference to consider:

- The adequacy of bed numbers across the system compared with the need and demand;
- The availability of specialised step-down services closer to where women and their babies live;
- A service model that builds coordination pathways with community programs and general acute psychiatric services for the management of pregnant and postnatal women; and
- Maternity hospital capacity for mental health admissions for this cohort of women needing an extended stay.

A2. To consider improving the level of enhanced psychology services within public hospitals to care for women experiencing high levels of depression and anxiety resulting from recovery of illness or as part of the maternity episode of care. Plus, better integration between hospital and community services to ensure continuity of care is guaranteed for these women.

A3. To advocate for additional funding for community based psychology services within the primary care sector to provide more affordable options for women including a review of the Better Access initiative to improve access to those in need.

A4. To undertake a review of the community mental health treatment plan scheme model and cost to improve accessibility and appropriateness of care for those most in need.

2. 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.

The following areas of mental health service provision have been highlighted as particular opportunities to improve good mental health outcomes for women and infants.

Infant mental health - the importance of the 'first 1000 days'

The basis of emotional and psychological health is recognised as being established in the crucial first 1000 days of development[1]. To achieve this, a focus on parental mental health and parenting sensitivity to improve a child's early development and increase resilience is a key factor in achieving good mental health for the child and the family. In families with conflict, violence and substance abuse there should be overall access to supportive and evidence based early childhood intervention models, such as parenting programs in the community.

Developmental research shows that an infant's early development is influenced by factors such as parental stress and mental disorder in utero, as well as the quality of postnatal

[1] Moore, T.G., Arefadib, N., Deery, A., Keyes, M. & West, S. (2017). The First Thousand Days: An Evidence Paper – Summary. Parkville, Victoria: Centre for Community Child Health, Murdoch Children's Research Institute. Accessible via: https://apo.org.au/system/files/108431/apo-nid108431-436656.pdf

care. High levels of stress in pregnancy affects fetal development in utero with poor growth, higher rates of premature delivery and poor neonatal developmental outcomes. In the longer term, child development is shaped by maternal mental health, particularly where a mother has prolonged experiences of depression and anxiety that affect her ability to parent sensitively and responsively. These findings support the approach of better integration of mental health services in maternity settings.

Investment in intervention in the early years is essentially an investment in the mental health and well-being of the community. In particular, there needs to be a focus on parents with specific risk factors for early parenting difficulties through the provision of specific programs for improving parental function thereby developing community access to particular support services.

Specific parental groups requiring enhanced service access and support include:

- Survivors of trauma and abuse who may have complex trauma-related health disorders where there are limited specialist service approaches
- Regional and remote families with mental illness issues requiring mental health supports for parenting development
- Women and parents impacted by family violence needing specific mental health treatment of trauma related disorders and depression
- Women and parents in need of psychological support that is readily accessible and affordable.

Women with cancer during pregnancy

Women diagnosed with cancer during pregnancy represent a highly specialised, vulnerable group who are at high risk of psychological morbidity. Cancer affects approximately one in 1000-1500 pregnancies. This incidence is slowly increasing in line with higher rates of cancer. Irrespective of the type of cancer, cancer diagnosed during pregnancy has historically been associated with poorer prognosis than when diagnosed outside of pregnancy.

Although some cancer treatments are considered relatively safe for the fetus after the first trimester, the psychological impact of the diagnosis for these women may still affect the baby: maternal exposure to stressful events has been associated with preterm birth, low birth weight and neurodevelopmental impairments. Further, if these women choose to and are able to continue the pregnancy in the context of the cancer diagnosis, they may experience difficulties with forming an attachment relationship, and have reduced emotional capacity and physical availability to bond with, feed, or parent the infant and other children due to the demands and side effects of treatment.

Parental cancer poses unique challenges to these families as parents must balance the demands of managing their illness with fulfilment of their caregiving responsibilities. For women with cancer who are also parents to young children, parenting concerns may constitute a particularly significant source of stress as women are traditionally the primary caregivers. This occurs in the context of the already considerable disease burden associated with cancer including living with uncertainty about one's future, undergoing possibly painful and protracted treatments, and high rates of psychological morbidity.

Despite the risks for poor mental health in women with cancer and the flow-on effects for their young families, current services to support mothers with cancer are absent. The

CWMH at the Women's has specialist expertise in parenting in the context of cancer and has only recently developed an accessible psychoeducation program to support the emotional health of parents with cancer. This service is currently accessible to women at the Women's based on geography, and is therefore a service gap, particularly for rural and regional patients.

Improved access to mental health services for cancer patients

Rates of psychological morbidity for all women with cancer are high – higher than in the general population – and the experience of depression and anxiety can persist long after diagnosis. Psychological and mental health care needs to be embedded into medical services to reduce the stigma experienced by women with cancer who also experience psychological morbidity. Patients with cancer often feel ashamed of 'not coping' and can be reluctant to seek help for their mental health issues. Typically, these women do not want to appear ungrateful for life-saving cancer treatment, and do not want to appear to be a burden to the treating medical team or the patient's own family. Societal narratives around being optimistic in the face of cancer and 'fighting' or 'battling' cancer can make it difficult for women who admit that they need additional mental health support. Mental health services that are built into 'the traditional medical model' would improve women's experience of cancer treatment and improve their recovery outcomes.

Children of parents with cancer

Children of a parent with cancer are at increased risk of poor psychosocial outcomes, particularly internalising problems such as anxiety and depression. This is consistent with the threat of loss inherent in a cancer diagnosis. Cancer in a mother of young children threatens the availability of the attachment figure for the child, which may be compounded by separation due to hospitalisation, decreased parental availability and disruption of usual roles and routines. Children may also become 'the parent', i.e., they may prematurely take on more adult roles. Psychological distress and impaired functioning depend on many factors including the child's age and gender, the gender of the ill parent, parental attachment, family dynamics and cohesion, and whether the family unit is intact. Family and parenting variables, particularly, communication, the quality of the parental relationship and parental (maternal) psychological morbidity are the most consistent predictors of child psychosocial outcomes.

Despite the risks for poor mental health in women with cancer and the flow-on effects for their young families, specific mental health services to support children of parents with cancer are absent. The CWMH at the Women's has specialist expertise in supporting the child through parenting in the context of cancer but this is unique and is not available to all women across the system.

Women with chronic pelvic pain

Chronic pelvic pain is a complex medical condition affecting significant numbers of women and is associated with high levels of depression and anxiety.

Chronic pelvic pain may be present in women who have experienced complex trauma - that is, physical, sexual or emotional abuse that has occurred in the context of family and intimate relationships. If not addressed, this will have a significant long-term impact on individuals' mental health, interpersonal relationships, and physical health. Women with this history often present with severe mood instability, anxiety, dissociation, substance abuse, self-harm and suicidal behaviour, aggression, interpersonal problems and difficulties cooperating with medical staff and embracing recommended care. These

women require appropriate psychological assessment in the first instance, followed by careful coordination of mental health and medical care.

Women also present to the Chronic Pelvic Pain Clinic at the Women's with chronic pain as a result of complex, long term or life-long issues arising from childbirth or gynaecological conditions, surgery or injury. If required, the Women's provide further information to the Commission about the mix of patients who attend the Women's Chronic Pelvic Pain Clinic.

To achieve an appropriate standard of care, in addition to the need for funded mental health staff to treat these women, better education is required for medical, nursing and allied health staff about the association between pelvic pain and its causes and consequences so as to provide a more patient-centred, sensitive and integrated response. In particular, well-trained, specialised psychologists are required in the community. Ideally community based services could be supported by and/or in partnership with specialised services such as those offered by the Women's.

In summary, the Women's recommends:

B1. That there is greater investment in funded programs that meet the needs of parents with specific risk factors for early parenting difficulties.

B2. That mental health services become more integrated into 'the traditional medical model' of women's cancer care. This would improve women's experience of cancer treatment and improve the recovery outcomes.

B3. That better clinician education programs are developed to improve the understanding of the association between pelvic pain and its causes. In doing so, clinicians would be able to provide a more patient-centred, sensitive and integrated response both in hospital and in the community.

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

The Women's regularly advocates on behalf of, and with, the following groups of women. These women are at greatest risk of acute and ongoing mental health disorders, and specific problems throughout a woman's lifecycle:

1) Asylum seekers and refugees

Asylum seekers and refugees are a group of women who may experience:

- Specific issues when they parent in a new country including limited family supports, language barriers, anxiety and adjustment issues;
- Limited access to multicultural mental health services with specialist expertise;
- An incidence of female genital mutilation (some communities/cultures); and
- High rates of pre-existing trauma and sexual assault.

There is a significant need to improve the system wide understanding of the mental health needs of asylum seekers that includes the impact of culture and gender norms on mental health and wellbeing. This information should then be used to develop programs to meet these needs.

2) *Alcohol and drug users*

The Alcohol and Drug Service at the Women's (WADS) is the only state-wide alcohol and drug service providing specialist clinical services to pregnant women with complex substance use dependence. It is a highly specialised service with high demand. The service uses a multidisciplinary team to advance women and infant health and wellbeing by providing medical care, counselling and support, and integrated clinical mental healthcare. These women often have complex social issues that directly impact on their mental health, such as long-term association with child protection services. The Women's has expertise in assisting women whose babies are born with substance-affected conditions.

The WADS service offers training targeted to professionals working in acute and primary health services and the community sector to increase the capacity of the Victorian drug and alcohol workforce to appropriately respond to the complex and diverse needs of pregnant women and their infants. The demand for these services is growing and further resources and models of care to meet the needs of these very vulnerable women is required.

3) *Transgender and gender diverse*

There is a need to develop comprehensive models of mental health and clinical care for transgender and gender diverse people and children (i.e. mental health care, clinical and surgical support with gender reassignment; fertility preservation; and research into the health implications of transgender hormone replacement therapy). Services for this emerging area of mental health are not well coordinated at present.

The Women's plays a lead role in the public sector in fertility preservation, both for adolescent and adult women, men, transgender and gender-diverse people.

4) *Aboriginal and Torres Strait Islander Women*

As part of a NHMRC trial, the Women's is providing a caseload midwifery model of care to Aboriginal and Torres Strait Islander women. This model of care is known as 'Baggarook' and women receive continuity and individualised care from a known midwife throughout their pregnancy, labour and birth and the first days as a new mother. This model of care is hailed as the "gold standard" of care and appropriately delivers services, which are culturally sensitive, and responsive to the needs of Aboriginal communities.

5) *Women as victims of violence and sexual assault*

There is evidence that women are significantly more likely to experience sexual harassment in the workplace at least once, and also more likely to experience sexual assault when compared with men. Women with a history of sexual assault also have significantly higher rates of clinically significant depressive symptoms, anxiety, and poor sleep than women without this history. The negative impacts of violence on women can also include poor mental health, as well as alcohol and illicit drug use and suicide.

The Women's runs a dedicated CASA (Centre Against Sexual Assault) service in Melbourne's north, which essentially provides sexual assault counselling services. It is associated with other CASA services around Victoria. There are clear links between the services of CASA and patients with specialised mental health needs.

In summary, the Women's recommends:

C1. That a range of funded strategies are developed to prioritise services that will

improve access and delivery of mental health care for the following cohorts:

- Women who are asylum seekers and refugees
- Women who us alcohol and other drug
- Transgender and gender diverse people
- Aboriginal and Torres Strait Islander women
- Women who are victims of trauma, violence and sexual assault

4. What can be done to attract, retain and better support the mental health workforce, including peer support workers?

Training and education of the mental health workforce must include upskilling clinicians to consider the impact of gender and increase awareness of the specific mental health needs of women. There is a need for specific training with support in the best use of mental health interventions for women and specifically to better meet the needs of women experiencing trauma and violence. The Women's recommends that the principles of gender transformative practice must be incorporated into mental health training, education and service provision.

Gender specific training to the health workforce

The Women's trains students, mental health professionals and general practitioners to identify and treat women:

- with symptoms of mental disorders including depression, anxiety and trauma related disorder;
- with serious mental illness who require specialist perinatal psychiatric care;
- who are experiencing trauma and domestic violence and/or who have experienced past trauma and abuse;
- with complex issues related to pregnancy and reproductive health choices; and
- who are likely to need clinical intervention to make the adjustment to parenting and to promote infant attachment.

The CWMH at the Women's trains clinical psychologists, psychiatrists and other mental health professionals, as well as generalist practitioners, such as maternal and child health nurses, social workers, midwives and family support workers in the ways that infants communicate their social and emotional needs, as well as using specific mental health assessment tools in standard clinical practice.

In the absence of standardised professional education for psychiatric trainees in perinatal mental health, the Women's coordinates and supports a well-subscribed elective subject in Perinatal Mental Health through the Masters of Psychiatry course at the University of Melbourne.

The Women's is also piloting an online supervision course for clinical mental health practitioners and provides training in the NBO, BEAR and parent infant interventions on a regular basis.

This experience in women and infant specific training, places the Women's in a unique role as a state-wide leader in the development of gender-sensitive, interpersonal violence-sensitive, and attachment-sensitive mental health care for women and newborns. The Women's has expertise in multidisciplinary training and workforce capacity

building initiatives and can lead the mental health service system to provide evidence-based solutions for women and newborns' mental healthcare across Victoria. The expansion of this training to clinicians beyond the Women's will also assist with attracting, retaining and supporting a specialised, skilled mental health workforce across the health sector into the future.

In summary, the Women's recommends:

D1. That the principles of gender transformative practice be incorporated into mental health training, education and service provision.

D2. That all clinicians are upskilled to manage the impact of gender and increase awareness of the specific mental health needs of women.

5. 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?

Reforms that integrate gender across the system

A Victorian mental health system that is fit for purpose in the 21st century, requires system level reform that integrates a gender analysis and clinical response, and is tailored to the different and diverse needs of women and young children. This includes ensuring access to mental health services that respond to the specific challenges women experience, comparative to men, over their lifespan: through childhood, adolescence, reproductive years and in mid-to-later life.

The status of mental health services provided by the Women's needs to be clarified, including the Women's status under the Mental Health Act

The Women's is not currently recognised as a '*mental health service provider*' as defined in the *Mental Health Act 2014* (the Mental Health Act). It is neither a designated mental health service, nor a '*publicly funded mental health community support service*'.

It is not clear whether and how the Mental Health Act applies to mental health services provided by the Women's. The Women's as an entity and its services are invisible in the current statutory framework. This lack of clarity creates significant risks for the hospital, its patients, and for the Department and sector.

The Women's has regular interactions with women needing to access mental health services. For example:

- It is common for antenatal and postnatal women to present for care to the Women's with an acute mental illness (eg. suicidal or psychotic).
- When women arrive at the Women's Emergency Centre (WEC) with an acute maternity or gynaecological condition requiring specialist medical care and hospital staff believe the woman may have a current or past mental health condition, staff currently have no access to the state-based mental health database (CMI). In this situation, the Women's staff must contact Melbourne Health to seek access to the woman's mental health history. This results in a delay in appropriate services and care for the woman and creates a risk to her health and safety.
- Some patients in the Women's care (inpatients) are classified as 'Compulsory Patients' under the Mental Health Act and subject to Treatment Orders made by

designated mental health services, often by North West Mental Health (Melbourne Health), which is collocated with the Women's in Parkville.

The Women's has expertise in women's mental health. For example:

- The Women's currently receives specific funding from the Department's Mental Health Branch to fund two Psychiatric Registrar positions to deliver mental health services to Women's patients.
- The Women's Director of Women's Mental Health is Professor Louise Newman AM. Her professorship is a joint appointment between the Hospital and Melbourne University.
- The Women's is an accredited training site for Registrar training for mother baby health with the Royal Australian and New Zealand College of Psychiatrists (RANZCP) and the Australian Psychological Society (APS).
- The Women's provides the qualifications and experience of its mental health clinicians to North West Mental Health (Melbourne Health), which is a designated mental health service. This operates as an informal accreditation and professional supervision arrangement.
- The Women's undertakes its own formal credentialing of medical staff working at the Women's including employed psychiatrists.
- The Women's undertakes some joint staff training with North West Mental Health (Melbourne Health).
- Considerable information sharing occurs between the Women's and North West Mental Health (Melbourne Health) in relation to patients with overlapping needs, typically maternity patients with severe medical or mental health conditions.
- The Women's has an informal accountability relationship with the Office of the Chief Psychiatrist. This is silent under the legislation as we are not included in the definition of a '*mental health service provider*'.
- The Women's collects and handles mental health information daily. The extent to which the Mental Health Act protects the use and disclosure of, and access to, this information is unclear.

The Women's is participating in a major IT change project to introduce a single Electronic Medical Record (EMR) across four health services in Parkville. A comprehensive Privacy Impact Assessment was recently undertaken by Minter Ellison, external lawyers. The lawyers were advised by the Women's and Peter MacCallum Cancer Institute that these two health services in Parkville:

1. Employ mental health professionals including senior psychiatrists; and
2. In practice provide specialised mental health services to patients, even though the Women's status in doing so is not clear under the Mental Health Act.

The authors of the Privacy Impact Assessment Report noted this information, however

concluded in their June 2019 Report that it is unsatisfactory that the Women's status as a '*mental health service provider*', that regularly collects and handles mental health information, is not clear or confirmed under the Mental Health Act. Minter Ellison recommended that greater clarity is necessary at least in relation to the issue of adequately protecting patient privacy and information handling, which was the scope of their brief.

The other two health services involved in the EMR project, the Royal Children's Hospital and Melbourne Health, are designated mental health service providers. The four health services will be using a single medical record platform from May 2020.

One way of recognising the status of the Women's under the Mental Health Act, is to amend the current definition of '*mental health service provider*' to include '*specialist designated hospitals*', with a view to the Secretary of the Department designating specialist hospitals such as the Women's, Peter Mac, and the Women's and Children's Hospital to be built at Geelong.

The EMR Privacy Impact Assessment Report recommended that the definition of '*mental health service provider*' in the Act should be amended to include the Women's and Peter Mac, in order to adequately protect mental health information collected and handled by those health services.

There are other statutory mechanisms and frameworks that could be considered to achieve suitable recognition for the mental health services provided by specialist teaching hospitals that, under the Act, are not designated mental health services. The Women's would be happy to further discuss statutory options with the Department and the Commission.

An integrated model of mental health and maternity services – including inpatient mental health services for maternity patients

The Women's believes that a specialist focus for women's mental health services must be maintained and strengthened, rather than incorporating such services as part of a designated mental health service.

Best practice in perinatal care responds to the physical and mental health needs of women and newborns. In Victoria's service system, the missing element is a comprehensive model for integrating mental health care into maternity services. This service system gap is imposing a burden not only on women and their families, but on the broader health system.

The establishment of integrated perinatal and infant mental health service hubs in the community would respond to such need. This recommendation aligns with the Victorian Parliamentary Inquiry into Perinatal Services and the need for more community-based services and day programs to reduce the rate of women's and newborns' hospitalisation. Services and models of care should be developed in coordination with child protection, maternal and child health nurses, early childhood services, mental health and primary care. These hubs could also integrate with other important reform initiatives relating to family violence, such as the Orange Door[2].

[2] https://orangedoor.vic.gov.au/

There is a need for dedicated, funded women's mental health beds in the system with appropriately trained mental health staff for perinatal and postnatal women who need a high level of mental health care. We have a steady number of patients in this category, some of whom are Compulsory Patients under the Mental Health Act, and some of whom are voluntary mental health patients with significant care needs (eg. Women who are substance users, violent, or in custody). We would be happy to provide further information to the Commission about the acuity of this group.

Currently the limitations in providing safe and adequate care for women who, late in pregnancy or after delivery, require integrated maternity and mental health treatment. The Women's preference is for such beds to be located in a maternity hospital, co-located with a designated mental health service. In the Women's view, the model of co-location would ensure the best possible continuity of care.

The benefits of such a model would provide capacity for a longer stay in a maternity hospital, with mental health support where necessary, as an 'acute step down' in the early post-natal period, with a focus on providing specialist antenatal maternal and infant mental health support. This period is an opportunity for clinical mental health observation, support and education and the ability to provide timely treatment or linkages with ongoing community services such as maternal child health nurses, family support services and primary health.

Currently, linkages into the community are very limited in some areas, especially in rural and regional Victoria. We recommend enhancement in the system's capacity for home based outreach in regional and non-metropolitan areas. Engaging vulnerable families in this process will lead to harm minimisation giving 'at risk' families the best possible start to their parenting journey. The Women's is well placed to play a state-wide leadership role in the delivery of specialised women's mental health services in non-metropolitan and rural areas.

A more integrated model of mental and maternity services will assist with engaging vulnerable families and increase the likelihood of an improved start to their parenting journey. It will also improve the transition to home when vulnerability is high and will promote integrated care aimed at both relapse prevention and monitoring of parental mental health and support for parenting and infant development. Enhancing the role of maternal child health nurses is an important strategy already supported by the MERTIL (My Early Trauma Informed Learning) a state wide training program on early infant trauma and risk co-led by the Women's and Deakin University. This has been well received and is an important opportunity to enhance these critical and well placed staff to recognise and respond to early developmental trauma and risk in vulnerable families.

State-wide leadership - Centre for Excellence in women's and newborn mental health

The CWMH at the Women's is well-established and has been in existence for nearly a decade. The role of the Women's as a specialist hospital would be enhanced if we were able to provide more state-wide leadership and training, as well as managing tailored mental health care for complex mental health patients across the system.

It is proposed that the Women's is supported to become a Centre of Excellence in Women's Mental Health. This would:

- strengthen the Women's current state-wide role through ongoing support and secondary consultations to all areas across Victoria;

- create a state-wide training program in women's mental health for all mental health services; and
- create a body to support policy development and research in areas of women's and infant mental health.

Women's safety in psychiatric facilities

Ensuring women's personal and sexual safety in psychiatric facilities is central to best practice treatment and care models that are safe and person-centred. This includes the need for women-only facilities to ensure the safety of vulnerable women and adequate responses to any cases of sexual harassment and assault in psychiatric services. This was highlighted in a past Mental Health Complaints Commissioner Review.

A Perinatal and Infant Mental Health Review Committee

The Women's recommends that an ongoing review function be re-established for perinatal and infant mental health services. This brings clinical experts together with policy makers and administrators, to ensure that unintended consequences of reform are signalled early and key goals and objectives are achieved. The Terms of Reference of this Committee could include:

- Reviewing outcome data and best practice evidence;
- Reviewing program efficiency;
- Identification and mapping of service needs including the management of high risk groups;
- Reviewing service capacity, gaps and community needs in pursuit of a coordinated state-wide model for women's and infant mental health;
- Reviewing current approaches to treatment an intervention and links between hospital based and community services;
- Develop clinical guidelines for improved response and management of perinatal and infant mental health disorders across maternity and mental health services.

In summary, the Women's recommends:

E1. That all hospital based maternity services across Victoria integrate a mental health service into their model of care. Features of this service could include:

- Early identification of women experiencing depression, anxiety or mental illness through antenatal psychosocial screening and treatment where required;
- Post-natal support for parents to improve their parenting skills, including attachment and understanding and responding to the needs of the baby;
- Seamless referral to gender specific, women's focused and skilled mental health practitioners at any time during the maternity episode of care.

E2. The establishment of integrated perinatal and infant mental health service 'hubs' in the community that bring together child protection, maternal and child health, early childhood services, mental health and primary care. These hubs would respond to the needs of women and children and could also integrate

with other important initiatives such as the Orange Door.

E3. The establishment of dedicated inpatient mental health beds for maternity patients (perinatal or post-natal women) who have high care needs. These beds could also provide capacity for a longer stay in a maternity hospital with mental health support in an 'acute step down' unit focusing on providing specialist antenatal maternal and infant intervention and mental health treatment in the early post-natal period.

E4. The establishment of a Centre of Excellence in Women's Mental Health to provide state-wide leadership and training, as well as provide clinical support of mental health patients across the system.

E5. An amendment to the definition of '*mental health service provider*' in the *Mental Health Act 2014* to recognise the mental health services currently provided by '*specialist designated hospitals*', which would include the Women's.

E6. That a specialist focus for women's mental health services is maintained and strengthened, rather than incorporating such services as part of a designated mental health service. A co-location model is preferred.

E7. The establishment of a perinatal and infant mental health review committee to ensure that the quality and safety of care is maintained.

6. Is there anything else you would like to share with the Royal Commission?

Gender Inequity in the system, why women matter:

The Women's strongly advocates that a gendered view on the provision of mental health services is essential because:

- Women experience high-levels of depression and anxiety impacting their health and wellbeing and that of their child/ren and their roles as parents and carers;
- Women with mental illness are more likely to experience violence, abuse and harassment;
- Women's biology influences their treatment needs, such as drug use and response;
- Women experience higher rates of abuse and trauma and as such, have significant rates of trauma related mental health disorders;
- Women experience specific developmental challenges that impact mental health, including adolescent development, pregnancy and the perinatal period, ageing and menopause;
- Women experience mental health issues relating to women's cancer and gynaecological issues.

The Women's focuses on the specific mental health needs of women across the lifespan and sees the importance of specific attention to the needs of women as essential to enhancing the mental health of the population. Women face specific mental health challenges at crucial developmental periods in their life. As well as pregnancy and transition to parenthood, challenges include adolescence and body image, fertility control and reproductive health, women's cancers and gynaecological conditions and ageing.

The Women's also focuses on the specific mental health needs of newborns as babies of women experiencing mental health issues are also at greater risk of developmental

problems (social, psychological, behavioural and cognitive).

It is well documented that mental illness and associated risks factors are among the top three causes of indirect maternal mortality in Victoria. A number of psychosocial factors including a previous mental health disorder, previous or current abuse, drug and or alcohol use, negative and stressful life events, and the availability of a social or emotional support network can affect a woman's mental health during the perinatal period with significant ongoing impact on family functioning and child development. Women's mental health should be a major priority in mental health service reform.

Despite this evidence, women continue to experience significant difficulty when it comes to identifying and seeking treatment for mental health. Ideally, a woman at any of these life stages is well informed about her mental health status, knows how to get help and has no barriers in accessing appropriate and timely mental health services with accessible treatment pathways. This includes, referral to specialist help both in the community and at a specialist health services, including maternity and women's health settings. Unfortunately, this is not always the case.

Suicide Prevention and women

The Women's is not providing a detailed response to the question of improvements in the system in relation to suicide prevention. However, in the area of women's mental health, an approach to prevention of suicide and self-harm needs to focus on the specific risk factors, associated with the role of family violence and abuse - including long-term impact of child abuse and trauma - and the prevalence of perinatal mood disorder. Early identification is a key strategy.

There is a clear need across mental health services and emergency departments to improve interventions and responses to women with complex trauma related disorders who may present with self-harming behaviours and suicidal ideation often in the context of lack of social support and interpersonal crisis. These presentations are frequently poorly responded to due to a lack of alternatives to acute hospitalisation and there is limited access to trauma focused interventions for women's complex needs resulting in frequent unproductive hospitalisation and repeated hospital presentations. An integrated approach to women survivors of trauma and abuse should include better collaboration and care planning across mental health and sexual assault services. There should also be a focus on raising skills in evidence based interventions of mental health staff to better manage women with these issues.

Privacy acknowledgement	I understand that the Royal Commission works with the assistance of its advisers and service providers. I agree that personal information about me and provided by me will be handled as described on the Privacy Page. ☒ Yes ☐ No