Royal Commission into Victoria's Mental Health System

WITNESS STATEMENT OF LOUISE NEWMAN

I, Professor Louise Newman AM, Director of the Centre for Women's Mental Health at the Royal Women's Hospital and Professor Psychiatry at the University of Melbourne, of 20 Flemington Road, Parkville, Victoria 3052, say as follows:

BACKGROUND

1 My full name, title and postnominals are as follows: Professor Louise Newman AM, BA Hons, MB BS Hons, PhD, FRANZCP, Cert Child Psych RANZCP.

Qualifications and experience

2 I hold the following qualifications obtained from the University of Sydney:

(a) Bachelor of Arts (**BA**) (Honours);

(b) Bachelor of Medicine and Bachelor of Surgery (**MBBS**) (Honours); and

(c) Doctor of Philosophy (**PhD**) after having completed my thesis on the topic of *'Trauma in Infancy – early adversity and psychological development'*.

3 In 1994, I obtained a Certificate in Child, Adolescent and Family Psychiatry from The Royal Australian and New Zealand College of Psychiatrists (**RANZCP**) and became a Fellow of the Royal Australian and New Zealand College of Psychiatrists (**FRANZCP**).

4 In 2011, I was appointed a Member of the Order of Australia for service to medicine in the fields of perinatal, child and adolescent mental health, to education, and as an advocate for refugees and asylum seekers.

5 I am currently the Director of the Centre for Women's Mental Health (**CWMH**) at the Royal Women's Hospital (**RWH**) and have held this role since 2014. I am a practicing infant psychiatrist with expertise in the area of disorders of early parenting and attachment difficulties in infants.

6 I have undertaken research into the issues confronting parents with histories of early trauma and neglect. My current research focusses on the evaluation of infant-parent interventions in high-risk populations, the concept of parental reflective functioning in mothers with borderline personality disorder and the neurobiology of parenting disturbance.

7 I also currently hold the following roles:

(a) Professor of Psychiatry at the University of Melbourne;

(b) Convenor of the Alliance of Health Professionals for Asylum Seekers; and

(c) Convenor Doctors for Justice.

8 Prior to my appointment as a Professor of Psychiatry at the University of Melbourne, I was appointed to the following roles:

(a) Professor of Developmental Psychiatry at Monash University;

(b) Director of the Monash University Centre for Developmental Psychiatry and Psychology;

(c) Chair of Perinatal and Infant Psychiatry at the University of Newcastle; and

(d) Director of the New South Wales Institute of Psychiatry.

9 Attached to this statement and marked **LN-1** is a copy of my current CV.

Current role

10 My current role is as the Director of the CWMH at the RWH.

11 The RWH is Australia's first and largest specialist hospital dedicated to improving the health of women and newborns. In 2007, the RWH established the CWMH in partnership with the University of Melbourne to provide expert clinical and therapeutic services for women, undertake research and provide education and training. The CWMH provides specialist care through a multidisciplinary team of psychiatrists, clinical psychologists, infant mental health clinicians and psychiatric consultation-liaison nurses.

12 My role as the Director of the CWMH involves management of psychiatric and mental health services to the RWH and leadership of a multi-disciplinary team of psychologists, nursing and psychiatric staff. I provide clinical consultation in infant and early parenting disorders, as well as abortion and contraception services.

13 In addition, I am the Medical Director of Allied Health and a member of the Quality and Safety Committee at the RWH. I also undertake research and teaching in the area of infant mental health and child development, which includes coordinating a substantial research program at the University of Melbourne's Department of Psychiatry. I teach both undergraduate and postgraduate students in the early development and psychotherapy areas and from time to time supervise advanced trainees in these areas.

Please confirm whether you are giving evidence to the Royal Commission in your personal capacity or on behalf of your employer or an organisation. If you are giving evidence on behalf of your employer or an organisation please confirm you are authorised to do so.

14 I give this evidence on behalf of the RWH, and am authorised by the RWH to give this evidence on its behalf.

15 The opinions and views expressed in my evidence are my own, and do not necessarily represent the opinions and views of the RWH.

16 I give this evidence from facts which I believe to be true and correct and which are within my own knowledge, unless otherwise stated. Where I refer to a document, I have read that document before signing this statement.

QUESTIONS FOR PANEL MEMBERS

Question 1: What could be done to better identify infants and children:

a. at risk of developing mental illness?

17 Unless otherwise stated:

(a) the expression 'infants and children' in this statement is a reference to children from newborn to three or four years of age; and

(b) this statement focuses on 'early in life' intervention in the context of infants and children, as opposed to early intervention in the onset of mental illness in teenage years.

18 There is increasing evidence of the importance of identifying early risk factors in infants and children for the later development of mental illness. The first three years of life are critical periods with respect to the development of neurological and psychological capacities and form the basis of ongoing healthy psychosocial development. These crucial developmental milestones are shaped by the quality of parenting and care received by the infant during this period. Trauma, disruption of care and attachment during this period are major risk factors for the onset of a range of developmental issues and contributes to the risk of vulnerability to mental illness at a later stage in life.

19 Accordingly, this illustrates the importance of early intervention and better identification of infants and young children experiencing challenges to development. This approach involves both identification of risk factors presenting with the infant or child (often presenting as developmental delay and/or behavioural disturbances) and also better identification and support for vulnerable families or carers during the early parenting stage. This is particularly important in cases involving vulnerable parents who have

experienced significant trauma themselves or are currently in high risk situations (for example, those experiencing domestic violence or social disadvantage).

20 In order to better identify infants and children at risk of developing mental illness later in life, there are formal screening methods available to identify risk factors during pregnancy. These factors may include a mother's existing mental illness, issues with substance abuse and experiences of domestic violence. Once these risk factors are identified, often by maternity services or maternal and child health (**M&CH**) nurses, the relevant service then has a role to play in facilitating referral pathways for those women to be assessed and supported.

b. experiencing or living with mental illness?

21 Infants and children who are at risk of developing mental illness later in life are more likely to show developmental delay, language delay and behavioural disturbances. While there is scientific evidence to demonstrate such links, the Victorian mental health system does not have the requisite service expertise or capacity to monitor child development or provide the necessary interventions when these factors are identified. This requires a coordinated and resourced approach across all layers of the health service, including primary and community health, and across educational and child protection services, amongst others.

22 Diagnosis of mental illness and defined disorders in infants and young children is a complex issue as disorders are in the process of developing and have less clearly defined boundaries in this age group. Children may present with a variety of mental health issues which than have a potential impact on cognitive and psychosocial development and impact their ability to control behaviour and emotions. It is a principle of child psychiatric practice to look at children's symptoms in the context of their family experiences and social context and the ways in which environmental and biological factors interact to produce the clinical picture. It is also important to note that disorders change in terms of impact and presentation over time and according to the child's developmental stage.

23 In infancy, early features of emerging disorders are broad and there are ongoing academic discussions around the validity of diagnosis in this age group and the best ways to look at the key developmental processes and impact of parenting and social factors in brain and psychological development. Practitioners may prefer to focus on assessment of risk factors and describe their developmental impact rather than define an infant as having a mental illness. There are also issues for those families who do not accept the validity of diagnosing mental disorder or illness in the very young and find this stigmatising and unhelpful.

Please consider the role of communities, schools, social services (including maternal and child health services, other health services, child protection services) as well as mental health services.

24 Communities, early childhood centres, social services and health services (including but not limited to mental health services) all have a role to play in identifying infants and children living with or at risk of developing mental illness, though there is variation across Victoria as to what services are accessible. Community health and primary care services play a significant part in screening infants and children for developmental problems, while early childhood centres may identify problems associated with sleeping or eating. Those workforces at the frontline of identifying risk factors and trauma in infants and children would be M&CH nurses.

25 To this end, the CWMH delivered a program called My Early Relational Trauma Informed Learning (**MERTIL**) in partnership with Deakin University's Centre for Social and Early Emotional Development led by Professor Jennifer McIntosh. The MERTIL program is a training program aimed at upskilling the state-wide work force of M&CH nurses in 'trauma informed practice'. The program was delivered via an online platform and clinical skills workshops and aimed to build skills in recognition of early in life trauma and appropriate initial responses. Evaluation of the program found the MERTIL program to be highly valued by staff and participants and effective in enhancing clinical practice amongst Victoria's workforce of M&CH nurses.[1]

26 Each of the abovementioned services could identify infants at risk and refer them and their families to specialist mental health services. Having said this, many parts of Victoria do not have child and adolescent mental health services or, where they exist, such services often only see children who are five years of age or older (some may rarely see four year olds). As a result, many infants and children are being seen and/or diagnosed with developmental or behavioural disorders far too late which, in turn, increases the risk of a misdiagnosis. Misdiagnosis or premature diagnosis is more likely to occur if the full early developmental history of the child is unknown and also the broad family and social context. A reduction in focus on the behavioural symptoms may be inadequate and mitigates against more thorough understanding of the child's experiences and context. Earlier identification of risk factors allows earlier intervention and provides an opportunity to influence the prevalence of mental health disorders or illness later in life.

[1] Clancy, Elizabeth M., Mcintosh, Jennifer, Booth, Anna T., Sheen, Jade, Johnson, Matthew, Gibson, Tanudja, Bennett, R. Nicolas and Newman, Louise 2020, Training maternal and child health nurses in early relational trauma: An evaluation of the MERTIL workforce training, *Nurse Education Today*, vol. 89, pp. 1-7

Question 2: What could be done to better support infants and children who are at risk of developing mental illness? What key changes would you recommend to:

- ***a. Victoria's mental health system? Please consider the community-based mental health system and early intervention approaches;***
- ***b. other service systems (including maternal and child health services, other health services, child protection services and schools) that support infants and children;***
- ***c. the way Victoria's mental health system and other service systems work together.***

Integration of services

27 In my view, one major change required to strengthen Victoria's mental health system is better integration across all disciplines and service sectors, particularly the following services which are currently quite fragmented:

(a) maternity services;

(b) child protection services; and

(c) M&CH services; and

(d) child and adolescent mental health services.

28 The above services can be integrated to prioritise 'early in life' intervention and each service has a unique contribution to make to better support infants and children who are at risk of developing mental illness.

29 For example, child protection services are able to become involved early on and plan around the needs of high risk infants including initial responses such as referral to child mental health services, carer support programs or social development programs (provided such services are available, referrals can be supported and followed up without requiring navigation by the consumer and form part of an integrated model of care).

30 Child and adolescent mental health services can be upskilled and enhanced so that they have the capacity to see children under four years of age (currently not possible due to age restrictions in service qualification criteria).

31 Maternity services are well positioned to identify women who may need additional support and intervention both during pregnancy and in the care of their infant. It would be effective for hospitals to screen patients for major risk factors such as mental illness and depression, substance abuse issues, experiences of trauma, domestic violence and housing insecurity, all of which increase the risk both for pregnant women and their infants. Beyond this, it is important that screening is linked to adequate referrals and mental health services to provide interventions and coordinate community services and supports. In particular, women with complex needs require integrated care and support

from a variety of services with the attendant risk of fragmentation of care. Ideally, there should be established processes for the review of management plans for women and ongoing discussions with them about which supports they find most appropriate.

32 The RWH has a dedicated mental health service and clinicians are integrated into antenatal and post-natal services. Maternity teams can readily refer women if there are concerns about mental health and can also refer women to drug and alcohol services and support if any concerns arise in relation to domestic violence. The mental health service at the RWH is limited by its available resources and is often forced to prioritise women with significant mental disorders and risk factors. There is limited capacity for women and infants to participate in a group intervention programme run by RWH and funded philanthropically. These approaches are under evaluation to provide much needed evidence to guide further development of early intervention services and to ascertain how best to meet the needs of the most vulnerable cohorts and to prevent the onset of developmental and psychosocial problems in infants and young children. Ideally, families should be able to better access early intervention and family supports in local areas, as well as ongoing M&CH support and primary care.

Governance and planning

33 An impediment to the integration of these services relates to governance. The above services are overseen and funded by different government departments and areas (including health, child protection and family services), each with differing objectives and approaches that do not always support complementary or integrated service provision.

34 In addition, there is currently no formal process of State level planning for the development and monitoring of perinatal, infant and early childhood mental health services or the development of practice guidelines and service models in this area. It may be worth considering the establishment of a perinatal and infant services committee to act as an advisory group to the Department of Health and Human Services (**DHHS**) on these issues across the integration and ongoing governance of the relevant services across sectors.

35 In a practical sense, adequate funding is necessary in order to facilitate better integration of these services across the various sectors.

Question 3: What could be done to better support infants and children who are experiencing or living with mental illness? What key changes would you recommend to:

- ***a. Victoria's mental health system? Please consider the community-based mental health system and early intervention approaches;***
- ***b. other service systems (including maternal and child health services, other health services, child protection services and schools) that support infants and children;***

c. the way Victoria's mental health system and other service systems work together.

36 In the context of supporting infants and children who are experiencing or living with mental illness (or at risk of developing mental illness at a later stage in life), the system integration issues are largely similar to those in the context of infants and children at risk of developing mental illness. It is often the case that by the time an infant or child is finally provided with access to a child and adolescent mental health service, developmental issues have manifested or they already have significant problems in functioning such as behavioural and learning difficulties.

37 Key changes are required to ensure that the early childhood sector and primary care are better informed in relation to mental health issues in high risk infants and children. While there are some existing school-based programs addressing mental health issues in primary school children, there are minimal services currently equipped to address these issues for infants and very young children at risk of developing mental illness.

38 In its current state, Victoria's mental health system and other service systems do not adequately work together. There needs to be recognition that infants and children are seen in a variety of non-mental health services and there is scope to integrate an approach where the mental health of infants and children are addressed across all sectors. This would improve the accessibility of mental health support and programs that can act as a back up to the existing mental health services.

Question 4: What features of system design need to be considered to make specialist mental health expertise available to advise other service providers, such as those working with infants, children or their families who have experienced trauma?

39 The siloed approach in the existing system design is an impediment to mental health services. There are currently no clear pathways for providing mental health care and no clear communication between services who are seeing the same infants, children and families.

40 Ideally, a clear model for the provision of mental health care for infants and young children needs to include an understanding of the importance of the early developmental period and the role of families/carers in shaping development during this period. The focus of support and intervention includes both the parents/carers and the infant/child and is based on a model that recognises the significance of attachment relationships and context. This requires comprehensive assessment of the child in the context of their family and caretaking relationships and their overall development. Without better identification of and response to risk factors in the environment and family, there is a risk of misdiagnosis and over-diagnosis of mental disorder in the very young. In practice, services could better be organised around a broad developmentally informed assessment

approach which is child-centred and skilled at developing collaborative relationships with families in need.

41 There is currently considerable variation across the systems involved with families and young children in terms of data collection, assessment processes and tools used and access to specialist clinicians. There are also limited opportunities for planning and review across the various agencies who may be involved in working with these families. Accordingly, there may be benefit in considering a coordinated State-wide system of intervention planning and monitoring for the most vulnerable families and infants, which aims to better integrate services and develop a shared understanding of the goals of intervention.

42 Although child protection services are mandated to coordinate care and do it proactively, it does not seem that mental health services and hospitals do this to the same degree. This may be due to the fact that there are currently minimal links between services and no articulated, centralised model guiding clinical practice in this area.

43 It may be beneficial to look at adopting a process comparable to the processes undertaken during the Royal Commission into Family Violence, where various sectors were brought together to enhance the approach and coordination of the mental health system. As mentioned above, the current system may benefit from a higher level planning approach guided by the establishment of a specialised perinatal and infant services committee to advise DHHS in this area. In my view, without commitment at a government and departmental level, the existing fragmentation in the current system will simply continue.

Question 5: What changes could be made to the current system that would better organise mental health and other social services around the needs of an individual child or cohorts of infants and children?

44 As mentioned above (see paragraphs 399 to 433), better integration of services and sharing of information could be improved by a process of formal interagency review and detailed planning of intervention and support.

Question 6 and 7: Should services for children, adolescents and youth be streamed by age? If so why and how? What are the challenges associated with age-based streaming?

45 In my view, mental health services for children, adolescents and youth do not necessarily benefit from rigid age-based streaming of services. Such an approach is unnecessary and risks neglecting some of the complexities around developmental periods and issues. Instead, mental health services for children, adolescents and youth should be development informed and equipped to address developmental change at all different age groups.

46 Currently, for example, many child and adolescent psychiatrists lack confidence in Victoria's mental health system as a child who is 12 years of age and a young adult are provided with the same service within adolescent and youth mental health services. This fails to acknowledge that both age groups have manifestly different developmental needs. In the same way, mental health issues present differently in infants and children, as opposed to older children, therefore necessitating different approaches.

47 In addition, there are particularly vulnerable groups which often miss out on services that are not available within age-based stream services. For example, women experiencing premature pregnancy, drug and alcohol issues, family violence or have a history of sexual abuse. These women experience a complex set of issues that do not fall comfortably within the range of issues usually managed by aged based services and instead require specialist support services, or access to specialist service regardless of which developmental stream they fall within.

Question 8: Could the aims of aged based streaming be met through alternative means? For example, by streaming based on different criteria.

48 As mentioned above, services could be organised to integrate key developmental periods and challenges into the service provision as opposed to age-based streaming. Specifically, this may involve ensuring capacity within a service to provide:

(a) an integrated perinatal and infant model which provides care from newborn to approximately three years of age;

(b) child and family services facilitating educational entry and support for children with developmental issues; and

(c) adolescent services stepping in at a later stage with respect to older children when developmentally appropriate.

49 At Monash Health, I was involved in the establishment of the Early in Life Mental Health Service (**ELMHS**) which is a service where young people who are experiencing emotional, behavioural or mental health problems are able to seek assistance. This model covers the whole spectrum of services from perinatal services, mother and baby units, child mental health units, early childhood services, up until young adulthood. However, under that umbrella, there is a multidisciplinary team who maintain a developmental focus (rather than an age-based focus).

Question 9: How important is family and carer engagement in the delivery of services to infants and children? What assists and what hinders successful family and carer engagement?

50 Family and carer engagement in the delivery of services to infants and children is absolutely essential, particularly in the context of the first 1000 days of an infant's life. The CWMH does not see infants and children alone, it sees them in the context of their parents, families and carers. This allows the CWMH to work simultaneously with the infant or child and their parent to attempt to support and enhance the quality of the child-parent relationship wherever possible. Where an infant or child has multiple carers, we enhance early childhood interaction by engaging all carers in the process. This engagement of families and carers is fundamental as infant neurological and psychosocial development is dependent on interaction with carers and shaped by the quality of attachment relationships.

51 There are various complex factors that hinder successful engagement with families and carers, particularly those from high risk cohorts. One major barrier is that parents in vulnerable or marginalised communities have trust issues about engaging with health services. There is an anxiety that if they are honest about their difficulties as parents or carers, their baby or child may be taken away from them by child protection services. In addition, families and carers who are indigenous, asylum seekers, or experiencing homelessness and drug and alcohol issues often find it difficult to engage with services or feel understood. Other barriers include language issues including difficulty in provision of interpreter services and lack of clinical expertise with respect to engagement with vulnerable groups who may be reluctant to accept support.

Question 10: What are the professional mindsets, capabilities and skills that are needed for working specifically with infants, children and their families and carers in mental health?

52 Firstly, the necessary attitudinal mindset is one that recognises the need for an approach that is based on a fundamental understanding of the importance of the development and the rights of a child. In addition, services should adopt a mindset that the earliest possible intervention will be the most successful (ie a preventative model). Given the current mental health system is overwhelmed by acute presentations and crisis responses, we cannot afford to have a system that is not informed by the science of early intervention.

53 Secondly, specialist training and a multi-disciplinary approach is required to implement early intervention or preventative models. An effective multi-disciplinary approach involves all disciplines from nursing, social work, psychology and psychiatry. Such an approach should also be adaptable to the needs of communities and flexible in the sense that the requisite professional skills can be built up regardless of where the professional is located within Victoria.

54 By way of example, the CWMH trains clinical psychologists, psychiatrists and other mental health professionals, other professionals including general practitioners, 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. A proposed comprehensive model for integrating mental health care into maternity services in Victoria's service system is further discussed at pages 17 and 18 of the RWH's submission to the Commission.[2]

55 Services and skills need to be embedded in metropolitan areas. However, people in rural or regional areas cannot be expected to travel into metropolitan areas to access tertiary health services. Instead, it is preferable to adapt the system to allow metropolitan services to offer supervision, consultation and support to professionals (from whatever discipline and from whichever rural or regional area) to be able to implement early intervention in their practices. Training packages can be developed and 'distant' support can be provided.

56 Finally, in order to increase the uptake in engagement with services, the focus should be on using a collaborative approach that is centred on the welfare of the infant or child. It is important for mainstream professionals to be able to build a rapport and work collaboratively with diverse families and carers. Staff and services should be well-trained in relation to cultural differences and the real anxieties that some families and carers have when engaging with services. In this sense, it is valuable for services to engage a diverse range of workers, including bilingual, bicultural and indigenous workers.

Question 11: What are the implications of the required professional mindsets, capabilities and skills you have identified above for the composition, training and deployment of:

- ***i. clinical workforces?***
- ***ii. non-clinical workforces?***
- ***iii. workforces in other service settings who may identify presenting mental health needs in infants and children (e.g. maternal and child health and early education staff)?***

57 This is answered below in paragraphs 588 and 599.

Question 12: What prevents existing workforces from providing optimal care, treatment and support to infants and children, and what steps can be taken to overcome these factors?

58 As mentioned above, lack of training and integration of services prevents existing workforces from providing optimal care, treatment and support to infants and children.

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[2] *Submission of the Royal Women's Hospital to the Royal Commission into Victoria's Mental Health System,* https://s3.ap-southeast-2.amazonaws.com/hdp.au.prod.app.vic-rcvmhs.files/1415/6513/7242/Royal_Womens_Hospital.pdf

Victoria does not currently have a system with embedded skills and there is no coordinated approach at the State level for addressing the needs of infants and children.

59 It should be noted that there is considerable professional interest in work with infants and young children, as evidenced by participation in training workshops provided by the CWMH. However, there remains limited opportunities for the development of clinical skills in this area due to the scarcity of services and limited positions. As mentioned above, many child and adolescent mental health services do not have the capacity to see infants and young children and there are also limited maternal infant mental health facilities or community services. Professional development in this area is available and supported by bodies such as the Australian Association of Infant Mental Health, which has developed a significant network of staff and clinicians interested in ongoing involvement in the field. These staff and clinicians are and will be an important resource if there are further developments in clinical service provision.

Question 13: What capabilities and skills are needed within the workforce to better engage with families and carers of infants and children as partners in their care, treatment and support?

60 Training in the area of infant development (covering infancy and early childhood) is required in order to upskill the workforce to better engage with families and carers of infants and children. Such training is required across all service streams. All disciplines of child and adolescent health care in particular should have access to this training, both at the undergraduate and professional level.

61 Within the social work and health care curriculum, a core module should be offered which covers a basic understanding of the importance of early development, models of development and the risk and protective factors for early development. By way of example, some existing courses and professional development programs at the University of Melbourne and Monash University offer infancy and early developmental theory modules within general psychiatry, clinical psychology and social work courses. For particular courses, extra modules are also available which address adverse impacts of domestic violence for early childhood development and the importance of recognising signs of child abuse.

62 However, in my opinion, the above training and skills are essential for anyone working in a clinical role, regardless of the discipline or the age of the consumer they are working with. For example, professionals who work with adolescents need to aware that development commences far earlier than during the adolescent years. These professionals need to be aware of how early development shapes psychological and neurological development and, more importantly, be able to ask appropriate questions about early development.

63 Finally, professional training in relation to the implications of this theory and how it translates into practice is important.

CONTEXT

Predicted changes in the prevalence of mental health issues for infants and children in Victoria

64 It is, of course, difficult to quantify or predict with any certainty the prevalence of mental health issues in infants and children in Victoria over the coming decades. There are increasing trends and rates in early developmental difficulties and risk factors for mental disorders, largely relating to social and environmental factors. In addition, there are increasing numbers of families, parents and carers who have limited access to mental health services, early parenting support and early childhood support.

65 I have co-authored a paper on this topic titled *'Early origins of mental disorder - risk factors in the perinatal and infant period.'*[3]

66 The impacts of mental health issues and mental illness on infants and children who experience disadvantage are particularly significant. For example, in a biological sense, substance abuse in pregnancy (particularly substances such as ice and stimulant drugs) are likely related to dysregulated babies. In addition, high levels of stress experienced by women during pregnancy are linked to difficulties in foetal development and early behavioural difficulties. This needs to be considered in light of family violence statistics indicating an increase in violent attacks on women particularly during pregnancy.

67 At a later stage, these risk factors can culminate into a major social problem. That is, it can contribute to a whole cohort of children who either do not make it into preschool or are expelled from preschool due to behavioural disturbances stemming from highly traumatised environments.

Presentation and identification of mental health issues or vulnerabilities in infants and children

68 Infant and child mental health issues or vulnerabilities may present in different ways and at various life stages, with some more difficult to identify than others. From a very young age (even from a few weeks of age), signs of high risk cases may be a failure to thrive or developmental delay. At the most severe or extreme end of the spectrum, often involving cases of neglect or abuse, there may be avoidance of eye contact, inability to regulate behaviour and failure to seek interactions with others. Amongst slightly older children,

[3] Newman, Louise & Judd, Fiona & Olsson, Craig & Castle, David & Bousman, Chad & Sheehan, Penelope & Pantelis, Christos & Craig, Jeffrey & Komiti, Angela & Everall, Ian. (2016), *Early origins of mental disorder - risk factors in the perinatal and infant period*, BMC Psychiatry International Journal

the earlier signs centre on tantrums and dysregulated behaviour, developmental delay, language delay and an inability to regulate emotions. Although these issues are more easily observed, children may also experience levels of depression and anxiety that impact development and contribute to withdrawal and difficulties in interaction (which, in turn, impact on development).[4]

69 Such vulnerabilities or mental health issues may be identified by professionals from all disciplines. However, within the current system of health services, the service providers who may be best placed to identify mental health issues or vulnerabilities in infants and children are likely to be M&CH nurses. M&CH nurses are well respected and, as they often visit family homes to provide nursing services, they have the necessary access to observe the relevant environment and interactions. During such visits, M&CH nurses may observe the interaction between a parent and his or her child and subsequently pick up signs that indicate, for example, that the child is scared of the parent.

70 In other cases, general practitioners can often identify infants and children who are vulnerable or parents with perinatal or postnatal depression. All clinicians, community workers and child protection workers may also make similar observations. The identification of difficulties or vulnerabilities can therefore come from various sources, what is important is that all sources are aware of what steps to take after making those preliminary observations to support the family to access help.

Access to services for infants and children presenting with mental health difficulties or vulnerabilities

71 Infants and children in Victoria who are presenting with mental health difficulties or vulnerabilities are undoubtedly missing out on access to appropriate services to some extent. However, it is difficult to quantify this gap as we can only base the numbers on what we actually see. There is, however, an obvious scarcity in child and adolescent mental health services that are accessible for infants and young children as intake criteria vary across services meaning we are likely seeing many less than those at risk or experiencing mental health issues. Some services have designated infant teams (to support newborns to children up to three years of age) whilst others do not have designated infant teams.

72 In addition, there are particular cohorts who are more likely to miss out on access to appropriate services in Victoria. Infants and children in high risk communities present with a range of contributing factors such as intrinsic vulnerabilities and adverse outcomes that predispose them to a range of behavioural problems and developmental difficulties.

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[4] Luby, Joan & Belden, Andrew & Pautsch, Jennifer & Si, Xuemei & Spitznagel, Edward. (2008), *The clinical significance of preschool depression: Impairment in functioning and clinical markers of the disorder*, Journal of affective disorders. 112 at pp 111-9.

More vulnerable cohorts include particular cultural groups and people living in regional or remote areas where minimal services are available. Further, there are vulnerable families who are anxious about the involvement of child protection services and choose to 'drift out' or live in more isolated areas in order to avoid such services.

73 In my view, rather than implementing universal intervention measures, groups that are particularly vulnerable should be prioritised and offered specialist support. There is evidence to support the finding that infants or children in these groups are more likely to become involved in criminal activity and exhibit antisocial behaviour or have adverse social outcomes. Despite there being a degree of awareness here, the system in its current state lacks the preparedness and ability to tackle this issue.

PREVENTION

Evidence on the extent to which mental illness, or the reoccurrence of mental illness, can be prevented

74 There is a growing body of evidence and increasing research in the area of prevention of mental illness and disorder. This work is extensive and is only summarised here to highlight the ongoing interest in early development of risk to later mental disorder and the opportunities for early intervention.

75 The current approach to this work is in respect of the better identification of the factors in early brain and psychological development that increase risk to developmental difficulties and increase vulnerability to mental illness.

76 A particular focus has been on the impact of early traumatic experience in the infant developmental period on the function of emerging brain structures and pathways needed to regulate stress and emotional health and which, if disrupted, can have broad impact on core areas of brain function such as cognitive development, emotional regulation, impulse control and interpersonal functioning. These are the foundations or underpinnings of later mental and emotional health.

77 Extant evidence is clear that early trauma and child abuse can have long-term implications for functioning with increased rates of depression, anxiety, personality dysfunction and post traumatic anxiety and on overall increased rate of all mental disorders in adult life. This appears to reflect the impact of high levels of stress-related hormones on brain development and the susceptibility to any later stress.[5]

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[5] See Gunnar M and Quevedo K, 'The neurobiology of stress and development' (2007) *Annual Review of Psychology* 58, 145-173.

78 Primary prevention of mental disorder notes the importance of early in life interventions (in infancy) which involve both vulnerable parents and infants in approaches to support healthy early neurodevelopment and recue early developmental distortions.[6]

79 On the basis of the current evidence, it is not clear to what extent later mental illness will be prevented in an absolute sense by early interventions. What is clear is that early interventions and the building of resilience and protective factors can ameliorate the severity of disorder and its consequences.

80 In short term follow up studies, early intervention support reduces rates of child mental disorders and improves outcomes.

81 Other factors such as genetic vulnerability, structural brain pathology and neurological disorders clearly also impact rates of mental disorder.

82 I am currently finalising a longitudinal study looking at infant intervention and child development to 4 years of age (the BEAR program) which is a randomized clinical trial at the RWH.

83 Most evidence related to early intervention has looked at severe early trauma and the reduction in risk of behavioural and emotional disorders including conduct disorder, oppositional defiant disorder and anxiety disorders. An important area of investigation is the relationship between early trauma and later complex trauma disorders (or Borderline Personality Disorder) where prevention essentially refers to prevention of child abuse, early detection of child trauma states and support for women with histories of abuse when they become parents. Rates of depression and anxiety and self-harm are significant in trauma related mental disorders and are an important focus of preventive models.[7]

Approaches to preventing mental illness

84 As mentioned above, the current preventive approach involves early intervention to enhance development of core neuropsychological structures and improve stress regulation. These are described as neuroprotective interventions. These are posited to improve core function and reduce overall risk of developing stress related mental disorders.[8]

85 In general, the preventive approach is one of improving resilience and reducing risk where possible through early identification and intervention. This does not necessarily delay

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6 See Newman L, 'Trauma-Informed Care in Infancy' in R Benjamin, Haliburn J and King S (eds), *Humanising Mental Health Care in Australia – A Guide to Trauma-informed Approaches* (Routledge Oxford, 2019).

7 See Kate MA, Dorahy M, 'Complex Post-traumatic Stress Disorder, Developmental Trauma' in R Benjamin, *Borderline Personality Disorder and the Dissociative Disorders* (2019) 84-99.

8 See Newman L et al., 'Attachment and early brain development – neuroprotective interventions in infant–caregiver therapy' (2015) *Translational Developmental Psychiatry* 3, 28-47.

onset of inevitable disorder but may contribute to reduction in severity and disability related to illness, including reduction in self-harm and secondary impacts such as interpersonal conflict, isolation and hospitalisation. Comprehensive risk reduction programs include a focus on social connection and interpersonal functioning as well as "symptom" reduction and management.

COMMUNITY BASED MENTAL HEALTH SERVICES

Types of care/services necessary for infants, children, families and carers

86 The community-based mental health system should be developed to offer more extensive care/services for infants, children and their families and carers. For example, the community-based mental health system should offer local community walk-in services that are accessible to families and staffed by the right mix of professionals who are able to assist with concerns around child care and early developmental issues.

87 While there are existing early childhood centres or 'hubs', these are currently focused mostly on issues around feeding and sleeping. It may be effective to enhance these facilities by adding on or linking specialist services in an accessible and non-threatening way. Early childhood hubs can, for example, implement developmental screening and adopt a more integrated model.

Mental health support through social service providers

88 In order to support the community-based mental health system, social service providers (such as education, M&CH and child protection services) can also deliver care/services to infants, children and their families and carers to support good mental health. There are no specific 'types' of care or services that other social services should be delivering to infants, children and their families and carers to support good mental health. Rather, these services should be alive to the risk factors and be equipped to identify those risks and make appropriate referrals based on their observations. These skills are not currently built into the Victorian mental health system as a necessary part of the system configuration.

89 As mentioned above, schools, social services and health services (including but not limited to mental health services) all have a role to play in identifying infants and children living with or at risk of developing mental illness:

(a) early childhood services or 'hubs' focus on physical childcare and involve a workforce who are skilled in providing support in respect of behavioural and other health issues but are offered limited (if any) training on identifying infants and children at risk of developing mental illness (eg toddlers with behavioural disorders);

(b) child care centres;

(c) schools may pick up risk factors in children at the primary school age through their school counsellors and on-site psychologists;

(d) M&CH nurses are well placed to observe the relevant environment and interactions between infants, children and their families and carers;

(e) child protection services must often prioritise cases of child abuse or maltreatment and do not have the capacity to provide parenting support and support with developmental issues with infants or children who may be a risk tier down from those serious cases. However, they are in unique position to identify and refer to specialist services if they are trained and provided with referral pathways.

90 In relation to the M&CH sector, the RWH has trained approximately 1,600 M&CH nurses with the clinical skills to identify risk factors, suggest interim strategies to support parents and provide appropriate referrals. Following this, the DHHS developed another program to assist M&CH nurses to identify early signs of autism in infants and children. Such programs are effective as M&CH nurses are ideally placed to closely observe and have a more meaningful relationship with the families and carers of infants and children.

91 Similar to M&CH nurses, child care service providers are also at the frontline in seeing infants, children and their families and carers. While the existing curriculum and training for early childhood care commonly involves modules for child development, child protection and the importance of emotional needs, such disciplines are ideally situated to undergo enhanced training in the area of recognition of signs of attachment and developmental difficulties in infants and children. As mentioned above, this training is particularly fundamental in the context of providing care/services for high risk communities.

92 In addition to being trained to identify attachment and developmental difficulties, social service providers need to be aware of the available pathways and how to access appropriate referrals in the event that a child of concern is identified. Many service providers are well versed in identifying instances of child abuse which must be reported to the DHHS, however are less familiar with the referral pathways where the concern relates to emotional wellbeing and falls short of the level that mandates child protection intervention.

Arrangements to better integrate mental health and other social services

93 In order to better integrate or coordinate mental health and other services (including M&CH and child protection services), Victoria's mental health system requires an evidence-based and trauma-focused model of care. The arrangements recommended to

ensure better overall health outcomes through integration of services would ideally involve all of the following:

(a) service planning and program coordination at a State level involving all disciplines and services (beyond mental health services);

(b) at a ground level, cross-disciplinary panels to provide better support and care to high risk infants and children;

(c) integrated mental health services and family support in early childhood hubs (with a focus on early parenting and enhancing childhood development, beyond physical childcare).

94 A system of cross-disciplinary panels addressing high risk infants and children already exists in some child protection jurisdictions. For example, the 'high risk infant panel' in Victoria coordinated by child protection services involves various disciplines or services coming together to discuss concerns arising from high risk cases. The participating services include whichever services might be involved in the care, coordination and planning of the child and may include but are not limited to early childhood, M&CH, infant and perinatal mental health services. In my view, cross-disciplinary panels can be quite effective for planning and coordinating support for newborns to children up to three years of age, particularly high risk infants and children.

95 The common theme is that a wide range of workforces need to be upskilled in the area of infant and early childhood development and there should be a coordinated approach to such training. A 'one size fits all' approach cannot be taken and specialist programs are also required to provide support to vulnerable groups who have experienced or are experiencing trauma.

96 In addition, while Victoria has some effective programs providing basic in-home support, many rural or regional areas do not have access to the same types of services.

Best practice in the provision of infant and child mental health services

97 When it comes to providing infant and child mental health services, some examples of best practice in Australia include:

(a) The CWMH at the RWH which I lead, is the national leader in women's mental health and early parenting and an academic research unit of University of Melbourne with a focus on innovative intervention models ; and

(b) Helen Mayo House in South Australia, which offers clinical services for women with complex trauma related mental disorders and their infants.

98 On a global level, there are some examples of best practice programs and initiatives that have similar models including:

(a) the Anna Freud National Centre for Children and Families in London, United Kingdom which is focused on developing and delivering the best possible evidence-based treatment through research and collaboration (particularly research around intervention);

(b) the Newpin model first established in the United Kingdom, which is focused on early intervention;

(c) the Head Start program in the United States which promotes the school readiness of children from birth to age five from low-income families.

99 There are several iterations in different parts of the United States and United Kingdom of the Head Start program. The evidence generated by such programs all tend to illustrate the importance of outcome-based approaches, addressing child development in high risk communities and early intervention during the life stage covering newborns to children up to three years of age. Such evidence supports the theory that supporting overall early childhood development in high risk communities would enable them to develop social and emotional competence, school readiness and resilience. In turn, this is likely to lead to fewer behavioural disturbances and cognitive development difficulties. Relevant papers on early intervention outcomes include *'Early Head Start: A Critical Support for Infants, Toddlers, and Families*[9]*'* and *'Neuroscience and the Future of Early Childhood Policy: Moving from Why to What and How'*[10].

100 The challenge when adopting some of the global approaches identified above is to address the coalescence of needs amongst particularly diverse community groups. Existing generalised programs and initiatives cannot simply be followed, as a vast majority of them are not designed for infants and children at the high risk end of the spectrum. Rather than assuming that a popular or generic program will suffice, there needs to be targeted intervention for the most vulnerable cohorts in pockets of social disadvantage. Community-based services are required and the approach adopted should be both non-judgemental and non-threatening.

PERINATAL HEALTH

Importance of a service focus on the perinatal period in relation to mental health and wellbeing

[9] Gebhard B, Ulrich R, Cole P, Patricia A, Matthews H, Schmit S (2017), Zero to Three, Centre of Law and Social Policy.
[10] Shonkoff, Jack & Levitt, Pat. (2010), Neuron 67 at 689-91.

101 As mentioned above, the first three years of life are crucial in establishing the basis for good emotional health, mental health and resilience in the face of adversity. The utilisation of interventions and supports for healthy child development are a critical strategy in the prevention of developmental disorder and reducing the burden of mental illness in the community. The challenge is essentially one of incorporating a preventive and early intervention focus to existing models centred on acute services and the management of immediate need. Available funding has largely been diverted to this area with under-resourcing of early in life care despite evidence of the role of prevention in reducing disorders.

102 The acute psychiatric services run by the RWH are both essential and very specialised and it would not be appropriate to admit pregnant and/or highly vulnerable women into mixed gender psychiatric units along with consumers who may be security consumers or exhibiting high risk behaviours.

Funding of perinatal psychiatric services

103 The RWH is currently not recognised by the DHHS or classified within the Victorian mental health system as a 'mental health service provider' as defined in the *Mental Health Act 2014* (Vic) (**Mental Health Act**). This means that the mental health work that I engage in as a psychiatrist at the CWMH and most of the positions at the RWH (apart from the two Registrar training positions) do not have the benefit of mental health funding. This is regardless of the fact that the RWH provides acute psychiatric services and mental health services in a broad sense to pregnant and vulnerable women and infants who are at a high risk of developing or are experiencing mental health illness. In addition, the RWH has no dedicated mental health beds to provide such services. The recommendations to clarify the status under the Mental Health Act of the RWH and the mental health services it provides is further discussed at pages 15 to 17 of the RWH's submission to the Commission.

104 Ultimately, this is a systemic anomaly which reflects the inadequate discussion around funding for and the spread of mental health services across the Victorian health system.

TRAUMA

Relationship between trauma and mental health

105 There is a clear, evidence-based relationship between trauma and mental health. However, this remains a fundamentally undertreated area. Trauma (such as severe or sustained child abuse from a young age) affects neurological development, cognitive development, capacity to regulate emotions and behaviour and the infant or child's understanding of relationships. The difficulty arises as the notion of complex

developmental trauma transcends what is addressed in the Diagnostic and Statistical Manual of Mental Disorders (**DSM**).[11]

106 Trauma from a young age is a clear risk factor for the development of mental illness at a later stage in life. Survivors of trauma often may also struggle as parents later in life given their experiences with trauma.

107 In addition to being a clinical problem, the relationship between trauma and mental health is also largely a social problem. The Spectrum Organisation (**Spectrum**), a not-for-profit organisation providing a range of services to support and engage the community, offers assistance to trauma survivors who have complex developmental disorders. It is often the case that prior to approaching Spectrum, trauma survivors move between services within the mental health system that are not appropriate for their circumstances. For example, the system fails to recognise that it is not ideal to treat an aged trauma survivor in an acute mental health unit alongside adolescents with psychosis.

Recommendations to support infants and children at risk of developing or experiencing mental illness

108 Infants and children need to have positive quality experiences with their parents and carers from a very young age. Recommendations on what could be done to better support infants and children at risk of or experiencing mental illness stemming from experiences of trauma are addressed at paragraphs 17 to 433 above.

109 In summary, in order to better support infants and children who are at risk of developing mental illness where it is related to experiences of trauma, the following areas should be focused on:

(a) addressing transgenerational trauma through better identification of parents with their own traumatic history or existing mental illnesses;

(b) early identification in infants of children of a very young age (particularly by non-clinical workforces); and

(c) relational work through specialised programs for treating trauma in relationships and improving the functioning of such relationships.

QUALITY AND SAFETY IN MENTAL HEALTH CARE

Improving the safety and wellbeing of staff and service users

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[11] American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders DSM-5* (American Psychiatric Press, Arlington, 2013).

110 There are particular issues that arise concerning the safety and wellbeing of staff and service users in the context of high risk families and attempts to integrate the protection of women who are homeless, abusing substances or subject to domestic violence.

111 For this reason, the CWMH has implemented an antenatal screening tool for all women during the perinatal period. Antenatal screening involves various tests such as drug and alcohol screenings, mental health screenings (eg using the Edinburgh Postnatal Depression Scale) and family violence screenings. This initiative was a direct response to the recommendation from the Royal Commission into Family Violence to implement family violence screening in public maternity services.

112 The purpose of the antenatal screening is to identify those babies at a higher risk of disorders or conditions. Following the antenatal screenings, cases that have 'high risk' results are offered clear referral pathways and support from mental health services, legal services and social work services. The aim is to provide integrated specialist programs that equip women with the tools and information to improve their safety and wellbeing. The antenatal screening tool implemented by the CWMH is further discussed at page 7 of the RWH's submission to the Commission.

113 Issues around the safety and wellbeing of staff at CWMH are very important, particularly around the rights of women to safety in a hospital environment. The CWMH has a 'zero tolerance' policy in relation to instances of violence or abuse against staff. All staff and security services are regularly trained and the CWMH has a good relationship with the police and local law enforcement services.

114 The CWMH does not offer direct treatment for perpetrators of family or domestic violence and instead refer those who need treatment and support to other suitable services.

Arrangements to minimise occurrence of adverse incidents

115 The CWMH has in place quality and safety review processes including a process for reporting any critical or harmful incidents that occur.

116 The Regional Maternal and Perinatal Mortality and Morbidity Committee (**Mortality and Morbidity Committee**) reviews all deaths and poor outcomes in the maternity area (up to 12 months post-partum). One of the leading causes of death during pregnancy or post-partum is suicide, often involving vulnerable women from marginalised communities. This illustrates the need to implement effective maternity screening processes and undertake a forensic review of the whole system of care, not simply the mental health system in isolation.

Challenges to ensuring consumer and staff safety

117 Management of mental health issues during pregnancy and early childcare involves an array of complex emotional issues and high levels of anxiety that a mother may experience concerning her infant. Issues such as concerns about physical health of the infant or experiences of delivery and care in the hospital may require additional support and discussions with clinicians about their treatment. At the RWH, this is led by consumer liaison staff who can facilitate both discussions and complaint processes as needed.

118 In terms of managing disruptive and disturbed patients, maternity staff at RWH may need additional support from the metal health team and security staff. In the absence of mental health beds in the hospital, another issue arising relates to finding suitable accommodation for women with mental illness, provision of quality and safety standards, incidents and other data.

119 Like other Victorian health services, RWH is within DHHS' general reporting framework. On a regular basis, RWH provides quarterly data to DHHS in accordance with the key performance indicators (KPIs). All high risk incidents are automatically reported to DHHS. However, given the RWH is not considered a 'mental health service provider', it is not involved in the same funding and regulatory requirements as other area mental health services within Victoria's mental health system.

120 In the event that there are major or critical incidents that occur at RWH, such incidents are reviewed internally. The Mortality and Morbidity Committee may also escalate particular concerns to Safer Care Victoria with an aim to eliminate avoidable harm and strengthen quality of care staff and service users. The RWH may also be involved with the Office of the Chief Psychiatrist (**OCP**) if a major incident occurs. However, the RWH does not interact with the OCP in relation to consumer issues. Generally, consumer queries and complaints are dealt with by the RWH's 'Consumer Liaison' department and can be escalated to the Victorian Health Complaints Commissioner if necessary.

Use of quality and safety data and associated feedback

121 The RWH receives the state-wide trend data released by DHHS following its analysis of the data sourced from all health services. The RWH then compares its internal performance against the state-wide data and identifies areas of improvement and areas where its performance exceeds that of other health services in Victoria. This is generally discussed at the RWH's monthly quality meetings amongst all clinical directors.

122 Where there is an identified issue or adverse trend (whether this is identified by DHHS or by the CWMH internally), the following process is observed:

(a) a critical review is internally conducted through CWMH's Quality and Safety Committee;

(b) the CWMH Quality and Safety Committee presents its findings to the centralised RWH Quality and Safety Committee;

(c) the centralised RWH Quality and Safety Committee provides recommendations to the RWH Board; and

(d) the RWH Board has the power to liaise with the DHHS where necessary.

123 If DHHS is concerned about a cluster of incidents (for example, that there are too many caesarean sections), it may raise the issue with CWMH.

Recommendations to strengthen existing standards, regulatory frameworks and independent oversight mechanisms

124 The existing standards, regulatory frameworks and independent oversight mechanisms are fairly robust. However, in my view, a greater degree of forensic and fairly systematic analysis is required to identify slippages and areas of improvements, rather than simply analysing blocks of data.

125 Specifically, there is value in conducting detailed case reviews in instances of poor outcomes or serious incidents followed by recommendations related to service improvements and monitoring (similar to the detailed case reviews conducted by the Mortality and Morbidity Committee). As well as comparisons to cohorts of data, what is useful from a clinical perspective is reviewing where things went wrong and why (ie a more case-based approach to improving quality and safety).

126 In the context of sexual safety for women in mental health facilities, there is a requirement for greater oversight across the mental health system in the context of inpatient sexual assaults. Detailed case reviews should be conducted internally with the ability to report more serious problems and escalate cases (if necessary) to Safer Care Victoria. The current practice is that cases of concern may be referred to the OCP, which may then construct a panel to examine the case independently.

127 There is currently no Mental Health Review Committee relating to women's mental health issues or perinatal health to further progress issues of gender appropriate safe services and access to women's mental health focussed services. The mental health system may benefit from the establishment of a body to focus on service development and clinical governance of women's mental health services.

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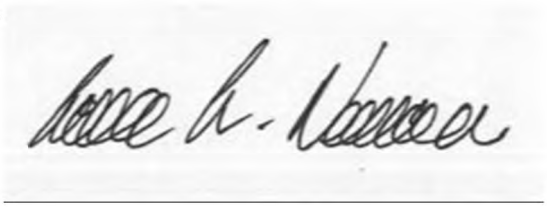

print name Louise Newman

date 1 May 2020

Royal Commission into
Victoria's Mental Health System

ATTACHMENT LN-1

This is the attachment marked 'LN-1' referred to in the witness statement of Louise Newman dated 1 May 2020.

CURRICULUM VITAE

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Education and Qualifications

Qualifications

2006	Doctor of Philosophy	University of Sydney
1994	Certificate in Child, Adolescent and Family Psychiatry	Royal Australian and New Zealand College of Psychiatrists
1993	Part 2 Examination	Royal Australian & New Zealand College of Psychiatrists
1992	Part 1 Examination	Royal Australian & New Zealand College of Psychiatrists
1988	Bachelor of Medicine Bachelor of Surgery (Honours Class 1)	University of Sydney
1981	Bachelor of Arts (Honours in Psychology)	University of Sydney

Postgraduate Education

Year

2006 Doctor of Philosophy, University of Sydney
- Topic: Trauma in Infancy, Infants of Parents with Borderline Personality Disorder.

2000 Master of Medicine, University of Sydney
- Topic: Trauma in Infancy – early adversity and psychological development

1992-1994 Fellowship Training in Child and Adolescent Psychiatry,
New South Wales Institute of Psychiatry

1989-1992 Psychiatry Training Programme, NSW
Royal Australian & New Zealand College of Psychiatrists

Tertiary Education

1982-1987 Bachelor of Medicine, Bachelor of Surgery
University of Sydney (Honours Class 1)

1981 Philosophy Honours
- Course Work: Semiotics, Philosophy of Foucault, Feminist Theory (Dr E Grosz)
- Reading Course in Lacan and Psychoanalysis

1977-1980 Bachelor of Arts, University of Sydney
- Majors in Psychology (Honours) and Philosophy (Honours)

Employment History

Current Positions

2014 – Present	Director, Centre for Women's Mental Health	Royal Women's Hospital
2014 – Present	Professor of Psychiatry	University of Melbourne
2009 - Present	Adjunct Professor of Developmental Psychiatry, School of Psychology & Psychiatry	Monash University
2009- Present	Clinical Professor of Psychiatry	University of Newcastle

Past Positions

2009-2014	Director, Centre for Developmental Psychiatry & Psychology	Monash University
2010-2014	Unit Head, Perinatal & Infant Mental Health Service	Monash Health
2007-2009	Chair-Perinatal and Infant Psychiatry	University of Newcastle
1998-2007	Honorary Child Psychiatrist	New Children's Hospital, Westmead, NSW
1998-2007	Director	The New South Wales Institute of Psychiatry
1997-1998	Director, Child, Adolescent and Family Psychiatry	The New South Wales Institute of Psychiatry
1994-1998	Clinical Director, Paediatric Mental Health Service	South Western Sydney Area Health Service
1997-1998	Director of Child, Adolescent and Family Psychiatry	The NSW Institute of Psychiatry
1994-1998	Clinical Director, Paediatric Mental Health Service	South Western Area Health Service, Liverpool, NSW
1991-1993	Locum Psychiatric Mental Health Officer • Experience in Acute Admission Unit • Emergency Psychiatry	Kenmore Hospital, Goulburn, NSW
1991	Registrar in Psychiatry • Six months Adult General Psychiatry • Clinical Fellow in Child Psychiatry • Early Intervention Unit – Dr Denise Guy	Concord Hospital, Sydney, NSW Redbank House, Westmead Hospital

	Registrar in Psychiatry • Six months Consultation Liaison Psychiatry • 600 bed adult teaching hospital • Experience in renal unit and burns unit • Redbank House • Six months Child Psychiatry • 20 bed family residential unit for primary school children	Concord Hospital, Sydney, NSW Redbank House, Westmead Hospital
1989	Registrar in Psychiatry, Acute and Chronic Adult General Psychiatry • Inpatients, outpatient experience • Part-time Resident Medical officer • Accident and Emergency Department	Northside Clinic, Greenwich, NSW St George Hospital, Kogarah, NSW
1988	Junior Resident Medical Officer • Professorial Surgery (Professor J Lusby) • Professorial Geriatrics (Professor A Broe) • Professorial Medicine (Professor J Lawrence) • Psychiatry • Emergency Medicine	Repatriation General Hospital, Concord, Sydney, NSW

Leadership Experience

Royal Australian and New Zealand College of Psychiatrists (RANZCP)

President Royal Australian and New Zealand College of Psychiatrists 2009-2010

General Councillor RANZCP and Chair of Child and Adolescent Psychiatry Faculty 2003-2009

Chair, RANZCP Committee Review Group 2007

Chair, RANZCP Regional Issues Committee 2008-2010–support for training in Asia and Pacific region

Member, RANZCP Publications Committee 2007-2009

Chair, RANZCP Workforce Review Committee 2005-2006

Chair, Faculty of Child and Adolescent Psychiatry 2000-2006

Chair, NSW Branch 1999-2006

Representative for Child and Adolescent Psychiatry, NSW Branch Training Committee 1997-1998

Honorary Secretary, NSW Branch 1994-1996

Member, NSW Branch Training Committee 1992

Portfolio on Sex, Gender and Women's Issues, NSW Branch 1996-2000

Training Registrar Representative, NSW Branch Committee 1990

Other professional organisations

Convenor Doctors for Justice 2018 – present

Convenor Asylum Seeker Health Advocacy Group 2000 – present

Invited member Australian Medical Association (AMA) Public Health Committee 2004-2005

Representative, NSW Psychologists Registration Board 1999-2002

Intern Representative Concord Hospital Board of Graduate Studies 1988

Representative Concord Hospital Resident Medical Officers Association 1988

Commonwealth Government appointments

Member, Immigration Health Advisory Group- regional processing committee advising on off shore processing of asylum seekers **Commonwealth Department of Immigration and Citizenship Immigration** 2012 to 2013

Member, National Child Disaster Mental Health Committee 2010-present

Member, Australian Child Trauma, Grief and Loss Network 2008-present

Chair, Detention Expert Health Advisory Group- independent health advisory group representing Professional bodies **Commonwealth Department of Immigration & Citizenship** 2010-2012

Chair, **Borderline Personality Disorder Expert Group,** Commonwealth Department of Health and Ageing 2010-2013

Member, **NHMRC** Clinical Guidelines Committee For Borderline Disorder 2010-2013

Member Medical Services Committee, Psychiatric Subcommittee 2003-2005

State Government appointments

Member, Standing Committee for the Training of Psychiatrists New South Wales Institute of Psychiatry 1993-2000

Member New South Wales Mental Health Implementation Group 2004-2005

Member New South Wales Health Systems Review Committee 2003-2006

Member NSW Health, Mental Health Priority Task Force 2005-2005

Member NSW Health Expert Advisory Committee on Gender 2003-2005

Member NSW Health Sentinel Events Committee 2003-2005

Member NSW Committee of Chairs of Medical College 2003-2005

Member, Task Force on Child and Adolescent Mental Health Services, Centre For Mental Health, NSW Department of Health 1997-2002

Conference organisation experience

Convenor, Association of Psychiatrists in Training Annual Conference 1991

Congress Member, Scientific Programme Organising Committee, Royal Australian & New Zealand College of Psychiatrists Annual Congress 1996-1997

Advisory and advocacy roles

Ministerial Delegate, Barwon Health Board December 2016 – June 2018

Mental Health Advisor, Barwon Health June 2018 – July 2019

Member, Australian Child Trauma, Grief and Loss Network 2008-present
Collaboration with **Professor Bev Raphael ANU** and **Commonwealth Health** to develop resources for the community and professionals regarding child trauma. I am responsible for early childhood trauma and child asylum seekers Active in advocacy to **Commonwealth Department of Health** around support for preventive and early childhood interventions in mental health based on an understanding of the critical early period of neurodevelopment. I have provided consultancy around child protection and interventions for child trauma and participated in the review of child protection guidelines and family support services. I was a member of the early childhood working group which established **Kids Matter** support program. I have provided advice to **State Governments in Queensland, NSW and WA** around service models for Perinatal and Infant mental health and will be providing training in Tasmania on parent infant interventions.

Convenor of the Asylum Seeker Health Advocacy Group
In my role as a psychiatrist I established a large grouping across the professions to advocate for the rights of asylum seekers to appropriate health and mental health care and to urge discontinuation of detention of children. In this role **I gave evidence at several Committees of Inquiry including the Human Rights and Equal Opportunity Commission inquiry** in to child detention and the **Amnesty International review of the Australian Immigration Detention System**.
Member of the Human Rights Commission review of self-harm and suicide in detention (2012)
Member, Immigration Health Advisory Group for the **Department of Immigration and Citizenship Immigration** and provide advice on mental health and child issues.

Consultancy to community organisations in support of victims of child abuse and neglect Most recently I provided consultation to the advocacy and support group Adults Surviving Child Abuse and contributed to the development of practice guidelines and a model for improving service delivery to those needing mental health support. This project received funding from the **Commonwealth Department of health and Aging [ASCA 2013 Practice Guidelines** for treatment of Complex Trauma and Trauma Informed Care and service delivery]

Also in this area I have **been invited to give evidence to the Royal Commission on child sexual abuse** regarding the developmental and mental health implications of abuse and complex mental health issues.
I have given evidence to the Victorian Royal Commission on Domestic Violence 2016.

Consumer organisations. I work with the Private Mental Health Consumer Network (Ms Janne McMahon) and have supported a recent consumer survey reviewing the experiences of abuse survivors with mental health services. This report was tabled at the **BPD Expert reference Group which I Chaired for DOHA** and presented to the Minister for Mental Health as part of advocacy for trauma informed services and interventions for this group.

National Media Profile.

- I have a high media profile in the areas of early child development, child protection and asylum seekers.
- I have media training and experience in public commentary and debate.
- I am frequently asked to comment on current issues and use these to provide sound academic input and to advocate for services and appropriate treatment.
- I have participated in public fora such as national debates and press club presentations.

International Engagements

International Consultancy and Teaching

Visiting Professor in Child trauma, Child Trauma Centre, Osaka, Japan –February 2004; development of interventions for traumatised children post school disaster

Supervision of **World Health Organisation** Fellows from Indonesia, Thailand and India 2002, 2004.Teaching provided in country and supervision of clinical placements in NSW

AusAid MONAP (Medical Officers Nurses and Allied Professions) Program – supervision of psychiatry trainees from Papua New Guinea (2000-2003).Clinical placements in NSW and teaching in country

World Health Organisation Consultancy – development of child and adolescent mental health services in People's Republic of China, May 2002.Delivery of educational program and clinical supervision at Nanjing Brain Hospital

Consultant to Victorian Department of Human Services Unaccompanied Minors Program – advising regarding mental health needs of young asylum seekers and program development

International Research Collaborations

University College London - Collaboration Professor Peter Fongy and his group on the development of metallization based clinical approaches to interventions for personality disorder. Planning a trial of this approach for young people in acute mental health services following self-harm based on UK approach. This commenced in 2014 at Monash Health adolescent unit.

Anna Freud Centre, London - Collaboration with this internationally renowned institute for psychoanalysis parent- infant psychotherapy program, development and trial of a manualised infant parent program for parents with personality disorder and past trauma. Program is currently under evaluation in Australia and training will be provided in UK in 2014

Yale University Child Studies Institute - Collaboration with Professor Arietta Slade focussed on training local researchers and clinicians in the assessment and rating of parental reflecting functioning and approaches to evaluation of early parenting. This has resulted in several group trainings and a cohort of accredited raters

Miami Family Studies Institute - Collaboration with Dr Patricia Crittenden , the 'Crittenden' approach to assessment and classification of parent child interaction and attachment has been significant for Australian research, Several training workshops have been held in Australia with a cohort of accredited raters. The International Society for the Study of Attachment has established an international theory development group, which meets annually. I currently contribute to the area of attachment-based interventions

Research Activities

Current Research Activities

BEAR (Building Early Attachment Resilience) Parenting support for at risk mothers. Mental Health Foundation of Australia Grant

Safe Mothers, Safe Babies – parenting and Domestic Violence. Liptember Grant

Reflective and attachment focussed interventions for parents with substance abuse problems and personality disorder, NSW Health Grants – evaluation of infant-parent intervention for high risk infants and parents with substance abuse issues as a component of comprehensive family support. This has resulted in two completed PhDs and ongoing support from NSW Health services for the program.

Getting to Know You: Evaluating of parental training in infant communication, Financial Markets Foundation for Children 2005-2009 – development of psycho-educational training materials in infant development

Evaluation of training programme for antenatal and postnatal nursing staff in infant communication, Victorian Department of Health and Monash University Department of Midwifery

Community Safety Research Project: Enhancing mental health in Aboriginal children, ARC Linkage Grant – development of assessment and interventions of children impacted by trauma and community violence in NSW indigenous communities

Completed Research Activities

- Treating Trauma in Refugee Youth: An Australian Experience, Beyond Blue Victorian Centre of Excellence - in Depression and Related Disorders. Currently this program has a PhD student, two Psychology Honours students and a B Med Science student and is examining factors contributing to recovery in trauma impacted young refugees. (Completed 2013)

- Small Mercies, Big Futures: Enhancing Law, Policy and Practice in the Selection, Protection and Settlement of Refugee Children and Youth, ARC Linkage Grant - Within the Settlement component of the project I focus on the development of approaches to identification of trauma related symptoms in young refugees and school based intervention programs. The program has attracted two D Clin Psych Students and one Psychology Honours student examining the process of trauma recovery in this group, cultural concepts of trauma and recovery and the use of trauma rating instruments in diverse cultural contexts. (Completed 2012)

- Children's Recovery Project – screening and identification of trauma related symptoms in bushfire exposed children 8-18 years. Project involved screening of schools in Victorian areas impacted by 2009 bushfires and training staff in trauma focussed intervention. Report prepared for Victorian Department of health and presented at Bushfire Recovery Conference 2010.

- Borderline Personality Disorder and parenting – neurobiology of aberrant parenting. (Kinsman Research Fellowship). fMRi study examining brain processing of infant affective communication in mothers with BPD. In partnership with Professor Carmel Loughland, , Newcastle University this is part of an ongoing research effort looking at the impact of mental disorder on parenting and the neurobiological underpinnings of parenting disturbance.

***Current Research Grants*:**

Title	Funding Source / Amount	Dates	Chief Investigators	Associate Investigators
Pratt Foundation Centre for Resilience and Mental Health – Mindfulness Attachment Based Interventions for Parents and Infants	Pratt Foundation $1,500,000	2014-2018	Prof. Louise Newman Prof. Fiona Judd Emeritus Prof. Bruce Tonge	
Community Safety Research Project: Enhancing mental health in Aboriginal children	ARC $2,300,000	2010-2014	Prof Louise Newman R.A. Bryant D. Silove	R. Brooks Z. Steel K. Senior S McFarlane
Parenting with feeling: Evaluation of an attachment focused mentalization-based group intervention for substance abusing parents	NSW Health $100,000	2010-2013	Prof. L.K. Newman A. Dunlop	
Neurobiology of parenting disturbance in postnatal depression	Kinsman Research Fellowship / $55,000	2010-2012	Prof Louise. Newman	
Treating trauma in refugee youth: An Australian experience	Beyond Blue $101,384	2010-2012	Dr Glenn Melvin Prof Louise Newman	Ann Locarnini Meredith Levi
Children's Recovery Project - Screening and identification of trauma related symptoms in bushfire exposed children 8-18 years	Victorian Health Bushfire Appeal $1,000,000	2011-2012	Prof Louise Newman Dr Glenn Melvin	
Small Mercies, Big Futures: Enhancing Law, Policy and Practice in the Selection, Protection and Settlement of Refugee Children and Youth	ARC $2,100,308	2011-2014	Prof Mary Crock Prof Louise Newman Prof Sandra Gifford Assoc Prof Ben Saul	

Selection of Completed Research Grant Support

Financial Markets Foundation for Children Grant 2005 $60,000
Getting to know you: training and education in early infant development. This project involved development of a DVD resource examining early infant social and emotional communication and capacity to engage with the social environment. This was used in antenatal and early parenting settings with positive evaluations and improvement in parental knowledge of infant communication.

NSW Department of Health 2007 $50,000
Hello Dad: fathers and attachment. Development of a DVD resource on fathering styles and role of fathers in promoting infant development. This is currently used in parenting programs in NSW,

HDR Student Supervision

Current HDR students

Natalie van Swet	PhD	2019 BEAR-Building Early Attachment Resilience in fathers (University of Melbourne)
Madi Batchelor	Master of Public Health	Recognition and management of psychological trauma in Refugees and Asylum Seeker patients (University of Melbourne)
Clare Bellhouse	PhD	2018 How can we better prepare first-time parents? Perspectives from new parents and healthcare providers (University of Melbourne)
Gen O'Connor	Master of MH Science (Infant)	2018 Infants and Contact Visits (University of Melbourne)
Donna Neemia	DPsych (clin)	2017 Sleep and Relationship: Co-regulation in Mother-Infant Dyads Across Pregnancy and Postpartum (Monash University)
Julie Searle	PhD Submitted October 2018	2009 Factors Influencing Risk of Child Abuse to Improve Risk Assessment in Child Protective Services (University of Newcastle)
Samantha Teague	DPsych	2007 Factors Influencing Risk of Child Abuse to Improve Risk Assessment in Child Protective Services (Monash University)

Previous HDR Students

Vesna Bejic	DPsych Awarded 2019	2013 Representation of the infant in mothers with BPD (Monash University)
Chris Kewley	PhD Awarded 2018	How do health beliefs of African refugees influence attribution of mental illness and help-seeking behaviour following resettlement in Australia? (University of Newcastle)
Ruth Tatnell	PhD Awarded 2017	2013 Emotional regulation and deliberate self-harm (Monash University)
Patricia O'Rourke	PhD Awarded 2017	The development of the maternal looking guide, a clinical tool for midwives to assess mothers' interactions with their newborns (University of South Australia)
Belinda Keenan	DPsych Awarded 2017	2011 Assessment of emotional regulation in ASD
Jeremy Quek	DPsych Awarded 2017	2012 Assessment of reflective functioning in borderline adolescents
Clair Cullen	DPsych Awarded 2017	2012 Parental functioning in families of adolescent borderlines
Jarrod White	DPsych Awarded 2017	2013 Trauma recovery in refugees and holocaust survivors
Sarah Pascall	PhD Awarded 2016/2017	2013 Evaluation of interventions for disruptive behaviours
Carmel Sivaratnam	DPsych Awarded 2016	2011 Attachment and relating in ASD (Monash University)

Ann Locarnini	PhD Awarded 2016	2012 trauma focussed interventions for young refugees (Monash University)
Jill Pullen	PhD Awarded 2016	Monash University
Lucy McGregor	DPsych Awarded 2014	2010 Psychosocial adaptation trauma recovery in young refugees (Monash University)
Christopher May	PhD Awarded 2014	2009 The Importance of Co-parenting Quality when Parenting a Child with an Autism Spectrum Disorder: A Mixed-method Investigation (University of Newcastle)
Natasha Perry	PhD Awarded 2013	Assessment of Parenting Risk in Substance Abusing Mothers (Newcastle University)
Melissa Harris	PhD Awarded 2011	Physical illness and Borderline Personality Disorder (Newcastle University)
Yara Abo	B Med Sci Awarded 2010	Trauma histories in mothers with BPD (Monash University)
Romi Goldschlager	B Med Sci Awarded 2010	Assessment of trauma related symptoms in refugee youth (Monash University)
Alison Fogarty	Psychology Honours	2013 Sense of cultural identity in adolescent refugees
Manognya Kamissetty	B Med Sci	2013 Models of psychosocial function in refugee youth
Belinda Melling	DPsych Submitted	2010 Attachment issues and school refusal

Awards and Professional Memberships

Awards

Year	Award	
2011	Order Of Australia (AM)	Member in the General Division
2010	Refugee Council of Australia for Refugee Health	Humanitarian Award
1987	Proficiency in Surgery and Clinical Surgery	Concord Hospital Prize
1986	Ophthalmology	Royal Australian College of Ophthalmologists Prize
1979	Psychology and Philosophy	Walter Reid Memorial Prize
1978	Psychology and Philosophy	Walter Reid Memorial Prize

Professional Memberships

1993 - present	Royal Australian and New Zealand College of Psychiatrists
2010 - present	The Australian College for Child and Family Protection Practitioners
2009 - 2010	Australian Institute of Company Directors
1993 - present	Australian Association of Infant Mental Health
1993 - present	World Association of Infant Mental Health
1992 - 2006	Women in Psychiatry Group New South Wales
1994 - 2000	Association for the Advancement of Philosophy and Psychiatry

Teaching experience

Curriculum development and organisation of teaching programs

Development of online course in Psychodynamic Psychiatry – University of Melbourne Masters

Convenor, Perinatal Mental Health Selective, Master of Medicine, University of Melbourne 2018 - present

Redeveloped psychiatry training program to be consistent with Australian Qualifications Framework (AQF) - As Director of the NSW Institute of Psychiatry and responsible for the provision of the psychiatry training program I undertook a review of the program and redeveloped the course in line with AQF accreditation as a Masters level award . The course focussed on clinical problem based learning and self-directed approaches.

Redeveloped the multi-disciplinary courses in Mental Health at the Institute of Psychiatry also and awarded Graduate Diploma to Masters level awards by the **NSW Higher Education Board**

Developed and implemented a Masters Degree in Infant Mental Health which operates via distance education from the NSW Institute of Psychiatry with good uptake across Australia and New Zealand. I have maintained a research project component and training in research methodologies in this program.

Director of Training in Child and Adolescent Psychiatry 1996-1997. New South Wales Training of Postgraduate Psychiatrists undertaking their Training in Child and Adolescent Psychiatry, University of New South Wales

Committee Member Psychological Medicine, Rotating Practice Placement Subcommittee, Graduate Medical Programme, University of Sydney 1997-1998

Convenor, Advisory Committee on Child and Adolescent Psychiatry, New South Wales Institute of Psychiatry 1997-1998

Trainee Representative, Course Review Committee, New South Wales Institute of Psychiatry 1992-1993

Teaching Experience

Current teaching commitments

2009-Present

- Master of Child Psychoanalytic Psychotherapy, Monash University
  - The Theories of John Bowlby
  - Attachment Theory and development
  - Infant/Parent psychotherapy
- 3rd Year BPsych (Hons) – neurodevelopment and infant development
- Psychology (Hons) Year 4 seminars in trauma and neurodevelopment, ; disorders of attachment and development
- MB BS Monash University – development in infancy and early childhood; early neurodevelopment; attachment and early parenting
- Doctor of Clinical Psychology – developmental neuroscience; child abuse and neglect; trauma related psychopathology
- Mindful child and adolescent psychiatry RANZCP Advanced training program seminars in infant mental health
- RANZCP Advanced training in Psychotherapy – perinatal and infant mental health early attachment and development
- Master of Psychological Medicine program – selective in Perinatal and infant Psychiatry; Selective in Psychodynamic Psychiatry

2009- Present

- 1st Year Psychiatry Tutorials – assessment and formulation
- Seminars in Child Development & Psychotherapy
- Psychotherapy Supervision
- Perinatal and Infant Mental Health
- MB BS Seminars – transcultural assessment and formulation

Monash Health, Mental Health Program

1994- Present

- Lecturer Master of Medicine (Psychotherapy)
  - Teaching of Feminism and Psychoanalysis
  - Lacan
  - Infant Psychiatry and Self Psychology
  - Developmental Psychopathology

Previous teaching experience

2007-2009

- MB BS Course , University of Newcastle

-Child Mental Health Course- Convenor of undergraduate program

2001

- Core Training in child abuse and neglect-Child Mental Health issues in child protection, Department Of Community Services (DoCS)

1994-2000

- Lectures to various professional groups including
  - Early Childhood Nurses
  - Developmental Psychology
  - Psychiatrists in Training
  - Fellows in Child Psychiatry
  - Infant Mental Health – Development of Masters program
  - Adolescent Mental Health, New South Wales Institute of Psychiatry

1994-1998

- Registrars in Psychiatry/Fellows in Child Psychiatry attached to Paediatric Mental Health Service
- Teaching of Medical Students
- Lecturer to Undergraduate Medical Students, Child Adolescent and Family Psychiatry

1991-1994

- Teaching Undergraduate Students in Psychiatry University of Sydney
- Department of Occupational Therapy Lectures: Ward Management of Acute and Chronic Schizophrenia, The Depressed Patient, Anorexia Nervosa
- Department of Nursing Studies Lectures: Psychodynamics of Anorexia Nervosa, Women's Issues in Psychiatry
- In-service Presentations, Department of Psychiatry
- Lectures: Postpartum Psychiatric Disorder, Sexual Assault Service, Borderline Personality Disorder and Sexual Abuse, Postnatal Depression

Publications - See Attachment A

Conference presentations

2014

- March 2014 *Cry Freedom! Child asylum seekers in Australia: the intersection of human rights and mental health.* Winston Rickards Memorial Oration, Melbourne.

- March 2014 *Beyond the island: experiences of asylum seekers in Australia.* Refugee Voices Conferences, Oxford, UK.

2013

- February 2013 *Evaluations of the Infant – Parent Interventions in High Risk Populations.* **Invited speaker** *at* Maternal and Child Health Conference, Melbourne.

- July 2013 *Mother-infant interaction and the development of attachment.* **Invited speaker** *at* International Lactation Consultant Association Conference, Melbourne.

- July 2013 *Pathways to Recovery – trauma and mental health issues for young refugees.* **Invited speaker** at National Forum on Children and Young People from Refugee Backgrounds, Sydney.

- August 2013 *Translational research to improve the health of refugees and asylum seekers*. **Keynote speaker** at the Primary Health Care and Refugee Health Forum, Dandenong, Vic.

- October 2013 *Seeking Asylum in Australia – Current Issues for Children and Adolescents.* Faculty of Child and Adolescent Psychiatry Conference, Melbourne.

- October 2013 *0-5 Mental Health.* Faculty of Child and Adolescent Psychiatry Conference, Melbourne.

- October 2013 *Trauma Informed Care.* **Invited speaker** at 2nd Annual Youth Dual Diagnosis Service Providers Forum, Melbourne.

- November 2013 *Children in Immigration Detention.* Danny Sandor Memorial Lecture, Defence for Children International AGM, Melbourne.

- November 2013 *Attachment and relationships in the New Millenium.* John Pougher Memorial Lecture, SCAP One Day Seminar, Perth.

2012

- February 2012 *Impact of trauma and child abuse on parenting and mental health.* **Keynote speaker** at Women's Health Conference, Gold Coast.

- March 2012 *Seeking asylum in Australia - mental health and human rights of children and families.* Australian Institute of Family Studies Seminar Series, Melbourne.

- June 2012 *Parenting and Borderline Personality Disorder – approaches to early intervention.* **Keynote speaker** at South Australian Mental Health Sharing Excellence Forum, Adelaide.

- July 2012 *Right from the start: Child protection and early trauma.* **Keynote speaker** at Australasian Conference of Child Trauma, Gold Coast.

2011

- March 2011 *How early should early intervention start?* **Invited speaker** at Grampians Region Mental Health Conference 2011, Ballarat.

- April 2011 *Early attachment relationships – risk and intervention*. **Invited speaker** at Perinatal Society of Australia & New Zealand 15th Annual Congress, Hobart.

- May 2011 *Getting in Early – Interventions in infancy and the prevention of mental disorder.* **Invited speaker** at Psychiatry Professorial Grand Round 2011

- May 2011 *Infant and child mental health particularly with reference to refugee children.* Victorian Transcultural Psychiatry Unit Seminar, Melbourne.

- May 2011 *When the cradle does not hold.* **Invited speaker** at the Freud Conference 2011, Melbourne.

- June 2011 *Child Development and the Impact of Trauma.* **Keynote speaker** at the Child Protection Legal Conference, Melbourne.

- June 2011 *Getting in Early: Interventions for substance abusing parents and infants*. **Keynote speake**r at the Drug and Alcohol Nurses of Australasia (DANA) Conference, Melbourne.

- June 2011 *Parenting and Personality Disorder.* **Keynote speaker** at the Hume Region Mental Health Services Conference, Bendigo.

- June 2011 *Trauma and Personality Development : Approaches to complex trauma.* **Keynote speaker** at Mental Health Coordinating Council Conference, Sydney.

- June 2011 *Advocacy for mental health in refugees and asylum seekers.* **Keynote speaker** at AMSA Global Health Conference, Sydney.

- July 2011 *Ghosts and Trauma in the Nursery: Borderline Personality Disorder and Parenting.* **Invited speaker** at RANZCP Psychotherapy Conference 2011, Melbourne.

- July 2011 *Seeking Asylum in Australia – Mental Health of Refugees.* **Invited speaker** at the 3rd World Congress of Asian Psychiatry, Melbourne.

- September 2011 *High risk attachment relationships and Borderline Disorder.* **Invited speaker** at the Perinatal Mental Health Symposium, Orange.

- October 2011 *Psychotherapy in an age of trauma.* David Ingamells Memorial Lecture, Melbourne.

- November 2011 *Mental Health of Asylum Seekers.* **Keynote speaker** at the Youth Health 2011 Conference, Sydney.

- November 2011 *The impact of early life stress on later psychopathology.* St.Vincent's Conference, Melbourne.

- November 2011 *Mothers with borderline personality disorders and their infants – an overview of issues & Skills for working with mothers with BPD and their infants*. **Keynote speaker** at Helen Mayo House 2011 Conference, Adelaide.

- November 2011 *Refugee health for women and children.* **Invited speaker** at WCHA Conference, Adelaide.

- December 2011 *Trauma & Development: the impact of trauma on children and parents*. **Keynote speaker** at Central Coast Connexions Conference 2011 8th Annual Event, Wyong NSW.

2010

- September 2010 *Developmental Implications of Early Trauma.* Invited speaker at Colloquia at LaTrobe University, Melbourne

- September 2010 *Attachment, Adjustment and Creativity. 'The Origins of the Creative Self'.* **Invited speaker** at ANZAP Seminar, Sydney.

- October 2010 *Developmental Implications of Early Trauma – Protecting Children.* **Invited Keynote speaker** at Australian Family Therapy conference - Diversity: Context, Culture and Community, Melbourne.

- October 2010 *Neurodevelopmental Impact of Early Trauma.* **Invited Speaker** at the Faculty of Child & Adolescent Conference in Adelaide.

- Newman, L. (November 2010). *Getting in Early - the science of perinatal and infant mental health.* **Invited presenter** at the Austin Grand Rounds, Melbourne.

- Newman, L. (November 2010). *Keeping Children in Mind – early intervention for traumatized parents.* **Invited Keynote speaker** at Creating Synergy Conference, organised by the Drug & Alcohol Clinical Services of Hunter New England Health, NSW.

- Newman, L. (November 2010). *Parenting With Feeling – Working with Traumatised Parents and Infants*. **Invited speaker** at QEC 6th Biennial International conference, Melbourne.

- Newman, L. (November 2010). *First Do No Harm – documenting the mental health impacts of immigration detention.* **Invited speaker** at Ethics Symposium - Researching Refugees and Asylum Seekers, organised by The McCaughey Centre Melbourne School of Population Health Faculty of Medicine, Dentistry and Health Sciences University of Melbourne.

- Newman, L. (November 2010). *Perinatal and infant mental health - challenges for rural and regional areas.* **Invited Keynote speaker** at 2010 Gippsland Mental Health Conference, at Monash University Gippsland Campus (Churchill).

- Newman, L. (November 2010). *Supporting Traumatised Parents*. **Invited Keynote speaker** at Mind the Baby Forum II 2010, organised by Peek a Boo Club of the Royal Children's Hospital.

Attachment "A" - Publications – Prof Louise Newman AM

Publications - Books

1.	Newman, L.K., & Mares, S. (2012) Contemporary Approaches to Child and Adolescent Mental Health. Volume 1 – Infancy and Early Childhood. Camberwell, VIC: IP Communications.
2.	Mares, S., Newman, L.K., & Warren, B. (2011). Clinical Skills in Infant Mental Health – The first three years (2nd ed.) Melbourne: ACER Press.
3.	Mares, S., & Newman, L.K. (Eds.) (2007). Acting from the Heart. Australian advocates for asylum seekers tell their stories. Sydney: Finch Publishing.
4.	Newman, L.K., Mares, S., & Warren, B. (2005). Clinical Skills in Infant Mental Health. Sydney: ACER Press.

Publications – Chapters

1.	Louise Newman (2019) Children Seeking Asylum-Mental Health and Human Rights in An International Perspective on Disasters and Children's Mental Health. C W Hoven et al (Eds). Springer Publishing. Chapter 17 pp343-361	BC 19.4
2.	**Louise Newman** (2019) Trauma-informed care in infancy in Humanising Mental Health Care in *Australia: A guide to trauma-informed approaches.* Richard Benjamin, Joan Haliburn and Serena King (ED). Routledge. Chapter 7 p 101-111 https://doi.org/10.4324/9780429021923	BC 19.3
3.	**Louise Newman** (2019) The Reality of Horror-Psychic Survival in the Face of Massive Trauma in Early Interaction in *Approaches to Psychic Trauma*. Bernd Huppertz (Ed). Rowman and Littlefield. Chapter 5 p 63-72	BC 19.2
4.	**Louise Newman** (2019) Development and Trauma-Recapitulation of Traumatic Themes in Early Interaction in *Approaches to Psychic Trauma*. Bernd Huppertz (Ed). Rowman and Littlefield. Chapter 3 p 39-51	BC 19.1
5.	Kerry Geritz, Scott Harden, **Louise Newman** (2017) Sexual Abuse of Children in *Expert Evidence: 75 expert areas* (eBook). Editor Hugh Selby. Thomson Reuters Australia	BC 17.1
6.	**Newman, L**., & O'Shaughnessy, R. (2015) Parenting and borderline personality disorder In Reupert, A., Maybery, D., Nicholson, J., Göpfert, M., & Seeman, M. (Eds.). Parental psychiatric disorder: Distressed parents and their families (3rd ed. Pp 163-173). Cambridge University Press	BC 15.3
7.	**Newman, Louise** and Locarnini, Ann. (2015) Trauma and recovery - the mental health of young people from refugee backgrounds in *Creating New Futures - Settling children and youth from refugee backgrounds*. Mary Crock (Ed). The Federation Press, Sydney	BC 15.2
8.	**Newman, L.** (2015). The Reflected Self. Margaret Boyle Spelman and Frances Thomson-Salo (Eds) *The Winnicott Tradition: Lines of Development*. London, Karnac pp 341-355	BC 15.1

9.	**Newman, L.** (2013). Collateral damage responses when policy causes harm in B. Douglas & J. Wodak (Eds.) *Refugees and asylum seekers: Finding a better way*. Canberra: Australia 21	BC 13.3
10.	**Newman, L.** (2013). Seeking Asylum – Trauma, Mental Health and Human Rights: An Australian Perspective in V.Sar, W.Middleton, M.Dorahy (Eds.) *Global perspectives on Dissociative Disorders: Individual and Societal Oppression*. Oxford: Routledge.	BC 13.2
11.	**Newman, L.K.** (2013). Researching Immigration Detention: Documenting Damage and Ethical Dilemmas. In K.Block, E.Riggs & N.Haslam (Eds.) *Values and Vulnerabilities; the Ethics of Research with Refugees and Asylum Seekers* Brisbane: Australian Academic Press.	BC 13.1
12.	Newman, L.K. (2012). Child Sexual Abuse – Developmental & Psychological Impact. In H.M.Selby (Ed.) *Child sexual abuse: victims and abusers.* Thomson Reuters.	BC 12/6 ✓
13.	Newman, L. (2012). The Developmental Impact of Early Life Trauma. In D.Castle, S.Hood, V.Starcevic (Eds.) *Anxiety Disorders: Current Understandings Novel treatments*. Melbourne: Australian Postgraduate Medicine.	BC 12/5
14.	Newman, L.K. (2012). Sex and gender – biology, culture and the expression of gender. In M. Dudley, D.Silove & F.Gale (Eds.) *Mental Health and Human Rights*. Oxford: Oxford University Press.	BC 12/4 ✓
15.	Newman, L.K. (2012) Children with atypical gender development. In J.M.Rey (Ed) *IACAPAP e-Textbook of Child and Adolescent Mental Health*. Geneva: International Association for Child and Adolescent Psychiatry and Allied Professions 2012.	BC 12/3 ✓
16.	Newman, L.K. (2012). The Impact of Sexualisation – Knowing and seeing too much. In W. Warburton & D. Braunstein (Eds.) *Growing Up Fast and Furious*. Sydney: Federation Press.	BC 12/2 ✓
17.	Newman, L.K. (2012). Questions about Gender – Children with atypical gender development. In J. Hutson, G. Warne, S. Grover (Eds*.) Disorders of Sex Development*. Pp. 31-40 Heidelberg: Springer.	BC 12/1 ✓
18.	Newman, L.K. (2011). Children seeking asylum: The psychological and developmental impact of the refugee experience. In Fitzgerald, H.E., Kaija Puura, Tomlinson, M., Campbell, P. (Eds.) *International Perspectives on Children and Mental Health. Vol 1. Development and Context. Pp. 217-224.* Santa Barbara, California: Praeger.	BC 11/1 ✓
19.	Newman, L.K. (2009). The psychological and developmental impact of sexualisation on children. In Melinda Tankard (Ed). *Getting Real – Challenging the sexualisation of girls* pp. 75-84, North Melbourne. Spinifex Press	BC 09/1 ✓
20.	Newman. L.K. (2008). Trauma and ghosts in the nursery: Parenting and borderline personality disorder. In A. Sved-Williams & V. Cowling (Eds.). *Infants of Parents' with Mental illness: Developmental, clinical, cultural and personal perspectives.* pp. 212-231. Sydney: Australian Academic Press.	BC 08/1 ✓
21.	Newman, L.K., Steel, Z., Mares, S., Black, B., & Dudley, M. (2004). The politics of asylum and immigration detention: Advocacy, ethics and the professional role of the therapist. In J. Wilson & B. Drozdek (Eds.). *Broken Spirits: The treatment of traumatised asylum seekers, refugees, war and torture victims.* pp. 659-988. New York: Brunner-Routledge.	BC 04/1

22.	Newman, L.K. (2000). Transgender issues. In J. Ussher (Ed.). *Women's Health: An International Reader.* London: British Psychological Society	BC 00/1
23.	Newman, L.K., Beaumont, P.J.V., & Russell, J. (1995). Legal and ethical issues in the treatment of low weight anorexics. In S. Job (Ed.). *Australia's Adolescents*. University of New England Press.	BC 95/1

Publications – Papers

1.	E Clancy, J McIntosh, A Booth, J Sheen, M Johnson, T Gibson, R Bennett, **Louise Newman** (2020) Training maternal and child health nurses in early relational trauma: an evaluation of the MERTIL workforce training. Nurses Education Today Vol 89, June 2020, 104390 https://doi.org/10.1016/j.nedt.2020.104390	20.5
2.	Karen Zwi, L Sealy, N Samir, N Hu, R Rostami, R Agrawal, S Cherian, J Coleman, J Francis, H Gunasekera, D Isaacs, P Larcombe, D Levitt, Sarah Mares, R Mutch, **Louise Newman**, S Raman, H Young, C Norwood, R Lingam (2020) Asylum seeking children and adolescents in Australian immigration detention on Nauru: a longitudinal cohort study BMJ Paediatrics Open 2020;4:e000615. doi: 10.1136/bmjpo-2019-000615	20.4
3.	Jarrod White, Lenore Manderson, **Louise Newman**, Glenn Melvin (2020) Understandings of trauma: contrasting Sudanese refugees and Holocaust survivors. *Journal of Refugee Studies* Vol. 0, No. 0 VC The Author(s) 2020. Published by Oxford University Press. https://doi.org/10.1093/jrs/feaa019	20.3
4.	Richard Fletcher, Jennifer St George, **Louise Newman**, Jaime Wroe (2020) Male callers to an Australian perinatal depression and anxiety help line-understanding issues and concerns. *Infant Mental Health Journal*. *Infant Mental Health Journal*, Vol 41, issue 1, pages 145 - 157 https://doi.org/10.1002.imhj.21829	20.2
5.	Vesna Newman-Morris, Kylie Gray, Katrina Simpson, **Louise Newman** (2020) Development and initial reliability and validity of a new measure of distorted maternal representations: The Mother–Infant Relationship Scale. *Infant Mental Health Journal*, Vol 41, issue 1, pages 40-55 https://doi.org/10.1002/imhj.21826	20.1
6.	M Sinclair, P Schofield, J Turner, P Raunch, C Wakefield, B Mann, **Louise Newman**, K Mason, L Gilham, J Cannell, L Stafford (2019) Maternal breast cancer and communicating with children: a qualitative exploration of what resources mothers want and what health professionals provide. *European Journal of Cancer Care*. First published 23/8/19 (early view only as at 9/10/19) https://doi.org/10.1111/ecc.13153	19.4
7.	Samantha Teague, Louise Newman, Bruce Tonge, Kylie Gray (2019). Attachment and child behaviour and emotional problems in autism spectrum disorder with intellectual disability. *Journal of Applied Research in Intellectual Disabilities*. First published 19/11/19 https://doi.org/10.1111/jar.12689	19.3
8.	H Gordon, S Nath, K Trevillion, P Moran, S Pawlby, Louise Newman, L Howard, E Monyneaux (2019) Self-harm, self-harm ideation and mother-infant interactions: a prospective cohort study. *Journal of Clinical Psychiatry* 10/9/2019 80(5). pii: 18m12708 DOI:10.4088/JCP.18m12708	19.2

9.	Bei Bei, Donna Pinnington, Lin Shen, Michelle Blumfield, Sean Drummond, Louise Newman, Rachel Manber (2019) A scalable cognitive behavioural program to promote healthy sleep during pregnancy and postpartum periods: protocol of a randomised controlled trial (the SEED project) *BMC Pregnancy and Childbirth* 19:254 DOI 10.1186/s12884-019-2390-8	19.1
10.	J Quek, G A Melvin, C Bennett, MS Gordon, N Saeedi, **Louise Newman** (2018) Mentalization in adolescents with Borderline Personality Disorder: A comparison with health controls. *Journal of Personality Disorders*. Feb 22:1-19. doi: 10.1521/pedi_2018_32_336. [Epub ahead of print]	18.13
11.	Fiona Judd, **Louise Newman**, Angela Komiti (2018) Time for a new zeitgeist in perinatal mental health. *Australian and New Zealand Journal of Psychiatry*. Vol 52(2) 112-116 DOI: 10.1177/0004867417741553	18.12
12.	Bennett, C., Melvin, G. A., Quek, J., Saeedi, N., Gordon, M. S., **Newman, L. K.** (2018) An investigation of the mentalization-based model of borderline pathology in adolescents. *Comprehensive Psychiatry*. Vol 84 P87-94 DOI: 10.1016/j.comppsych.2018.04.005	18.11
13.	Bennett, C., Melvin, G. A., Quek, J., Saeedi, N., Gordon, M. S., **Newman, L. K.** (2018) Perceived Invalidation in Adolescent Borderline Personality Disorder: An Investigation of Parallel Reports of Caregiver Responses to Negative Emotions. *Child Psychiatry and Human Development.* DOI: 10.1007/s10578-018-0833-5	18.10
14.	Richard Fletcher, Jacqui Macdonald, **Louise Newman** (2018). Men get postnatal depression too, and as the mother's main support, they need help. *The Conversation* published 7/12/18 https://theconversation.com/men-get-postnatal-depression-too-and-as-the-mothers-main-support-they-need-help-108256	18.9
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