mater

Perinatal Mental Health

Submission to the Mental Health Select Committee

February 2022

Acknowledgements

Mater acknowledges the Traditional Owners of country throughout Australia, and their continuing connections to land, sea and community, and pays respect to Aboriginal people and cultures, and to Elders past, present and emerging.

Mater recognises the strength of people living with trauma, neurodiversity, mental ill health and substance use or addiction, and their families, carers and supporters, and remembers those who have been lost to suicide.

Mater acknowledges the many individuals and organisations who contributed their time, stories, experience and wisdom to guide and contribute to the development of this submission.

For your safety:

Some people may find parts of the content of this submission confronting or distressing. If any of the following material raises any concerns, contact Lifeline on 13 11 14 or click to see other ways to seek help.

This submission was prepared by Mater Family Wellbeing Service Steering Committee.

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A note on language and terminology

There is no single set of definitions used to describe how people experience their mental health and wellbeing. Although the language used in this document has at all times aimed to be inclusive and respectful, it is acknowledged that not everyone will agree with the terminology chosen.

In this submission, a decision has been made to use descriptors such as 'person' and 'person with lived experience' and 'consumers' rather than terms such as 'clients', 'service users' or 'patients'. For similar reasons, use of the terms 'families', 'carers' and 'supporters' has been used and is intended to include partners, carers, significant others, friends and anyone whose primary relationship with the person concerned is a personal, supporting and caring one.

Executive summary

Every year, there are 59,490 births in Queensland.[1] The period leading up to and in the months following birth is one of significant adjustment. One in five mothers experience critical psychological distress or mental illness during the perinatal period. Mental illness during the perinatal period is among one of the most preventable and treatable of all mental illnesses, yet Queensland has one of the highest rates of maternal postnatal depression in the country (10.2 per cent).[2]

There is a significant shortfall in services in Queensland. With only four (4) dedicated public perinatal mental health beds available to support over 12,000 births per annum[3], there is a devastating gap in the ability of the Queensland health system to meet the needs of the community.

The stark void in perinatal mental health services in Queensland is larger than for any other state in Australia, with limited or poor quality perinatal mental health care, support and treatment.[4] Tragically, the lack of available supports for new mothers in distress has resulted in deaths, with suicide being one of the top two causes of maternal death in Queensland for the past 20 years. There is an urgent, unmet need in the community to respond to the mental health needs of women, their partners and children before and after a baby is born. The Queensland Government must respond.

An investment in perinatal mental health and wellbeing will positively influence the trajectory of the mental health and wellbeing of future generations and reduce future demand for youth, adult and older adult mental health and wellbeing services. It will also help to address a range of social issues, with research suggesting that crime, poor education outcomes and unemployment can often be traced back to adverse experiences in the early years.

Past inquiries have highlighted the critical need for appropriate service support, inpatient beds and integration of perinatal mental health services across Australia. The Royal Commission into Victoria's mental health system heard of the urgent need for reform to infant and perinatal mental health services in Victoria, where the accessibility of services exceeds that of Queensland by a factor of eight.

There are significant economic benefits associated with investing in supports for new parents in the perinatal period.[5] The economic impact to Queensland is estimated to total $417.2m during the first three years of life.[6] The Queensland Government cannot afford not to act. The lack of comprehensive, integrated perinatal mental health care in Queensland has devastating consequences for families, with suicide being one of the leading causes of maternal death in Queensland.

Mothers, infants, and families urgently require treatment, care and support that is compassionate, recovery-oriented and proportionate to need. Timely and responsive perinatal mental is not only life changing; it is lifesaving.

Mater is a major provider of hospital-based healthcare and provides a wide range of clinical services to support people with both physical and mental health needs. The Mater Mothers'

[1] Queensland Government Statistician's Office. 2020.

[2] Queensland Mental Health Commission. 2014 Discussion Paper – Perinatal and Infant Mental Health Service Enhancement.

[3] Queensland Government, Open data portal., 2021 Births by hospital.

[4] Queensland Mental Health Commission. 2014. Perinatal and infant mental health service enhancement: community views.

[5] Mental Health Productivity Commission Inquiry Report, 2020

[6] The Cost of Perinatal Depression and Anxiety in Australia, 2019

Hospital in Brisbane is Australia's largest maternity service, supporting approximately 12,000 mothers/births per year.[7]

Mater Health is working toward the introduction of a dedicated perinatal mental health and wellbeing service, integrated with The Mater Mothers' Hospital. The Mater Family Wellbeing Service will expand and integrate contemporary evidence-based, multidisciplinary perinatal mental health services with maternity and obstetric services, providing integrated and accessible perinatal mental health support to thousands of families every year.

The service will build on the Mater mission, to respond to unmet community need, and empower people to live better lives through improved health and wellbeing, by providing a continuum of specialised care throughout the perinatal period. The Mater Family Wellbeing Service is expected to be operational from November 2022.

The following submission will highlight the need to prioritise funding for specialist inpatient and outpatient perinatal mental health services in Queensland, including the opening of eight public dedicated perinatal mental health beds at the Mater Family Wellbeing Service.

[7] Queensland Government, Open data portal., 2021 Births by hospital.

Recommendations

1. **The Mental Health Select Committee makes the finding that there is a significant deficit in available and appropriate perinatal health care in Queensland and there is an urgent need for investment in perinatal mental health in Queensland.**

2. **Queensland needs an adequate baseline of acute mother-baby inpatient beds.**

a. The Queensland Government should directly fund the opening of eight public dedicated perinatal mental health beds at the Mater Family Wellbeing Service. Current planning with Queensland Health and partners will have this service operational by the end of 2022.

b. The Queensland Government should directly fund appropriate perinatal mental health services by prioritising recurrent funding to ensure the Mater Family Wellbeing Service can sustain operations beyond its opening in 2022.

c. Mothers should receive inpatient support together with their infant, ie. mothers and infants should be admitted to dedicated perinatal mental health beds, freeing up general mental health beds and responding to the importance of attachment in the early years.

d. The Queensland Government should investigate opportunities to provide dedicated perinatal mental health beds in wider Queensland to meet the baseline demand for perinatal mental health supports.

3. **Queensland needs an appropriate level of integrated and responsive outpatient mental health support for mothers and infants and families during the perinatal period.**

a. Prioritise quality perinatal mental health care for 12,000 mothers who access maternity and parenting services at Mater. Women with a pre-existing mental illness who give birth at a public hospital should have their physical and mental health needs supported by that hospital.

b. Prioritise statewide primary and secondary consultation support for the broader sector to improve mental health and wellbeing outcomes for mothers, infants and families. With more widely available 'specialist backup' provided to primary and secondary care and related services, more prospective and new parents will be able to get their treatment, care and support close to where they live.

4. **The Queensland Government should support the development of a comprehensive and statewide approach to perinatal mental health** in the form of a Comprehensive Centre for Women's Health and Wellbeing, based in the largest maternity hospital in Australia (as distinct from the Queensland Centre for Perinatal and Infant Mental Health). This would enable the following:

a. Deliver service excellence in perinatal mental health

b. Enhance the translation of perinatal research through the expansion of the existing partnership between Mater and the Queensland Centre for Perinatal and Infant Mental Health

c. Enhance access and integration of peer support, through expansion of the existing partnership between Mater and PeachTree, the peak body for perinatal lived experience service delivery

d. Deliver statewide secondary consultation and perinatal expertise to enhance workforce capability and support better outcomes for families across Queensland

e. Educate the workforce in evidence based best practice for perinatal mental health including:
    i. Shared care General Practitioner program
    ii. Training nurses and other health professionals
    iii. Rural and regional training and development
    iv. Support statewide clinical networking
    v. Expand the footprint of the existing Parent Aid program

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1 Prevalence of perinatal mental health

The purpose of this section is to describe the prevalence of perinatal mental health issues in Queensland. It outlines the prevalence for the general birthing population, as well as at-risk or vulnerable populations, and the impacts of the COVID-19 pandemic on perinatal mental health.

The perinatal period is a time of significant change and transition. Adjusting to pregnancy and parenthood brings both joy and stress to families. This period of life is associated with a significantly increased risk of onset and relapse of mental health conditions.[8]

Mental health conditions during the perinatal period can affect a parent's emotional wellbeing and happiness, as well as the experience of pregnancy and parenting.[9] These conditions are associated with an increased risk of obstetric and neonatal complications and can impact maternal and paternal bonding with a newborn as well as an infant's psychological adjustment and development over the life course.[10]

What do we mean by perinatal mental health?

'Perinatal mental health' refers to the mental health of a prospective or new parent and their infant from conception until 24 months after birth.[11]

The term perinatal mental health is inclusive of both parental mental health and the health of the unborn infant or young infant, and the developing parent-infant relationship.[12]

Whilst experiences of mental illness or psychological distress during the perinatal period vary widely, perinatal mental ill-health is relatively common.[13] Approximately one in five women will experience postnatal depression or anxiety within six months of the birth of their child.[14,15] One in 10 women will experience clinically significant symptoms of depression during pregnancy.[16] While perinatal depression and anxiety are the most common presentations,

[8] Centre of Perinatal Excellence, 2017.

[9] O'Hara et al. 2014. Perinatal mental illness: definition, description and aetiology. *Best Pract Res Clin Obstet Gynaecol.* Accessible: https://pubmed.ncbi.nlm.nih.gov/24140480/#:~:text=Perinatal%20mental%20illness%20is%20a,usually%20manifests%20as%20bipolar%20disorder

[10] Mental Health Care in the Perinatal Period. 2017. Australian Clinical Practice Guideline.

[11] Queensland Health, Caring for a Person Experiencing Mental Illness in the Perinatal Period, 2010, p. 37.

[12] Royal Commission into Victoria's Mental Health System, 2021. Final Report, Volume 2, p. 128.

[13] O'Hara et al. 2014. Perinatal mental illness: Definition, description and aetiology. *Best Pract Res Clin Obstet Gynaecol.*

[14] Jane Yelland, Georgina Sutherland and Stephanie J Brown, Postpartum Anxiety, Depression and Social Health: Findings from a Population-Based Survey of Australian Women, BMC Public Health, 10:771 (2010), p. 1.

[15] Centre of Perinatal Excellence, Mental Health Care in the Perinatal Period: Australian Clinical Practice Guideline, 2017, p. 6.

[16] Louise Michele Howard and others, Accuracy of the Whooley Questions and the Edinburgh Postnatal Depression Scale in Identifying Depression and Other Mental Disorders in Early Pregnancy, The British Journal of Psychiatry, 212.1 (2018), 50–56 (p. 53).

women may also experience a range of other mental health conditions, with research estimating that one to two in every 1,000 new mothers will experience postnatal psychosis.[17]

Postnatal psychosis can be a 'potentially life-threatening condition that can put both mother and baby at risk', requiring urgent medical assistance and, in most cases, a hospital admission for specialised treatment.[18]

Despite the prevalence of these presentations, mental health conditions during the perinatal period often go undetected and untreated, placing mothers, infants and families at risk and imposing a significant burden on the health system.[19] If untreated, perinatal health issues, such as depression and anxiety, can result in long-term emotional, social and wellbeing impacts for parents, children and families. In acute cases, perinatal mental illness can result in maternal suicide or infant death.[20]

Maternal suicide was the leading cause of maternal deaths in the perinatal period in Australia from 2004 to 2017.[21]

Early detection of psychological distress or mental illness is critical. Without access to timely and suitable treatment, care and support, these presentations can have tragic consequences.[22],[23]

There is less research available for the mental health of fathers during the perinatal period, however, evidence suggests that approximately 10 per cent (or one in 10) men will experience depression after the birth of a child.[24] Anxiety is also common, and a recent review estimates that the prevalence of anxiety in men in the perinatal period is one in four.[25]

1.1 The prevalence of perinatal mental health issues in Queensland

Queensland has one of the highest rates of maternal postnatal depression in the country (10.2 per cent).[26] This figure does not include antenatal mental health problems, mental health problems other than postnatal depression, or postpartum issues in the context of pre-existing mental illness. There is a serious disconnect between the prevalence of maternal perinatal mental health problems and the number of women receiving appropriate treatment.[27] Each year, nearly 10,000 Queensland women require primary care for perinatal mental health issues, nearly 3,000 require specialist psychiatric treatment, and over 200

[17] Lauren M Osborne, Recognizing and Managing Postpartum Psychosis, Obstetrics and Gynecology Clinics of North America, 45.3 (2018), 1–22 (p. 1).

[18] Perinatal Anxiety and Depression Australia, Postnatal Psychosis, <www.panda.org.au/info-support/postnatal-psychosis>, [accessed 17 November 2020].

[19] Mental Health Care in the Perinatal Period. 2017. Australian Clinical Practice Guideline.

[20] Mental Health Care in the Perinatal Period. 2017. Australian Clinical Practice Guideline.

[21] Modini et al. 2021. Maternal deaths by suicide in Queensland, Australia. Arch Women's Ment Health

[22] The University of Queensland, The National Mental Health Service Planning Framework—Service Element and Activity Descriptions, 2016, p. 60.

[23] Lauren M Osborne, Recognizing and Managing Postpartum Psychosis, Obstetrics and Gynecology Clinics of North America, 45.3 (2018), 1–22 (p. 1).

[24] Paulson JF. Et al. 2020. *J Am Med Assoc.* Prenatal and postpartum depression in fathers and its association with maternal depression: a meta-analysis.

[25] Perinatal Anxiety & Depression Australia (PANDA). 2022. Prevalence of mental illness in the perinatal period.

[26] Queensland Mental Health Commission. 2014 Discussion Paper – Perinatal and Infant Mental Health Service Enhancement.

[27] Queensland Mental Health Commission. 2014 Discussion Paper – Perinatal and Infant Mental Health Service Enhancement.

require hospitalisation.[28] Mental illness during the perinatal period are among the most preventable and treatable of all mental illness, yet Queensland has limited dedicated public beds for perinatal mental health admissions.[29]

The Queensland Partners in Prevention project data reports significant numbers of new mothers presenting to emergency department with suicidal intent (2015-17).[30] Every year, almost 1,000 mothers with children under 12 months of age will present to Queensland emergency services in a suicidal crisis. Of these mothers, 3.8 per cent identify as Aboriginal or Torres Strait Islander.[31] This further highlights the high incidence of perinatal mental health crises, requiring specialist and culturally appropriate responses and care.

1.2 Increased risk for perinatal mental health issues

The perinatal period is one of increased vulnerability to mental ill-health, with perinatal mental illnesses caused by a combination of biological, sociological and psychological factors.[32] Factors preceding the onset of perinatal mental illness can include a history of trauma, psychological distress or mental illness, a lack of partner or social support, and stressful life events.[33] These experiences may be entirely new, coinciding with the birth of a child or they may be recurrent.[34]

Families from minority communities can be at an increased risk of perinatal anxiety and depression.[35] Populations most at risk include LGBTIQ+ parented families, Aboriginal and Torres Strait Islander communities, refugee families, culturally and linguistically diverse (CALD) families and mothers experiencing substance abuse and addiction or young mothers (aged 26 years and below).[36]

Young mothers disproportionately experience mental ill-health and adverse life events which require comprehensive care. A study of Australian adolescent parents (between 13 and 19 years old) reported that 20.5 per cent had experienced sexual or physical abuse, which was associated with postnatal depression and anxiety.[37] Children born to mothers aged under 25 are at a higher risk for perinatal mortality and children to parents under 20 are at a higher risk of being born pre-term. Given that young mothers are disproportionately overrepresented in Queensland, there is a real need for the Queensland government to ensure services are accessible to support these vulnerable groups.

Similarly, indigenous women are at increased risk of mental health problems during the perinatal period, particularly depression, anxiety, and substance misuse.[38] Whilst the

[28] Queensland Mental Health Commission. 2014 Discussion Paper – Perinatal and Infant Mental Health Service Enhancement.

[29] Queensland Mental Health Commission. 2014 Discussion Paper – Perinatal and Infant Mental Health Service Enhancement.

[30] Queensland Government. Partners in Prevention: Understanding and enhancing first responses to suicide crisis situations – Data Linkage Study. 2020.

[31] Queensland Government. Partners in Prevention: Understanding and enhancing first responses to suicide crisis situations – Data Linkage Study. 2020.

[32] The Royal Australian and New Zealand College of Obstetricians and Gynaecologists, Mental Health Care in the Perinatal Period, 2012, p. 5.

[33] Alessandra Biaggi and others, 'Identifying the Women at Risk of Antenatal Anxiety and Depression: A Systematic Review', Journal of Affective Disorders, 191 (2016), 62–77 (p. 62).

[34] The Royal Australian and New Zealand College of Obstetricians and Gynaecologists, p. 5; The Royal College of Psychiatrists, London, Perinatal Mental Health Services: Recommendations for the Provision of Services for Childbearing Women, 2015, p. 8.

[35] Perinatal Anxiety & Depression Australia (PANDA). 2020/2021 Budget Submission.

[36] Perinatal Anxiety & Depression Australia (PANDA). 2022. Prevalence of mental illness in the perinatal period.

[37] Gilson KJ, Lancaster S. Childhood sexual abuse in pregnant and parenting adolescents. Child Abuse Negl. 2008;32(9):869-77

[38] Owais, S., Faltyn, M., Johnson, A. (2019). The Perinatal Mental Health of Indigenous Women: A Systematic Review and Meta-Analysis. *Canadian Journal of Psychiatry*, 65(3)

prevalence of perinatal mental health is considered to be high for this cohort, given that Indigenous women are exposed to high rates of risk factors for perinatal mental health problems, the magnitude of their risk is not known.

Mental health impacts to young mothers are likely disproportionate and places them at risk for experiences of mental ill-health later in life.

Orygen, Supporting young parents[39]

Experiences of perinatal mental illness can be further exacerbated by barriers to accessing safe, appropriate services. For example, there is limited support available for mothers experiencing substance abuse and addiction nationally.[40]

Experiences of discrimination and isolation, and the fear of further discrimination and isolation, discourages help seeking at a time of particular risk for these vulnerable families. Access to culturally safe, readily available and inclusive services is critical to target the perinatal mental health needs for these vulnerable populations.

[39] Fava N, Borninkhof J, Baker D. (2021). Supporting young parents: addressing perinatal and youth mental health needs. Melbourne: Orygen 2021

[40] Emerging Minds. (2022). Working with mothers affected by substance use: Keeping Children in Mind.

1.3 The impact of the COVID-19 pandemic on perinatal mental health

Over 2020 and 2021, there has been a significant increase in demand for mental health services, compounded by the COVID-19 pandemic. This was not only due to concerns around contracting the virus, but also the measures necessary to contain the spread. The Australian COVID-19 response has been centred around social confinement measures, strict quarantine and geographic isolation. Increased isolation and limited social support for new mothers and families during the perinatal period is a strong predictor for perinatal mental illness.[41] Many mothers report clinically significant increases in moderate and severe depression and anxiety as a result of changes in antenatal care, home schooling responsibilities, uncertainty around birth plans, an increase in domestic and family violence, and uncertainty into the environment children are raised in.[42]

These restrictive measures have had devastating consequences for maternal mental health.[43]

Perinatal Anxiety and Depression Australia (PANDA) report that the number of new telephone calls to their helpline doubled between March and October 2020, as did the average duration of call times. There has been an increase in requests for state-wide e-PIMH telepsychiatry consultations for perinatal mental health service by a factor of four from the previous month.[44]

While the data regarding the impact of COVID on mental health is still emerging, it is clear that there is a direct need for increasing support for mothers and parents now and in the immediate future.

[41] Polchleb et al. 2021. COVID-19 and pandemic perinatal mental health in Australia. Australian Journal of General Practice.

[42] Sakalidis, VS., et al. Wellbeing in breastfeeding women in Australia and New Zealand during the COVID-19 pandemic: A cross-sectional study. Nutrients. 2021 May 27;13(6)

[43] World Health Organisation (WHO). 2020. Substantial investment needed to avert mental health crises.

[44] Queensland Centre for Perinatal and Infant Mental Health. 2021.

2 The devastating impact of perinatal mental illness

The purpose of this section is to describe the impact of perinatal mental illness for women, children and families. It outlines the risks associated with perinatal mental illness, many of which could be avoided with accessible perinatal mental health care.

The right treatment, care and support, delivered compassionately and as soon as mental health and wellbeing challenges emerge, can be life-changing for a mother and her infant, as well as and their family, carers and supporters. Conversely, when this treatment, care and support is difficult to access or not offered in a timely way, the consequences can be devastating for the mother and infant, and their family, carers and supporters.

2.1 Infant development

Pregnancy and the first few months and years of a child's life are critical for brain development, laying the foundation for future learning, behaviour and health. Longitudinal studies have shown that perinatal mental health problems may be associated with long-term negative effects on the infant's cognitive, social, emotional and behavioural development if timely and appropriate support is not received.[45]

Maternal anxiety and depression during pregnancy is also associated with an increased likelihood of difficult infant temperament, and behavioural problems in infancy.[46] Maternal mental illness in the postpartum period has been found to contribute to developmental delays in motor function, language acquisition, cognitive skills, emotional self-regulation, and adaptive behaviour.[47]

Children born to a parent who experienced antenatal depression have an increased likelihood of experiencing depression themselves. Similarly, antenatal depression has been associated with increased likelihood of anxiety in children at 18 years of age.[48]

Parental mental illness can also negatively impact on the development of healthy attachment. An infant who does not develop a healthy attachment relationship with their parent internalises negative working models of self and others. This leads to poorer developmental outcomes in childhood and curtails the ability to function in relationships. It may also impair future parenting, contributing to intergenerational cycles of mental health problems and social disadvantage.[49] Parental mental illness may also lead to increased exposure to childhood adversity, such as neglect, out-of-home placement and abuse, which has been found to account for more than 30 per cent of psychosis in adulthood.[50]

Traumatic experiences during infancy and childhood interact with genetics to change the structure and function of the brain, compromising emotional and cognitive development

[45] Muzik M et al. (2010). Perinatal depression: implications for child mental health. *Ment Health Fam Med*

[46] O'Conner, T., Heron, J., Glover, V., Antenatal anxiety predicts child behavioral/emotional problems independently of postnatal depression. *J Am Acad Child Adolesc Psychiatry*. 2002 Dec;41(12):1470-7.

[47] Milgram, J., Westley, D., Gemmill, A. (2004). The mediating role of maternal responsiveness in some longer-term effects of postnatal depression on infant development. *Infant Behavior and Development*. 27(4)p443-454.

[48] Biaggi A et al. (2016). Identifying the women at risk of antenatal anxiety and depression: A systematic review.

[49] Fonagy, P., Steele, H., & Steele, M. (1991). Maternal representations of attachment during pregnancy predict the organization of infant-mother attachment at one year of age. *Child development*, *62*(5), 891-905.

[50] Varese, F., Smeets, F., Drukker, M., Lieverse, R., Lataster, T., Viechtbauer, W., ... & Bentall, R. P. (2012). Childhood adversities increase the risk of psychosis: a meta-analysis of patient-control, prospective-and cross-sectional cohort studies. *Schizophrenia bulletin*, *38*(4), 661-671.

and initiating a pathway to pathology.[51] Neurobiological research suggests the immaturity of the brain, combined with the unique processing of trauma, may underlie the enduring effects of abuse, which emerge as mental health issues later in life.[52]

As a result, infants and young children may require secondary and tertiary mental health services in their own right. A comprehensive and integrated perinatal mental health service is required in order to respond to the mental health needs of both the mother and the infant.

2.2 Obstetric and neonatal complications

The experience of a perinatal mental health condition is correlated with increased complications during pregnancy and birth, including poorer obstetric outcomes, such as increased risk of placental abruption, postpartum haemorrhage, stillbirth and neonatal deaths.[53]

Maternal prenatal mental health disorders appear to be associated with a moderate increase in the risk of stillbirth and infant mortality, although the mechanisms are unclear.[54] The infant mortality rate in Queensland was 3.0 per 1,000 live births in 2020 and the rate of stillbirths in Australia in 2018 was 2.2 per 1,000 births.

Efforts to prevent and treat perinatal mental illness reduces the incidence of stillbirth / infant deaths in Queensland.[55]

2.3 Maternal and infant death

Serious perinatal mental ill-health is associated with maternal or infant death.[56] Suicide is and has remained one of the top two causes of maternal death in Queensland for the past 20 years.[57] The impact on an infant and families as a result of a suicide can have devastating, lasting emotional impacts.[58]

The contributing factors for suicide in women include poor or limited screening to identify those at risk; lack of continuity of care, meaning they are more likely to fall through the gaps between and within services; a lack of community-based support, especially mother-baby units; and poor follow-up, particularly if the baby is removed from the mother due to child protection concerns.[59]

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[51] Sullivan, R. M. (2012). The neurobiology of attachment to nurturing and abusive caregivers. *The Hastings law journal*, *63*(6), 1553.

[52] Sullivan, R. M. (2012). The neurobiology of attachment to nurturing and abusive caregivers. *The Hastings law journal*, *63*(6), 1553.

[53] Royal College of Psychiatrists. 2021. Perinatal mental health services: recommendations for the provision of services for childbearing women.

[54] Adane et al. 2021. The impact of maternal prenatal mental health disorders on still birth and infant mortality: a systematic review and meta-analysis. *Arch Women's Mental Health.*

[55] Adane et al. 2021. The impact of maternal prenatal mental health disorders on still birth and infant mortality: a systematic review and meta-analysis. *Arch Women's Mental Health.*

[56] Modini et al. 2021. Maternal deaths by suicide in Queensland, Australia. Arch Women's Mental Health

[57] QMPQC Report 2019.

[58] Bergman et al. 2017. When a parent dies – a systematic review of the effects of support programs for parentally bereaved children.

[59] Submission to Royal Commission into Victoria's Mental Health System from the Consultative Council on Obstetric and Paediatric Mortality and Morbidity, Consultative Council on Obstetric and Paediatric Mortality and Mor http://rcvmhs.archive.royalcommission.vic.gov.au/Consultative_Council_on_Obstetric_and_Paediatric_Mortality_and_Morbidity.pdf

Tammy presented to the Logan Hospital Emergency Department 2 months after the birth of her infant with thoughts of suicide. She presented on the Friday, just before the weekend... There were no available beds in Logan Hospital or at the Lavender Mother-Baby Unit. The Emergency Department ended up discharging her that same day. Devastatingly, Tammy took her life on the weekend.[60]

Whilst rare, severe cases of perinatal mental illness can result in the death of an infant. Sadly, most infanticides are committed by the natural mother, who in half of all cases is suffering from a perinatal mental disorder.[61]

Research indicates that, in cases where the mother was experiencing mental illness, this was commonly related to the manifestations of a pre-existing mental illnesses, such as psychosis.[62] It is critical that appropriate screening and mental health care can be provided for mothers at risk of a psychotic or other mental illness.[63]

It is particularly important that women with backgrounds of early trauma, current exposure to conflict and violence in relationships, and a poor understanding of the requirements of parenting receive adequate mental health screening and intervention in order to prevent these tragedies. Interventions in the perinatal period are a significant strategy for improving safety, health and wellbeing for both mothers and infants.[64]

Timely and responsive crisis intervention in the form of an inpatient stay at a specialist mother -baby unit is not only essential for the provision of support for mothers in distress, but can be lifesaving.

[60] Blackwell, Cindy, Letter of support, dated 09 February 2022

[61] Porter T et al. 2010. Infanticide and Neonaticide: A review of 40 years of research literature on incidence and causes. *Trauma Violence & Abuse*.

[62] Porter T et al. 2010. Infanticide and Neonaticide: A review of 40 years of research literature on incidence and causes. *Trauma Violence & Abuse*.

[63] Porter T et al. 2010. Infanticide and Neonaticide: A review of 40 years of research literature on incidence and causes. *Trauma Violence & Abuse*.

[64] Submission to Royal Commission into Victoria's Mental Health System from the Consultative Council on Obstetric and Paediatric Mortality and Morbidity, Consultative Council on Obstetric and Paediatric Mortality and Mor http://rcvmhs.archive.royalcommission.vic.gov.au/Consultative_Council_on_Obstetric_and_Paediatric_Mortality_and_Morbidity.pdf

3 The failure to support perinatal mental health in Queensland

The purpose of this section is to describe the current demand for comprehensive and integrated perinatal mental health services. It outlines articulates the current gaps in the service system and the associated impacts on the Queensland mental health service system.

There are approximately 60,000 births per year in Queensland.[65] Given that one in five new mothers will experience clinically significant mental health difficulties within six to twelve months of birth, approximately 12,000 Queensland women may require perinatal mental health support in 2022.

The recommended ratio for mother-baby specialist inpatient beds is 1 bed per 1,500 to 1,600 births.[66] Figure 3-1 provides a national comparison of the number of dedicated perinatal mental health beds available and the number of births supported by each bed.

In Queensland, there are four public mother-baby beds, equating to one public bed per 14,879 births.

By comparison, in Victoria, there are 33 operational beds in the six public parent and infant units (for an average of 75,000 births per annum). This equates to one public bed per 2,261 births[67].

In order to meet the estimated demand for perinatal mental health services, Queensland should provide between 38 and 40 dedicated beds for mothers, along with their baby.[68] This would allow for an additional 255 mothers to access specialist perinatal mental health support with their infant, aligning with the Queensland Mental Health Commission recommendation suggesting a the need to provide care for more than 200 mothers.[69]

[65] Queensland Government Statistician's Office. 2020.

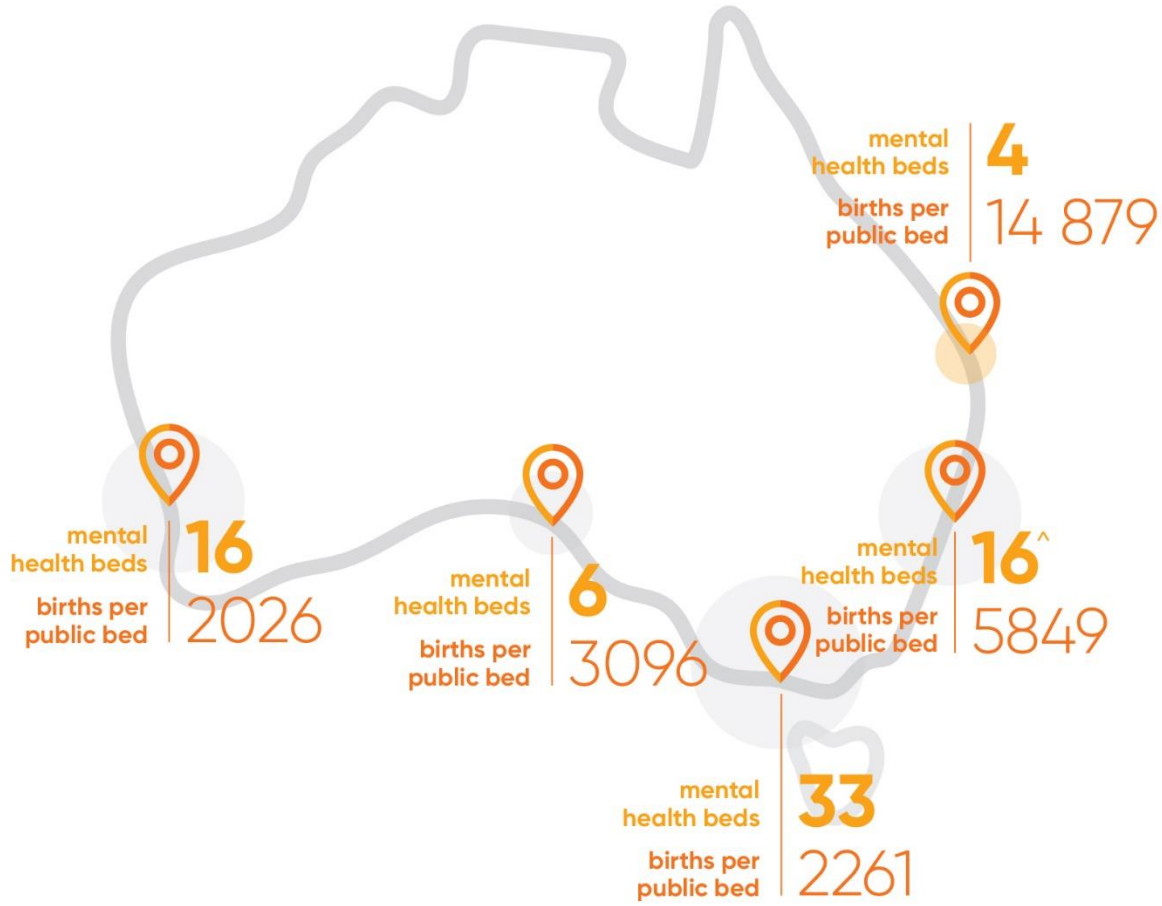
[66] Oates M. Perinatal mental health services: Recommendations for the provision of services for childbearing women, College Report CR197. Royal College of Psychiatrists; 2015.

[67] Royal Commission into Victoria's Mental Health System, 2021. Final Report, Volume 2, p. 128.

[68] Oates M. 2015. *Royal College of Psychiatrists.* Recommendations for the provision of services for childbearing women.

[69] Queensland Mental Health Commission. 2014 Discussion Paper – Perinatal and Infant Mental Health Service Enhancement.

Figure 3-1: National comparison – Ratio of perinatal mental health beds by births



^Includes mother and baby mental health facilities under development.
Based on 2020 birthing data.

Despite the range of services that are currently provided for perinatal mental health, Queensland has failed to keep up with, let alone meet, the demand for perinatal mental health care.

There is only one specialist public mother-baby unit in Queensland. The Lavender Mother and Baby Unit is a four-bed specialist state-wide acute service located at Gold Coast University Hospital. The unit provides specialist perinatal mental health care for women who require an admission to hospital in the first year following childbirth.[70] Mothers are admitted with their infant for treatment for a range of mental health conditions, including depression, anxiety, and psychotic illnesses. The unit is supported by the Lavender Perinatal Mental Health Community Team who assess and triage potential referrals to the Lavender unit.

[70] Gold Coast Health. 2022. Lavender Mother and Baby Unit.

The Lavender Mother and Baby Unit has an extensive waitlist, with some women waiting up to six weeks for an admission. Due to the limited capacity and accessibility, admissions are typically provided only to those in acute crisis or at risk. As a result, the level of psychological distress and need for support has to be extremely high in order to access existing services. This results in a shortfall for families who may seek early intervention, and are turned away from services, who may then start to see things unravel.

3.1 System navigation

Effective perinatal mental health care, support and treatment requires referrers, from general practitioners (GPs) through to specialist mental health clinicians, to be able to access a range of service and referral options and pathways, to enable continuity of care and individual choice.

Due to the limited availability of services and limitations in perinatal workforce capability, clinicians in Queensland are often unable to identify accessible care pathways required for mothers and their infants. GPs and psychiatrists report challenges in facilitating access to mother-baby beds required to ensure the safety and recovery of their patients. In addition, maternal and child health nurses often describe being required to refer to GPs or trying to provide ongoing support for the mother until a place at a mother-baby unit becomes available.

> *Dr Majella Henry (GP) states, "We might identify high scores on the Edinburgh Postnatal Depression Scale, showing thoughts of self-harm and indicating depressed mood, but there are limited pathways and options to support mothers who need that support 24/7 to ensure the safety of the mother and infant."*

3.2 Access and availability

There is a significant focus of the current system on mental health and wellbeing challenges that occur in young people and adults, with relatively fewer resources allocated to perinatal, infant and child mental health and wellbeing. In addition to the acknowledged service gaps, due to the large geographical area of Queensland and the limited number of community services, availability of services for this vulnerable cohort is sparse. This highlights the need for improved availability and geographical co-location of innovative, contemporary treatment, care and support.

There is little Queensland data to support access and availability due to the profound long-term lack of service availability. Data from other States, Coronial Inquests, and the Royal Commission in Victoria have continued to highlight the significant gap in service access and availability in Queensland.

3.3 Sub-standard care

The limited availability of perinatal mental health services in Queensland requires mothers to access psychological care through alternative services, including general adult inpatient mental health units, psychiatric facilities and in acute situations, emergency departments. These services do not support nor allow the admission of an infant.

Every year, more than 250 mothers are admitted to inpatient mental health care without their infant.[71]
'A facility that doesn't let you take your baby….it was horrible'[72]

As a result, mothers are separated from their infant, sometimes with devastating consequences. The impact of separation during the early weeks and months of life can result in significant psychological distress for mothers and infants, disruption to breastfeeding, as well as potentially detrimental impacts to the developing attachment relationship between mother and child.[73] In addition to the devastating impacts to an infant's development, this separation can also result in delayed or interrupted development of the mother's parenting skills and bonding.[74]

'I was involuntarily admitted overnight into a public hospital psychiatric unit. My baby was only one month old at the time, and I was breast-feeding her every few hours. This immediately ceased upon my admission; the public hospital psychiatric unit didn't allow for babies to accompany their sick mother. I was separated from my baby for 16 hours, a punishment for being unwell'.[75]

There is a need for an integrated model that services mothers and babies from pregnancy to after birth, and across the continuum of care from prevention to treatment of severe mental illness. Currently, there is no mental health support available that meets this critical gap in mainstream service delivery in Queensland. There is a clear opportunity for Queensland Health to provide an effective service, a more efficient use of Queensland Health funding, and the ability to free up adult mental health beds.

[71] Queensland Health - Health Analytics Team. 2016.
[72] Depressed mums put in Danger, Courier Mail Article. 2021
[73] Krol K et al. 2018. Psychological effects of breastfeeding on children and mothers.
[74] Winston R et al. 2016. The importance of early bonding on the long-term mental health and resilience of children.
[75] Richardson, Mary-Anne, Letter of support, dated 09 February 2022

4 Future directions for perinatal mental health care

The purpose of this section is to describe the current and emerging evidence relating to best practice in perinatal mental health, highlighting the critical directions needed for the future of support and treatment services for perinatal mental health in QLD. It also describes the alignment between the Mater vision and the better practice recommendations from the Productivity Commission and a range of other evidence informed sources.

The time around the birth of a child is one of life's most important stages, but at the same time, is also a high-risk period for mental health and wellbeing challenges.

A responsive and integrated perinatal mental health service should enable treatment, care and support to be provided proportionate to people's needs, strengths and individual situations. It should wrap a system of care around prospective or new parents as their needs change, with coordinated transitions between the levels of the system.

The integration of mental health services into maternity services throughout pregnancy and the period following birth enables health professionals to:

- Support a mother's mental health and adjustment during pregnancy and identify risk factors for adjustment difficulties
- Actively treat women with serious mental disorders to optimise their mental health through the perinatal period
- Support positive interactions with the infant and attachment relationships that optimise infant development.[76]

To facilitate this integration requires the provision of specialist care, the introduction or continuation of early intervention programs and adequate training for health professionals. Most importantly, it requires accessible and available options for admission.

The integration of maternity and mental health, in the form of a co-location model, is an approach recommended to improve care planning and coordination.[77]

Centralisation of triage functions over larger geographical areas promotes consistency of practice, strong clinical governance and accountability, and the development of a workforce that is highly skilled in assessing and responding to requests for urgent or specialised perinatal mental health assistance.[78]

In addition, perinatal mental health care must be culturally responsive and family-centred. It should involve collaborative decision-making between families and services. Health professionals providing care should have appropriate specialist training and skills and should work together to provide continuity of care for women, infants and their families.

[76] Submission to Royal Commission into Victoria's Mental Health System from the Consultative Council on Obstetric and Paediatric Mortality and Morbidity, Consultative Council on Obstetric and Paediatric Mortality and Morbidity http://rcvmhs.archive.royalcommission.vic.gov.au/Consultative_Council_on_Obstetric_and_Paediatric_Mortality_and_Morbidity.pdf

[77] Ibid

[78] National Mental Health Commission, The National Children's Mental Health and Wellbeing Strategy, 2020, p. 2.

4.1 Mater's vision for perinatal mental health services

Mater envisages a system of care that provides responsive and integrated mental health treatment, care and support for prospective and new parents and for infants and children. Mater will deliver an evidence-based, contemporary system of perinatal mental health care where parents, infants and children receive developmentally appropriate, integrated and responsive treatment and support.

Specialist perinatal mental health services are critical in the development of infant wellbeing through protecting and enhancing the relationship between mother and baby.[79] By ensuring and providing infants with a better start to life, the effects will be sustained across the entire life course and into the next generation.

The Mater Family Wellbeing Service is consistent with recommendations of the National Mental Health Commission and Productivity Commission. At a high level, both reports outline the need to invest – as a priority – in integrated, responsive perinatal mental health services that provide a continuum of care from prevention, crisis response, harm reduction, treatment and recovery. The recommendations clearly articulate the importance of integrating perinatal mental health services with infant mental health services, and the provision of care, support and treatment options to the whole family.

In addition, the recommendations clearly state the importance of supporting the mental health needs of people at greater risk of poor mental health. Given that the perinatal period is a period of significant risk to women with the effects impacting infant development across the lifespan, and for generations to come, there should be ongoing prioritisation of treatment, care, and support, as well as research into all aspects of perinatal mental health.

[79] Perinatal mental health services. 2021. Royal Australian & New Zealand College of Psychiatrists (RANZCP).

5 The Mater story

The purpose of this section is to articulate the well-established history and capability of Mater in responding to unmet needs in the community and empowering people to live better lives through improved health and wellbeing. It will describe the extensive work undertaken by Mater to respond to the significant gap in perinatal mental health support in Queensland and outline Mater's readiness to provide services to meet growing community demand.

For more than a century, Mater has supported the Queensland community by providing compassionate health care to those who need it most. Mater provide sustainable, socially relevant health care that is genuinely designed to empower people to live better lives through improved health and wellbeing.

Mater Health is the largest private provider in Queensland, delivering comprehensive public and private healthcare services across 10 hospitals, including the iconic Mater Mothers Hospitals, Australia's largest maternity service. More than 1 in 5 Queenslanders are born at a Mater Mothers Hospital, and Mater Mothers is recognised on the international stage as an exemplar in women's health services.

Mater is Australia's largest and most experienced maternity service provider, delivering more than 12,000 babies every year.[80] Mater also leads the nation in maternity foetal medicine and provides specialist neonatal critical care support for more than 2000 babies annually.

Unlike other hospital and health services in Queensland, Mater has the flexibility to deliver contracts as a public, private or non-government health service provider. Mater offers maternity services across five leading private maternity hospitals, and one public maternity hospital.

Mater has had a long and direct partnership with the Queensland Department of Health which has resulted in the establishment of several well-regarded public mental health and substance use services. Strong mental health advocacy has resulted in significant growth in the last five years. Some examples of past and recent developments include:

- Prior establishment and operation of a comprehensive and integrated child and adolescent mental health service from 1995 to 2014. The service transferred to the Queensland Children's Hospital when the Mater Children's Hospital closed
- Establishment of the Mater Consultation and Liaison Psychiatry Service in 2017
- A public youth specific mental health response. This service was established as part of the Mater Young Adult Health Centre and was expanded in 2019 with the opening of a private mental health inpatient unit. The Centre also includes comprehensive substance use services for young people developed over the last 20 years and includes residential programs and community outreach to support young people with substance use issues
- Ongoing provision of Mater Intellectual Disability and Autism Services.

These initiatives are evidence of Mater's commitment to the continual pursuit of innovation. While Mater provides a comprehensive range of services across acute mental health, obstetrics, maternity and paediatric medicine, there remains a burning need to deliver and expand perinatal mental health services specifically.

[80] Queensland Government, Open data portal., 2021 Births by hospital.

5.1 Readiness to expand services

Mater is in a unique position to respond to this urgent challenge. Mater is a nationally accredited, hospital-based registered training organisation and a lead provider of contemporary interprofessional healthcare education, training and simulation. Furthermore, Mater already offers care to mothers and their families in the form of consultation psychiatry services, a Perinatal Mental Health Team, a Parenting Support Unit and the Parent Aide Program. With an already operational perinatal mental health service and a track record of successful establishment and delivery of high-quality services, Mater is poised and ready to expand on current services to meet the growing demand.

Working closely with the Queensland Department of Health and the Queensland Mental Health Commission, Mater has consistently heard the need for additional public acute perinatal mental health inpatient facilities. Mater has proactively led advocacy and fundraising efforts and has been the beneficiary of more than $15 million in financial support from the community, providing capital funding to increase perinatal mental health services in Queensland. This significant investment is evidence of the urgency felt by the community at the lack of current services available to consumers for what is a treatable illness.

This contribution, along with significant investment from Mater, has led to the commencement of work to establish a dedicated perinatal mental health facility at the Mater Hospital South Brisbane campus. The establishment of this new facility was approved by the Mater Board in 2020 and construction is currently underway. Once complete, this will provide a purpose-built, inpatient facility for perinatal mental health as part of the Mater Family Wellbeing Service.

With the support of partner organisations, such as PeachTree, and as a commitment to providing the best possible care, Mater has and will continue to collaborate closely with consumer groups to co-design a model of perinatal mental health care that genuinely meets the needs and preferences of families. Extensive planning work has been undertaken to ensure that existing perinatal mental health services can transition seamlessly into the new facility and begin to offer enhanced perinatal mental health services opposite Mater's maternity and obstetric services.

To support this transition, Mater has invested significantly in developing a skilled workforce, with leadership from people with lived experience of perinatal mental illness. Lived experience expertise is embedded in all aspects of service design and delivery, with a comprehensive peer support model in place to support families before, during and after an admission.

Upon completion of the new facility build, Mater will be in a position to open the extended perinatal mental health service by November 2022, dramatically reducing the current gap in the availability of care for mothers, infants and families across Queensland.

The establishment of the Mater Family Wellbeing Service will be a landmark development for the health sector in Queensland.

The introduction of this service will address an urgent need in the community and provide quality services to improve the mental health and wellbeing of women and families in the perinatal period.

6 The Mater Model of Perinatal Mental Health Care

The purpose of this section is to provide an overview of the proposed Mater Model of Perinatal Mental Health Care. It provides an overview of the Mater Family Wellbeing Service, and the proposed Comprehensive Centre for Women's Health and Wellbeing, which will lead excellence in innovative and integrated women's perinatal health care.

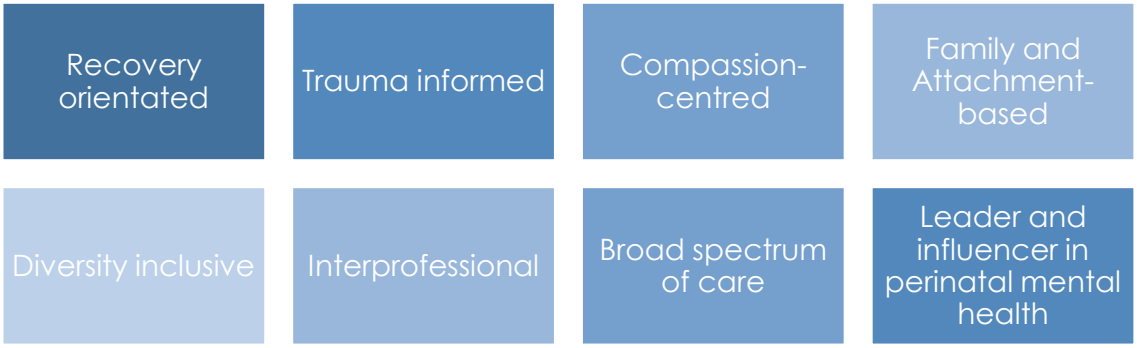
6.1 The Mater Family Wellbeing Service

The Mater Family Wellbeing Service will be multidisciplinary and staffed by clinicians and support workers specialising in perinatal mental health and wellbeing. Mater has worked in partnership with Queensland Health, the Mental Health Alcohol and Other Drugs Branch (MHAODB), the Queensland Centre for Perinatal and Infant Mental Health (QCIPMH) and the Queensland Mental Health Commission to research the sector and design options for a model of care with a broad spectrum of intervention.

In order to design a best practice service, the Mater team conducted exploratory site visits to every perinatal mental health service in Australia and have incorporated the lived experience of the consumer into the design of the model.

The resulting model of care is built on eight service principles:

Figure 6-1: The Mater Model of Care, service principles



The model of care integrates with existing services and will provide eight public and two private mental health, inpatient mother and baby beds. The mother and baby beds will augment other offerings in the public and private health sectors in Queensland. This will be a quaternary level component in the continuum of public mental health care in Queensland for mothers, babies, and families in the perinatal period. It will be co-located with new private services and existing Mater offerings, providing integrated perinatal mental health and psychosocial support for new parents.

Working in partnership with PeachTree and lived experience representatives, consideration will be given to how best to maximise the experiences and insights of consumers. This will include coordinating non-clinical supports and providing emotional support to help navigate the system.

The service will also assist families, carers and supporters to better understand perinatal mental illness and how to best support the person they are caring for. This could include connecting them to locally based supports, such as PANDA's National Helpline, online

communities and self-help material, or a range of community services including community mental health, GP, private psychologist/psychiatrist, infant mental health therapist, child health nurse, playgrounds, domestic and family violence-specific organisations, multicultural-specific mental health organisations, mental health day programs, and partner support groups.

The co-location and integration of services on the Mater campus to become the 'Mater Family Wellbeing Service' creates a model of care focused on the mental health needs of birthing mothers across the care continuum. This includes presentations in the pre-conception period, from pregnancy to postnatal care.

The model of care will provide continuity of care for mothers and their families in the perinatal period through co-location with existing Mater programs as outlined in Figure 6-2.

Figure 6-2: The Mater Family Wellbeing Service model

6.2 The Mater Comprehensive Centre for Women's Health and Wellbeing

The development of perinatal mental health services at Mater is part of a wider vision for mental health services. The vision is to provide contemporary evidence-based, multidisciplinary mental health services to the unique populations accessing Mater services whose needs are typically not met by mainstream mental health services.

The development of the continuum of psychosocial care in the perinatal period on the Mater Brisbane campus provides a foundation to assess the need for psychosocial support services across perinatal services provided by facilities in the Mater Group in Queensland.

Mater's approach to the implementation of a centre of excellence model will be driven by collaboration, draw on partnership and leverage multiple funding mechanisms to ensure its seamless integration within the broader health system.

Excellence in service delivery

The Mater Family Wellbeing Service will complement and integrate with other Mater health services across Queensland, including Mater's Neonatal Critical Care Unit, 24-hour Pregnancy Assessment Centre, Parenting Support Centre, Parent Aide Unit and shared care arrangements with GPs. The intention is to work towards the establishment of a Centre of Excellence for mothers, babies and families, with a focus on providing the *best start* for all children during the early years of life.

The Mater Family Wellbeing Service will strive for excellence in perinatal mental health care and aims to become a leader in the sector by nurturing partnerships with service providers, consumers, researchers and educators, and by attracting and retaining a skilled workforce to provide the highest standard of care.

Inclusive practice

The Mater Mother Baby Unit will integrate a high level of carer and family involvement in line with the National Mental Health Standards.

In addition to Mater's commitment to improving the health of homeless, refugees, and asylum seekers, the dedicated perinatal mental health would extend Mater's interactions in these vulnerable communities and existing network of partnerships which support improved health outcomes for vulnerable communities.

Lived experience expertise and peer support

The approach to carer and family engagement will include the concept of peer support workers. Peer support workers are workers who have a lived experience of mental health issues. Peer work is an essential element in a comprehensive spectrum of care, adding to consumer choice, Importantly, peer work is less stigmatising than traditional models of care. Evidence suggests that peer support workers foster hope and facilitate recovery as consumers meet someone who has been on the same journey. The role of peer support workers will range from general orientation, guidance and support to co-facilitation of group activities. This service will be an integral element to the Mater Mother-Baby Unit.

Services based on the expertise and the lived experience of women and families are essential to increase community awareness and de-stigmatisation, as well as in health promotion, prevention, identification, support and recovery of women experiencing perinatal distress or mental illness.

In addition, Mater support the development of peer and primary care sectors, through the design and delivery of dedicated training focused on building capacity and capability. The training approach, co-designed with lived experience subject matter experts Peach Tree,

Workforce capability

For more than 100 years, Mater has delivered quality training for clinicians and healthcare professionals. The training philosophy is founded in the synthesis of leading research, evidence-based contemporary education and clinical practice. Mater Education is a leading provider of interprofessional healthcare education and training, with world-class clinical simulation programs, facilities and faculty.

As a nationally accredited training provider, and the largest private provider of Enrolled Nurses training in Australia, Mater delivers contemporary, interprofessional workforce training and translational simulation services across a wide range of health care settings.

Mater intend to upskill community perinatal mental health and wellbeing teams to be able to conduct 'initial support discussions' and 'comprehensive needs assessment and planning discussions'.[81] Those discussions will support a thorough assessment and consideration of needs with clinicians and support workers trained in perinatal mental health.

In addition to enhanced workforce capability, Mater propose to offer enhanced consultation regarding perinatal mental health to a range of professionals, including maternal and child health nurses, GPs and maternity services. It will be in the form of primary and secondary consultation, where clinicians and support workers from the community perinatal mental health and wellbeing teams provide specialist capability building, limited joint clinical care and in some instances formalised shared-care arrangements.

Translational research

Mater Research is an internationally recognised leader in medical research. Mater research and Mater Education work collaboratively with a growing network of partners and collaborators to take a lead role in the iterative discovery of the best possible practice in relation to treatment, care, and outcomes for patients. Its bench-to-bedside philosophy means it works across Mater's hospitals and health services, The University of Queensland and the world-class Translational Research Institute. Mothers and Baby research is a key area of focus.

Mater is involved in research longitudinally examining families from antenatal to beyond through the Queensland Family Cohort Study - Mater Research. Mater also has the NHMRC Stillbirth Centre of Research Excellence and a dedicated Mother-Baby research stream.

Mater has currently awarded over $200,000 across the next three years to evaluate a postnatal father's group, evaluate a physiotherapy mental health mother's group, and evaluate the use of a mindfulness app to improve maternal mental health.

[81] Mater Family Wellbeing Service Plan. 2021

Innovation and continuous improvement

Mater have a strong culture of continuous improvement and actively encourage innovation and program development. This focus on service innovation enables Mater to be more effective, reach more people and ensures better health outcomes for those who access the service.

An ability to provide virtual consultations has been built into the new facility with workstations, meeting rooms and offices all telehealth capable. This provides an important opportunity to expand Mater's capability to provide virtual services and secondary consultations to consumers across the State.

7 Return on Investment

The purpose of this section is to outline how investment by the Queensland Government can enhance outcomes for Queenslanders requiring perinatal mental health treatment and support. It details the social and economic costs of perinatal mental illness in Queensland and examines the potential return on investment.

The mental health productivity commission highlighted the potential for significant economic benefits associated with investing in supports for new parents in the perinatal period.[82] The economic impact to Queensland specifically is estimated to total $417.2m during the first three years of life.[83] The details are included in the table below.

Table 7-1: Summary of lifetime costs associated with PNDA in Queensland[84]

Timeframe	Health Costs	Economic Costs	Wellbeing Costs	Total impacts
Year one impacts	$45.4m	$128.6m	$1.4m	$175.4m
Years two to three impacts	$39m	$200m	$2.8m	$241.8m
Total impacts - Years one to three				***$417.2m***

The costs within Table 7-1 comprise of:

- Increased use of primary and community health services and hospital healthcare services
- Productivity losses due to increased workforce exit, absenteeism and carer requirements; and
- Social and wellbeing impacts including increased likelihood of depression and anxiety and developmental issues.

Investment in perinatal mental health services has well-established positive impacts on those in receipt of care, support and treatment. Prevention, early intervention, tailored treatment, and integrated support pathways are essential in the reduction of financial burden and on the improvement of mental health and wellbeing of families.[85] In addition, investment in perinatal mental health services has the potential to realise major cost savings for the health system in Queensland. This includes a reduction in the likelihood for mothers to present to emergency departments during times of crisis to receive care.

Hospital services that are not tailored towards the needs of mothers and babies are ineffective and do not provide the level of care that is required. In some cases, these hospital services can lead to further healthcare costs due to the impact of the separation of the mothers and their infants when the mothers are admitted. However, no alternative service providing the required care is available within the state.

Investment in perinatal mental healthcare ensures a reduction in difficulties associated with mother and infant attachment, ongoing mental illness and distress, and can reduce the

[82] Mental Health Productivity Commission Inquiry Report, 2020
[83] The Cost of Perinatal Depression and Anxiety in Australia, 2019 (Queensland only costs based on births)
[84] The Cost of Perinatal Depression and Anxiety in Australia, 2019 (Queensland only costs based on births)
[85] National Mental health Commission. Psychological Interventions for the prevention of Post-Natal Depression.

likelihood of failure to thrive. Children of parents with PND are at high risk of lifetime impacts to development, productivity, and wellbeing. There is emerging evidence to suggest that what is learned in the first 1000 days can have a profound impact on not only the neurological system, but also other bodily systems to which the brain is connected. An 'unhealthy' start to life will reduce biological reserves, but this is then overlaid by maladaptive psychological and behavioural responses, and in some instances by enduring unhealthy behaviours. Some of this is impossible to regain.[86]

The consequences over the course of life can be devastating, with evidence suggesting negative impacts for future education and employment opportunities.[87] Children born to a parent who experiences ante-natal depression are at greater risk of experiencing depression later in life, resulting in health and productivity impacts. Antenatal depression has been associated with increased likelihood of anxiety in children at 18 years of age which has been found to result in an additional $1.3 billion of lifetime costs.[88]

The explicit benefits associated with the implementation of eight additional mother-baby beds at Mater includes:

- Appropriate, responsive and integrated perinatal mental health care for mothers, infants and families
- Improved mental health and wellbeing outcomes for mother, infants and families
- Fewer emergency department presentations for those experiencing perinatal mental illness
- Increased capacity in the mental health system as a result of reduced admissions to general inpatient beds
- Increased capacity to support acute psychiatric admissions as a result of a mother being admitted without her infant (in the absence of more appropriate care); and
- Overall improved mental health outcomes for Queenslanders.

Analysing the return on investment for a systemic issue such as perinatal mental health is complex due to the limited availability of data for those experiencing perinatal mental health issues in Queensland. However, the cost of failing to invest, as well as the ongoing avoidable costs to Queensland's health system, highlights the criticality of implementing a model that is not only fit for purpose but that can also meet the significantly increasing demand for perinatal mental health care.

[86] Moore, T.G., Arefadib, N., Deery, A. and West, S., (2017). The first thousand days: An evidence paper. Parkville. Victoria.

[87] Currie and Stabile (2006), Child Mental Health and Human Capital Accumulation: The Case of ADHD

[88] Capron et al (2015), Associations of maternal and paternal antenatal mood with offspring anxiety disorder at age 18 years.

7.1 Investing in Mater Health

The operational costs for the Mater Family Wellbeing Service of the service proposes:

1. **$7 million in non-recurrent capital costs** in 2022 for the redevelopment of the Mater Convent as Catherine's House. The location is adjacent to the Mater Mother's Hospital in South Brisbane and will deliver eight (8) public inpatient beds in addition to clinical outpatient services.

2. **$11.9 million in recurrent funding per year** from 2022/2023 for ongoing workforce and service delivery. This includes a total of 42.27 Full Time Equivalent (FTE) staff who may also support the other programs. The workforce will include medical, allied health professional, nursing, administration and other supporting staff.

The development of the Mater Family and Wellbeing Service is a significant development for the health sector in Queensland and nationally. The integrated model of care is evidence based and informed by lived experience. It has received significant community support through philanthropic contributions as described above ($15 million) which further adds to the need for the service within the local community.

8 Supports and partners

Mater has a strong and proud history of partnering with the community and leading organisations that focus on defining excellence in education, research and care delivery for families, women and children in Queensland.

It outlines includes a number of supporting letters of endorsement.

The following letters of support have been provided in recognition of the importance and urgency for investment in perinatal mental health in Queensland:

- Blackwell, Cindy, Letter of support, dated 09 February 2022
- Richardson, Mary-Anne, Letter of support, dated 09 February 2022
- Clark, Brett and Maria, Letter of support, dated 04 February 2022
- PeachTree Perinatal Wellness, Letter of support, dated 03 February 2022
- Queensland Centre for Perinatal Mental Health, Letter of support, dated 07 February 2022

Appendix A

Letters of support

[redacted]

Mr Joe Kelly MP

Chair

Mental Health Select Committee

Cnr George and Alice Streets

Brisbane Qld 4000

9th February

RE: Support for Mother-Baby Unit at Mater Catherine's House

Dear Mr Kelly,

I lost my sister, [redacted] to suicide just last year (2021) due to the lack of mother-baby beds available in Queensland. As such, I am writing this letter to strongly support the establishment of Catherine's House at the Mater Hospital to save lives, support families and treat perinatal mental health.

[redacted] and her husband [redacted] were a lovely couple who were excited to be new parents. [redacted] gave birth on the 12th April 2021 to the beautiful baby [redacted] [redacted] was a strong, smart, determined and caring young woman who wanted nothing more than to become a mother. The family were enjoying the first few weeks of parenthood with all its ups and downs, however [redacted] started to develop the symptoms of postnatal depression.

[redacted] lived in Logan and presented to the Logan Hospital Emergency Department 2 months after giving birth with suicidal ideations. She was then admitted to the mental health ward at Logan where she stayed for a couple of days before being discharged.

During this time [redacted] had stated how unsafe she felt due to an environment that Is not conducive to mother's experiencing postnatal depression. Even though she was really unwell, as there were no beds on the Lavender Mother-Baby Unit, the Logan Mental health ward ended up discharging her

Devastatingly, just one day post discharge. [redacted] took her life.

While she was due to be triaged by the Lavender Unit on Monday, this was too late. Even so, the four beds were full and would not have been able to take her.

For those who know [redacted] he is the most kind and genuine bloke who should never have been faced with raising his son alone. Now he is a single dad with a son who will never get to hold, kiss or even touch his mother.

I lost my sister as a direct result of not being able to access proper services. I don't want to see this happen to someone else. I want to advocate for more mother-baby units and perinatal mental

health services so that this doesn't happen to other families. Four beds are not sufficient for the whole of Queensland.

This has been incredibly traumatic and I am hell bent on making a change.

When I found out that there is only 1 bed for 15,000 women who birth, I was disgusted to say the least. All of the other major states have, on average, 1 bed for 3308 women who give birth. That means Queenslanders are about five (5) times less likely to get the right help they need in a specialised perinatal facility compared to other Australians.

Suicide is also the leading cause of maternal deaths in the peripartum period and has been so for at least the last 15 years in Queensland. This is a major problem that needs to be rectified immediately.

I have been through postnatal depression myself, and personally want to say that something needs to be done. Not only are inpatient services required, but outpatient services to prevent and support recovery of women and families affected by mental illness. That's why Mater's integrated model of care with parent aid, day programmes and therapy practitioners is so vital. By establishing this Catherine's House, this will provide the much needed help to women and families affected by suicide and mental illness.

There is an extreme lack of resources for new mothers to treat significant mental health and prevent suicide in Queensland. These dedicated public mother-baby beds will go a long way to change the system that is severely broken. Having Catherine's House will save lives, and contribute to happy and healthy families. This is the best investment that the Queensland Government can do to help build thriving families.

Whilst we couldn't save [redacted] I want to endeavour to help others in the same position and implore the government to do all they can as well.

I don't want this tragedy to occur to other families.

Kind regards,

[redacted]

[redacted]

www.chemistwarehouse.com.au • www.mychemist.com.au • www.mybeautyspot.com.au • www.epharmacy.com.au • www.vitamin-warehouse.com.au

[redacted]

Mr Joe Kelly MP
Chair
Mental Health Select Committee
Cnr George and Alice Streets
Brisbane Qld 4000

RE – Catherine's House – Mater Foundation

4th February 2022

Dear Mr Kelly,

My wife [redacted] and I are writing this letter of support for the establishment of Catherine's House at the Mater Hospital to help treat perinatal Mental Health. Maria and I are Patrons of the Mater Foundation, as well as health care professionals and for close to 20 years have been involved in raising and/or pledging over two million dollars to help fund research and equipment for the Neonatal Intensive Care Unit (NICU) , and more recently the capital campaign for the establishment of Catherine's House.

We have experienced the firsthand excellence of treatment and care from the Mater over many years having had three premature babies and spending collectively almost 9 months in NICU and ICU. Today we have 2 strong, vibrant and successful young daughters aged 20 and 24, and work tirelessly to ensure the loss of our middle daughter Olivia was not in vain and to help others have a better outcome. At all times we were able to be with our daughters during their care in NICU/ICU, and we feel this played a massive part in not only their outcomes, but also the mental wellbeing for Maria and I as young parents. The lack of resources for new mothers to treat perinatal mental health and the statistics of long-term mental health issues for not only them, but also their children if not treated meant that Maria and I had to support this cause.

However, being self-employed and having started a number of businesses, I financially or emotionally only ever invest in anything where I can see a high level of experience, capacity and knowledge to ensure that the effectiveness and sustainability of the model can be delivered. The Sisters of Mercy, Mater Staff and the Mater Foundation have shown for an extended period this ability, and rather than just rely on

Chemist Warehouse Group
41 Tradecoast Drive
Eagle Farm 4009

Government handouts, continue to engage with the community to ask for their support to ensure they can support others in areas of need.

We cannot recommend or support any higher institution to address this hugely under resourced area of perinatal Mental health.

Yours Sincerely

[redacted]

[redacted]
Patrons of Mater Foundation

[redacted]

[redacted]

Mr Joe Kelly MP
Chair
Mental Health Select Committee
Cnr George and Alice Streets
Brisbane Qld 4000

9th February 2022

RE: Urgent Need for Public Inpatient Mother-Baby Unit and Integrated Models of Care

Dear Mr Kelly,

I am aware that Mater Health are making a submission to the "Queensland parliamentary inquiry into the opportunities to improve mental health outcomes for Queenslanders". I believe that this submission is related to Mater Health's ambition to increase mental health support services to women and families during their perinatal period. This ambition is something that resonates with me deeply and personally.

I am a proud mother of three healthy, gorgeous, capable children. I have a four-, eight- and ten-year old, who have just started at school for the year (the same school for all three!). Ten years ago, however, I almost didn't survive to see this milestone. Prior to the birth of my first daughter, I became very unwell with extreme anxiety and deep depression. In fact, my baby was induced two weeks early to allow me to start medication without fear of harming my unborn child. This was the first of many events in the weeks and months to come that didn't go "as planned".

The private health insurance policy my husband and I had at the time was basic. We carefully considered whether to include "obstetrics and gynae", but I had worked in the public health system for many years and was adamant my babies would be born publicly. Our basic cover did not include inpatient psychiatric care, either; this wasn't something either of us had needed before. This was all about to change.

After the (induced) birth of my baby, I became increasingly suicidal and slipped further down into a pit of depression. I was involuntarily admitted overnight into a public hospital psychiatric unit. My baby was only one month old at the time, and I was breast-feeding her every few hours. This immediately ceased upon my admission; the public hospital

psychiatric unit didn't allow for babies to accompany their sick mother. I was separated from my baby for 16 hours, a punishment for being unwell.

It was only through intense, round-the-clock family support that I was able to return and stay at home for the next few weeks. Without the support of my family, this inpatient psychiatric facility would have been my home; while I would have been safe and medicated, I would have been separated from my newborn baby for the duration of my admission.

After serving a two-month waiting period (my husband had organised a new insurance policy), I was eventually admitted into the only "Mums and Bubs" unit in Queensland at the time (BCPND at Belmont Private Hospital). My three-month-old baby was admitted alongside me. Together, we received the support, care and therapy I needed to complete my journey towards mental wellness; we also continued our journey as mother and daughter, learning and growing through this journey together (as all mothers and newborns, do).

Without a "Mums and Bubs" unit, the only option for mothers who experience extreme perinatal mental illness is to be admitted to a general psychiatric inpatient unit; the only option is for mothers to be separated from their babies. In Queensland, there are only two "Mums and Bubs" inpatient psychiatric care facilities; one allows only private admissions, while the other has four publicly-funded beds. This is not good enough.

But this is not the situation in all states of Australia. Queensland has one of Australia's lowest number of publicly-funded beds within dedicated "Mums and Bubs" inpatient care facilities. When considered alongside the total number of births within the state every year, Victoria and Western Australia have one (1) bed for every 2,000 births, whereas Queensland has one (1) bed for 15,000 births. This is unacceptable. Funding is required to bring Queensland into line with the ratios of other states.

Alongside more inpatient beds within dedicated facilities, funding is also needed for health services with integrated models of care. Providing support to those with perinatal mental health concerns across the *entire* journey, is essential. Funding should focus on prevention, outpatient services, day programs, parent aids, multidisciplinary treatment and recovery. Maternal health services provided through state-funded hospitals (including Mater Health) ensure mothers and families receive support at all stages from pregnancy, to birth and throughout the early years as a parent. This support should be extended to include the mental health and well-being of the mother (and the entire family). This is Mater Health's ambition through the development of Catherine House.

The Mental Health Select Committee undertaking this inquiry should consider the significant amount of work (and funding) already undertaken by Mater Health in this area. Mater has worked with consumers (like myself), the philanthropic community (and many generous donors) and experts to bring this project together, so far. Funding from the Queensland government towards a project like Catherine House would ensure the mental health needs

of a group of people at great risk of poor mental health, has been considered. It also considers the current needs of and impacts on the mental health service system in Queensland. Having dedicated support-services for mothers and families during the perinatal period, both as an inpatient and outpatient, would provide opportunities for the service to improve economic and social participation of people with mental illness through comprehensive, coordinated, and integrated mental health services (including suicide prevention). This not only helps the mother, but her children and the future generations to come.

As a mother with first-hand experience, I can reassure you that services like this *work* and are much-needed. I was admitted to the "Mums and Bubs" inpatient care facility for two of my three pregnancies. I assure you that being alive to complete this letter today, is (in-part) thanks to the support I received from this dedicated service after the birth of my babies.

Please consider.
Signing off, so I can return to being a parent,

[redacted]

Queensland Government

Children's Health Queensland
Hospital and Health Service

Enquiries to: Dr Elisabeth Hoehn
Telephone: 07 3266 0300
Date: 07 February 2022

Mr Greg McGahan
Senior Manager, Young Adult & Mental Health Services
Level 5, 41 Annerley Road Campus
South Brisbane Qld 4101

Dear Greg,

Re: Letter of support

The Queensland Centre for Perinatal and Infant Mental Health (QCPIMH) has partnered with Mater Health Services over the past two years to assist in the integration and expansion of perinatal and infant mental health services in Queensland. This collaboration has included the development of an appropriate model of care in line with international best practice for the mother-baby inpatient service currently being built and known Catherine's House.

One in 5 mothers and one in ten fathers will experience perinatal depression and anxiety. The social impacts of untreated parental mental illness and perinatal suicide and suicidal crises include the development of chronic and enduring mental illness for mother; marital break-down; infants and young children suffering in relation to their attachment needs and development; negative health outcomes and longer-term intergenerational effects. In 2012, Deloitte Access economics estimated the cost of perinatal mental health to be $310.34m in lost productivity associated with perinatal depression. Maternal depression cost Australia $86.59 million in lost productivity alone in 2012. In the same year, paternal depression cost Australia $223.75 million in lost productivity (Deloitte Access Economics 2012). The report can be accessed here: https://www2.deloitte.com/au/en/pages/economics/articles/perinatal-depression-australia-cost.html#

Mater Health Services has made significant capital investment to build bed capacity in perinatal and infant mental health but is yet to obtain operational funding. The QCPIMH supports the allocation of operational funding to enable this service to be delivered as soon as the facility is built.

Dr Elisabeth Hoehn
Medical Director

E. Hoehn

Queensland Centre for Perinatal and Infant Mental
Child and Youth Mental Health Service
Children's Health Queensland Hospital and Health Service
Queensland Health

Office	Postal	Phone	Fax	Email
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Thursday 3rd February 2002

Mental Health Select Committee
Parliament House
George Street
BRISBANE QLD 4000

Peach Tree
PERINATAL WELLNESS
ABN: 87 545 227 108

Dear Select Committee Members

Peach Tree is delighted to provide this letter of support to the Mater Hospital's Parliamentary Inquiry submission to Mental Health Services in Queensland.

Peach Tree confirms our commitment to working in partnership with Mater Hospital and particularly supports the need for their specialist Family unit to be located at Catherine House, South Brisbane.

Peach Tree is a community-based specialist perinatal, infant and early parenthood mental health organisation with more than 10 years of experience in the delivery of peer led, recovery-oriented services. With over 20 staff, we annually support approximately 450 individual parents/carers in the Brisbane area. We are currently accredited to the National Standards for Mental Health Services (NSMHS) and are highly driven to deliver a safe and quality service to our community.

We have had a strong working relationship with Mater for many years, with each service encouraging and supporting referrals across our organisations, particularly between the *Together in Mind* day program and our *Sunshine Parenting Program* and other community supports. Since mid-2020 a number of Peach Tree Lived Experience staff have been leading the work involved with the Consumer Advisory Group for Catherine House.

Peach Tree and Mater share a commitment to providing services which addresses gaps in service delivery. Peach Tree strongly reinforces the need for the specialised PMH services that Catherine House will offer Queensland families.

Kind regards,

Vivianne Kissane

Viv Kissane
Founder/CEO

E: [redacted]
M: [redacted]
www.peachtree.org.au