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PANDA

Submission to the Productivity Commission Mental Health and Suicide Prevention Agreement Review

Submitted by Perinatal Anxiety & Depression Australia
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Introduction

PANDA Perinatal Anxiety and Depression Australia is federally funded to provide specialist, digital perinatal mental health and wellbeing support to Australian parents, their support people and healthcare providers.

Our National Perinatal Mental Health Helpline provides evidence informed mental health counselling, peer support, service navigation and care coordination for people planning their family, navigating pregnancy and birth, through the first 12 months postpartum.

We also deliver a state funded intensive care and counselling program (funded in Victoria, Northern Territory and Queensland), an innovative pilot Pregnant in Prison program (in partnership with NSW Justice Health), the MumMoodBooster coaching service (in partnership with the Parent-Infant Research Institute), and SMS4Dads phone-based support for expecting, new and bereaved fathers (in partnership with the University of Newcastle). PANDA is also soon to commence delivery of a specialised miscarriage support service for parents requiring mental health support.

PANDA's national network of over 700 community and clinical volunteers (with lived and practice experience of perinatal loss) raise awareness, provide education, and co-design our resources for families and healthcare providers.

In addition to our Helpline programs and services, PANDA provides a free Secondary Consultation service for healthcare providers supporting families in the perinatal period. We have developed a range of free, evidence-informed digital self-support and educational resources for our service users.

As a specialist perinatal mental health and wellbeing service, PANDA's submission focuses on feedback related to the effectiveness of screening, programs and services delivered under the Mental Health and Suicide Prevention Agreement as well as the way governments work to achieve the goals of the Agreement.

PANDA commend the joint commitment to Mental Health and Suicide services, and the commitment to embedding lived experience within the mental health system.

Funding models benefits and limitations

PANDA are heartened by the bilateral agreement to collaboratively undertake planning and funding commitments between the States and Commonwealth. It was clear that the Agreement was intended to bridge gaps and address disparities between the States, Territories and Commonwealth, with Primary Health Networks (PHNs) also at the table. As a Commonwealth and State funded service, the bilateral agreement funding allows PANDA to focus on delivering our person-centred model of care. The Agreements aimed to ensure specialist perinatal mental health care, workforce and training was a priority for States and Territories, while national primary/community centred care was delivered by the Commonwealth and funded agencies, like PANDA.

While the Mental Health and Suicide Prevention Agreements were not rolled out consistently, the intent was there. A significant limitation of the disparate timelines was the State, Territory and PHN funding cycles that were already committed to. In the case of perinatal screening, implementation was delayed due to local state investment and work already in train. This was evident from the perspective of a service provider, such as PANDA.

We also commend the commitment to aftercare, postvention and distress brief intervention services within the agreements, and ensuring that this service is culturally appropriate.

However, the Agreement fails to address mental health and suicide prevention workforce issues which significantly reduces the preparedness and effectiveness of mental health and suicide prevention services. The existing workforce needs to be better supported to prevent burn-out and high turn-over, so the workforce is sustainable into the future. PANDA would also like to see greater focus in the Agreements for the expansion of peer workforce, in a way that is sustainable and with better models for career progression in the mental health and suicide prevention sector.

PANDA also believe that more research funding should be given to services so that new models of care, delivery and ideas can be tested or evaluated in mental health and suicide prevention, especially for areas which have seen little improvement. This would contribute towards building stronger, evidence-informed, consumer-led services. Further evidence of PANDA's approach to suicide support opportunities can be seen in our past tender response for specialised supports to parents via Helplines like PANDA's.

There is a further limitation of the Agreements, with contracting and procurement approaches failing to reinforce collaborative service system planning, design, and integration across the primary and tertiary care systems.

Creating partnerships, effective service pathways and connectivity is an unrecognised opportunity in the Agreements between States and territories, PHN's and the Commonwealth.

Perinatal screening and data collection

The inclusion of perinatal mental health screening in most states was a positive step forward, although PANDA notes that it has not been implemented consistently across all states and territories. The intent of the Commonwealth commitment to screening was commendable,

however the scoping of existing state and hospital screening was not considered, for example the development of new Victorian perinatal mental health screening guidelines. This resulted in disparities and dilution of the impact of national screening.

PANDA is committed to ensuring our own data is contributing towards the National Perinatal Data Collection, to better represent the perinatal mental health needs of Australians. This data should continue to be held and made publicly available by the Australian Institute of Health and Welfare (AIHW), not held by any organisation or Government body leading the perinatal screening program.

In addition, we advocate for changes to the routine collection and reporting of perinatal data at a national and state/territory level to reflect the perinatal experience more accurately, specifically when reporting on perinatal mental distress and suicide.

Australia does not yet routinely collect and report annual perinatal mental health, self-harm, and/or suicide data for expecting and new fathers. Yet we know the years of increased suicide risk for young men coincide with a time of life when many are becoming dads. Approximately 10% of callers to PANDA are male, and 10% of male callers present with suicide risk.

To date, we also lack data insights regarding parents living in rural Australia who require emergency psychiatric care for severe perinatal mental health deterioration.

PANDA recommends the sharing, linking, and reporting of data that gives us a comprehensive picture of perinatal mental distress, self-harm, and suicide, including socio-economic factors and upstream drivers of suicide. In all Australian states and territories, for inclusion in the National Perinatal Data Collection, National Maternal Mortality Data Collection, and novel Perinatal Mental Health pilot (paternal/non-birthing parent data), this includes routine collection of:

- All ‘late maternal deaths’ (from 43 to 365 days post-birth).
- Perinatal data for expecting and new fathers, and non-birthing partners.
- Data for rural parents requiring emergency perinatal psychiatric care.

PANDA has and will continue to advocate for universal screening for birthing and non-birthing parents. We also advocate for appropriate training for those administering the screening (in Primary and Tertiary care settings), to be trained in mental health conversations and culturally responsive care, referral pathways and creating spaces where screening questions can be answered accurately and honestly.

Included in future Agreements, we would like to see commitment to, and more research into, culturally safe adaptations of perinatal screening and data collection. Cultural adaptations of the Edinburgh Postnatal Depression Scale like the Kimberly Mum’s Mood Scale and Mt Isa Postnatal Depression Scale for First Nations women have demonstrated the benefits of culturally relevant perinatal screening, but further research is needed regarding their appropriateness for use with Aboriginal and Torres Strait Islander communities across Australia.

Similarly, the limitations of current screening tools for First Nations and culturally diverse families, especially those with low-English proficiency or newly arrived in Australia, needs more research. Findings from the co-design projects for the development of new Victorian perinatal mental health screening guidelines by the Victorian Refugee Health Network/Foundation House

(multicultural co-design) and Karabena (Victorian Aboriginal co-design) should be key in informing the cultural appropriateness of perinatal screening for future Agreements.

Localised hubs

PANDA commends the bilateral establishment of community-based health and wellbeing services for infants, children, and families. We also commend the inclusion of the commitment to leverage existing services to deliver the model. While we have seen some localised reach out from services running these Hubs in Victoria, there has been little to no attempt to integrate with PANDA's services through either referral pathways or communication channels. There has also been no dedicated funding to agencies like PANDA to undertake the additional work to engage these services.

PANDA recommends that funding is made available to ensure that all funded agencies can work to integrate with existing local services via scale-up and scale-out activities.

Unintended consequences

PANDA commend the commitment to reducing duplication in local, state and federally funded mental health initiatives. However, the mental health sector has noted the risk of States, Territories, and Commonwealth to disinvest from some mental health commitments, as they saw the other being able to fund these activities. Future agreements should include greater clarity on whose role it is to fund the delivery of specific services and supports.

Recommendations

PANDA recommends further exploration and investment in the following areas for future Agreements:

1. Improved alignment of the rollout timing of initiatives that interface with national primary health structures.
2. Commitment to aggregating perinatal data by the AIHW to better represent the health and well-being of Australians, and including routine, universal collection of perinatal data for expecting and new fathers, non-birthing parents, and rural/remote parents who require emergency psychiatric care.
3. Funding further research into Aboriginal and cultural adaptations of perinatal screening and outcome measures.
4. Consider extending the 'maternal mortality' definition from 42 days to 12 months post-birth to reflect the perinatal experience more accurately, specifically when reporting on perinatal suicide. If the current definition is retained, change 'late maternal death' from 'optional' to routine/universal data collection in all states and territories.
5. More research funding should be given to services so that new models of care, delivery and ideas can be tested and contribute to the evidence base, especially where there has been little improvement/change.
6. Funding is made available to ensure that all funded agencies can work to integrate with existing local services.

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