Government of **Western Australia**
Department of **Health**

Perinatal and Infant Mental Health Sub Network Establishment Report

Including outcomes of the Perinatal and Infant Mental Health Sub Network inaugural Open Meeting

health.wa.gov.au

Contents

Executive Summary 2
Introduction 4
  Mental Health Network 4
  Mental Health Sub Networks 4
Perinatal and Infant Mental Health Sub Network Open Meeting 5
  Open meeting process 6
  Panel discussion 6
  Workshop outcomes 7
Next steps 8
Appendix A: Open Meeting program 9
Appendix B: Detailed participant input 10
Appendix C: Inaugural Perinatal and Infant Mental Health Sub Network Steering Group 20
Appendix D: Acronyms 21

Executive Summary

Perinatal and Infant Mental Health Sub Network

The Mental Health Sub Networks were established to support the Mental Health Network (MHN) in engaging with and delivering outcomes for specific cohorts.

This report outlines the process of establishment of the Perinatal and Infant Mental Health Sub Network Steering Group, with a focus on the outcomes of the Open Meeting that will inform the Group's work.

Open Meeting

The MHN in conjunction with the Mental Health Commission (MHC) hosted the Perinatal and Infant Mental Health Sub Network Open Meeting on Monday 15 February 2016.

The Open Meeting was attended by 128 people, including mental health service consumers, families, carers, mental health advocates, health professionals, university academics, service providers and organisations. The participants were highly engaged and motivated throughout the meeting and actively contributed to information collected.

The Open Meeting program is available in Appendix A.

The points below capture the common issues raised during the plenary and in the workshop, as identified by the Open Meeting facilitator:

- Lack of clearly defined referral pathways for parents and infants, and poor coordination or low understanding of the referral pathways that do exist.
- Lack of integration between diverse and fragmented services leaves providers unaware of appropriate referrals and families without critical information.
- A lack of knowledge and competency for perinatal and infant mental health and inconsistent use of terminology, particularly for primary care providers.
- Key performance indicators do not adequately reflect outcome measures that demonstrate perinatal and infant mental health, and are inconsistent across the spectrum of care.
- Need to better integrate services to focus on the mother and child relationship, plus include the family unit.
- Require a more effective response to the needs of Aboriginal women, infants and families.
- Require increased access to tools to identify issues for infant and mother, and articulate observations in the relationship between mother and baby (e.g. private providers still not using the Edinburgh Postnatal Depression Scale).
- Clinical supervision and support is needed for workers own mental health and wellbeing.
- Low public awareness of the importance of perinatal and infant mental health, and the need to address the stigma attached.
- Need to ensure a focus on the infant isn't lost in the system.

Following the Open Meeting on February 15, a video conference was arranged for regional participants. This meeting was held on 16 February and facilitated by Dr Helen McGowan; Ms Alison Xamon; Ms Leanda Verrier and Dr Felice Watt. Fourteen participants registered for the event.

The following issues were raised in the video conference:

- A monthly video case consult with multidiscipline resource professionals to guide the clinical, social and developmental perinatal mental wellbeing from antenatal to at-risk families.

- Take into account social, environmental, intergenerational and cultural health determinants.
- Consider services and clinical care for the infant and child in the early years who experiences social and emotional stressors that impact on neurodevelopment.
- Consider the social and emotional wellbeing of premature infants and children in the early years; develop strategies to protect neurodevelopmental pathways which may include adjusting the neonatal unit environment.
- Development and mapping of early years clinical services and care for newborns, infants and young children to develop and coordinate a multidisciplinary approach to the social and emotional wellbeing of early years children at risk.
- Development of a clinical stream of clinicians that can be accessed by infants and small children to work with disrupted social and emotional wellbeing and consequent developmental delay; probably needs to include attachment work.
- Development of prenatal and antenatal education on the social and emotional wellbeing of infants and small children in high risk communities; this should also target those who are caring for children in the community.
- Services in regional areas are patchy, unmet need particularly high in isolated areas, for fathers and for the Aboriginal community.
- History of the sector in terms of achievements and changes to services important to acknowledge.
- In addition to the difference between regions and the metropolitan area, the difference between regions needs to be acknowledged.
- Custodians for knowledge and resources are important and are at risk when services are cut

The themed outcomes from the workshop session are outlined under Workshop outcomes with the detailed participant input available in Appendix B.

Steering Group

At the conclusion of the Open Meeting, expressions of interest were called for from individuals to join a Steering Group to drive the work of the Sub Network.

All nominations were considered by the Implementation Group and the names of the successful applicants presented to the MHN Executive Advisory Group for final approval. A list of the Inaugural Steering Group for the Perinatal and Infant Mental Health Sub Network is available in Appendix C.

The information collected from the Open Meeting workshop will be used to guide the Perinatal and Infant Mental Health Sub Network Steering Group in the development of their work plan and to inform and support the MHC in the delivery of the *Western Australian Mental Health, Alcohol and Other Drug Services Plan 2015-2025* (Plan). The Perinatal and Infant Mental Health Sub Network will also be engaged to support consultation undertaken by the Department of Health on the planning of health services.

Introduction

Mental Health Network

The establishment of the Mental Health Network (MHN) was undertaken by the Department of Health with the support of Professor Bryant Stokes, Acting Director General, Department of Health in partnership with Mr Timothy Marney, Mental Health Commissioner, Mental Health Commission (MHC).

The MHN was launched during Mental Health Week in October 2014. The MHN is led by Co-Leads Dr Helen McGowan and Ms Alison Xamon.

The MHN Executive Advisory Group (EAG) membership includes consumer and carer representatives as well as representatives from the Department of Health, MHC, Office of Mental Health, Primary Care, Mental Health Clinician Reference Group, Office of the Chief Psychiatrist, the Western Australian Primary Health Alliance (WAPHA) and the Western Australian Association of Mental Health.

The objective of the MHN EAG is to support and guide the MHN to undertake the following:

- Contribute to improving the mental health and wellbeing of Western Australians.
- Draw upon a community of practice approach to share information, engage with the sector and community, foster collaboration and develop partnerships.
- Engage with organisations and individuals to support innovation and change.
- Develop an agreed set of strategic priorities across the mental health sector.
- Promote system change including continued development of a person-centred and recovery orientated culture, with better integrated and connected services.
- Promote adoption of recognised best practice across the sector.

The Mental Health Sub Networks structure was created to support the MHN to meet these objectives.

Mental Health Sub Networks

The Sub Networks are intended to focus on the needs of a particular cohort, be task orientated and to deliver products by bringing together the right people, from the community sector, Health, consumers, carers and other interested parties. A structured approach was taken to engagement and the establishment of each of the Sub Networks.

A prerequisite to the establishment of each Sub Network included confirmed sponsorship from a health service, identified co-ordinators and support of key stakeholders within the sector prior to progressing the development of the Sub Networks.

The MHN Co-Leads took a leadership role in networking with individuals and organisations to identify and establish the Sub Networks.

An Implementation Group of key stakeholders was then formed to assist in the organisation of an Open Meeting, including the selection of appropriate panellists to provide snapshots of key sector issues. The aim of the Open Meeting was to give the community the opportunity to actively participate in the formation of the Sub Network and provide critical input to shape its priorities moving forward.

At the conclusion of the Open Meeting, expressions of interest were called for from individuals to join a Steering Group to drive the work of the Sub Network.

Each Mental Health Sub Network Steering Group was required to have representation from:

- consumers
- carers or family members
- community managed organisations
- public community mental health services
- inpatient public mental health services
- inpatient and community private mental health services
- primary health services
- agencies delivering prevention and promotion programs and initiatives
- MHC
- mental health professionals from a range of disciplines including:
  - peer workers
  - allied health
  - nursing, medical
  - psychology
  - psychiatry
- individuals and agencies working in regions across the state including:
  - rural and remote and metropolitan districts / regions (particularly relevant for cross-sectoral working groups)
- individuals and agencies working with different age cohorts (relevant for cross-age cohort working groups), including:
  - infant children and adolescents
  - youth
  - adults
  - older adults
- the sponsoring organisation.

All nominations were considered by the Implementation Group and the names of the successful applicants presented to the MHN EAG for final approval. In order to keep the Steering Groups at workable sizes, applicants were selected on the basis of their ability and willingness to represent the concerns of multiple cohorts.

A list of the Inaugural Steering Group for the Perinatal and Infant Mental Health Sub Network is available in Appendix C.

Perinatal and Infant Mental Health Sub Network Open Meeting

Stakeholders for perinatal and infant mental health services in Western Australia met for the inaugural open meeting of the Perinatal and Infant Mental Health Sub Network at The Rise, Maylands, on Monday15 February 2016.

A total of 128 people attended the Open Meeting including mental health service consumers, families, carers, mental health advocates, health professionals, university academics, service providers and organisations.

- 136 people registered to attend the Open Meeting.
- 128 people attended the Open Meeting (94% of those that registered).
- 55 organisations were recorded as having representatives at the meeting.

A video conference session was also held with the WA Country Health Service (WACHS) on Tuesday, 16 February 2016. The outcomes of the video conference session are also captured in this report.

Open meeting process

The energy and good will demonstrated throughout the establishment of the Perinatal and Infant Mental Health Sub Network continued to develop momentum throughout the Open Meeting.

The Open Meeting program is available in Appendix A.

Following the acknowledgement to country given by Mental Health Co-lead Alison Xamon, the Open Meeting heard overviews from Dr Helen McGowan, regarding the MHN; Ms Elaine Paterson regarding Mental Health – The Big Picture, and Ms Leanda Verrier regarding the perinatal and infant mental health sector.

Panellists recommended by the Perinatal and Infant Mental Health Sub Network Implementation group then shared snapshots of key issues and perspectives in the perinatal and infant mental health sector.

Following a networking break the meeting resumed with a workshop session facilitated by an external provider.

The outcomes of the panel discussion and workshop session as captured by the facilitator are themed and summarised below.

Panel discussion

The panel consisted of representation from the following perspectives:

- Carer — Mr Michael Telow
- Aboriginal — Ms Phyllis Winmar
- Primary health — Ms Miriam Krouzecky
- Psychiatrist (perinatal) — Dr Caroline Zanetti
- Clinical (infant) — Ms Rochelle Matacz

The following points were captured by the facilitator during the panel session:

- Clinical staff can sometimes be careless with language around distressed mothers and partners.
- There appears to be no central coordination or red flag for the mental health issues, so midwives need to address situations on their own accord, depending on their level of compassion.
- It is important to address physical and mental health needs together and encourage the application of holistic medicine and early intervention.
- Networking is the key because we're all experts but sharing across services is really important to help mothers and babies develop and heal together.
- Assistance for mothers to close the gap between Aboriginal people and mainstream services is really important.
- Referrals from primary care providers are often rejected or delayed.
- Access to universally embedded early intervention community services is important.
- We need better linkage and integration for improved referral pathways with interagency protocols and tools to address infant risks.

- Advocacy for perspective of infants is required but often overlooked in an Activity Based Funding outcomes focused model; we need to seek best practice standards.
- Integration of perinatal and infant mental health with the services provided in later stages of life (intergenerational and inter-sectorial) so that parents, babies and children can be involved in the remedy (i.e. provide for the family as a whole).
- Parents and families access a range of clinical and non-clinical services and the Model of Care needs to consider the impacts of all these services on the wellbeing of the family as a whole.
- Integration of perinatal and infant mental health into the wide range of other services a family accesses is an important and cost effective initiative.
- There are very few dedicated services but they do exist across all sectors and this sub network bringing people together is important.
- Infants and young children can't speak for themselves, so they require our advocacy.
- This Sub Network needs to focus on integrating services to agree on terminology, age periods, where services are delivered and by whom.
- We need to bridge the gap between perinatal and infant services.

Workshop outcomes

Participants were asked to consider the panel presentations and take into account their own knowledge and experience of the sector to answer the following questions:

  - What do you see as key issues that are still to be resolved?
  - For this issue, what potential solutions would you propose?

Responses were shared in real time via GroupMap - allowing cross pollination of ideas from all participants. The participants were highly engaged and motivated throughout the meeting and actively contributed to information collected.

The following points were captured during the workshop session by the facilitator, summarised and themed:

- Lack of clearly defined referral pathways for parents and infants, and poor coordination or low understanding of the referral pathways that do exist.
- Lack of integration between diverse and fragmented services leaves providers unaware of appropriate referrals and families without critical information.
- A lack of knowledge and competency for perinatal and infant mental health and inconsistent use of terminology, particularly for primary care providers.
- Key performance indicators (KPIs) do not adequately reflect outcome measures that demonstrate perinatal and infant mental health, and are inconsistent across the spectrum of care.
- Need to better integrate services to focus on the mother and child relationship, plus include the family unit.
- Require a more effective response to the needs of Aboriginal women, infants and families.
- Require increased access to tools to identify issues for infant and mother, and articulate observations in the relationship between mother and baby (e.g. private providers still not using the Edinburgh Postnatal Depression Scale (EPDS)).
- Clinical supervision and support is needed for workers own mental health and wellbeing.
- Low public awareness of the importance of perinatal and infant mental health, and the need to address the stigma attached.
- Need to ensure a focus on the infant isn't lost in the system.

The input from the Video Conference is summarised below:

- Hold a monthly video case consult with multidiscipline resource professionals to guide the clinical, social and developmental perinatal mental wellbeing from antenatal to at risk families.
- Take into account social, environmental, intergenerational and cultural health determinants.
- Consider the social and emotional wellbeing of premature infants and children in the early years and develop strategies to protect neurodevelopmental pathways which may include adjusting the neonatal unit environment.
- Development and mapping of early years clinical services and care for newborns, infants and young children to develop and coordinate a multidisciplinary approach to the social and emotional wellbeing of early years children at risk.
- Development of a clinical stream of clinicians that can be accessed by infants and small children to work with disrupted social and emotional wellbeing and consequent developmental delay; probably needs to include attachment work.
- Development of prenatal and antenatal education on the social and emotional wellbeing of infants and small children in high risk communities; this should also target those who are caring for children in the community.
- Services in regional areas are patchy, unmet need particularly high in isolated areas, for fathers and for the Aboriginal community.
- History of the sector in terms of achievements and changes to services important to acknowledge.
- In addition to difference between regions and the metropolitan area, the difference between regions needs to be acknowledged.
- Custodians for knowledge and resources are important and are at risk when services are cut.

The detailed participant responses are available in Appendix B.

Next steps

The information collected from the Open Meeting workshop will be used to guide the Perinatal and Infant Mental Health Sub Network Steering Group in the development of their work plan and inform the MHC to support the delivery of the *Western Australian Mental Health, Alcohol and Other Drug Services Plan 2015-2025* (Plan). The Perinatal and Infant Mental Health Sub Network will also be engaged to support consultation undertaken by the Department of Health on the planning of health services.

In addition to working on identified projects, the Steering Group will work to foster engagement and communication in the perinatal and infant mental health sector.

Issues for broader discussion and achievements will be reported back to the broader Perinatal and Infant Mental Health Sub Network membership via the Health Networks.

Appendix A: Open Meeting program

Department of Health
Mental Health Commission
GOVERNMENT OF WESTERN AUSTRALIA

Perinatal and Infant Mental Health Sub Network Inaugural Open Meeting

Monday 15 February 2016

Venue – The RISE, Eighth Avenue, Maylands

Registrants of this event will have the opportunity to find out how they can actively participate in the Perinatal and Infant Mental Health Sub Network and help shape its priorities

Time	Program	
9.00am	Registration	
9.30am	Introduction Acknowledgement to Country	Ms Alison Xamon (MC)
9.35am	Mental Health-The Big Picture	Ms Elaine Paterson
9.45am	Overview of Mental Health Network and Sub Networks	Dr Helen McGowan
9.50am	Womens and Newborn Health Network	Dr Janet Hornbuckle
09.55am	Overview of Perinatal and Infant Mental Health Sub Network	Ms Leanda Verrier
10.05am	Consumer perspective Partner perspective Aboriginal perspective Primary health perspective Psychiatrist perspective (perinatal) Clinical perspective (infant)	TBC Mr Michael Tetlow Ms Phyllis Winmar Ms Miriam Krouzecky Dr Caroline Zanetti Ms Rochelle Matacz
10.25am	Networking break	
10.50am	Reflect and build on themes	Mr Will Bessen
11.45am	Joining the Perinatal and Infant Mental Health Sub Network and Steering Group	Ms Alison Xamon
11.55am	Concluding remarks and acknowledgements	Dr Felice Watt
12.00pm	**Close and Networking**	

Appendix B: Detailed participant input

The table below captures the individual issues and respective solutions raised by participants in the workshop session using Group Map technology.

Issue	Proposed Solutions
• Require a better range of funding options through Medicare.	
• Lack a commonly understood referral pathway for anyone working with this population of young parents (e.g. co-location of early childhood services with child care).	• Creation of specialised infant mental health consultancies to provide consultation across services. • What about something like a headspace concept for infant mental health and parents?
• Address the gap in knowledge, education and training.	• Work closer with General Practitioners (GPs) to develop a more standardised model of assessment. • Endorse infant mental health competencies and qualifications. • Build a strengths based approach to deliver services as opposed to a deficit based approach. • Become more client focused as opposed to outcomes focused.
• Antenatal education is patchy for mums and dads.	
• Artificial separation between the infant and the family unit as the client.	• KPIs need to be reoriented to reflect the work that needs to be done regarding infant and perinatal mental health.
• Clinical supervision is necessary for all clinicians working in this area.	
• Difficult to build collaboration between the multitude of diverse private sector services, and government and not for profit (NFP) services.	• Allow cross promotion of all services regardless of funding models thereby allowing timely treatment. • Facilitate better information sharing between services.
• The community is not always aware of services and pathways.	• Share what is available with other service providers. • Regularly update existing knowledge. • Utilise online portal called ‘Drop In’ sponsored by Western Australian Council of Social Service.
• Current lack of integration.	
• Department of Health plans not taking into account the feedback and advice	• Align the plans against key stakeholder feedback points.

Issue	Proposed Solutions
from key stakeholders, even when sought.	
• Early discharge from hospital, with little or few resources, resulting in increase in difficulties in relationships, breast feeding, and an increase in loneliness and reliance on blogs, which are possibly inaccurate.	• Provide more accurate information on line and encourage more use of Telehealth.
• Education of primary providers, especially junior staff; without the tools and understanding, staff often don't find the time to properly respond to individual patients.	• Provide tours or opportunities to spend time with service providers, to build the knowledge of primary care providers.
• Engagement with university and other tertiary institutions to facilitate the translation of research into provision of clinical services and provide future workforce and specialist training.	• Relevant training programs need to incorporate perinatal and infant mental health content. • University clinical services need to build capacity to manage women and infants. • Development of evidence based interventions by encouraging clinical research partnerships between government, NFP and private services. • Ensure clinical sub specialist training opportunities and experience in Perinatal and infant mental health across all sectors (government, NFP and private). • Ensure research translation is embedded into research.
• Ensure that women's mental health during the preconception and the antenatal period receives adequate attention. • Beyond screening to active treatment services and recognition of social determinants of mental health.	
• Families, health professionals and service providers do not know how to navigate the system to enable them to know what is available (primary, secondary and tertiary services).	• The Healthy WA website is the current information portal for this State and it could be further developed, utilised and advertised so that everyone is able to access the information easily.
• Father inclusion with services is critical.	• Encourage support for the family as a whole (unit over mother).
• Fragmented and siloed services leaving providers unaware of appropriate	• Develop a central register or directory of appropriate services.

Issue	Proposed Solutions
referrals.	• Ensure a consistent standard of services across regions in WA.
• Funding to meet the needs of the growing population, as well as sustainability of funding.	
• Health information is not transparent and accessible to health providers and families, at the detriment of the families.	• Development of inter-service agreements to enable communication across sectors, which must take into account and include the privacy and consent of the families.
• High non-attendance rate.	
• How can we do a 'headspace' or develop the groundswell that Patrick McGorry has created.	
• How to identify medical traumatic stress in babies (and parent) once they have been discharged from hospital.	• Protocols and guidelines on identifying infant trauma at the primary level care. • Universal screening instrument specific for the paediatric population. • Awareness for early childhood and community services of medical trauma in an infant. • Parent training to identify psychological issues in their baby and / or toddler.
• How to better influence politically at key points; who are the most effective people?	
• Need for increased communication between agencies for a standardised approach to identifying issues.	• When risk is identified by a Child Health Nurse (CHN) it needs to be respected and acted on; there is currently a lack of education and understanding into services provided by health professionals. • Clear communication pathway for referrals. • More funded services that are recognised as referral agencies. • Tiered approach to services to offer more under one umbrella. • Relationships between organisations providing services need to be addressed and improved in order to make the relationship between mother and baby stronger.
• Screening (obstetrics and private still not using the EPDS).	• Really need to focus training and education for private practitioner

Issue	Proposed Solutions
	screening. • Universal screening tool for all sectors who contact families.
• Lack of knowledge and competency for infant mental health and inconsistent use of terminology.	• Assumptions around what professionals know and what parents know or are comfortable with. • Infant is an add on buzz word. • Heteronormative focus that doesn't culturally recognise other family structures in our language. • Infant's needs change rapidly over time while mum's needs are fairly standard across the care continuum which impacts on services accessed at different times.
• Lack of advocacy for parents and infants, and a voice for the infant.	• Training across professions. • Who sees infants if there's an issue between three months - five years of age? Is this a gap? How do we identify during this critical development phase? CHN- voluntary attendance? • Build better relationships with communities and families to enable access, disclosure and recognition.
• How to identify areas of most need, particularly those without a voice.	• Effective advocacy for vulnerable and disadvantaged groups. • Earlier identification and intervention. • Lower thresholds for action and referral.
• Need for an increased focus on the needs of children in care, and mothers and families.	
• Infant gets lost in the system.	• Fragmentation of care requires educational frameworks linking adult and infant mental health. • Training and development for primary health care providers to identify risk and problem indicators for infants and children. • Develop a new role for adult and infant mental health coordinators that facilitate people not falling between the cracks and assist people to access services best suited to their needs. • Community education (e.g. circle of security (COS) and Foetal Alcohol Spectrum Disorder awareness) for parents and families in the community

Issue	Proposed Solutions
	and in homes.
• Lack of clarity around pathways to care and poor universal knowledge about these.	• Good updated websites and one stop shops. • Funded network with auspices to regularly meet and update information. • No wrong door approach. • Political and service delivery structures that integrate services; breaking down silos generated by funding structures. • Continuing workforce development planning and education.
• Low recognition of layers of loss and trauma and the need to break cycles of intergenerational trauma.	• Strengths based approaches vs stigmatised risk identification.
• Cannot work with infant without the family system.	• Integration of services. • Identifying the risk to the mother child relationship early in the pregnancy. • Education and skills development around the relationship and family early in schools and community centres.
• Lack of coordination creates silos and territorial approach. • Lack of communication.	• Which services are not clinical? Same care should be available whether accessing the public or private system.
• No dedicated time in appointments across the continuum of care that focuses on mental health.	• Clearer role of child care centres and training for these staff around referrals. • Support for these staff (but it can be funding territorial).
• KPIs do not adequately reflect outcome measures that demonstrate perinatal and infant mental health.	• Need to consider quality vs. quantity and develop KPIs that reflect mental health as well as general health measures.
• Lack of clear and defined clinical pathways for parents and infant.	• Ensure comprehensive and coordinated care to prevent clients falling between the gaps. • Ensure long term continuity of care between service providers (collaborative discharge planning). • Provide support with advocacy to access services and case management (e.g. Fremantle Family Support Services.
• Lack of communication on antenatal screening scores and outcomes to the CHN in the immediate postpartum period.	• To ensure that the scores and outcomes of screening are included in the “STORK summary” to CHN.

Issue	Proposed Solutions
• Lack of integration between mental health, child development and disabilities services (e.g. children with autism).	• Merge child development and mental health services with the 0-5 years stream, 6-11 years stream and 12-16 years stream.
• Lack of knowledge of community services for infants in primary tiers two and three.	• Expert facilitation of local networks to develop local resource directory and to update on a regular basis. • Regular network meetings to build relationships and collaborate.
• Lack of recognition of the young child's developmental (social and emotional) capacity for school readiness.	
• Lack of time, funding and capacity for research.	• Better links with universities. • Centralised portal for research and funding information.
• More understanding and training required for several parts of the sector including child care and child protection; Need to link up between those with the knowledge and those who are decision makers.	• A good map of services and a mapping of ways to integrate through taking advantage of training that is available.
• Need effective networks that recognise the complexity and variety of the work in the perinatal and infant mental health network.	• Clear referral pathways are required.
• Need to consider integrated services for mother and infant dyad.	
• Often it a crisis that leads to change but not in infant mental health.	
• Primary care providers lacking competence and confidence in managing perinatal, infant and maternal mental health in their own services.	• Specific psychological liaison services for midwives, CHNs and GPs to up skill them in managing their clients in a familiar setting.
• Prioritising the baby in services and a shift in thinking from the mother focus.	• Outcomes based funding may be hindering shifting the focus from mother to baby. • Social emotional deficits identified in infant assessment need to be addressed and a referral process needs to be in place. • Programs like ‘COS’ used in antenatal education as well as postnatal. • Change language in the education

Issue	Proposed Solutions
	process to be baby focused.
• Require progressive levels of care and services.	• Better funded community services (e.g. counselling, support groups and practical care).
• Need to raise public awareness of the importance of infant mental health from both a social and economic perspective.	• Develop a paper outlining the social and economic benefits.
• Unable to respond effectively to Aboriginal women, infants and family.	• Ongoing funding and support for services (e.g. Mirrabooka recently closed despite meeting community needs well). • Recognition of what we know works with Aboriginal families - family centred approach relevant to issues identified by women.
• Services are located in different areas and opportunities for collaboration are lost to capitalise on public health campaigns around the mother / child relationship.	• Creation of a face to face one stop shop service state-wide where there are existing child health centre or school infrastructure. • Include child health, GPs, social workers, midwives, mental health, non-government organisations.
• So much evidence that home based services for antenatal and the first year really helps for vulnerable families. • Why don't we have that and how can we use the local Australian Association for Infant Mental Health training competence framework to train primary health workers in perinatal and infant mental health.	
• Stigma being a significant barrier to specialist services.	• Midwife, child health and GP liaison service provided by specialist mental health clinicians and psychiatrists.
• Support services needed for Aboriginal mums and dads to network within Aboriginal communities.	• Use of mentoring programs to help young men and women to promote the relationship between parents and babies.
• Fundamental social needs underlie an important proportion of women with perinatal mental health issues, including domestic violence, homelessness, unemployment, financial, intergenerational trauma.	• Sub network needs to acknowledge this and advocate for services to link with other networks and avoid inadvertent competition between Networks.
• KPIs need to be developed to have consistency across the spectrum of care	

Issue	Proposed Solutions
from prevention and early intervention through to tertiary services.	
• The psychosocial and economic factors that impact on poor mental health outcomes, and impact on the capacity to parent, be recognised including poverty, domestic violence, drug and alcohol use and history of poor attachment.	• KPIs need to address this.
• The ongoing challenges of engaging and coordinating the care of complex families across sectors.	• Development of clinics that include a variety of services (GP, CHN, Mental Health, Department of Child Protection (DCP) and Family Support).
• Tools to identify issues for infant and mother, and articulate what we observe in the relationship between mother and baby.	• Need ways to articulate observations and concerns that are identified. • Tool needs to be developed around the relationship between the mother and baby.
• What are the infant mental health red flags that indicate a tier three referral?	• Educate referrers to have a common language around referrals. • Develop a list of infant mental health moderate to severe criteria. • Train referrers in identifying and articulating moderate to severe indicators.
• What does the community really understand? Issues of shame around mental health.	
• Worker support for their own mental health and wellbeing (i.e. clinical supervision).	• Clinical supervision has been taken away and needs to be replaced. • Understand the relevance of clinical supervision and professional development.

Detailed input from the WACHS Video Conference

- The National Perinatal Depression Initiative (NPDI) – was a good service, those services are still needed and should be replaced.
- Staff training - No training available in the region.
- Awareness on local level challenging.
- Some resources in Geraldton Women's Health Centre but not enough.
- Isolation an issue for service provision.
- No child health staff based in Murchison (1x fortnight fly-in fly-out).
- Possible changes to child health schedule concerning.
- Concerned high risk antenatal clinic in Bunbury seeing some consumers that should be the domain of the family doctor.
- Family management issue, as well as ongoing health.
- Variation in skills and capacities of GPs in the area- some GPs out of their depth.
- How to sure up support when community health care is unavailable.
- Previous NPDI program was really good.
- We need to remember to celebrate the gains we've made and look on the positive side – women don't go to Graylands any more they go to mother and baby units.
- Normalise going to hospital rather than mental health institutions, which are better suited to care as have they have rooms for dads, double beds, laundry facilities and other practical services.
- Perspective of service providers – losing services in regional areas causes much grief although notes 'the ground work doesn't get lost, it gets buried a bit but we'll dig it up'.
- Partnerships important between CHNs, maternity, doctors, family.
- NPDI was a good scheme – it's very important to have that person who fulfils the role of a go-to person who keeps the ball rolling on promotion, education, staff training and clinical time.
- Enhanced child care nurse role.
- There are gaps in services for fathers, Aboriginal community, raising the profile of the infant in decisions.
- Needs to be mapping/scoping what's available in the regions - especially where there isn't a critical mass.
- Not enough services – there's no social worker in our region for perinatal and infant mental health, we only have one and their time is split between palliative and general care enhanced CHNs.
- Child and Adolescent Mental Health Service (CAMHS) can only see acute.
- Enhanced CHNs not core business so difficult as not attached to KPI/funding.
- One hour to Bunbury so even though there are good services there women further south women can't access them.
- CAMHS is available but only for acute.
- Perinatal/infant mental health not KPI not funded.
- Looking at getting KPIs on WACHS dashboard would be a good idea.
- No cohesive program in the region especially with mental health.
- No pre-planning we need a multi-disciplinary team: mental health, child health, DCP, social work, midwives, GP.
- Gap between good GPs/ Obstetric GPs - continuity of care for women.
- Struggle to get buy-in with Aboriginal families.

- Liaison through child health helpful.
- Resources need to be held by/with roles rather than individuals.
- Lack of health provision for infant who is experiencing social and emotional stress.
- No softer/quieter neonate units (as in Royal Melbourne).
- Lot of work here for perinatal specialists.
- Paediatric and obstetric specialists only visit a few days an month.
- Support and education for staff also have ability for whole families to access support (via video conference).
- Keep in mind we are regional and diverse within these regions.
- Telehealth psychiatry service helpful.

Appendix C: Inaugural Perinatal and Infant Mental Health Sub Network Steering Group

At the conclusion of the Perinatal and Infant Mental Health Sub Network Open Meeting, expressions of interest in joining the Steering Group of the Sub Network were called for. The Sub Network Implementation Group chose the following representatives to form the inaugural Perinatal and Infant Mental Health Sub Network Steering Group:

- Alison Evans
- Angela O'Connor
- Anna Roberts
- Anne Marie Loney
- Caroline Zanetti (co-chair)
- Elizabeth Izett-Seah
- Jacquie Frayne
- Kim Hamilton
- Leanda Verrier (co-chair)
- Megan Galbally
- Nicole Wade
- Nicole Wood
- Phyllis Winmar
- Ros West
- Louise Soia

Appendix D: Acronyms

Acronym	Definition
CAMHS	Child and Adolescent Mental Health Service
CHN	Child Health Nurse
COS	Circle of Security
DCP	Department of Child Protection
EAG	Executive Advisory Group
EPDS	Edinburgh Postnatal Depression Scale
GP	General Practitioner
KPI	Key Performance Indicator
MHC	Mental Health Commission
MHN	Mental Health Network
NFP	Not For Profit
NPDI	National Perinatal Depression Initiative
WACHS	WA Country Health Service

This document can be made available in alternative formats on request for a person with a disability.