29 January 2024

Ms Mary de Groot
Secretary
Select Committee on reproductive, maternal and paediatric health services in Tasmania

Email: rmphs@parliament.tas.gov.au

Dear Ms de Groot,

Thank you for the opportunity to make a submission to this Committee regarding the assessment of reproductive, maternal, and paediatric health services in Tasmania. The Committee's commitment to this endeavour marks a progressive stride toward enhancing the long-term well-being of both mothers and children.

AMA Tasmania is the only medical association to represent doctors across all professions. We are therefore in a unique position to be able to comment from various perspectives. This submission largely draws on the input of Dr Stephanie Lorimer (perinatal psychiatrist) and Dr Katja Lindeman (child psychiatrist) as well as, Dr Heinrich Weber (paediatrician) and Dr Anagha Jayakar (paediatrician). Other members' comments have also been incorporated.

General Comments:

Women's healthcare is an essential service to all those living in Australia. This must include termination services, obstetric services, gynaecological services, as well as reproductive services including IVF.

In Tasmania, if you are in need of acute care for paediatric admissions and or other urgent medical issues, you will generally receive the care you need when you need it in an acute care facility within the state, noting some specialty skills would further enhance the services able to be provided here. However, in the non-acute services there are big gaps, for example services in developmental problems such as ADHD or ADD, leaving children undiagnosed and without treatment for too long. These issues are even worse when looking at services outside of Hobart and Launceston.

It is important to note, in all aspects of what the inquiry is considering, there is a vast disparity between the different regions in Tasmania, South, North and North West. Most current reforms or initiatives, new services start as a state wide service on paper, but reality is different: The North West is the last where changes are made and reforms are implemented, despite the North West having evidently the highest need for reform and funding for services and is difficult to recruit to. The North West is the area with the biggest socio-economic burden, the highest number of low income families, the highest number of people on disability pension, NDIS funding applications,

lowest literacy and health literacy levels and highest aboriginal population. There seems to be a lack of accountability regarding current reform processes to identify if and how state wide reforms are reaching the areas with the highest needs. There also seems to be a lack of communication with local professionals in the North West and North, when reforms are rolled out starting in Hobart. Our submission will address these concerns further in the submission.

Terms of Reference:

a. to assess the adequacy, accessibility, and safety of the following services for Tasmanian parents and their children in relation to:—

(i) reproductive health services;

a. adequacy, b. accessibility and c. safety

Reproductive services are essential services, in particular for individuals and families with infertility (both primary and secondary, including those with congenital anomalies, previous cancer treatment, surgical complications, same sex couples, and couples seeking surrogacy). Withholding public services discriminates against these Tasmanian individuals and families, many of whom have not chosen infertility. Members, some of whom have their own experiences of requiring IVF, find the lack of public services in Tasmania deeply distressing and disappointing.

Two private clinics in Hobart offer reproductive healthcare in the form of IVF (and associated) services in Tasmania, however this is at a significant out of pocket cost to consumers (limiting accessibility for many Tasmanians). Neither private service publishes its outcome or safety data (available in some other states in Australia), limiting the capacity for Tasmanians to compare outcomes and safety with mainland services.

Tasmania does not have any publicly funded nor bulk-billing IVF reproductive services. This is an incredible disadvantage to all those living in Tasmanians, but particularly in the North West where there are also no private services to give people a choice. While there are no services in the North West, services in the North are not much better. Essentially all services are now run out of Hobart with patients having to travel to Hobart at short notice for all procedures - this is very arduous for those in the North let alone the North West. A person in the North is sometimes required to travel to Hobart for a 5-minute ultrasound due to unavailability of services at short notice when needed.

Added to these issues, there is no Patient Transport Access Scheme (PTAS) for people undergoing IVF treatment, further disadvantaging women in the North West who cannot afford to travel to access any treatment at all. And, the lack of services outside of Hobart also creates issues for urgent fertility preservation options in young patients with new diagnosis of aggressive malignancies requiring urgent chemotherapy in the North.

More services in the North (including procedural and IVF lab) and far better patient holistic care/support is needed.

(ii) maternal health services;

a. adequacy, b. accessibility and c. safety

Unfortunately, the model of shared care whereby GPs help manage pregnancies has rarely been used since the booking-in appointment system was put in place in the public system and diverted women to midwife run care. This means there is no longer a cohort of experienced GPs to assist with

maternal care. A shortage of obstetricians, special interest GPs and midwives has also meant the withdrawal of low-risk births from rural hospitals like Scottsdale and Smithton reducing accessibility to services in rural areas. There are also ongoing issues with maternity services at the North West Regional Hospital with an unstable obstetric and midwifery workforce, which is very reliant on locum doctors and agency nurses. With an appropriate state-wide plan in place, these issues could be addressed, including using an under-utilised rural generalist workforce with obstetric training in our rural hospitals. Such a plan would also need to address the specific needs of First Nations and CALD women.

With declining births and a shortage of obstetricians there are also issues in the south of the state particularly in private, to ensure all maternity services across the hospitals remain sustainable. The AMA has been requesting a round table on maternity services to address some of these issues now, before a crisis hits.

(iii) birth trauma;

Many women will experience some form of difficulty in the birthing process. As many as 1 in 3 have reported their birthing experience as traumatic.

While there can be degrees of trauma experienced, it would be appropriate to create a formal birth trauma pathway. This would:

- Formalise a process of referring women experiencing birth trauma to an appropriate a multidisciplinary service with obstetric, midwifery, paediatric, SW, psychology and psychiatric care;
- Train and upskill workforce in birth trauma and treatment of same; and
- Train and upskill obstetric and midwifery staff re trauma-informed care

Funding for a designated postnatal clinic at both the LGH and RHH for birth trauma is needed. The impact of birth trauma and its ongoing health consequences is well documented. Early intervention, support, and counselling are key to reducing this lifelong impact and health cost.

Presently, the majority of birth trauma presents to GP's. In our current GP climate (of shortage in Tasmania, and with the highest OOP cost of all states), this healthcare issue is increasingly going to be unserviced, or at best, poorly serviced. GP's are also not sponsored (or required by CPD) to do any training in birth trauma counselling, nor are our midwives or obstetricians. This places increased pressure on the already stretched and under-resourced psychologists in our state. This has also been further exacerbated by the closure of the Mother and Baby Unit at St Helen's Hospital.

(iv) workforce shortages;

Workforce shortages are being experienced across the health professions, including general practice, midwifery and paediatrics all impacting on the services able to be provided to women seeking to have a child, pregnant or having given birth.

This is particularly a pressing concern in North West Tasmania where there is a lack of adequately staffed obstetric services, which then has a significant impact on neonatal care. This concern underscores the critical need to ensure the provision of comprehensive healthcare services for mothers and newborns in our region.

The shortage of permanent obstetric staff in North West Tasmania has become a growing issue that directly affects the care of expectant mothers and their infants. The obstetrics department in our region relies heavily on locum obstetricians, leading to inconsistent care and potential gaps in expertise. Obstetric services are vital for ensuring safe pregnancies, deliveries, and postnatal care for both mothers and newborns. Therefore, addressing the staffing challenges in this department is of utmost importance.

As previously mentioned, the repercussions of inadequate obstetric services extend to neonatal care. Neonates born to mothers facing challenges during pregnancy or delivery may require specialized care and monitoring. Ensuring that expectant mothers receive comprehensive prenatal care and that the delivery process is managed by experienced professionals is crucial in preventing neonatal complications. When these services are suboptimal or inconsistent, neonates can face a higher risk of adverse outcomes.

(v) midwife professional Indemnity Insurance;

Fears around being sued are not for midwifes alone. Obstetricians are insured for their work, but still live with that fear in this ever growing litigious world we live in. It would help if there were publicly funded community birth centres in the state, with staff covered by a state-based indemnity package. This would help to insure obstetricians and midwives are available to provide appropriate services to birthing mothers. Without this, the legal vulnerability for obstetricians outside of public roles is too high and some a choosing to leave the profession as a result.

Continuity of care and birth centres have excellent evidence for their improved outcomes. We believe government should provide this additional model to our current services, especially as we see families withdraw from Private Health Funds and birthing increasing in the public system.

(vi) perinatal mental health services;

a. adequacy, b. accessibility and c. safety

With perinatal mental health impacting 1 in 5 women, and 1 in 10 partners, we know this is an underfunded and under resourced area of healthcare in Tasmania. The closure of the Mother Baby Unit (MBU) was devastating, as tertiary inpatient services for perinatal mental health is not equivalent to an MBU.

As it is, perinatal mental health services are inadequate and not easily accessed. The service provided is safe, but parents may feel that engagement increases the risk of child safety intervention and avoid using it. Perinatal and Infant Mental Health (PIHM) services will see parents flagged during pregnancy or in the 6 months after, but it is difficult to access for patients in the North and North West, regional patients, and the vulnerable patients not already booked. There are also inadequate drug and alcohol services for this group.

The Tasmanian Health System does not have a dedicated women's service for mental health. Creation of a women's specific mental health service would help to address some of these issues. Such a service would provide:

- a secondary consult service;
- support women through all life stages;

- be informed through a trauma-informed lens; and
- provide expert specialist care from women, for women.

Problems are exacerbated in the North West where the currently perinatal service is run by two part-time nurses, as part of a state wide service managed from Hobart. The challenge lies within the structure as the state wide perinatal service is based as part of CAMHS, whereas the service in the North West is based within Adult Mental Health community service.

It is further challenging to have patients being accepted in the North West, due to lack of resources. The referral criteria for the service are mainly focusing on the mother's mental health, such as severe mood disorder (e.g. bipolar disorder) or severe psychotic disorders.

In the North West the absence of a functioning and sufficient service results in other NGO's with less trained teams, such as Anglicare, Mission, Life without barriers etc covering some of the mental health burden. Safety remains a major issue in the absence of a mother baby unit that is accessible for mothers from regional areas such as the West Coast.

How can perinatal services be improved?

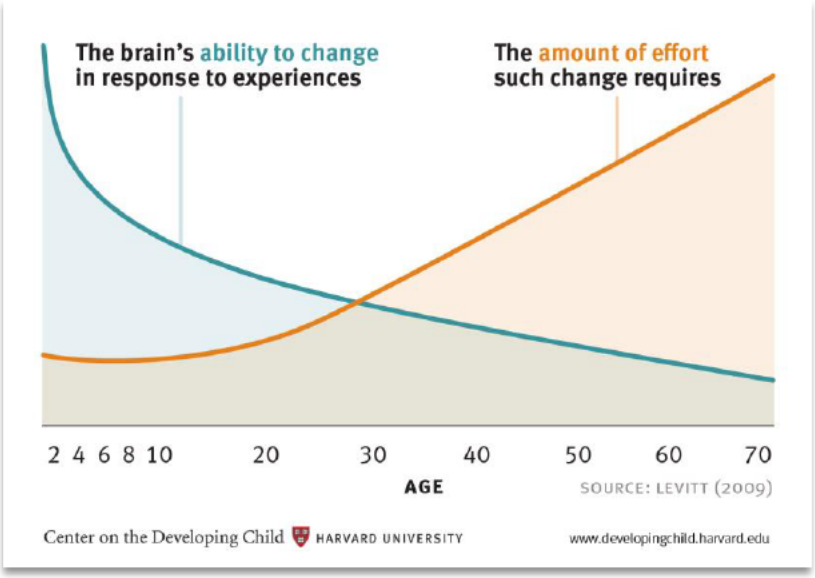
1) To ensure equality of access to Perinatal and Infant Mental health (PIMH) services across Tasmania, consideration should be given to development of a Statewide PIMH service.
2) Commensurate with a Statewide model of care, there needs to be appropriate resourcing to allow provision of timely, appropriate, best practice care to vulnerable parents and infants across the State, irrespective of location or socioeconomic status.
3) Embedding a Statewide PIMH service within the already established Statewide Child and Adolescent Mental Health service would be beneficial as it would decrease barriers to access for families with children in the early years (0-5), streamline service provision, and allow for efficient collaboration at this crucial time for infants and young people. It is also in keeping with the First Thousand Days paradigm and best practice care.

The importance of Perinatal and Infant mental health has grown in recognition and attention at a national level over the past two decades, with the development of the National Perinatal Depression Initiative in 2008, and the first Australian perinatal-specific Clinical Practice Guidelines released in 2017 (Austin et al, 2017). A recent update to this guideline was released in October 2023 (Highet et al, 2023). The perinatal period is defined as the period covering conception to the end of the first postnatal year, but in some settings can cover up to 2-3 years postpartum (Austin et al, 2017).

Attention to this area is with good reason. Pregnancy, childbirth, and postpartum are periods of unique risk for women for new episodes and relapse of mental disorders, with evidence also demonstrating the potential impact on partner/father's mental health. The effects of these disorders can be devastating to families and have huge impacts on the broader community. The World Health Organisation rates poor mental health among the biggest threats to early childhood development (WHO, 2018). Mental illnesses such as anxiety and depression are highly prevalent in the perinatal period, with studies suggesting 1 in 10 women have depression in pregnancy (Buist and Bilsztra, 2006), and 1 in 6 have depression postpartum (Woolhouse et al, 2015); for anxiety, research indicates that 1 in 5 women will experience anxiety either during pregnancy, or in the first postpartum year, or both (Highet et al, 2023). It has been estimated that 3-5% of women who deliver will require the services of specialised perinatal mental health teams (Stein et al, 2018). Suicide is regularly reported as a leading indirect cause of maternal death (AIHW, 2017). Other

mental disorders, such as bipolar disorder, schizophrenia and personality disorders also require specialist PIMH service intervention to support families and promote mental health during this vulnerable period. The prevalence of borderline personality pathology (and complex trauma) is highly prevalent in our local population (Judd et al, 2019), and women with this particular mental illness are considered 'high-risk' caregivers, with associated negative impacts on their offspring (Judd et al, 2018) and high need for specialist service intervention. Thus, a robust PIMH service reflective of the need and accessible to all Tasmanian families is a must to prevent significant morbidity and mortality for women and poorer outcomes for children and families.

In keeping with this, the First Thousand Days paradigm refers to the period from conception, during pregnancy, and up until the end of a child's second year. This is a time of maximal developmental neuroplasticity and critical brain development in infants, and thus, a time of maximal vulnerability to external influences – positive or negative. Experiences at this stage of life have profound effects on subsequent physical and mental health across the lifespan and even into future generations (Moore et al, 2017). Investment in preventative and early intervention at this stage of life brings greatest opportunity to minimise and/or avert subsequent mental health and chronic physical health problems later in life:



Similar to the effects of institutional childhood sexual abuse, it is well established that adverse experiences in the First Thousand Days are associated with a wide range of subsequent negative cognitive, social, emotional and neurodevelopmental sequelae for affected offspring (Moore et al, 2017). Supporting parents during pregnancy and postpartum results in long-lasting improvements not only for the parents' mental health, but also for their infant's developing brain and later physical and mental health and well-being (Moore et al, 2017). This was echoed in a recent review for the Queensland Child Death Review Board into reducing the risk of suicide in vulnerable young people (McDermott, 2021). The review clearly showed that experience of adverse childhood events (ACEs) – such as maternal mental illness, exposure to abuse or neglect, and/or other comorbid psychosocial factors, is associated with changes in gene function (via epigenetic mechanisms) that dictate and alter an individual's later physical and mental health. These effects are likely to be worse in minority and disadvantaged groups. Importantly, parental warmth may be a protective factor to this biological change (McDermott, 2021). Thus, early PIMH intervention is a foundation for lifelong mental health and may further limit the intergenerational transmission of trauma (RANZCP, 2023).

It follows, that the cost benefits of investment in mental healthcare in the First Thousand Days are huge (Strong Foundations, 2019). Investment in preventative and early access to mental health care in this period of life has profound health and cost benefits to society. A 2019 report into the cost of perinatal depression and anxiety in Australia (PwC, 2019), found that estimated impacts of these disorders to be $877 million per year, comprised of:

- health costs attributable equaling $227m, comprising increased use of primary and community health services and hospital health care services and increased risk of certain conditions for both the parent and child.
- economic costs of $643m are attributable to productivity losses associated with increased workforce exit, absenteeism, presenteeism and carer requirements.
- monetised social and wellbeing impacts include increased likelihood of developmental issues, depression, anxiety and child ADHD diagnoses, totaling $7m.

Beyond this, the report estimated lifetime impacts of $5.2 billion attributable to the increased risk of depression, anxiety and ADHD in the children of parents with perinatal depression and anxiety, affecting wellbeing, productivity and health system use (PwC, 2019). The scope of this report considered the costs associated with perinatal depression and anxiety alone, but it stands to reason that other mental disorders occurring in the perinatal period also have broad and far-reaching costs to society. Access to preventative and/or early treatment for perinatal mental health disorders would subvert or avoid many of these costs to broader society.

As a result of this huge body of evidence, contemporary Australian guidelines support the development of robust PIMH services. The RANZP College Section of Perinatal and Infant psychiatry recently released a report which recommended the need for a highly skilled, collaborative workforce to provide prevention and early intervention to support vulnerable infants and children (RANZCP, 2023) and further cited PIMH services as central to the effective promotion of child mental health and well-being. This work begins in pregnancy.

The RANZCP College also has a position statement in support of dedicated PIMH services for perinatal and infant well-being (RANZCP, 2021). The College position is that subspecialty skills are required, and services should be highly integrated with maternity settings, community services, and have inpatient mother-baby units as an integral part of a stepped-care model. Best practice recommends joint mother and infant admissions when hospitalisation is required for mental health care in late pregnancy and the first postpartum year (Highet et al, 2023), so consideration should be given to creating a mother-baby unit with an appropriate therapeutic environment to support such admissions.

The recent Centre of Perinatal Excellence (COPE) guideline echoes these recommendations for specialist PIMH multidisciplinary teams to support birthing women and their families (Highet et al, 2023), as does the UK Royal College of Psychiatrists (Royal College of Psychiatrists, 2021).

It is likely that in an under-developed PIMH service, infant mental health and well-being is often overlooked, especially given the recency of knowledge and recognition of infant emotional and neurocognitive development. There is also a paucity of clinicians with this particular skillset at a National and Statewide level.

There needs to be a clear determination of whether infant mental health services are being provided at a Statewide level, particularly in the North and North-West. Robust PIMH services have a clear permanent establishment, reflective of population need, and failing to provide such services is not only risky for vulnerable parents and infants, but also has longer-term costs in terms of later physical health and mental health service utilisation.

To bring Tasmania in line with best practice Australian principles, we should expand existing PIMH services to improve adequacy of service provision, as well as develop a Statewide model, to improve equity of access across the State, including to the North and North-West, and other regional and remote areas where socioeconomic and health status is also often lower. A Statewide model would also allow for sharing of subspecialty resources and development of consistent Statewide best practice care, while still maintaining local expertise and knowledge. It is important, however, funding is allocated appropriately across the regions to ensure local delivery of service in a model that also reflects the available workforce.

The Committee should also consider where a PIMH service should sit operationally. AMA Tasmania believes a Statewide PIMH service, as part of Child and Adolescent Mental Health Service (CAMHS), would allow for continuity and ease of access for consumers as they progress through the early years. It would also allow for collaboration and sharing of subspecialty skills across these important areas, minimise barriers to access and service fragmentation, allow for development and upskilling of workforce, and is also reflective of the First Thousand Days paradigm and best practice guidelines nationally.

Commensurate with creating a Statewide PIMH service under CAMHS, appropriate resourcing would allow those in the field to:

- provide care to fathers as well as mothers, as there is a growing body of evidence that addressing paternal mental health in the perinatal period also yields positive outcomes for families (Dhillon et al, 2022) and almost 10% of fathers/partners also suffer perinatal depression (Cameron et al, 2016)
- Provide therapeutic interventions to support infant neurodevelopment and wellbeing, which has profound long-lasting positive outcomes, as described above.
- Provide longer term follow-up of vulnerable families.
- Allow for secondary consultation to occur to the primary health sector and other stakeholders.
- Provide home visiting services and increased outreach capacity.
- Allow for primary preventative interventions and groups.
- Potential to provide parenting capacity assessments and increased service collaboration between PIMH and Child Safety Services
- Provide education and training opportunities for interested stakeholders and affiliated services.
- Conduct research into this important area of practice.
- Establish an appropriate Parent-Infant unit (formerly known as Mother-Baby Units) to support parents with severe mental illness and their infants to be admitted together, which is supported by evidence as best practice.

(vii) paediatric services for children aged 0-5 years;

a. adequacy, b. accessibility and c. safety

Previously, Tasmania had a successful "Children Developmental Unit" for children 0-5 years to assess and manage developmental disorders as well as disabilities. However, it didn't include medical staff in the team and was disconnected from the Paediatrics service causing long waiting periods in between referrals. Unfortunately, this service seems to have stopped.

Currently, children are referred to the Paediatric team via GP's. Long wait lists are causing challenges and ever changing referral criteria to NGO's (St Giles) for autism diagnostic in this early age are making it almost impossible for parents to navigate the services. Consequently, children are not diagnosed in a timely manner, and are not therefore receiving support when they need it, which can lead to secondary mental health issues and inadequate education supports being put in place leading to significant disadvantage later in life. Even if children are diagnosed early, the NDIS pathway takes over and yet again it is dependent on the parent's knowledge and education of how well they can navigate the system to access the appropriate health and allied health professionals.

Sadly, waiting times for children to access speech pathology, OT, Physio or a Psychologist are many months to years, especially in the North West. There are several non-urgent cases who have been on the waitlist for "behaviour assessment" for over 700 days! This is a disaster for a child that potentially has a neurodevelopmental disorder. Delayed access, diagnosis and treatment can lead to severe mental health concerns later in life, particularly throughout puberty including depression, anxiety, eating disorders and suicidality.

While there is no specific paediatric service for children 0-5 years, there is the Tasmanian Community Paediatric Service (TCPS), a service committed to the well-being of children and families. It is important to note here, there are no specific paediatric services for First Nation families or CALD families. The TCPS represents a state-wide expansion of community paediatrics THS-South. This expansion, made possible through time-limited funding from the Department of Premier and Cabinet (administered by the Tasmanian Health Service), aligns with the Tasmanian Premier's 'It Takes a Tasmanian Village' Child and Youth Wellbeing Strategy Action 30. The team comprises paediatricians, allied health clinicians, nurses, and administrative staff.

The 'Kids Care Clinics' are multidisciplinary community-based paediatric clinics with a primary focus on early identification of health and well-being concerns for children. The objective is to offer priority access to paediatric care for Tasmanian families experiencing vulnerability. They receive direct referrals from entities such as Strong Families Safe Kids, Child Safety Services, Aboriginal health organizations, Child Health and Parenting Services (CHaPS), and tertiary hospital pathways. It is important to note that a GP referral is not required for children to be seen in their paediatric clinics. The services encompass the wellbeing of unborn babies, children, and young people up to at least the age of 18. The KCC team conducts comprehensive multidisciplinary assessments and collaboratively works with other community services to identify short and long-term solutions for families.

This service model of care was deliberately designed to address the accessibility, adequacy and safety of paediatric care to children and families experiencing vulnerability:

- The absence of a requirement for GP referrals stems from the scarcity of general practitioners and the rising cost of accessing their services in Tasmania, which poses a significant barrier for geographically and financially disadvantaged families seeking paediatric care.

- The triage pathway is designed to prioritize children experiencing vulnerabilities, ensuring the timeliest interventions for those facing social disadvantages. This approach aims to safeguard the health and wellbeing of children at the earliest possible opportunity.
- The multidisciplinary team can provide "in-house' neurodevelopmental assessments to avoid further waiting lists, allowing direct multi-disciplinary communication and avoid families being lost in the system.
- The clinics are strategically co-located with community services such as Child and Family Learning Centres, Community Health Hubs, Aboriginal Controlled Community Health Organizations, and Neighbourhood Houses for several reasons:
    - **Reducing Barriers:** We seek to minimize the obstacles of travel, the cost of travel, and parking expenses for families accessing paediatric care.
    - **Fostering Connections:** We aim to connect families with on the ground appropriate community and social services.
    - **Building capacity:** We hope to provide professional education to the co-located services to build up capacity and empower communities from within.

Having said this, AMA Tasmania draws to the Committees attention that while the intent of 'Kids Care Clinics' is to provide care for children in out-of-home care, as well as address the concerns of infant mental health, and plays an important part in addressing the wellbeing of children in the 0-5 year age group, it is disheartening to note that the funding has been allocated to the Royal Hobart Hospital in the south, with not a single position allocated to the THS-North West. This distribution of funding further exacerbates health inequities in the region, as the greatest need for such services exists in regional North West Tasmania, where underprivileged communities require additional support. With the allocation of resources largely to the south of the state, it also follows that the service provision is largely in the south. With the provision of services concentrated in the south, and virtually all positions allocated to the RHH or the south, this has the unintended consequence of worsening the disparity in healthcare.

While it is true the first 2000 days are the most crucial in a child's life to ensure strong attachment, mental health and resilience, we believe the inquiry should also be looking beyond five years of age as the issues around paediatric services and access to them do not cease when a child is five. Sometimes diagnosis does not occur until a child has started school and learning abilities are exposed.

In Tasmania, there is a big gap in developmental services such as for ADHD and ADD. There is not enough public or private access to professional help and what is available varies from region to region. The time from presentation to get all the allied health and then paediatricians sign off is often a year, when early intervention/medication would make a big difference to a child leading their best lives.

Private paediatrics is at capacity with ASD/ADHD patients with no or very few private paediatricians taking new referrals across the state. It would help if the department could make it easier/more attractive for those in public roles either to help increase capacity in private practice or to expand public services in this area. The other option would be to work more closely with GPs, with special skills (overseen), who could sign off repeats/ongoings/diagnose those clearly worked up in public or private to help with the demand, noting that primary care for children is inadequate and patchy due to a lack of GPs and the lack of publicly funded GP and integrated clinics. Most new families cannot afford the fees that GPs are obliged to charge with poor Medicare rebates. Community services tend to only serve children deemed to be vulnerable- mainly those already involved in child safety services.

There is a major gap in child safety services. Strong families safe kids is meant to provide support to families to improve the care of children at home, not to remove kids. They are woefully under-resourced. Dealing with families early to support them with their children's health and development will decrease CSS and health involvement down the track. Most cases referred are closed fairly promptly as 'families choose not to engage'. Perhaps this reflects how families are wary and cannot see the benefits to them and their children.

Once children get to the major paediatric outpatient services the service is safe and adequate BUT there are long waits especially for developmental and behavioural issues (requests for ASD and ADHD assessments are skyrocketing). Even from the RHH it is very difficult to access the allied health assessments required for good diagnoses, as there are very few Allied Health workers attached to clinics. We too need to refer to the Education based TADS, or refer to NDIS type services. The waits experienced by families are unacceptable. Early assessment and intervention can change trajectories for kids.

The problem is access block - no private paediatricians are regularly accepting routine new referrals and there are around 3,300 children on public waiting lists (according to the Mercury recently). The most significant reason for this is the single prescriber laws in Tasmania for prescribing stimulant medication for ADHD plus annual review by a specialist. Given ADHD is the most common disorder in children with 8.2% of children and 11% of boys (probably reflecting under diagnosis in girls) https://www.aihw.gov.au/reports/children-youth/australias-children/contents/health/children-mental-illness for which stimulant medication is first line treatment, every paediatrician in Tasmania is spending most of their time simply servicing the repeat prescription requirements of children who have been diagnosed and are on continuing treatment and simply getting bigger. If they all did nothing else ever, they would not keep up with demand. In other jurisdictions, there are other models of care that allow for GPs to participate in diagnosis and in continuing provision of treatment along with allied health support, with 'review by specialist' timeframes both longer and with greater flexibility. Nurse led clinics focusing on specific developmental disorders, supported by Paediatricians, may also be appropriate to establish where there are demand and workforce shortages.

There are multiple costly implications of this ruling - firstly for the roughly 12,000 Tasmanian children likely to have the diagnosis, which is associated with large increases in injuries including head injuries, in substance abuse, interactions with the justice system including incarceration, suicide, insomnia, educational and workforce underperformance, anxiety and depression, domestic violence exposure and so on. The failure to assess, diagnose and treat these children quickly leads to educational trajectory loss that will never be recovered and adverse impacts on their teachers and fellow students. Many of these children will have comorbid diagnoses that also need assessment and management.

The other major implication is the lack of availability for support for all the other children requiring paediatrician support, including asthma, allergy, epilepsy, developmental delay, failure to thrive, autism and other neuro-developmental and often comorbid conditions, genetic syndromes and so on. Very seriously ill children will be seen, but the toll of less acute issues like unresolved constipation and faecal incontinence have large and preventable impacts and are tough for GPs to manage alone.

The alternative to a paediatrician for some of these cases would be a child and adolescent psychiatrist - an endangered species in Australia in general and certainly in Tasmania.

(viii) the Child Health and Parenting Service (CHaPS).

a. adequacy, b. accessibility and c. safety

Child Health and Parenting Service (CHaPS) nurses could play more of a role in addressing paediatric concerns within the community helping to significantly improve healthcare access, particularly in rural and disadvantaged areas such as North West Tasmania.

CHaPS nurses are uniquely positioned to provide valuable support to families and children in the community, acting as a bridge between primary care providers and the acute hospital setting. Their expertise in child health and parenting issues, along with their accessibility and community presence, makes them an invaluable resource for addressing paediatric concerns early on and preventing the unnecessary use of acute hospital services.

In the North West region, where healthcare access can be challenging due to geographical factors and workforce shortages, leveraging the capabilities of CHaPS nurses is of paramount importance. By empowering these nurses to take on a broader role in providing comprehensive paediatric care within the community, we can achieve several key objectives:

1. Early Intervention: CHaPS nurses can identify and address paediatric health and developmental concerns at an early stage, preventing conditions from escalating to the point where hospitalization is necessary.
2. Education and Support: These nurses can provide parents and caregivers with essential education, guidance, and support on various child health and parenting matters, empowering families to make informed decisions and manage minor health issues effectively.
3. Reducing Hospitalisation: By proactively managing paediatric concerns, CHaPS nurses can help reduce the burden on acute hospital services, ensuring that hospital resources are allocated to cases that truly require specialized care.
4. Enhancing Equity: The availability of CHaPS services throughout Tasmania, including rural areas, can contribute to more equitable healthcare access for families, regardless of their geographic location.

CHaPS is a great service, but there is now a massive gap for assistance to settle an infant through an overnight service. The new RHH MBU service provides three beds, however, St Helen's Hospital had an eight bed unit supporting women struggling with their baby's sleep behaviour. While the beds at the RHH are welcome, there is a need for a community based overnight mother baby unit, away from an acute hospital. An option would be to support the community not-for-profit model of the Tresellian Family Care Centres, which are doing well in interstate. They have tried to come to but can't get support from government. A service like this would complement not compete with ChaPS.

(b) to examine disparities in the availability of services, staffing and outcomes between:—

(i) Tasmania and other Australian states and territories;

In summary, Tasmania has:

- No publicly funded reproductive services in Tasmania.
- No outpatient based MBU in Tasmania.
- No birth centre model of care in Tasmania.
- No COGU (O&G ultrasound sub-specialists) FRANZCOG in Tasmania.
- No O&G uro-gynaecologist sub-specialist (only part time - FIFO - in Launceston) in Tasmania.

- No succession plan for a future MFM (one current), CREI (one current) or gynae-oncologist (1 1/2 current) sub-specialists in Tasmania. There must be a forward plan for these.

There's a lot of data on the mental health worker numbers in Tasmania - we are well below, especially for psychiatrists.

Other states seem to be more innovative and faster in implementing evidenced based approaches. For example, NSW was already promoting the first 2000 days in 2019 and Queensland offered the Triple P parent program for free to parents. Out of home care children have a clear pathway regarding access to medical services and specific diagnostic pathways regarding developmental disorders (children who are experiencing any form of abuse have significantly higher risk of delayed development and developmental disorders).

Pay disparity of all health professionals between the different states, makes it extremely difficult for Tasmania to recruit and retain specialised staff. The new EBA for Salaried Medical Practitioners makes Tasmania more competitive, but time will tell if it is sufficient to attract doctors here in those hard to recruit specialties like psychiatry.

(ii) Tasmanians living in rural, regional and metropolitan areas

> *Being a health professional in the North West, I have often found myself in the position of having to correct and educate people about the difference between the North and North West. It doesn't seem to be common knowledge among people in decision making positions, that it is not the same.*

There are disadvantaged communities across the state with your suburb determining your life expectance, literacy and job prospects. However, as a region, the North West is the hardest hit and it is this region that we want to turn the spot light on in this submission.

The low health literacy in the North West contributes to ongoing intergenerational disadvantage and further increases the burden of small communities who are already stretched for resources. Tasmania already allows for postcode discrimination. Existing and New Services are allowed to "choose" the area they would like to service, with the result that the same regions such as the West Coast are missing out on services over and over again.

The North West region of Tasmania faces several distinct challenges related to healthcare access and service provision. It is a predominantly rural area characterized by a dispersed population, which often results in limited access to medical facilities and specialists. This geographic isolation exacerbates issues related to maternal and paediatric healthcare, workforce shortages, and the availability of perinatal mental health services. Families in this region often have to travel long distances to access essential healthcare services, which can be a significant barrier, particularly for those experiencing socio-economic disadvantage.

Workforce shortages, including shortages of midwives, paediatric nurses, allied health services and obstetricians, are particularly acute in North West Tasmania. The reliance on locum staff in the Obstetrics department highlights the precarious nature of healthcare delivery in this region. Additionally, midwife professional indemnity insurance remains a concern, potentially impacting the recruitment and retention of midwives.

The disparities in healthcare outcomes between North West Tasmania and other regions within Tasmania and the rest of Australia are well-documented. These disparities often result from a combination of limited access to care, socio-economic factors, and geographical barriers. Furthermore, the lack of resources allocated to paediatric and perinatal mental health services in the North West compounds these challenges.

Considering these circumstances, the parliamentary inquiry into the adequacy, accessibility, and safety of reproductive, maternal, and paediatric health services in Tasmania is not only welcome but also urgently needed. Understanding the extent of these disparities and recommending actions to address them is crucial to ensuring equitable healthcare access for all Tasmanians, regardless of their geographic location or socio-economic status.

We also welcome the recent efforts aimed at addressing infant mental health in the region. The addition of staff, such as a dedicated social worker to specifically address infant mental health, is a positive step forward. This acknowledges the importance of early intervention and support for children's mental well-being from the very beginning of their lives.

However, it is important primary care services are bolstered as addressing these problems should largely be in the domain of the primary care services. This is also a more cost-effective approach.

Apart from the CHaPs services, the role of the rural generalist GP, esp. those with a special interest, is important and should be supported. Likewise, the Government should consider other models of care, such as nurse-led clinics following up high risk babies. The Government could also consider different models of care in different parts of the state, as there appears to be an over-reliance on hospital-based care, which is not only more expensive, but should also largely be reserved for acute medical services. It is also more difficult to attract such specialists in North West Tasmania.

In addition, it is important to highlight the acute shortages of health services along the west coast, the most disadvantaged and remote part of our state. We should consider additional resources in order to address the problem of health inequity as the failure to do so will only perpetuate the current concerns and the problems become inter-generational.

The staffing challenges for the Child and Adolescent Mental Health Services (CAMHS) in the North West region is a growing concern. Despite additional funding allocated to CAMHS, North West services have regressed, and currently do not have a single employed paediatric psychiatrist or psychologist. The invisibility of the additionally allocated funding for child and adolescent mental health services is troubling, given the increasing demand for these crucial services. It is essential this gap in mental health care for our children and adolescents is addressed to ensure their well-being.

It is evident that from the funding of Kids Care Clinic and CAMHS, that the allocation of funds to run statewide services often do not have the intended consequences. If appropriate allocations are not reserved and dedicated to each region, the impression is that such funding ends up largely being utilised in the south of the state. This undermines the intention of such funding and only serves to worsen the health inequity that already exists in the state and across Australia as the poorer health outcomes in regional and rural communities in Australia is well documented.

(iii) Tasmanians experiencing socio-economic disadvantage; and

As previously mentioned, the disparity and discrepancy between the different regions is a major issue in the current system, leading further to socio-economic disadvantage and increased socio-economic burden and rural and remote communities. This must be addressed when trying to impact the social determinants of health. If we do not address the underlying problems, such as employment, housing, nutrition, etc, we will not achieve long-term improvements in health outcomes as each of these factors impacts on the mental health and wellbeing of people. AMA Tasmania is concerned there is an under-appreciation of the impact of these factors on healthcare, and we should work collaboratively across various departments to address this.

When addressing the social determinants of health, it is important to not only focus on medical concerns. A holistic approach that considers factors such as housing, education, and community support will provide a more lasting solution to improving the health and well-being of Tasmanian families and children. Furthermore, it is crucial to explore the possibility of introducing community services to address early behavioural and child and adolescent behavioural concerns, as well as offering parenting courses to prevent the progression of these issues to mental health challenges in later life. Currently, these problems are consuming our acute health services at significantly greater costs compared to if services were provided in the community. These issues have largely been medicalised, and a shift towards community-based support can lead to more effective, cost-efficient, and sustainable solutions.

I would also like to highlight the positive impact of the IMPROVE program, aimed at reducing stillbirth rates in the state, which is already delivering significant benefits. In particular, the efforts to address tobacco smoking before and during pregnancy represent a low-hanging fruit that can yield substantial improvements in maternal and child health outcomes. Supporting and expanding such initiatives can provide the most significant return on investment and contribute to better health equity across the state. IMPROVE is not only running workshops in the state but also nationally, demonstrating its potential to make a broader impact on reducing stillbirth rates. As part of a suite of interventions, the reduction in tobacco smoke exposure, especially during pregnancy is the intervention yielding the biggest reward in improving healthcare for mother and the baby, both in the short term and especially in the long-term.

(c.) to make recommendations on actions that can be taken by the State Government to ensure reproductive, maternal and paediatric health and perinatal mental health services meet the needs of Tasmanian parents, families and children.

There are three main areas of understanding that the committee must hold at the forefront of solution planning.

1. An understanding of well-being

For all services to have a focus on the health and wellbeing of the birthing person, unborn babies, and children, first there must be an understanding that wellbeing is grounded in safe psychological and emotional wellbeing, as well as physical health.
Solution opportunities:

- Universal access to no-cost contraceptive and sexual health care for all young people to promote planned pregnancies.
- Better access to publicly funded psychological support for women with psychological needs, not only those considered at the highest risk to address the 'missing middle'.
- Improved prioritisation of pregnant women in social services to promote social determinants of health e.g. housing access.

2. A focus on getting it right in the early years

Children need the opportunity to learn and build positive early relationships, to build the foundations for positive relational and emotional health. Universally accessible services to build parenting capacity and early intervention services will contribute to reducing the current rising burden of behavioural issues presenting to paediatric services in Tasmania.

Solution opportunities:

- Improved targeted services to support parents and carers to understand the emotional needs of infants and children to prevent behavioural issues occurring or provide early access to interventions. It is these services that are currently under resourced, underfunded, inadequate or non-existent.
- These services should be integrated into existing universal antenatal and post-natal care models with improved designed to reduce barriers to engagement though home visiting programs. For example:
    - More extended midwifery visits
    - Improved early infancy support services, particularly for families identified as experiencing vulnerabilities through home visiting programs. For example, expanding services like the home-visiting program for young mums "CU@ Home", to the broader evidence-based home visiting program such as in place in Victoria "right@home".
- Better access to early parenting supports for infant sleep and settling
    - Coordinated outpatient services with breadth of clinicians skilled in evidence-based approaches to supporting parents with sleep and settling and other issues related to infant regulation
    - community based residential family, mother, and baby care centres

3. A collaborative healthcare landscape

Currently due to repeated funding model changes or service remit changes it is impossible to keep an up-to-date directory of services providing care to women and children in Tasmania. Service development often occurs in isolation, without appropriate collaboration contributing to a lack of transparency and accountability to ensure that all Tasmanians have equal access to care - from low-priority to high priority.

Solution opportunities:

- Strategic service mapping and dedicated service development into creating streamlined and tiered service models.
    - E.g. a centralised public neurodevelopmental assessment service with clear mandates of which children will receive assessments by what service.
- Workforce development for publicly accessible allied health intervention
- Services held in the public collaborative domain e.g. St Giles
- IT systems that enable cross-agency collaboration rather than contributing to communication barriers within departments. E.g. CHaPs and Paediatrics using the same record keeping.

Further, the Committee could consider the following:

4. Creation of a Statewide PIMH service with services delivered in all regions.
5. Ensure the PIMH establishment is of a size to provide a robust service, in line with best practice guidelines to meet the needs of vulnerable Tasmanian families.
6. Provide an overarching structure that oversees the need for funding per region, that also has an accountability to ensure services receive the funding allocated. Especially, when state wide services only occasionally visit the North West, instead spending 80% of their time and effort in the South.

7. Implement a new system that compliments the already existing structures regarding early development, the first 2000 days.
8. Take a holistic approach, where the assessment of the child and family is the focus in the beginning and all the “issues, concerns” can be discussed and jointly with the family and a health pathway be developed.
9. Re-establishing the Child-Developmental-Unit imbedded into the Paediatric service and not as standalone silo.
10. GPs are already overwhelmed with the flood of “behaviour” presentations or “mental health presentations” among the young age group. As Medicare fails to cover the cost of these time consuming assessments for GPs, a different funding structure that would involve GP’s in a more appropriate way to take pressure of the tertiary system would be beneficial. Perhaps a GP special interest in Paediatrics and families might be equally important as the rural and remote special interest.
11. Look at other countries such as Scandinavia or other European countries as how early developmental screens are promoted by Paediatrician’s or GP’s. E.g. 10-11 standardised and specialised screening appointments are scheduled at different ages for children 0-14 years. During these appointments the vaccination is checked as well and other important health advice is provided enhancing the health literacy of families. (some countries have these as mandatory, others as optional for families). In Tasmania this would be a great opportunity for Nurse practitioners or Clinical Nurse Consultants to specialise in children developmental screening and general developmental health advice. All could be imbedded into the first 2000 days framework and child safety framework.
12. Not leaving any Gaps of services regarding the age group . some services stop at age 2 ½ or 4 ½ leaving the families hanging. Or as soon as the child is attending school, certain public health services are no longer available as it is provided by the education department. These silos and complicating factors are not helpful for families. The access to health services need to be simplified urgently, funding silos need to stop.
13. Services should be tailored as per need of the area and community. To which it would be crucial to have a “service map” of what is where available for children and families. Then establishing a plan to fill the gaps. The overarching structure needs to take responsibility to ensure equal distribution, but not just on population based numbers. equal distribution also need to take into account economic burden, health literacy, travel time, remoteness and already existing structures.
14. A Perinatal Mental Health Service (or better infant mental health service) that addresses the need of a family as whole and not just focusing on the mother’s mental illness.

Thank you for the opportunity to comment on your Terms of Reference. I trust our submission will help in your deliberations.

Kind regards

Dr John Saul
President AMA Tasmania

References:

- Austin M-P, Highet N and the Expert Working Group (2017) Mental Health Care in the Perinatal Period: Australian Clinical Practice Guideline. Melbourne: Centre of Perinatal Excellence.
- Australian Institute of Health and Welfare (AIHW). Maternal deaths in Australia 2012-2014. 2017.
- Buist A & Bilsztra J (2006) *The beyondblue National Postnatal Screening Program, Prevention and Early Intervention 2001–2005, Final Report. Vol 1: National Screening Program*. Melbourne: *beyondblue*.
- Cameron, E.E., Sedov, I.D. and Tomfohr-Madsen, L.M. (2016) 'Prevalence of paternal depression in pregnancy and the postpartum: An updated meta-analysis', Journal of Affective Disorders, 206, pp. 189–203.
- Dhillon HS, Sasidharan S, Dhillon GK, Babitha M. Paternal depression: "The silent pandemic". Ind Psychiatry J. 2022 Jul-Dec;31(2):350-353.
- Highet, NJ and the Expert Working Group and Expert Subcommittees (2023) Mental Health Care in the Perinatal Period: Australian Clinical Practice Guideline. Melbourne: Centre of Perinatal Excellence (COPE).
- Judd, F., Newman, L. K., & Komiti, A. A. (2018). Time for a new zeitgeist in perinatal mental health. The Australian and New Zealand journal of psychiatry, 52(2), 112–116.
- Judd, F., Lorimer, S., Thomson, R. H., & Hay, A. (2019). Screening for depression with the Edinburgh Postnatal Depression Scale and finding borderline personality disorder. The Australian and New Zealand journal of psychiatry, 53(5), 424–432.
- Moore, T.G., Arefadib, N., Deery, A., & West, S. (2017). The First Thousand Days: An Evidence Paper. Parkville, Victoria; Centre for Community Child Health, Murdoch Children's Research Institute.
- McDermott, BM (2021). Highly vulnerable infants, children and young people: A joint child protection mental health response to prevent suicide. Commissioned by the Queensland Child Death Review Board (CDRB).
- PwC Consulting Australia (2019). The cost of perinatal depression and anxiety in Australia. Accessed on 14/01/2024, available from: Download.ashx (perinatalwellbeingcentre.org.au) .
- Royal College of Psychiatrists (2021) College Report CR232: 'Perinatal mental health services: Recommendations for the provision of services for childbearing women'.
- Stein, A. et al. (2018) Mitigating the effect of persistent postnatal depression on child outcomes through an intervention to treat depression and improve parenting: a randomised controlled trial, The Lancet Psychiatry, 5(2), pp. 134–144.
- Strong Foundations collaboration. (April 2019). The First Thousand Days: A case for investment. Available from: The First Thousand Days - A case for investment (aracy.org.au).
- The Royal Australian and New Zealand College of Psychiatrists (2021). Position Statement 57: Perinatal mental health services. Section of Perinatal and Infant Psychiatry. RANZCP: Melbourne.
- The Royal Australian and New Zealand College of Psychiatrists (2023). Building mental health and wellbeing in Australia and New Zealand through early support for infants, children and their families. RANZCP: Melbourne.
- Woolhouse, H. et al. (2015) Maternal depression from early pregnancy to 4 years postpartum in a prospective pregnancy cohort study: implications for primary health care, BJOG: An International Journal of Obstetrics and Gynaecology, 122(3), pp. 312–321.
- World Health Organization, United Nations Children's Fund, World Bank Group (2018). Nurturing care for early childhood development: a framework for helping children survive and thrive to transform health and human potential. Geneva: World Health Organization.