Australian College of Midwives

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Mental Health and Related Services Act 1998 Review
(Exposure Draft Mental Health Bill 2024)

ACM Submission

Issued May 2024

Exposure Draft Mental Health Bill 2024

The Australian College of Midwives

The Australian College of Midwives (ACM) is the peak professional body for midwives in Australia; and welcomes the opportunity to provide a written submission to the ***Mental Health and Related Services Act 1998 Review (Exposure Draft Mental Health Bill 2024 – 'The Bill')***. ACM represents the professional interests of midwives, supports the midwifery profession to enable midwives to work to full scope of practice (SoP), and is focused on ensuring better health outcomes for women, babies, and their families.

Midwives are primary maternity care providers working directly with women and families, in public and private health care settings across all geographical regions. There are 33,594 midwives in Australia and 1,195 endorsed midwives[1]. ACM is committed to leadership and growth of the midwifery profession, through strengthening midwifery leadership and enhancing professional opportunities for midwives.

Terms of Reference

This submission will address the proposed Bill in relation to antenatal and postnatal women.

Background

Mental health conditions can occur during pregnancy and the postnatal period, with approximately 10% of women in high-income countries experiencing depression and 10-20% experiencing anxiety perinatally[2]. As well as women with pre-existing mental health challenges, pregnant and postnatal women are at a higher risk of developing a mental health condition, or of an existing condition being exacerbated. There are also specific conditions related to this life event, such as postpartum psychosis and childbirth-related post-traumatic stress disorder[2]. Mental health disorders for pregnant, postnatal and breastfeeding women impact both the woman and her baby, and the impact can be long-term, affecting the child for life[2]. Fathers, partners, and other non-birthing parents or guardians can also experience new or worsening mental health conditions during this time[2].

It is important to address perinatal mental health disorders, to improve outcomes for women and babies in the Northern Territory (NT), with suicide in the postnatal period being a leading cause of maternal death[3]. Postpartum psychosis is a significant concern that may lead to separation of mother and baby in mental health institutions. Care for women experiencing severe perinatal psychiatric conditions such as postpartum psychosis must include consideration of the mother-infant dyad and the wider family[4].

Consideration of pregnant, postnatal and breastfeeding women in the Bill

Currently the Bill does not specifically address the needs of pregnant, postnatal, and breastfeeding women with mental health disorders. Women who have undergone a mental health assessment and have been deemed in need of treatment should simultaneously have the needs of their pregnancy, postnatal care and breastfeeding addressed. For instance, breastfeeding has well established short- and long-term benefits for women and babies[5] and a woman's right to care for and breastfeed her baby should be considered in any mental health treatment and admission plan.

Some services in Australia offer specialised mother / baby inpatient or day use mental health units[6]. These services support the mother and baby to remain together, and provide specialised, targeted support for perinatal women. Some examples in other states include St John of God Burwood Hospital Mother and Baby Unit in New South Wales, Mother Baby Unit Inpatient Services Mercy Health in Victoria, Mater Catherine's House for Mothers, Babies and Families in Queensland, and Helen Mayo House in South Australia. There is no specialist mother-baby inpatient mental health service in the Northern Territory, and this is a missed opportunity to provide optimal treatment and care for perinatal women and their babies. The only adult mental health inpatient services in the Northern Territory are the Royal Darwin Hospital, Alice Springs Hospital, and the Darwin Clinic, a private hospital service. The Darwin clinic does not mention perinatal women on their website, and refers to staffing by nurses but not midwives. There are long wait times for the 26 mental health inpatient beds at the Royal Darwin Hospital[7]. With a new 18 bed mental health unit at Royal Darwin Hospital currently under construction, there is an opportunity to embed a specialist perinatal mother-baby mental health unit within this service.

Currently there is a need for:

- Better data collection, validation, analysis, audit and reporting on perinatal mental health conditions and context within the NT to better inform education of support staff, development of specific perinatal mental health programs, and where services are to be best used.
- Dedicated mother and baby units to support women and babies in the early parenting period.
- Dedicated facilities for women and babies to safely stay together when the woman is an inpatient of mental health services.
- Services that are widespread across rural, regional, remote and urban centres.
- Training for midwives around trauma informed care as the first step to minimising Non-First Nations workers' impact on the mental health of First Nations childbearing women, which would positively impact the Cultural Safety of women to disclose perinatal mental health concerns.
- Implementation of existing validated and appropriate tools for screening and treatment of First Nations mothers, such as the Kimberley Mums Mood Scale.

The shortfalls in perinatal mental health support across the NT can lead to exacerbation of mental health disorders for pregnant, postnatal and breastfeeding women, who then may need admission to mental health services. These services would need to adhere to the legislation within this Exposure Draft Bill. Ensuring that the Exposure Draft Bill specifically considers and protects the needs and rights of perinatal women will provide a framework for inpatient mental health services.

Recommendations

- Include in the guiding principles the right of the pregnant, postnatal or breastfeeding women to antenatal and postnatal care, and the right to breastfeed her baby.
- Facilitation of safely keeping the woman and baby together, including rooming in and breastfeeding for babies.
- A requirement for holistic assessment by mental health professionals with expertise in perinatal mental health to determine and address the mental health challenge with consideration of perinatal factors e.g. birth trauma, postnatal depression, sleep deprivation.
- Holistic assessment by mental health professionals with expertise in First Nations trauma informed care, as relevant.
- Inclusion of First Nations Mental Health care workers in all management process of perinatal mental health.
- Access for the woman's support people to inpatient facilities.

- Protection of the unborn baby if she is pregnant.

Continuity of care

Midwifery Continuity of Care (MCoC) is a maternity care model where women see the same midwife or small team of midwives throughout their perinatal experience. Midwifery Continuity of Care is known to be the gold standard of maternity care[8]. Women and babies experience reduced interventions and better outcomes, both physically and psychosocially[9.10,11]. MCoC improves satisfaction with the birthing experience and can reduce birth trauma[12]. Midwives are also more satisfied working in MCoC models[13], with lower levels of burnout and psychological distress[14]. In addition, MCoC costs the healthcare system 22% less than other models of care[15]. Midwives provide MCoC in publicly funded models and in private practice. In remote areas where there is genuinely not a safe referral pathway for women experiencing intrapartum complications, an adapted MCoC model which excludes intrapartum care is an option which provides effective primary maternity care during the antenatal and postnatal period. This model of care, known as Maternal and Postnatal Service (MAPS), has demonstrated positive outcomes, is well received by women[8]. It is the ACMs position that the majority of women in Australia should be cared for in a full MCoC model, and we recommend all women for whom this service is not available should be offered care in a MAPS model. The ACM cautions against health services assuming MAPS is an acceptable replacement for full MCoC and defaulting to MAPS models of care due to assumptions about midwives' preferences or challenges setting up MCoC models. Women cared for in MCoC models experience less mental health challenges due to the psychosocial support offered by their known midwife.

Conclusion

The Exposure Draft Bill should include reference to and provision for perinatal women, including a recommendation to provide specialised mother-baby units where possible, or accommodation for the needs of perinatal women where this is not possible. Assessment and care by mental health professionals with expertise in perinatal mental health is also essential.

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Consent to publish

ACM consents to this submission being published in its entirety, including names.

Sexed language statement

Biological sex may differ from gender identity. Using the pronouns and language the person receiving care prefers is important to many people accessing maternity care, including LGBTQIA+ individual[16]. There has recently been movement from the use of sexed language in maternity care (e.g. woman) to alternative phrases and more gender-neutral language (e.g. person with a cervix, birthing person). While the intent behind this change is inclusivity, this risks multiple unintended consequences, including misunderstanding, dehumanisation, widening of the female data gap, and reduction in protection of the mother-infant dyad[17]. The ACM will continue to use the term 'woman', and strongly supports the individualised use of preferred pronouns and language in clinical practice.

Consent to provide further information

ACM is available to provide further expert opinion and advice if required.

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