Submission to Australian Productivity Commission Mental Health Public Inquiry

23rd January 2020

Gidget Foundation Australia
Promoting emotional wellbeing for expectant & new parents
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1. Introduction

Gidget Foundation Australia’s Interest in the Mental Health Public Inquiry

This document outlines a background of perinatal mental health in Australia (including insight into prevalence and cost), the contribution made by Gidget Foundation Australia to the perinatal mental health sector in Australia and lastly, a set of recommendations to improve the mental health outcomes for new Australian parents. This submission is informed by current research, the Gidget Foundation community (including lived experience through new and expecting parents, as well as, clinicians such as psychiatrists, psychologists, obstetricians, GPs, midwives) and program outcomes.

In 2019, the Australian Government announced a $36.6m funding commitment to the ‘Maternity to Home’ Program which supports undertaking national screening of all expectant and new parents to identify and diagnose those at risk of or experiencing Perinatal Depression and Anxiety (PNDA). The commitment does not detail expansion on pathways to support the cohort. The existing resource and referral pathways are already beyond capacity. A fundamental requirement for screening programs is the provision of appropriate and accessible interventions for those screening positive.

Whilst Gidget Foundation Australia supports National Screening in accordance with the Perinatal Mental Health Clinical Guidelines, the concern is that identifying additional individuals through screening will add a significantly increased burden onto existing perinatal mental and general health services that are already underfunded and at capacity.

This, coupled with the social impact of Gidget Foundation Australia’s programs, form the basis of the proposed recommendations which cover two specific strategies to immediately improve perinatal mental health outcomes:

1. Introduction of the Perinatal Treatment Plan (PTP); and
An independent evaluation of the *Cost of Perinatal Depression and Anxiety in Australia* was conducted by PricewaterhouseCoopers (PwC) in November 2019. Using data pools from Gidget Foundation Australia, Peach Tree Wellness, Perinatal Wellbeing Australia and PANDA Australia, the evaluation concluded costs were $877 million in the first year alone. The costs are attributed to health services, the economy and wellbeing. It is imperative to address perinatal mental health with early intervention. Adverse outcomes of perinatal depression and anxiety have been observed to have impact beyond the parent - to partners, children and the wider family unit. The welfare of the community into the next generation is at stake.

These two recommendations target early mental health intervention, prevention and health promotion to minimise significant familial and intergenerational impact. The goal of these recommendations is to ultimately aim to reduce long term emotional and economic costs to the extended family unit with a focus on risk reduction.

Lastly, the recommendations ensure consistent perinatal support and services to regional, rural and remote areas of Australia that provide accessible and inclusive care that meets the needs of expectant and new parents.

2. Gidget Foundation Australia

2.1 Gidget Foundation Australia’s Story

“Gidget Foundation Australia is focussed on raising awareness, providing advocacy and education and delivering services for the treatment of Perinatal Depression and Anxiety in Australia.”

Gidget Foundation Australia is a not-for-profit organisation that provides programs to support the emotional wellbeing of expectant and new parents. The mission of Gidget Foundation Australia is “to promote the importance of emotional wellbeing amongst expectant and new parents, their healthcare providers and the wider community to ensure that those in need receive timely, appropriate and supportive care”.
Nearly 1 in 5 mothers and 1 in 10 fathers will experience perinatal depression and anxiety (PNDA) and related disorders such as PTSD and Complicated Grief that are often hidden and not fully understood. Nearly 50% of all parents experience Adjustment Disorders. This range of problems impacts in excess of 100,000 Australians each year, and suicide is the leading cause of maternal death. Gidget Foundation Australia is supported by the generosity of philanthropic individuals and businesses, Government and independent grants and fundraising events and activities.

The Gidget Foundation provides support for those people experiencing perinatal mental health disorders through:

1. Support services for families suffering emotional distress during pregnancy and early parenting
2. Education, advocacy and awareness programs aimed at various stakeholders including health professionals and the wider Australian community.

“Gidget” was the nickname of a vibrant young mother who tragically took her own life while suffering from unrecognised postnatal depression. She hid her suffering from even her loving family and friends. Gidget Foundation Australia was established by Gidget’s friends and sisters. The Foundation has grown and is now supported by many passionate individuals, community leaders, government and health professionals across Australia. The Foundation is a grass roots volunteer organisation that is able to leverage its impact and strengthen outcomes by working collaboratively with many professionals who support vulnerable parents.

2.2 Gidget Foundation Australia’s Programs

Gidget Foundation Australia support parents with the following mental health treatment programs:

- **Gidget House** provides ten clinical psychological sessions for expectant and new parents in person at various locations across two states, NSW and Qld.
• **Start Talking Telehealth Program** provides ten clinical psychological sessions for expectant and new parents nationally via video call service.

• **Gidget Emotional Wellbeing Screening Program** covers preadmission midwife screening and support for pregnant women at selected hospitals.

• **Gidget Village** provides group therapy sessions for expectant and new parents at various locations.

• **Gidget Emotional Wellbeing Workplace Program** offers tailored programs for employees and management to promote engagement and develop strategies for mentally healthy workplaces.

• **Education, Research and Online Tools** for the community and health professionals as well as professional medical contribution to workshops, conferences, media and professional publications.

• **Annual Tresillian Scholarship** for a child and family health nurse to undertake a 12-month professional mental health course.

• **Advocacy and active memberships** of professional networks

• **Research and contribution** to mainstream and professional publications

• **Development and distribution of resources** to assist parents.

To support these mental health programs, Gidget Foundation Australia has a Clinical Governance Committee comprising of a number of experts in perinatal lived experience, psychiatry, psychology, midwifery, obstetrics, general practice and other primary health stakeholders. The Clinical Governance Committee provides oversight of the delivery of all the Foundation’s clinical programs.

In addition to the above, Gidget Foundation Australia provides a variety of support services including:

• Resources including brochures, books, video and online

• Community presentations

• Corporate presentations on parental leave and staff engagement

• Health Professional Education including students, health and allied health professionals
3. Perinatal Mental Health Background

3.1 Prevalence in Australia

Perinatal Depression and Anxiety is diagnosed in 1 in 6 parents, or over 100,000 Australians each year (1 in 5 mothers and 1 in 10 fathers). Numbers are higher in areas negatively affected by Gaps and Gradients and Social Determinants of health. By identifying additional individuals through expanded screening this number will likely significantly increase. The initial onset of symptoms may occur anytime from pregnancy to the first year after birth, although both risks and actual illness may have preceded conception. Research indicates males underreport mental health symptoms; 45% of fathers are not aware they are susceptible to PNDAs. [1] The Edinburgh Postnatal Depression Scale (EPDS; Cox et al 1987) is an internationally accepted instrument for assessment of depressive symptomatology. Research into supporting fathers successfully supported the use of the EPDS to screen for paternal distress and depression.

3.2 Cost of Perinatal Mental Health in Australia

In the first year alone, $877 million is the cost of perinatal mental health. This combined cost triangulates impacts to health services, the economy and wellbeing. [1]

|$877 million Total Cost Of Impact In The First Year |
|$643m Economic Costs |
|• Parent cost – workforce exit, absenteeism, presenteeism |
|• Wider Family cost – family breakdown and carer role |
|$227m Health Costs |
|• Parent health cost – primary and community services, hospital care, chronic disease, substance abuse |
|• Child health cost – low birth weight, premature death, reduced immune system, asthma and respiratory conditions |
|$7m Social and Wellbeing Costs |
|• Child cost – ADHD diagnosis |
$7.3 billion is the total lifetime cost to health services, the Australian economy and wellbeing. [1]

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<th>Year One</th>
<th>Parent</th>
<th>$648m</th>
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Further, the likelihood of parents remaining married after experiencing PNDA is decreased. [2]
One sample of mothers with no psychiatric history were 46 times more likely to have a recurrence of PNDA. [3] PNDA can recur in subsequent pregnancies with significantly increased likelihood.

The strain of PNDA is felt on the family unit, specifically in childhood outcomes. Children are more likely to experience behavioural and neurological disorders and Attention Deficit Hyperactivity Disorder (ADHD). [4, 5] As adults these conditions can persist with increased risks of anxiety and depression. The key recommendations outlined in this document aim to significantly reduce or avoid these costs via addressing them in early intervention.

“I'm grateful I finally found a practice specifically catering to new parents.”

Client Feedback Nov 2019
4. Recommendations

Below are two recommendations Gidget Australia Foundation suggest to substantially improve the mental health outcomes of expecting and new parents in Australia.

4.1 Recommendation 1: Perinatal Treatment Plan (PTP)

The first recommendation is the creation of a dedicated Perinatal Mental Health Care Plan – called the ‘Perinatal Treatment Plan’ (PTP). This is specifically a mental health care plan designed for early intervention and facilitates GP referrals directly to appropriate care pathways. This is similar to the Australian Eating Disorder Treatment and Management Plan which provides specific and tailored support for patients.

The goal of the PTP is to:

a) Provide holistic and dedicated treatment of perinatal mental health disorders to address the current difficulties and the risk of recurrence
b) Assist in the identification of PNDA
c) Prevention method for ongoing suffering for those at risk
d) Provide tailored support and intervention options according to the needs of patient
e) Minimise potential risk to the infant

4.1.1 Recommendation Details

Below is the proposed Perinatal Treatment Plan’ (PTP) structure:

| Eligibility Criteria | 1) Parent having had a birth, pregnancy or adoption within the last 12 months.
|                     | 2) A diagnosis of perinatal depression, anxiety, trauma, loss disorders from a GP, obstetrician or psychiatrist.
<p>| Outcome tool used   | 3) DASS 21 - *score 10 or above and EPDS – score 10 or above[6] |</p>
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<td><strong>NB:</strong> Scores of 1-3 on the EPDS question 10 (self-harm) is a prompt to further immediate assessment.</td>
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<td><strong>Risks and comorbidities [1]</strong></td>
<td>OR 2 or more of the following risks or comorbidities:</td>
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<td>• Infant loss or other problems</td>
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<td>• Unplanned pregnancy</td>
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<td>• Other outside stresses eg illness, job loss</td>
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<td>• Alcohol and/or drug misuse</td>
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<td>• Personality characteristics such as pre-disposition to worry/ruminate, OC</td>
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<td>• Marital difficulties</td>
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<td>• Medical or temperamental difficulties with baby</td>
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<td><strong>A member of the following cohorts with additional risk of PNDA (due to reduced access to support)</strong></td>
<td>* Fathers/partners*</td>
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<td>* Aboriginal and Torres Strait Islander communities</td>
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<td></td>
<td>* Culturally and Linguistically Diverse (CaLD) communities</td>
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<td>* Lesbian, Gay, Bisexual, Trans, Intersex and Queer (LGBTIQ+) communities.</td>
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<td><strong>Referral Process</strong></td>
<td>* Initial – GP, obstetrician, psychiatrist or other medical specialist makes referral*</td>
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**NB: Same referral process as Better Access Mental Health Care Plan however broadened to include referral from Obstetricians and Psychiatrists and increased for a further 10 sessions (totalling 20).**

- 10 sessions (currently 6th session) - GP makes referral for ongoing treatment of a further 10 sessions

### Treatment Process (Rebates from Medicare)

- Up to 20 sessions available for evidence-based psychological treatments - including face-to-face (one-on-one) and telehealth sessions

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#### 4.1.2 Outcome Tools and Score Guide

The plan uses two outcome tools: The Depression, Anxiety and Stress Scale (DASS) 21 and the Edinburgh Postnatal Depression Scale (EPDS). The EPDS assesses perinatal anxiety and depression.[10] The DASS differentiates anxiety, stress and depression states from personality traits.[11, 12] The questionnaire comes in a 42 or 21 question format. The DASS 21 questionnaire gives statistically robust scores and is time efficient. This combination of psychometric tools, although not diagnostic, provides a reliable and valid measurement of PND. The EPDS is currently translated into 36 languages and can facilitate CaLD families receiving appropriate care. Gidget Foundation Australia have indicated a score guide targeted to early intervention from empirical evidence. Extensive research shows that males are likely to under report symptoms of distress, thus our score guide is modified accordingly.[7-9, 13, 14]

#### 4.1.3 Risks and Comorbidities

To promote early intervention a list of non-exhaustive risk factors is included. These factors are cumulative, and risk increases with each factor. A diverse eligibility criterion allows at-risk parents effective treatment and reinforces prevention. Closing this gap in healthcare services can ultimately contribute to reducing costs to Australia’s economy, health and wellbeing.
4.1.4 Treatment Process

The onset of PNDA and related disorders can occur anytime from pregnancy through to the first year of birth, and they may also be pre-existing. It is vital to support parents through the duration of the perinatal period. The increased number of psychological treatments ensures equity of access and longevity of support. The option of additional treatments allows parents requiring more than 10 sessions in a year to receive effective treatment. Accordingly, positive treatment outcomes can be observed across socioeconomic groups, rather than limited to those able to privately pay for additional treatment. Further, patients could elect to use their available sessions on group-based sessions. This can assist in building community and promoting awareness. The continuation of treatment beyond 10 sessions is preventative to recurring and ongoing PNDA.

4.1.5 Access via TeleHealth

To promote convenient, accessible and inclusive care to regional, rural and remote areas, parents living in locations 4 - 7 in the Modified Monash Model may opt for all sessions via telehealth. A further recommendation as part of the PTP is to expand the geographical criteria specifically to include locations 2 and 3 of the Modified Monash Model (MMM).

Currently, Australians with a Mental Health Care Treatment Plan living in MMM locations 4 - 7 can receive psychological treatment via Telehealth with Medicare endorsement. We recommend reform expanding these geographical criteria specifically within the PTP.

Use of audio call or telephone is not currently permitted. Those living in rural and remote areas often have restricted access to stable internet service. By offering up to half of the consultations by telephone will ensure that those parents who are particularly isolated are still able to receive significant support.

From a perinatal perspective, this is critical as a new mother may not be able to drive a car or travel due to surgical procedures (such as caesarean), or simply because she has a baby, or because the baby also may be unwell.
4.1.6 A Case for PTP

To support the creation of the PTP – please see below a summary of parents experiencing PNDA and receiving treatment. A total of 105 responses were received and a summary of the results demonstrates:

- 89% respondents reported sessions improved their sense of wellbeing
- 97% respondents reported they were satisfied with the care provided by their Gidget Foundation Australia clinician
- 99% respondents reported their Gidget Foundation Australia clinician made them feel safe
- 96% respondents reported their Gidget Foundation Australia clinician focused on what was important to them

Survey of Gidget Foundation Australia’s Patient Feedback (October- November 2019)

“I think this is such an invaluable service to new mums and second time mums. I know it’s very difficult to get appointments now so obviously the more clinicians you can provide the better. It may also be useful to add that it would be nice where appropriate to link up parents who have similar challenges”

“It was an incredibly helpful experience. I started out as a nervous, crying new mom and am now such a happy, confident person and have a wonderful bond with my baby and a better relationship with my husband and myself!”

“Such a supportive service providing lifelong skills. Mental health is something to be invested in and I feel this to be a very important program.”
In summary, the creation of the PTP is an immediate way to provide early intervention-based treatment and prevention plans that can provide relevant and specific care to new parents at risk of or diagnosed with PNDA. It supports the patient for the duration of the perinatal period and is preventative for recurring PNDA. Moreover, its implementation is significant in limiting intergenerational impacts and supporting the development of resilient family units who remain united.

4.2 Recommendation 2: Expansion of Telehealth Services

4.2.1 Background

On 1st November 2017, the Australian Government introduced a new measure to improve equity of access to mental health treatment services for people in rural, remote and very remote locations.

The changes announced at the time allowed up to 7 of 10 Better Access mental health consultations to be provided through video conferencing, with one of the first four sessions required to be delivered through a face-to-face consultation.

The patient must be located in Modified Monash Model areas 4 - 7 (a town of 15,000 people or less) and at least 15km distance from the treating allied mental health professional by direct road at the time of consultation.

The treating professional can be located anywhere in Australia, subject to the 15km minimum distance requirement being met. A GP Mental Health Treatment Plan is required.

The Telehealth Access to Psychological Services measure was introduced to enhance ease of access to, and increase choice in, mental health services in rural and remote areas of Australia. It is widely recognised that there is a scarcity of mental health professionals in regional areas of Australia, and this can act as a significant barrier for those who need to access these services.

The eligibility criteria, combined with the treatment provision guidelines, in the past prevented the service from being accessed. The restrictive barriers to access the service,
primarily due to unintentional exclusion, contributed to low uptake of the service. From a perinatal perspective, the service also did not take into account that a new mother may not be able to drive a car or travel due to surgical procedures (such as caesarean), or simply because she has a baby, or because the baby also may be unwell.

In September 2018, the Australian Government removed the face-to-face consultation requirements under the Better Access to Psychiatrists, Psychologists and General Practitioners initiative through Medicare, taking immediate effect. Previously, three of the ten telehealth psychology sessions were required to take place face-to-face. By removing this requirement, many more Australians in these communities are now be able to easily access Gidget Foundation Australia’s Start Talking telehealth program, providing up to 10 free perinatal psychology sessions via video call.

Suicide is the leading cause of maternal death in Australia, with rates in regional areas increased by a further 40%. The positive impact this change had on new and expectant parents in the regional, rural and remote Australia, who have suffered for too long with a lack of access to specialist psychologists, is significant.

4.1.2 Recommendation Details

Therefore, the second recommendation is to expand the Telehealth Access to Psychological Services measures, specifically to include locations 2 and 3 of the Modified Monash Model (MMM) as well as allow up to half of the consults to occur by telephone.

Currently, Australians with a Mental Health Care Treatment Plan living in MMM locations 4 - 7 can receive psychological treatment via Telehealth with Medicare endorsement. We recommend reform expanding these geographical criteria.

Use of audio call or telephone is not currently permitted. Those living in rural and remote areas often have restricted access to stable internet service. By offering up to half of the consultations by telephone will ensure that those parents who are particularly isolated are still able to receive significant support.
This investment provides further reach opportunities to parents and combats challenges to receiving treatment. An expansion to this scheme can be implemented quickly and without additional costs of developing new programs.

This rural, regional and remote health strategy is effective in treating perinatal mental health patients with the Gidget Foundation’s ‘Start Talking’ Program (which is currently undergoing an independent evaluation by PwC with the report due in mid February 2020). With expansion, this program will be accessible to those living in:

- **MM2** - Large rural towns: Inner (ASGS-RA 2) and Outer Regional (ASGS-RA 3) areas that are not MM 2 and are in, or within a 15km drive of a town between 15,000 to 50,000 residents. For example: Dubbo, Lismore, Yeppoon and Busselton
- **MM3** - Regional centres: Inner (ASGS-RA 2) and Outer Regional (ASGS-RA 3) areas that are in, or within a 20km drive of a town with over 50,000 residents. For example: Ballarat, Mackay, Toowoomba, Kiama, Albury and Bunbury.

Importantly, the expansion redistributes mental health services without relocating clinicians. Reforming this scheme goes some way to meeting the perinatal mental health support needs of new parents in regional, rural and remote communities. People living in regional, rural and remote Australia (i.e. not MMM1) would no longer experience the distress, inconvenience, time and expense of travelling significant distances to access perinatal support services. For some patients, just leaving their home to seek treatment is not possible, with new mothers often facing barriers such as not being able to drive due to the constraints of caesarean or general physical recovery, fatigue and a new baby. This practical change allows all perinatal mental health specialists to better service their patients’ mental health care needs.

Patients’ Experiences of Gidget Foundation Australia’s Telehealth Program, ‘Start Talking’

"Useful to prevent the stress of trying to get out of the house with a small baby and also useful because my access to good support isn’t limited by my location"

"Working with Gidget so far has been outstanding. I enjoy the online aspect so I don’t have to rush to appointments with my baby. I’ve been given amazing targeted advice for my circumstances"

"I live very remote ... [face to face] would have been impossible or required significant logistics/travel cost/time"
5. Conclusion

The prevalence and cost of perinatal mental health disorders is paramount. This submission outlines two recommendations to promote early intervention and extend the treatment period to combat ongoing mental ill-health. To prevent recurring illness and support those experiencing PNDA, the first proposed recommendation is the creation of the Perinatal Treatment Plan (PTP). The occurrence of PNDA is widely spread and is being experienced by at least 1 in 6 parents. The breadth of PNDA’s impact is felt beyond a parent receiving a diagnosis and longer than the duration of symptoms.

Further, with the ‘Maternity to Home’ announcement centred on national hospital screening, it is evident (and presumably desirable) that screening tools will identify parents currently undetected. With 100,000 parents per year currently diagnosed with PNDA, an inevitable increase in this number is a pandemic needing attention. Receiving treatment will remain an unaddressed challenge without adequate referral pathways and resources. These recommendations for treatment are tailored to new and expectant parents and promote early intervention and prevention. A Medicare-endorsed Perinatal Treatment Plan caters for relevant referrals at any time in the perinatal period from conception to one year post-partum.

The second recommendation is an expansion of the Telehealth Access to Psychological Services. The geographical and accessibility expansion of the existing scheme can ensure rapid and meaningful impact on communities. Further, clinicians and mental health services can assist quickly and without relocation costs. Reforming this scheme meets requirements for expecting and new parents in regional, rural and remote communities nationally.

In summary, Gidget Foundation Australia is open to continuing the dialogue with the Australian Productivity Commission Mental Health Public Inquiry to improve the outcomes of perinatal mental health disorders. The implementation of these two recommendations will provide support to those identified as at risk, experiencing mental ill-health and help reduce consequent adverse effects on the 100,000 Australian families known to be affected by PNDA as well as the many more likely to be identified.
6. Contact Details

Should any questions or further discussion be required, please contact the CEO of Gidget Foundation Australia:
Ms Arabella Gibson

Gidget Foundation Australia
C/- Gidget House
34 McLaren Street
North Sydney NSW 2060

7. Appendices

References

EPDS\textsuperscript{[15]}
DASS\textsuperscript{[16]}
Cost of PNDA report
References

# Gidget Foundation Australia

## DASS 21


**INSTRUCTIONS**

Please read each statement and check the box 0, 1, 2 or 3 which indicates how much the statement applied to you over the past week. There are no right or wrong answers. Do not spend too much time on any statement.

*The rating scale is as follows:

- 0 Did not apply to me at all — NEVER
- 1 Applied to me to some degree, or some of the time — SOMETIMES
- 2 Applied to me to a considerable degree, or a good part of time — OFTEN
- 3 Applied to me very much, or most of the time — ALMOST ALWAYS

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**Totals**

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*Gidget Foundation Australia exists to promote the importance of emotional wellbeing among expectant and new parents, their health providers and the wider community to ensure that those in need receive timely, appropriate and supportive care.*

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Gidget Foundation Australia

DASS 21


DASS Severity Ratings

The DASS is a quantitative measure of distress along the 3 axes of depression, anxiety and stress. It is not a categorical measure of clinical diagnoses.

Emotional syndromes like depression and anxiety are intrinsically dimensional - they vary along a continuum of severity (independent of the special diagnosis). Hence the selection of a single cut-off score to represent clinical severity is necessarily arbitrary. A scale such as the DASS can lead to a useful assessment of disturbance, for example individuals who may fall short of a clinical cut-off for a special diagnosis can be correctly recognised as experiencing considerable symptoms and as being at high risk of further problems.

However for clinical purposes it can be helpful to have ‘labels’ to characterise degree of severity relative to the population. Thus the following cut-off scores have been developed for defining mild / moderate / severe / extremely severe scores for each DASS scale.

**Note:** the severity labels are used to describe the full range of scores in the population so ‘mild’ for example means that the person is above the population mean but probably still way below the typical severity of someone seeking help (i.e. it does not mean a mild level of disorder.

The individual DASS scores do not define appropriate interventions. They should be used in conjunction with all clinical information available to you in determining appropriate treatment for any individual.

Notes:
1. Symptoms of psychological arousal
2. The more cognitive, subjective symptoms of anxiety

<table>
<thead>
<tr>
<th>DASS 21 SCORE</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>DEPRESSION</strong></td>
</tr>
<tr>
<td><strong>ANXIETY</strong></td>
</tr>
<tr>
<td><strong>STRESS</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Depression</th>
<th>Anxiety</th>
<th>Stress</th>
</tr>
</thead>
<tbody>
<tr>
<td>Normal</td>
<td>0–4</td>
<td>0–3</td>
<td>0–7</td>
</tr>
<tr>
<td>Mild</td>
<td>5–6</td>
<td>4–5</td>
<td>8–9</td>
</tr>
<tr>
<td>Moderate</td>
<td>7–10</td>
<td>6–7</td>
<td>10–12</td>
</tr>
<tr>
<td>Severe</td>
<td>11–13</td>
<td>8–9</td>
<td>13–16</td>
</tr>
<tr>
<td>Extremely Severe</td>
<td>14 +</td>
<td>10 +</td>
<td>17 +</td>
</tr>
</tbody>
</table>

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INSTRUCTIONS

We would like to know how you have been feeling in the past week. Please select the box for each question that comes closest to how you have felt in the last seven days, not just how you feel today.

Name: ________________________________________________________________________________  Date: ___________________

Weeks pregnant: ____________________ or weeks postnatal: ______________  SCORE TOTAL: ____ Q 10: ______

1. I have been able to laugh and see the funny side of things
   □ As much as I always could
   □ Not quite so much now
   □ Definitely not so much now
   □ Not at all

2. I have looked forward with enjoyment to things
   □ As much as I ever did
   □ Rather less than I used to
   □ Definitely less than I used to
   □ Hardly at all

3. I have blamed myself unnecessarily when things went wrong
   □ Yes, most of the time
   □ Yes, some of the time
   □ Not very often
   □ No, never

4. I have been anxious or worried for no good reason
   □ No, not at all
   □ Hardly ever
   □ Yes, sometimes
   □ Yes, very often

5. I have felt scared or panicked for no very good reason
   □ Yes, quite a lot
   □ Yes, sometimes
   □ No, not much
   □ No, not at all

6. Things have been getting on top of me
   □ Yes, most of the time I haven’t been able to cope at all
   □ Yes, sometimes I haven’t been coping as well as usual
   □ No, most of the time I have coped quite well
   □ No, I have been coping as well as ever

7. I have been so unhappy that I have had difficulty sleeping
   □ Yes, most of the time
   □ Yes, sometimes
   □ Not very often
   □ No, not at all

8. I have felt sad or miserable
   □ Yes, most of the time
   □ Yes, quite often
   □ Not very often
   □ No, not at all

9. I have been so unhappy that I have been crying
   □ Yes, most of the time
   □ Yes, quite often
   □ Only occasionally
   □ No, never

10. The thought of harming myself has occurred to me
    □ Yes, quite often
    □ Sometimes
    □ Hardly ever
    □ Never
Gidget Foundation Australia

Edinburgh Postnatal Depression Scale (EPDS)

Scoring Guide — Instructions

Add the number next to each circle that has been filled in.

This is the total score. See below for the range of scores on the EPDS.

SCORE TOTAL: ________ Q 10: _______

1. I have been able to laugh and see the funny side of things
   0 As much as I always could
   1 Not quite so much now
   2 Definitely not so much now
   3 Not at all

2. I have looked forward with enjoyment to things
   0 As much as I ever did
   1 Rather less than I used to
   2 Definitely less than I used to
   3 Hardly at all

3. I have blamed myself unnecessarily when things went wrong
   0 Yes, most of the time
   1 Yes, some of the time
   2 Not very often
   3 No, never

4. I have been anxious or worried for no good reason
   0 No, not at all
   1 Hardly ever
   2 Yes, sometimes
   3 Yes, very often

5. I have felt scared or panicky for no very good reason
   0 Yes, quite a lot
   1 Yes, sometimes
   2 No, not much
   3 No, not at all

6. Things have been getting on top of me
   0 Yes, most of the time I haven’t been able to cope at all
   1 Yes, sometimes I haven’t been coping as well as usual
   2 No, most of the time I have coped quite well
   3 No, I have been coping as well as ever

7. I have been so unhappy that I have had difficulty sleeping
   0 Yes, most of the time
   1 Yes, sometimes
   2 Not very often
   3 No, not at all

8. I have felt sad or miserable
   0 Yes, most of the time
   1 Yes, quite often
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9. I have been so unhappy that I have been crying
   0 Yes, most of the time
   1 Yes, quite often
   2 Only occasionally
   3 No, never

10. The thought of harming myself has occurred to me
    0 Yes, quite often
    1 Sometimes
    2 Hardly ever
    3 Never

Scoring

QUESTIONS 1, 2, & 4 (without an *)
Are scored 0, 1, 2 or 3 with top box scored as 0 and the bottom box scored as 3.

QUESTIONS 3, 5-10 (marked with an *)
Are reverse scored, with the top box scored as a 3 and the bottom box scored as 0.

Range of EPDS Scores

0-9: Scores in this range may indicate the presence of some symptoms of distress that may be short-lived and are less likely to interfere with day to day ability to function at home or at work. However if these symptoms have persisted for more than a week or two further enquiry is warranted.

10-12: Scores within this range indicate presence of symptoms of distress that may be discomforting. Repeat the EPDS in 2 weeks time and continue monitoring progress regularly. If the scores increase to above 12 assess further and consider referral as needed.

13+: For postnatal clients, scores above 12 require further assessment and appropriate management as the likelihood of depression is high. Referral to a psychiatrist/psychologist may be necessary. The same applies to antenatal clients when they present with a score of 14 or above.

Item 10: Any client who scores 1, 2 or 3 on item 10 requires further evaluation before leaving the office to ensure her own safety and that of their baby.
November 2019

The cost of perinatal anxiety in Australia and depression and perinatal anxiety in Australia

Report prepared by PwC Consulting Australia
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Australia (ABN 69 063 649 123) unless otherwise stated.
Contents

1. Executive Summary
2. Introduction
3. Approach to Modelling
4. Key Findings
5. Recommendations
6. References
understanding of its impacts to the individual, family and community more broadly. The cost of prenatal depression and anxiety to both parents and the broader community beyond the estimated lifetime impacts of $25.25 attributable to the increased risk

| Costs | $25.25m | $45.14m | $77.87m |

Cost of PNDs in Australia

45% of fathers are not aware that men can experience postnatal depression as well as women

Postnatal Psychosis

21% of mothers

Disability Days, Healthcare Costs

Prevalence of PNDAs

Executive Summary

The cost of perinatal depression and anxiety (PNDAs) in Australia
Introduction
1. Introduction

PNDAs affects 3 in 10 mothers and 1 in 10 fathers/partners with PNDAs experience distress during the perinatal period. PNDAs is a common condition that many women experience, having lasting effects on the parent, partner, and family. Psychological, social, and physical factors increase risk.

1. Socioeconomic status
2. Social support network
3. Previous history of mental illness
4. Perinatal depression

The perinatal period is defined as 8 weeks before birth to 6 weeks postpartum. The duration of the perinatal period is unique for every parent within this context. The perinatal period is defined as the Australian Health System and its associated costs. The Australian Health System covers the perinatal period and associated costs, including maternal health care, birth-related care, and postpartum depression.

This prevalence rate has been calculated by estimating a range of severity of the condition. However, there is limited data on PNDAs in Australia. There is a need for further research to better understand the prevalence of PNDAs in Australia and its impact on maternal and child health.
Support services for PNDAs are threatened by severe economic and cultural challenges. The likelihood of PNDAs being identified is low, and support networks that could assist are often inadequate. Lower economic status can also lead to reduced access to health care, which is critical to promote mental health and reduce the risk of outcomes associated with PNDAs.

In Australia, fathers/partners’ Aboriginal and Torres Strait Islander communities have a higher risk of PNDAs compared to other Aboriginal women. These groups are also less likely to receive targeted interventions, which are critical to provide mental health support and reduce the risk of PNDAs. There is a need for further research on factors that contribute to the higher risk of PNDAs in these communities.

1. Introduction
1. Introduction

The perinatal period encompasses both the antenatal period and postnatal period and stage the costs associated with PNDa is summarized in the diagram below. The impacts of PNDa are varied, depending on the stage that the parent and child are in pregnancy and life. The approach to frame PNDa has varied and long-lasting impacts for the parent, child, and wider family.
02

Approach to modelling
Costs are presented over a one, three and lifetime period as appropriate and attributable to PND.

Considered and costed are the impacts of perinatal depression and anxiety on the mother and father/partner.

Impact domains and stakeholders.

Figure 1: Impact domains and stakeholders of PND.

Figure 2: Summary of key modelling parameters.

The impacts of factors influencing the cost of PND are included in Figure 2.

These costs were then modelled within the framework to quantify the impact on individual cost. The impact of costs is quantified and then estimated based on the prevalence, but not the incidence. There are no studies available to establish a link between PND and the impact is quantified and the associated impact is quantified and the associated impact is quantified. The modelled data is not available to estimate an impact.

Figure 3: Overview of the framework.

Impact domains include: health, economic and productivity and social/wellbeing.

Using existing cost studies and research, a cost framework has been conducted over a number of impact domains and stakeholders groups.

2. Approach to modelling...
Figure 3: PNDA cost framework

PNDA affects stakeholders across a number of impact domains.

2. Approach to modelling
<table>
<thead>
<tr>
<th>Child of parent with PND</th>
<th>1 year</th>
<th>3 years</th>
</tr>
</thead>
<tbody>
<tr>
<td>Economic</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Wellbeing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Health</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Parent with PND</th>
<th>1 year</th>
<th>3 years</th>
</tr>
</thead>
<tbody>
<tr>
<td>Economic</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Health</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Figure 4**: Modelling time period for individual cost elements. "PND4a affects stakeholders across a range of time periods."

2. **Approach to modelling**

- Economic
- Wellbeing
- Health

- Increased likelihood of family breakdown
- Increased risk of ADHD
- Increased risk of anxiety
- Increased risk of depression
- Increased likelihood of asthma/respiratory conditions
- Reduced immune system response
- Increased risk of low birth weight/premature birth
- Increased use of primary and community health services

- Presenteeism
- Absenteism
- Increased workforce exit
- Increased risk of substance abuse
- Increased risk of chronic diseases
- Increased use of hospitals

- Estimation of maximum quantifiable modelling period

Note: The table above shows the impact of PND on different domains such as economic, wellbeing, and health, across two time periods: 1 year and 3 years. The effects are quantified and present an estimation of the maximum measurable period.
Key Findings
Estimated impacts of PND&A on the first year alone total $877m, with additional lifetime costs.

Figure 6: Summary of costs associated with PND&A.

Key Findings

3. Key Findings
3. Key findings

The parent, child and wider family are all affected by PNDA

There are three stakeholder groups directly impacted by PNDA, as outlined in the figure below. In addition to these groups, each of these impacts also has flow-on effects to the wider economy, and wellbeing of wider Australia.

Figure 7 Summary of impacts PNDA by stakeholder group

Parents with PNDA not only face a lower overall quality of life and increased health system use, but are also impacted by PNDA in their personal and work lives. Impacts for parents with PNDA include:

- increased use of primary and community health services
- increased use of hospitals
- increased risk of chronic diseases
- increased risk of substance abuse
- increased workforce exit
- absenteeism
- presenteeism
- lower quality of life
- increased risk of suicide.

The wider family of a parent with PNDA, including partners without PNDA and other children are also impacted by an increased likelihood of family breakdown in addition to the increased likelihood that they will have to step up and fill a carer role.

Children of parents with PNDA are affected in both the short and long term, with a number of impacts including:

- increased risk of low birth weight/premature birth
- increased likelihood of childhood injury
- reduced immune system response
- increased likelihood of asthma/respiratory conditions
- increased likelihood of childhood trauma
- increased likelihood of neurodevelopmental issues
- increased risk of depression
- increased risk of anxiety
- increased risk of ADHD.

Whilst the health care costs of low birth weight, premature birth, reduced immune system response and asthma/respiratory conditions are captured in the first year costs of PNDA, the more significant impacts on children of parents with PNDA are not seen until later in life. These include reduced productivity and increased health system costs due to depression, anxiety and ADHD.
Children of parents with PND are estimated to cost society $157.5 billion in lifetime health care costs.

### Health Costs for Children of Parents with PND

<table>
<thead>
<tr>
<th>Cost Category</th>
<th>Year One</th>
<th>Year Two</th>
<th>Lifetime</th>
</tr>
</thead>
<tbody>
<tr>
<td>NA</td>
<td>$155m</td>
<td>$77m</td>
<td>$1.17Trn</td>
</tr>
<tr>
<td>NA</td>
<td>$10m</td>
<td>$20m</td>
<td>$200bn</td>
</tr>
<tr>
<td>NA</td>
<td>$8m</td>
<td>$16m</td>
<td>$160bn</td>
</tr>
<tr>
<td>NA</td>
<td>$67m</td>
<td>$77m</td>
<td>$770bn</td>
</tr>
</tbody>
</table>

### Health Costs for Parents with PND

<table>
<thead>
<tr>
<th>Cost Category</th>
<th>Year One</th>
<th>Year Two</th>
<th>Lifetime</th>
</tr>
</thead>
<tbody>
<tr>
<td>NA</td>
<td>$157.5m</td>
<td>$77m</td>
<td>$1.17Trn</td>
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<td>$10m</td>
<td>$20m</td>
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<tr>
<td>NA</td>
<td>$8m</td>
<td>$16m</td>
<td>$160bn</td>
</tr>
<tr>
<td>NA</td>
<td>$67m</td>
<td>$77m</td>
<td>$770bn</td>
</tr>
</tbody>
</table>

### Causes of Additional Costs
- Increased risk for substance abuse
- Increased risk for chronic disease
- Increased risk for hospital care

### Key Findings

Health care and well-being costs annually:
- Unpredictable childhood injury likely to result in increased overall costs of care and increased lifetime costs of care for children of parents with PND.
- Increased risk for substance abuse (alcohol and tobacco) resulting in increased lifetime costs of care for children of parents with PND.
- Increased risk for increased lifetime costs of care for children of parents with PND.
3. Key Findings

Economic impacts are greatest for the parent with PND&A and wider family.

- Reduced productivity and energy levels due to reduced productivity in the first year.
- Economic impacts include lower earnings and reduced productivity.
- Parents with PND&A face a reduced probability of employment, leading to lower income and reduced productivity.

Figure 10: Estimated costs for parents with PND&A.
Figure 12: Estimated lifetime wellbeing costs for children of parents with PND

There are significant lifetime wellbeing costs for the child and parent with PND.

Figure 13: Summary of all estimated costs by stakeholder.
3. Key Findings

That additional research would reduce

There are a number of limitations to this study.
Recommendations
4. Recommendations

PDNA is a complex and far-reaching issue that requires holistic prevention and treatment.

Despite the challenges of diagnosing and initiating the necessary treatment, still exist.

Programs and services should include a focus on supporting interventions and partnerships to address treatment and other community health needs of women and their families.

This information should be used to highlight the importance of identifying women who are at increased risk of PDNA and to tailor interventions according to their specific needs.

In the first episode of PDNA, the risk of occurrence was 6.5 times higher for those who have experienced previous episodes of PDNA. A study has found that the risk of PDNA is highest when the PDNA is experienced in the first trimester of pregnancy. Furthermore, the risk of occurrence is higher for those who have a previous history of mental illness.

The risk of experiencing PDNA is higher for those who have a history of mental illness, and those who have experienced previous episodes of PDNA. In the current episode of PDNA, the risk of occurrence was 5 times higher than the national average.
Life after becomes available.

Teaching PNDs should continue and be built upon as new data and research is gained in relation to the experiences of pregnant women and their newborns. Research in this area should be conducted on the needs of individuals, families, and communities that support them.

Further Research Opportunities Exist

Conditions in general, in particular, in the field of perinatal health, are complex and require a holistic approach. Encouragement to reduce the stigma around maternal health issues is needed. Support for all groups should be provided for ongoing support and further studies. These policies and recommendations for all levels should be developed and adopted. Additional research is needed to examine these factors. This research should be conducted in a way that promotes and encourages the use of perinatal health.

They could find a way to

Treatment

PNDAs is a complex and far-reaching issue that requires holistic prevention and treatment. With ongoing research and development, these approaches can be improved to better support pregnant women and their families.

4. Recommendations

Building community understanding.

An increased focus on awareness raising would assist in
References
5. References

Australian Population-Based Study


17. Eastwood et al. (2019), ‘The Impact of Perinatal Depression on Perinatal Outcomes in Australia: Women’s Health Matters.’


5. Eastwood et al. (2019), ‘The Impact of Perinatal Depression on Perinatal Outcomes in Australia: Women’s Health Matters.’


2. Eastwood et al. (2019), ‘The Impact of Perinatal Depression on Perinatal Outcomes in Australia: Women’s Health Matters.’

5. References

- Australian Government Department of Families, Housing, Community Services and Indigenous Affairs (2011). The costs of caring and the


- Zaborowski and Miller (1989). Stress and support as related to postpartum paternal mental health and perceptions of the infant.

- Yermolaev et al. (2016). Association between Maternal Postpartum Depression and Unintentional Injury Among 4-Month-Old Infants in