

beyondblue: the national depression initiative

Perinatal Mental Health Consortium

Perinatal Mental Health National Action Plan

2008-2010
Summary Document

September 2008



A large, stylized white butterfly graphic is centered on a light blue background. The butterfly is depicted in profile, facing right, with its wings spread. The wings have a soft, watercolor-like texture with subtle gradients and some darker blue shading to suggest depth and movement. The body is a simple white shape with two antennae extending upwards.

Please note that the costings in this report are preliminary only and subject to further scoping and analysis in the implementation of the Plan.



Table of Contents

Vision, Mission and Goal of the Plan.....	iv
Acknowledgments.....	iv
Abbreviations	v
Executive Summary.....	1
Table 1: Strategic Objective 1 - Training and workforce development.....	3
Table 2: Strategic Objective 2 - Universal routine psychosocial assessment.....	4
Table 3: Strategic Objective 3 - Pathways to care	5
Modelling the direct costs of implementation	6
Table 4: Option 1, Projected Total State/Territory Implementation Costs, \$M, 2007 prices, Years1-6.....	7
Table 5: Option 2, Projected Total State/Territory Implementation Costs, \$M, 2007 prices, Years1-6.....	7
Table 6: Recommended National Key Activities requiring Funding: Years 1-3	8
Table 7: Grand Total Costs, Australia: Years 1-6	8
Table 8: Projected Timeline of Key National and State/Territory Activities, Years 1-3.....	9



Vision, Mission and Goal of the Plan

The vision, mission and principles underpinning the Plan lay the foundation on which the strategic objectives and priority activities are built. They also highlight the key areas to be addressed to achieve long-term sustainability.

Vision	Optimal mental health and well being for all Australian mothers, infants fathers/partners and families in the perinatal period
Overall Mission	To develop for <i>beyondblue: the national depression initiative</i> a comprehensive National Action Plan to address perinatal mental health and wellbeing
Principles*	Principle 1: Equity of Access and Outcome Principle 2: Evidence based Principle 3: Family and Community Engagement Principle 4: Comprehensive approach Principle 5: Workforce and Service Integration

**Detailed principles can be found in the beyondblue National Action Plan for Perinatal Mental Health 2008-2010: Full Report*

Acknowledgments

The *beyondblue* team and the Perinatal Mental Health Consortium wish to thank St John of God Health Care as lead agency, the National Steering Committee, Working Parties and all of its stakeholders for their generous input into the development of this National Action Plan.

We acknowledge the foundation work that the NSW government provides through its investment in the Families NSW early intervention and prevention strategy aimed at giving children up to 8 a good start in life. Specifically the recent investment in NSW Health's 'Supporting Families Early' Package which includes the SAFE START model for prevention and early intervention in perinatal and infant mental health. The SAFE START model encompasses universal psychosocial assessment and depression screening for all women expecting or caring for an infant. SAFE START includes workforce training programs and the identification of integrated care pathways. This work builds on the model which was originally titled Integrated Perinatal and infant Care (IPC) and was developed in NSW from 1998 through Mental Health funding. SAFE START has been implemented throughout most of NSW over the past ten years and is currently being further implemented with attention to integrated care pathways for vulnerable families.

We similarly wish to acknowledge the very significant developments in perinatal mental health policy and clinical care in all States and Territories, in particular those developed in Western Australia, South Australia, and Victoria over the last ten years.

Appreciation is given for the time and effort provided by the Perinatal Mental Health Consortium members: Marie-Paule Austin, Anne Buist, Anne Sved-Williams, Barbara Wellesley, Bryanne Barnett, Helen Lindner, Jeannette Milgrom, Jenny Gamble, Jonathon Rampono, Leanne Wells, Nick Kowalenko and *the team*: Wendy Thiele, Kerry Lockhart, Nicole Reilly and Marie Simmons.



Abbreviations

AGPN	Australian General Practice Network
AHMAC	Australian Health Ministers Advisory Council
AIHW	Australian Institute of Health and Welfare
APS	Australian Psychological Society
ATAPS	Access to Allied Psychological Services
COAG	Council of Australian Governments
DoHA	Department of Health and Ageing
EDS/EPDS	Edinburgh Depression Scale
FaCSIA	Department of Families, Community Services and Indigenous Affairs
FaPMI	Families where a Parent has a Mental Illness
GP	General Practitioner
IPC	Integrated Perinatal Care (from June 2007 known as SAFE START)
MBS	Medicare Benefits Schedule
MHCA	Mental Health Council of Australia
NGO	Non-Government Organisation
NHMRC	National Health and Medical Research Council
NICE	National Institute of Clinical Excellence (United Kingdom)
NMDS	National Minimum Dataset
PANDA	Post and Antenatal Depression Association
PANDSI	Post and Antenatal Depression Support and Information, Inc
PMH	Perinatal Mental Health
PIMHIC	Perinatal and Infant Mental Health in the Community
PIRI	Parent and Infant Research Institute
PND	Postnatal depression
PNDSA	Postnatal Depression Support Association
PTC	Pathways to Care
RACGP	Royal Australian College of General Practitioners
RANZCOG	Royal Australian College of Obstetricians and Gynaecologists
SBO	State Based Organisation
SJoG	St John of God Health Care
The Plan	the <i>beyondblue</i> National Action Plan for Perinatal Mental Health



Executive Summary

Context

The importance of robust mental health in the perinatal period (pregnancy and the first postnatal year) for the mother, infant and partner/father and community has been championed in Australia by a number of advocates from the fields of Mental Health, Midwifery and Maternal Child and Family Health, General Practice and Allied Health community services. It was given significant impetus by the *beyondblue* Phase I National Postnatal Depression Program (2001-2005). The comprehensive work done at this time demonstrated the extent of maternal psychosocial morbidity in Australia, and the widespread acceptability of routine psychosocial assessment for both consumers and health professionals in the perinatal setting. The Phase I reports, and seminal documents such as the British NICE Antenatal and Postnatal Mental Health Guidelines (2007), the Canadian Reproductive Mental Health Guidelines (2003), the Australian National Agenda for Early Childhood (2007) and National Action Plan for Promotion, Prevention and Early Intervention for Mental Health (2000), have informed the development of Phase II - the *beyondblue* National Action Plan for Perinatal Mental Health (the Plan).

The implementation of this Plan, in keeping with the current Council of Australian Governments National Action Plan on Mental Health (2006-2011), requires a whole of government and whole of community approach. While the Plan has arisen from within the health sector, it interfaces with the consumer, carer and non-government sectors (particularly early childhood). The Plan is embedded within the need for broad community awareness, health promotion and education about perinatal mental health and wellbeing, its effect on the infant, father/partner and family, warranting a whole of family approach to care.

Scope of the problem

It is now well recognised that vulnerability to psychological distress and disorder is accentuated in the perinatal period not only for the mother, but also her infant, partner and family. Poor maternal mental health can significantly affect the emotional, social, physical and cognitive development of her child, and is associated with increased incidence of chronic disease. The perinatal phase is critical developmentally, both in terms of the attainment of parenting skills and secure parent infant attachment.

Scope of the Plan

The Plan provides a population health approach to improving the perinatal mental health (PMH) and well-being of women and their relationship with their infant. While the long-term goal is to also improve the mental health and wellbeing of infants, fathers/partners and families, the Plan does not provide recommendations to address their particular needs. Addressing issues for rural and remote communities and the respectful engagement of Aboriginal and Torres Strait Islander people and culturally and linguistically diverse communities remains an ongoing priority as the Plan progresses.

Plan overview (see Tables 1-3 for further details)

The Plan outlines the implementation of three strategic objectives:

- **Universal, routine psychosocial assessment** by primary health care professionals as part of mainstream perinatal care: addressing the skilled identification of both current distress and depressive symptoms *and a range* of demographic, psychological and social factors (including anxiety) known to affect perinatal mental health for both mother and infant. The assessment is **not** intended to *predict* postnatal depression or to *replace* clinical diagnosis by mental health professionals.
- The roll-out of **workforce training and development** to attain the core competencies required for adequate psychosocial assessment and early interventions: a quality workforce that is trained, skilled and well supported is fundamental to achieving this Plan. Training simultaneously targeting those who will undertake assessment and those who will provide intervention and care for the mother, for the whole family including the infant, requires a range of programs varying in length, level of knowledge and skill, delivered in environments promoting collaborative, coordinated care.
- The **identification of quality local pathways to care** underpinning the implementation of universal psychosocial assessment: to address the care and intervention needs of women identified as being at risk, experiencing mild or moderate difficulties, through to women experiencing complex and or severe mental illness. The wide range of services and sectors required involves developing a system of care that is effectively networked, collaborative and responsive to the whole family.



Underpinning these objectives is a consultation and communication strategy that engages partners/fathers, the Australian community and key stakeholders, to understand and respond to women's mental health needs and those of infants in the perinatal period.

The Plan identifies a number of key activities, supported by a National governance structure, to be undertaken in the first three years of implementation for full roll-out and evaluation:

- 1) Communication and consultation strategies targeting key stakeholders and the community
- 2) Detailed mapping of existing services at jurisdictional level
- 3) Development and endorsement of National PMH Guidelines
- 4) Establishment of a National PMH database for evaluation and benchmarking
- 5) Development and endorsement of an Aboriginal and Torres Strait Islander PMH Plan
- 6) Development of training and clinician packages
- 7) Commencement of Plan implementation aiming at long-term sustainability across Australia

Resources and Implementation

While the primary health care workforce (General Practice, Maternity and the Early Childhood Services) is the key vehicle for universal, routine psychosocial assessment, the Plan will only be viable if the mental health care sector provides the necessary access to secondary and tertiary services as well as ongoing supervision and support. The challenge for implementation is that while there is recognition of PMH as an emerging priority within mental health, this recognition is not as developed within Maternity and the Early Childhood sectors. The Plan is a unique opportunity for the mental health and primary health care sectors to jointly support an initiative that has the potential to deliver outcomes in terms of prevention, early intervention and health promotion from the earliest phase of the life cycle. To achieve this outcome will require a degree of re-orientation from both sectors, and better interfacing between the two. The recent introduction of the Better Access to Mental Health Care Medicare items will facilitate this process in terms of provision of mental health pathways for the perinatal population, most of who are, and will continue to be, managed in the community. Implicit in this process is the degree to which privately funded systems embrace the Plan and the maintenance of collaborative partnerships and practices that are a critical influence for sustained change.

Current status of Perinatal Mental Health in Australia

In addition to the Plan, our PMH Consortium was charged with the compilation of a National Perinatal Mental Health stocktake examining each aspect of the Plan. The stocktake revealed some examples of high quality perinatal mental health service provision, evidence of implementation of routine psychosocial assessment plus adequate workforce training packages in a number of centres in urban Australia (and occasionally rural Australia). There was acceptance of the value of routine perinatal psychosocial assessment of some form **as long as adequate pathways to care and training were available**. Great variation was identified between the antenatal and postnatal settings, and across jurisdictions, with pathways to care not always adequate or well integrated. Not surprisingly, the biggest gaps identified were the lack of services and available workforce in remote and rural settings and Aboriginal and Torres Strait Islander communities. At this stage the population coverage of current services is not known.

Through extensive engagement of many of its key stakeholders, the Plan delivers a broad mapping of current PMH activity in Australia, and identifies resources and structures (both at policy and operational level) required to implement universal, psychosocial assessment, training and workforce development, and pathways to care perinatally.

Concluding Statement

Poor mental health in the perinatal period is not only a significant issue for parents and infants but is also associated with a large financial burden for the Nation. The perinatal period offers us a unique window of opportunity for promotion, prevention and early intervention in mental health, enabled by the routine contact all women in Australia have with primary health care services at this time. While successful intervention strategies and assessment tools exist, there **is currently a gap** within existing systems in the coverage of training, assessment and pathways to care. This Plan addresses these critical links. We acknowledge that all jurisdictions are sensitised to the needs of PMH and that many are developing policies to reflect this. **The time is therefore right for National Action towards effective early intervention, and the PMH plan provides such a stimulus.**



Table 1: Strategic Objective 1 –Training and workforce development

Strategic Objective: To identify and develop a quality framework for workforce training and development to address perinatal mental health care

Strategies	Strategic Activities	Timeline	Responsibilities
1.1 Develop National Guidelines for training and workforce development	<p>1.1 Finalise and endorse National Guidelines on perinatal mental health training and workforce development based on existing and/or Guidelines in development eg the Australian Qualification Framework</p> <ul style="list-style-type: none"> Identify, map and enhance core competencies for all providers (<i>refer: Strategic Objectives 2: Assessment & 3: Pathways to Care</i>) Finalise national standards for accreditation of workforce training, postgraduate and undergraduate programs Negotiate inclusion of recommended core competencies with relevant accrediting bodies eg professional, academic and regulatory accrediting bodies 	Years 1-2	DoHA , NHMRC AHMAC, FaCSIA <i>beyondblue</i> implementation team
<p>1.2 Plan for and implement quality training and workforce activities to attract and retain qualified, skilled and experienced workforce in perinatal mental health</p> <p>1.2.1 Workforce Development</p> <p>1.2.2 Professional Development</p> <p>1.2.3 Organisational and practice change</p>	<p>1.2.1 Workforce Development</p> <ul style="list-style-type: none"> Finalise and implement a structure to support workforce training and development programs that are multidisciplinary and multiagency in nature (<i>refer: Strategic Objective 2</i>) Identify and implement a full range of educational initiatives for the current workforce to ensure a skilled and competent workforce eg. appropriate certification for training programs Build the capacity of local services and the current workforce to universally and routinely assess and manage perinatal mental health and wellbeing that has a whole of family approach 	Year 1- ongoing These activities will begin in Year 1 and will be an ongoing process	Responsible partners for implementation of training and workforce development: <ul style="list-style-type: none"> <i>beyondblue</i> implementation team State/Territory Health Departments Regional Health and community Services Local Perinatal Mental Health (PMH) advisory committee with coordinating capacity AGPN &SBO's RACGP Better Outcomes Standards Collaboration RANZCOG APS NGO sector Private sector Health Insurers
	<p>1.2.2 Professional Development</p> <ul style="list-style-type: none"> To identify existing and implement a range of incentives for perinatal mental health competence, that is whole of family inclusive, across all sectors eg. professional accreditation, organisational accreditation, graduate diplomas and programs 		
	<p>1.2.3 Organisational and Practice Change</p> <ul style="list-style-type: none"> Addressing organisational and managerial competencies for support, supervision, staff training Identify and endorse core principles of effective service design and delivery Recommend Key Performance Indicators (KPIs) to be included in senior employment contracts and service agreements 		
<p>1.3 Endorse and implement recommended key components required for accredited core curriculum for:</p> <p>1.3.1 Current Workforce</p> <p>1.3.2 Postgraduate and Undergraduate courses where perinatal mental health would appropriately be taught</p>	<p>1.3.1 Current Workforce</p> <ul style="list-style-type: none"> Endorse and disseminate provisional recommended core components of course curricula to assist with mapping against existing workforce training programs until national guidelines are available 	Year 1- ongoing These activities will begin in Year 1 and will be an ongoing process	<i>beyondblue</i> Implementation team
	<p>1.3.2 Postgraduate & Undergraduate Courses</p> <ul style="list-style-type: none"> Identify programs at baseline, intermediate and complex levels of knowledge and skill (program levels 1, 2, 3) and map against provisional recommended course curricula that is inclusive of cultural considerations and competencies (social, cultural and linguistic) 		
<p>Resources: Provision of necessary resources requiring dedicated perinatal mental health funding will be dependant on the degree to which governments, the private sector and non-government organisations take up the recommendations of the Plan. The commitment and support of local management teams will also be required. Existing infrastructures may be utilised to incorporate the Plan's recommendations, and existing relevant resources may be drawn up on. Responsibility for activities outlined above will be dependent on the degree of coordinating capacity within the perinatal mental health workforce. Coordination and quality monitoring for roll out of training programs nationally and development and distribution of clinical and training resources is recommended.</p>			



Table 2: Strategic Objective 2 - Universal routine psychosocial assessment

Strategic Objective: To develop a quality framework for universal implementation of routine psychosocial assessment.

Strategies	Key priority activities	Timeline	Responsibility
2.1 Endorse National Guidelines for psychosocial assessment	2.1.1 Finalise and endorse National Guidelines for routine psychosocial assessment in the perinatal period <ul style="list-style-type: none"> • Build upon and enhance existing Perinatal Mental Health guidelines developed both within Australia and internationally • Adapt National Guidelines to meet jurisdictional needs and infrastructure for implementation of routine psychosocial assessment • Review jurisdictional plans for routine psychosocial assessment to ensure they address the National Guidelines to meet a range of population groups 	Years 1-2	DoHA , NHMRC, AHMAC, FaCSIA, the <i>beyondblue</i> implementation team
2.2 Plan for, and implement, routine psychosocial assessment across Area/regional Health and community Services	2.2.1 Establish local Perinatal Mental Health advisory committees of key stakeholders to advise on and manage implementation in public and private settings. These committees will: <ul style="list-style-type: none"> • Identify existing Area/regional Health and community networks and service structures relevant to implementation of routine psychosocial assessment • Provide evidence of strategies to reduce identified barriers to implementation • Establish and maintain links with current national and State/Territory initiatives • Monitor and evaluate the implementation of area/ regional plans; utilise evaluations to enhance current practice 	Year 1 - ongoing These activities will begin in Year 1 and will be an ongoing process	State/Territory Government Depts, Area/regional Health and community Services
	2.2.2 Identify and support the development of appropriate assessment procedures for specific groups, where this has not yet occurred (including father/partner-focused initiatives)		Local Perinatal Mental Health advisory committee with coordinating capacity
2.3 Build infrastructures to support implementation of routine psychosocial assessment	2.3.1 Workforce infrastructure <ul style="list-style-type: none"> • Establish adequate coordinating capacity within management and the workforce in public and private settings • Induct a skilled workforce to undertake routine psychosocial assessment (<i>Refer: Strategic Objective 1</i>) • Where required, allocate human resources to support implementation, including clinical practice and administration tasks 		Responsible partners for implementation will involve: <ul style="list-style-type: none"> • State/Territory Health Departments • AGPN • Private hospitals • Area/regional Health and community Services • Local Perinatal Mental Health advisory committee with coordinating capacity
	2.3.2 Information and referral system infrastructure <ul style="list-style-type: none"> • Finalise and endorse clear assessment, management and referral protocols for the local setting, based on level of need, resources and service structure • Endorse and implement information management systems to ensure reciprocal flow of information across the continuum of care, e.g. psychosocial care plans (<i>see Strategic Objective 3</i>) • Review information pathways across the continuum of care, in line with increases in implementation activity 		
	2.3.3 National data collection <ul style="list-style-type: none"> • Establish partnerships with leading research centres and develop strategies for the inclusion of psychosocial assessment items in national data collections 		
	Resources: Provision of necessary resources requiring dedicated perinatal mental health funding will be dependant on the degree to which governments, the private sector and non-government organisations take up the recommendations of the Plan. The commitment and support of local management teams will also be required. Existing infrastructures may be utilised to incorporate the Plan's recommendations, and existing relevant resources may be drawn upon. Responsibility for Activities 2.2.1 to 2.3.2 will be dependent on the degree of coordinating capacity within the perinatal mental health workforce.		



Table 3: Strategic Objective 3 - Pathways to care

Strategic Objective: To identify and develop a framework for and recommend activities that supports the establishment or enhancement of quality pathways to care

Strategies	Activities	Timeline	Responsibility
3.1 Develop and endorse National Guidelines for service delivery of quality perinatal mental health pathways to care	3.1 Finalise and endorse National guidelines for service delivery across the spectrum of care and severity based on existing and/or Guidelines in development <ul style="list-style-type: none"> Identify and endorse key components of quality pathways to care 	Years 1-2	DoHA NHMRC, FaCSIA AHMAC <i>Beyondblue</i> implementation team
3.2 Identify and develop infrastructure and resources required to establish sustainable local pathways to care	3.2.1 Endorse and disseminate recommendations for core components of quality pathways to care that are informed by consumer preferences for care and recovery <ul style="list-style-type: none"> Establish networking and protocols (<i>refer: 2.2.1</i>) Provide evidence of strategies to reduce identified barriers to quality pathways to care 	Year 1	Responsible partners for implementation of quality pathways to care: <i>beyondblue</i> implementation team FaCSIA DoHA AHMAC Individual Jurisdictions <ul style="list-style-type: none"> State/Territory Health Departments delete bullets? Regional Health and community Services Local Perinatal Mental Health advisory committee with coordinating capacity <ul style="list-style-type: none"> AGPN APS NGO sector Private sector
	3.2.2 Map existing local pathways to care across sectors for each jurisdiction	Year 1	
	3.2.3 Establish and implement processes to benchmark local pathways against National Guidelines	Years 1-3	
	3.2.4 Endorse monitoring and evaluation processes for staged implementation of quality pathways to care at local, State and National levels <ul style="list-style-type: none"> Support development and endorsement of jurisdictional plans and frameworks Support infrastructure development and organisational re-design for a range of settings 	Year 1- ongoing These activities will begin in Year 1 and will be an ongoing process (deleted transition phase ref)	
3.3 Identify consumer and carer preferences for care and recovery to inform the establishment and enhancement of pathways to care	3.3.1 Establish and support collaborative partnerships between service providers and consumer-led support services	Year 1- ongoing These activities will begin in Year 1- and will be an ongoing process	DoHA Consumer-led services eg <i>bluevoices</i> PANDA, PNDSA, PANDSI Local jurisdictions MHCA NGOs Private sector
	3.3.2 Identify and develop strategies to assist mothers, infants, fathers/ partners and families to access and participate in care <ul style="list-style-type: none"> Develop processes for consultation and advice from consumers and consumer-led self help, support and advocacy organisations Develop processes for monitoring and audit of progress on implementation of plans 		
Resources: Provision of necessary resources requiring dedicated perinatal mental health funding will be dependant on the degree to which governments, the private sector and non-government organisations take up the recommendations of the Plan. The commitment and support of local management teams will also be required. Existing infrastructures and relevant resources may be utilised to incorporate the Plan's recommendations. Responsibility for Activities 3.2.1 to 3.2.4 will be dependent on the degree of coordinating capacity within the perinatal mental health workforce. In addition, the development of clinical resources, tools, and print and electronic media resources (for example a perinatal website) will be required.			



Modelling the direct costs of implementation

Accommodating costs within existing contributions¹

The approach to modelling the direct costs of the Plan addresses the major resource implications required to deliver a national program of **universal routine psychosocial assessment and associated workforce training**. It is important to acknowledge however that in some settings, these needs are being met within existing initiatives and funding contributions at both National and State/Territory level.

Tables 4 and 5 outline program costs based on two scenarios of staged implementation over a six-year business horizon: Option 1 (preferred) assumes a gradual rate of program uptake (target workforce to be trained by Year 5 and a more considered rate of program coverage; Option 2 assumes a more rapid rate of program uptake (target workforce to be trained by Year 3 and a more accelerated rate of program coverage). The projected cost range of \$82M-95M² represents the ideal and **assumes the absence of current funding initiatives**. Hence, *this estimate of costs should not be viewed as the predetermined costs of implementing these components of the Plan*. The potential for cost savings by governments where exiting initiatives are already in place may be significant. *Detailed state-based mapping* provides jurisdictions a strategic method to make recommendations on the implications of costed models for local sustainability by identifying existing local resources, service gaps, and areas to be supplemented.

beyondblue: the national depression initiative is committed to establishing an equitable and sustainable national program for routine psychosocial assessment that incorporates training for health professionals. However, the process of full national implementation, including the provision of robust pathways to care, is likely to extend beyond *beyondblue's* second term to 2010. **The long-term and sustainable success of the Plan requires investment and continuing effort by the private sector, the Commonwealth and all State/Territory governments - across Mental Health, Maternity and Early Childhood sectors.**

What has been costed?

In keeping with the requirement to accommodate the Plan within existing structures and services, the target providers of routine assessment in the current costing model are Midwives, Maternal, Child and Family Health services, Allied Health professionals and General Practitioners. It is thus acknowledged that the current model **does not include**:

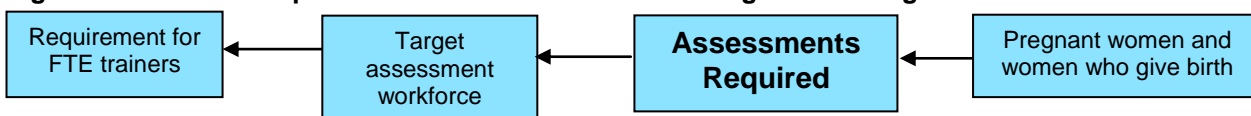
- costs associated with routine assessment and training in additional service areas (including those based in non-government and consumer-led settings)
- the direct costs of establishing (where necessary) and sustaining recommended primary, secondary and tertiary pathways to care

These cost estimates will require separate attention during the implementation phase.

Methodology

The fundamental driver of the model is the number of women that are projected to fall pregnant, which in turn drives the requirement for antenatal and postnatal assessments (see Figure 1 below)³.

Figure 1: Schematic representation of assessment and targeted training model



In the absence of an extensive series of local data sets detailing local payrolls, practice and current level of activity, the model projects program costs by utilising broad, high level national assumptions about the character of the assessment and training workforce, and draws upon the knowledge and experience of those working in settings where perinatal mental health initiatives have been successfully sustained⁴.

Costs of implementing the program will vary between locations and with respect to different groups of clientele. Thus, assessment costs are weighted more heavily relative to the general population for Aboriginal and Torres Strait Islander and culturally and linguistically diverse pregnancies and births. Allowance is also made for differences in client mix between jurisdictions.

¹ Projected State/Territory Implementation Costs outlined in this report incorporate changes suggested by the NSC 29 August 2007. These amendments include 1) inflated projected births numbers (using Series A: Population Projections, Australia 2004—2101, ABS cat. no. 3222.0); 2) specific inclusion of selected Allied Health professionals in the target training and assessment workforce; and 3) increased rate of appointment of Local PMH Coordinators. As such, projected costs are greater than those presented in the Draft report (August 2007).

² Costs expressed as constant net present values (NPV) at discount rate of 3%

³ The term 'full time equivalent' (FTE) covers all dimensions of the workforce, including full time permanent or casual personnel as well as fractional and backfill appointments.

⁴ A summary of key assumptions is provided in Appendix 4.2 of the National Action Plan for Perinatal Mental Health 2008-2010: Full Report



Table 4: Option 1⁵, Projected Total⁶ State/Territory Implementation Costs, \$M, 2007 prices, Years1-6

State/Territory	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	TOTAL COSTS ⁷ Years 1-6 ^{8,9}	
							NPV, 0%	NPV, 3%
ACT	0.2	0.3	0.4	0.5	0.5	0.4	2.2	2.0
Northern Territory	0.3	0.3	0.4	0.5	0.5	0.5	2.5	2.2
Tasmania	0.2	0.3	0.5	0.6	0.6	0.5	2.7	2.4
Western Australia	0.5	1.0	1.7	2.1	2.2	2.0	9.6	8.5
South Australia	0.5	0.8	1.2	1.5	1.5	1.3	6.7	6.0
Queensland	0.8	1.7	3.2	4.0	4.2	3.8	17.6	15.6
Victoria	0.9	2.2	3.9	5.0	5.0	4.4	21.4	19.0
New South Wales	1.2	3.0	5.4	6.9	7.0	6.2	29.7	26.3
TOTAL Australia	4.6	9.6	16.8	21.0	21.5	19.1	92.5	82.0

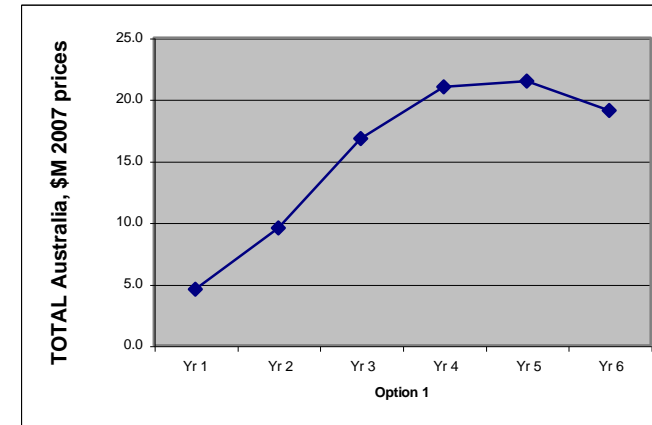
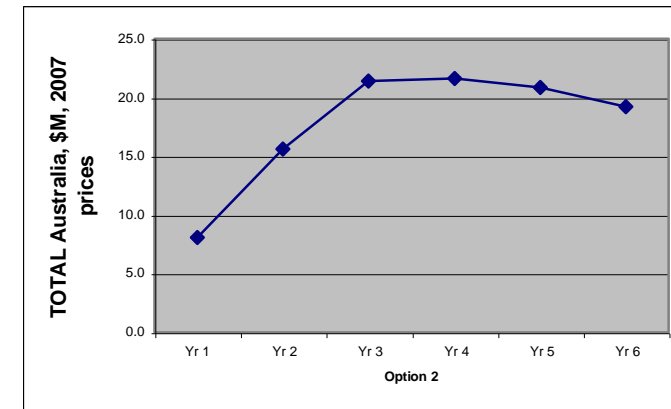


Table 5: Option 2¹⁰, Projected Total State/Territory Implementation Costs, \$M, 2007 prices, Years1-6

State/Territory	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	TOTAL COSTS Years 1-6	
							NPV, 0%	NPV, 3%
ACT	0.2	0.3	0.5	0.4	0.4	0.4	2.2	2.0
Northern Territory	0.3	0.3	0.3	0.4	0.5	0.4	2.3	2.1
Tasmania	0.3	0.5	0.6	0.6	0.6	0.5	3.0	2.7
Western Australia	0.8	1.5	2.0	2.2	2.2	2.0	10.8	9.7
South Australia	0.7	1.2	1.5	1.5	1.5	1.3	7.6	6.8
Queensland	1.4	2.7	3.9	4.1	4.0	3.8	19.9	17.8
Victoria	1.8	3.9	5.1	5.1	4.8	4.4	25.0	22.4
New South Wales	2.7	5.2	7.3	7.2	6.9	6.4	35.7	31.9
TOTAL Australia	8.1	15.6	21.4	21.6	20.8	19.2	106.7	95.4



⁵ Option 1 assumes a more gradual rate of program uptake, ie target workforce to be trained by Year 5; considered rate of program coverage

⁶ Total State/Territory costs *include*: 1. Set-up, establishment and maintenance costs including eg. external consultancy costs (eg Train-the-Trainers, mapping); salary and travel costs for State/Territory staff; printing of materials, and evaluation; 2. Local coordinating capacity; 3. Assessment costs (weighted unit labour cost of assessors); 4. Workforce training costs (including weighted unit labour cost of trainers (baseline, CPD); trainer travel costs; GP attendance at training)

It was outside the scope of the current model to project national costs for eg recruitment, venue hire, and local communications. Hence these expenses are excluded in the Total State/Territory costs outlined above.

⁷ Costs are expressed as constant net present values (NPV) at varying rates of discount (0%, 3%)

⁸ See Appendix 4.1 of the National Action Plan for Perinatal Mental Health 2008-2010: Full Report for a more detailed summary of National Total set-up and establishment, coordination, assessment, and training costs, including metro vs non-metro costs

⁹ Figures may not add due to rounding

¹⁰ Option 2 assumes a more rapid rate of program uptake, ie target workforce to be trained by Year 3; accelerated rate of program coverage



Table 6: Recommended National Key Activities requiring Funding: Years 1-3

A summary of recommended key national activities that will need to be undertaken in the first three years of the implementation phase to provide a secure foundation for the full rollout and evaluation of the Plan is provided in Table 6 below. These costs are in addition to overall State /Territory costs outlined above. A summary of TOTAL NATIONAL COSTS for key national activities and State/Territory set-up and implementation is provided in Table 7

Task	Estimated required funding Years 1-3	Potential partners
Roundtable: in early Year 1, a roundtable for senior policy makers across jurisdictions will be held to seek commitment to the Plan and to discuss strategies to build upon existing policies and frameworks	\$42K	<ul style="list-style-type: none"> ▪ DoHA ▪ FaCSIA ▪ <i>Beyondblue</i> ▪ NHMRC ▪ Rural Health Education Foundation ▪ Research grants eg. Rotary
Development and endorsement of National PMH Guidelines: in Year 1-2 will help achieve a coordinated, consistent and high quality level of care for mothers, infants and families at this significant developmental stage	\$500K	
Development of Aboriginal and Torres Strait Islander PMH NAP: A Plan that specifically addresses the mental health and wellbeing needs of Aboriginal and Torres Strait Islander women in the perinatal period must be a national priority.	\$300K	
Enhancement and development of training packages (Train-the-Trainer, Baseline and Advanced, e-learning, with review and refinement Year 3): training programs will build on existing PMH packages and will provide for different levels of knowledge and skill	\$410K	
National Governance & Organisational Structure (incl travel): to help ensure successful and sustainable implementation at a national level	\$2970K (\$4455K)¹¹	
Consortium / NSC activities: to provide expert opinion from a range of fields	\$510K	
National psychosocial assessment data collection: NMDS items would provide: epidemiological information relating to routine psychosocial assessment; a simple means of summarising national uptake of implementation; information for national and international comparison.	\$500K	
Total:	\$5.2M (\$6.7M)	

Table 7: Grand Total Costs, Australia: Years 1-6

	Yr 1	Yr 2	Yr 3	Yr 4	Yr 5	Yr 6	TOTAL COSTS Years 1-6	
							NPV, 0%	NPV, 3%
Option 1: TOTAL Australia: State/Territory set-up and implementation costs (see Table 4)	4.6	9.6	16.8	21.0	21.5	19.1	92.5	82.0
TOTAL key national activity costs (see Table 6)	2.0	1.9	1.3	-	-	-	5.2	4.9
Option 1: GRAND TOTAL							97.7	86.9
Option 2: TOTAL Australia: State/Territory set-up and implementation costs (see Table 5)	8.1	15.6	21.4	21.6	20.8	19.2	106.7	95.4
TOTAL key national activity costs (see Table 6)	2.5	2.4	1.7	-	-	-	6.7	6.3
Option 2: GRAND TOTAL							113.4	101.7

¹¹ National governance and organisational structure costs will increase by 50% in Option 2, due to increased staffing requirements

