

TRANSCRIPT

FAMILY AND COMMUNITY DEVELOPMENT COMMITTEE

Inquiry into perinatal services

Melbourne — 16 October 2017

Members

Mr Paul Edbrooke — Chair

Ms Cindy McLeish — Deputy Chair

Ms Roma Britnell

Dr Rachel Carling-Jenkins

Ms Chris Couzens

Ms Maree Edwards

Mr Bernie Finn

Witness

Ms Terri Smith, CEO, Perinatal Anxiety and Depression Australia.

The CHAIR — I welcome to these public hearings Ms Terri Smith, CEO of Perinatal Anxiety and Depression Australia, otherwise known as PANDA. Thank you for attending here today. We appreciate your time. All evidence at this hearing taken by the committee is protected by parliamentary privilege as provided by the Constitution Act 1975 and is subject to the provisions of the Parliamentary Committees Act 2003 and other relevant legislation. Any comments you make outside the hearing will not be afforded such privilege. It is also a contempt of Parliament to provide false evidence. These proceedings will be recorded, and you will be sent a proof copy of the transcript. Again, welcome. I would just invite you to make a 10 to 15-minute statement to start with, and then we will follow up with some questions if that is okay.

Ms SMITH — Of course. Thank you very much for the opportunity to be here today. Just to start very briefly by telling you a little bit about PANDA, PANDA is a not-for-profit organisation that was established 30 years ago here in Victoria by women around a kitchen table who had had an experience of perinatal depression who felt like it really could be managed better. Their commitment we acknowledge through the service that we provide today, although it is a very different service to the one they imagined. As a consumer organisation we draw extensively on peer support as a model, and we are driven by that lived experience of perinatal mental health. We feel a real responsibility to pass on what we know, so it is great to have an opportunity to be here today at the other end of the service delivery spectrum, coming in and hearing about the acute services that are so important. I guess if there is a message from me today, I really want to say there is a lot of work we can do before birth that we are not currently doing in all cases.

We have a unique expertise at PANDA given the focus of the work we do. We do now have funding to provide a national helpline. We have been providing that service for seven years. It is quite a unique position we sit in. Across the country we manage around 10 000 conversations a year with families experiencing perinatal depression or anxiety, and around about 5000 of those calls are actually from Victoria, largely due to extensive funding support we have received from the Victorian government. We have been funded through various programs and the Victorian government for about 20 years now. I think we have been able to do some terrific work that has not been replicated in other states, but I will be flagging that there are still some gaps in service provision.

You know a lot about perinatal mental illness. The thing I really want to tell you about it is that because it is a complex illness there is a lot of misunderstanding in the community or in fact a lack of information in the community, because we are talking about antenatal and postnatal, we are talking about depression and anxiety and in fact postpartum psychosis — roughly one in 500 birthing mums will experience that very, very severe illness. We are also talking about women and about men. I am going to focus my conversation today around women's experience, but I will touch on dads just at the end.

Early identification is something that is really so crucial for us to talk about, and managing best practice in this illness begins with early identification. We can deal with it at the extreme end in the acute setting, but it is a much better idea to be able to identify it very quickly and avoid escalation of the illness. In simple terms, very often new parents do not understand what is happening to them, and if you do not understand what is happening right now, it is very difficult to get help, particularly at this time. It is an extraordinary time of transition, so what is normal is really difficult to measure. We know the perinatal period is the period in a woman's life when she is most likely to have her first episode of mental illness. Understand that the thing we hear day in and day out through PANDA's helpline is, 'I was blindsided. I just didn't know what was happening', so you cannot get help. For us there is a message that says, 'Let's get in early'. I do not think I need to tell you about the benefits of early intervention, not just for the benefit of those families but at a cost level. It makes much more sense to be intervening early.

I want to remind you that this illness really does not discriminate. It will be important for us to talk about social risk factors, because they all play a role as well, but in fact I swear there is no profession that we have not spoken to on our helpline, and I include obstetricians in that, I include maternal and child health nurses, I include those professional women who say, 'You'd think I would have known'. It is a very, very difficult illness to understand and to come to terms with, not least of all because there is an enormous shame and stigma still attached to it.

Regarding the lack of awareness in the community, expecting and new parents regularly do not know about perinatal mental illness as something that exists in the community, and they certainly do not understand the incidence — the high chance that as a parent they will experience that illness. For me that suggests two failures

in the system. One is that we have failed to educate the community broadly about this illness so that they can understand it and can deal with it up-front, just as you would any other health issue. But probably the key failure — because I think this is the answer to how we can best address it — is the failure of perinatal health professionals to share this information with expecting and new parents, and I say that with enormous respect and regard for perinatal mental health professionals, who are doing an amazing job right across the community, but they do have a great opportunity to make sure that parents know about this illness and can look out for the illness.

From our helpline data, so the national helpline we run, we know that 53 per cent of callers to our service have had symptoms for more than four weeks. Basically symptoms of two weeks is when you know it is time to get help, so we are talking at least double that period for 53 per cent, but more importantly 25 per cent of our callers have actually had symptoms for six months or more, and in some cases that is more than one year. This is before they have called our service.

The question for us every day is, ‘Gosh, most women having a baby are in regular contact from the first point in their pregnancy, very early in their pregnancy, so how do they get this far down the track without actually getting help?’. We know there are two key reasons for that. The first is that they simply do not understand what is happening to them. I will go back to my earlier point about how this is an extraordinary transition — probably the most extraordinary transition people make in life. So very commonly what we hear is, ‘Oh, it’s not what I thought it would be, but I just assumed this is it — I thought this is what I had to have’. We know that that is not the case — we know that it is actually a very recoverable illness — so for us that priority to focus on early intervention is so crucial.

PANDA undertook some community research last year with some support from Priceline. We have a terrific partnership with Priceline. We are very fortunate to have that relationship. They fund a range of projects for us that we are not able to undertake. They supported us with some broad community research that is as yet unpublished but hopefully will be quite soon. We used that opportunity to replicate and expand on some work Beyondblue had undertaken in 2009, obviously with their permission.

We wanted to look at how the community understood perinatal mental illness in that time. We asked about key health conditions after the birth of a baby. People readily identified depression in fact, so there is a really good news point about awareness of postnatal depression — 52 per cent. That is great recognition that says there is an awareness and people are thinking about keeping an eye out. Anxiety was not mentioned at all in that time, so you are going to hear me say today that anxiety is an area we simply have to do a lot more work around helping the community understand that anxiety is a very serious health condition, both during pregnancy and after.

When we asked about key health issues during the antenatal period, so during pregnancy, only 5 per cent in total could come up with, depression and anxiety. So, really, the broad community are not talking about anxiety at all, whether it is during the pregnancy or after the birth of the baby. It is not on the agenda. The problem with that is that the symptoms are so different to depression, so we will often have callers saying, ‘Well, I knew something was wrong, but I clearly wasn’t depressed because I was having palpitations. I just had a heightened mood, not the depressed mood that we commonly talk about’.

I will move on to talk a bit about the attitudes of primary health care and some midwives, GPs, maternal child health nurses who all have such a crucial role to play in the system. They have an opportunity to educate, to screen and to assist women who are at risk of perinatal mental illness, which in effect is every parent, but we can also identify a group who are much more at risk. Having an earlier experience of depression or anxiety is a key risk factor. There is some work being done here, but there is significant room for improvement.

I want to share some data again from PANDA’s helpline from the last financial year. Eighty-four per cent of callers from Victoria had not told their midwife or maternal child health nurse about their feelings or symptoms of perinatal depression or anxiety. That is 84 per cent. We were fairly shocked by that figure. We are dealing with this issue all the time, but we were actually really shocked when we pulled that data. It is a very concerning figure. I can tell you that if we look at the figures nationally, it is worse — it is 87 per cent — so Victoria has actually made some inroads in that area. But it is still really concerning that 84 per cent of Victorian new mums or expecting mums have not told their primary health providers.

That leads to some comments about screening for perinatal anxiety and depression. We have had screening in place for some time. I know you have heard other presenters talk about the importance of screening, and

screening is absolutely crucial, but we know that in spite of the guidelines screening is not universally undertaken for starters. Sometimes what happens with screening is that the health professionals start it, but they actually fade off by the time you get to the pointy questions, which are at the end because they think, ‘Mum looks okay’. In the Edinburgh score the pointy questions at the bottom are, ‘Have you thought about hurting your child?’, ‘Have you thought about hurting yourself?’. It is not uncommon for professionals to think, ‘No, you’re looking fine, you’re doing okay, you’ve answered the other questions well, we’ll close that off’.

You have heard, I know, about electronic screening and the opportunities to use a different tool. We think that is a great step forward, but it is not the answer in itself, because what button you press might not be what you are feeling, so there is an important message there about the skill of the health workforce. We think that the midwives out there, the maternal child health nurses out there, are all there to do a great job. They are good people, mostly women, getting on every day dealing with a busy life and a busy job, but they are not always doing the best work they can do because of, in our view, a lack of skill around having conversations around mental illness and perhaps making some judgements around things that might not be quite true up-front.

I do just want to take a moment to say that because we work nationally we do have a picture across the country, and I absolutely want to say that services in Victoria, while we can see lots of room for improvement, have been well supported. Perinatal mental health services are doing better in Victoria than across the rest of the country. We have a pretty unique picture as an organisation. Certainly at PANDA we have benefited from that funding. We did absolutely notice the impact of the withdrawal of the NPDI funds, and we welcome the recent return to some of those services as well as the increase. We are really looking forward to seeing those new services rolling out in this financial year. So I would congratulate Victoria as a state for having taken some really considerable steps and making a vital commitment to perinatal mental illness, but having said that I am still going to argue that there is still some way to go.

The CHAIR — Terri, are you happy to take some questions at this point?

Ms SMITH — Yes, absolutely.

The CHAIR — Just from myself, a couple of quick ones: what is the breakdown of PANDA’s funding?

Ms SMITH — That is an excellent question. Let me see. I guess around —

The CHAIR — Just off the top of your head.

Ms SMITH — Roughly 60 per cent federal funding, 30 per cent state funding — in Victoria — there is a bit of PHN money that we have picked up from South Australia, and then the rest of it is our fundraising.

The CHAIR — How does PANDA evaluate the services you provide?

Ms SMITH — We have an evaluation tool built into any of the services we provide, but for the national helpline in particular, we have had a substantial external evaluation. That was undertaken by the Judith Lumley Centre, a midwife-driven research unit here in Victoria. We have consumer feedback built into all activities; in fact at each contact there is an opportunity for consumer feedback. That information is evaluated internally. We do not have resources for evaluation beyond that, but we certainly have a focus on consumer feedback.

Ms EDWARDS — Thanks, Terri. It is a great organisation.

Ms SMITH — Thank you.

Ms EDWARDS — I was with some of your colleagues yesterday for our walk in Bendigo, the memory walk. It was really nice.

Ms SMITH — Yes. Beautiful.

Ms EDWARDS — Just in terms of regional Victoria, what is your stretch across the regions in terms of delivery of service, education programs and training? The second part of that is: do you have a breakdown of differential data between women in regional Victoria seeking your service and perhaps the metropolitan?

Ms SMITH — The first answer is that PANDA has chosen to focus our work mostly via telephone. To be perfectly honest it is a really cost-effective measure, but it is also really accessible to both expecting and new mums. Picking up the telephone is a very accessible service. Our data works out very evenly with population data across city and country in terms of those calling our helpline. We have state government funding to provide through DET some education with maternal and child health staff. That work is more focused in metropolitan Victoria. It is a scattering of money. It is a useful pool of money, but it is about \$100 000 a year. That does not allow us to reach right across the country. For some of the sessions we run — we advertise broadly — we have good participation from country areas, but when we actually go out to services we have very limited reach to the country, just through sheer resources. It takes a long time to get to country areas. That is a small frustration for us. It would be good to increase that work.

Ms BRITNELL — I am just interested in PANDA's definition of the postpartum perinatal period. What is the period?

Ms SMITH — For our work we would describe perinatal as from the point of conception through to one year after birth.

Ms BRITNELL — Secondly, can you just tell me a bit about the intensive care coordination program?

Ms SMITH — The intensive care coordination program in my 30 years of working in the community sector is the most exciting program I have been involved in in my life in terms of actually making an enormous difference, and we really appreciate the funding from the state government now. It started as an NPDI-funded program. That work is high-need families are referred to us, mostly through hospitals, and we pick up a service coordination role with those. If we start with the notion of screening and effectively identifying risk, the next step is you want to refer women to services, for some women it is really difficult for them to actually take that step in getting to services, so we pick up those high-need families. There is an intake process to ensure those families are appropriate, but our work with them — we never see those families. We do not actually sight them. We do not need to meet the mum and baby. We know them really, really well though. It is all managed by telephone. It is about making sure we are meeting that family where they are.

There is a lot of what we call assertive advocacy. That is us on the phone saying, 'No, no, she really doesn't', 'No, she does', and pushing to get women into services that are in the community that they are not able to get into. So it is advocating for them when they are unable to advocate for themselves to get into services.

But it is also matched with supportive counselling. So it is not just us making sure there are the services that you are getting into. We maintain engagement with anyone in that family who needs support, so if there is a second parent, a father, a same-sex parent or even if there is not a partner — it could be that it is the mum's mother that we are supporting to support the mother. Sometimes we will talk to a mum three or four times in a day if it is a bad day, because it is a very volatile period; it is a very changeable time. It is really about holding that family. Sometimes we will work with that family over a period; it could be six months or it might be from before they go into a mother-baby unit or while they are in a mother-baby unit. Very commonly one of the things we are doing is advocating to get someone into a mother-baby unit but not always. There are women who do not need that. It might be advocating around family violence services or drug and alcohol services.

But we can stay with that mum over a period of time so we can get her through, keep contact and keep her safe. If she is in and out of services, we can keep contact perhaps with the partner, sometimes with the mum, and eventually, once we disengage through the intensive program, they still know that PANDA is available through the helpline.

As I said, I feel very fondly about the program. I think it really has an extraordinary capacity to make a difference at a really crucial time. In fact, really it is an illness that can be resolved and women can live through it and can step back into getting on with life. If I have a message, it is that it is such an important time to make a commitment for the child and the mother's future. It is a chance to really reduce intergenerational trauma.

Ms McLEISH — Thank you very much, Terri, for your presentation today. I just want a little bit of an understanding first of all about what your organisation looks like, because you said you are phone call based. How many employees do you have? Where are they? Do people take phone calls in their own homes?

Ms SMITH — Thank you. It is a great question. We are based up in North Fitzroy, and the service is run entirely from those premises. This is not what those women envisaged 30 years ago. At that time they envisaged supporting mildly depressed mums. That is an important group to support. More than 50 per cent of our calls now are in the moderate-to-severe range.

We have both a professional staff — professional counsellors, and that is funded through the national helpline, so it is the federal government — but we also have a peer support team, and they are half-funded through state government funding. So those peer support volunteers go through an extensive training program. Everyone does the work in the building for the reason that they all need extensive support and monitoring. It is a very open environment, the helpline, where the peer support volunteers are literally on one side of the room and the professional counsellors are on the other side of the room.

One of the beautiful things that the peer support volunteers can do is a lot of follow-up calls. The professional counsellors take all the incoming calls to the service now. That is not the model we used to have, but basically as we became more competent, the nature of the calls just started to move up the risk scale. But there is still a large group of women who, once we sort out the key issues for them, can really benefit from the peer support volunteers, who are able to say, ‘It happened to me, and I’m fine’ — that message of recovery.

I started in my presentation talking about peer support. It is such an important message — that this happens to all sorts of women across the community, and you are going to be okay even though it is really hard to see that right now. So with peer support volunteers — we would not reduce it to friends; they are not friends — the feedback we so often get is, ‘Someone cared about me. They called me back. They kept in contact’. There is a lovely moment when that contact breaks because everyone is okay. That might be anywhere between three and 12 follow-up calls. We do not have a limit. We do not want to keep hounding women if they do not need it.

Ms McLEISH — How many peer support volunteers do you have?

Ms SMITH — We have about 25 peer support volunteers who take the telephone calls, but we also have peer support community education volunteers — this is all funded through the mutual support and self-help program through Health and Human Services, and it has been funded for probably 15 or 20 years; it certainly predates me — who go out to share their experience in first-time-mum groups, in maternal and child health settings and in some community organisation groups, but they also share information through some media and awareness-raising work we undertake.

Ms McLEISH — Is your helpline 24 hours?

Ms SMITH — No. The helpline runs from 9.00 a.m. to 7.30 p.m. Monday to Friday. We are satisfied with that. We obviously refer on to some other crisis services with our answering machine. It would be a very expensive activity to run 24/7, and the reality is that you tend to be dealing at a very different level in the middle of the night, and we are happy to refer. We have of course the Maternal and Child Health Line here in Victoria that we would refer to. We refer to Lifeline for crisis and to the Pregnancy, Birth and Baby 24/7 maternity service.

Ms McLEISH — Just a final question. You mentioned that 84 per cent of people in Victoria who call have not told their maternal health nurse or primary health provider about the symptoms. What have you done with that data?

Ms SMITH — I present that data to anyone who will listen, to be honest. In fact more have shared with their GP — it is around 72 per cent that have not told their GP. We started sharing that data, and then we were not as confident about the maternal and child health midwife data, partly because it is a data problem and that is not our specialisation. We had to get solid data. What we were concerned about was: is this looking exaggerated because some are antenatal and some are postnatal? We sorted out the data and came back, so this is really the first time we have had that data from the last financial year. I will be presenting it in a couple of weeks at a national conference in Brisbane. I will be talking to anyone who will listen, basically.

The CHAIR — We are listening.

Ms SMITH — We do not want to put those health professionals offside. We do think they are doing a great job, so I do it cautiously.

With the training work we do with maternal and child health nurses, DET actually came to us three years ago to offer us money. We did not even ask them; we loved that. I think they probably thought we were going to present content, and we started off thinking that we would present content, but it is actually about 5 per cent content and 95 per cent values. It is really about shifting how you have a conversation, being able to have a conversation and being able to open up a conversation. Those staff will tell us consistently that they are scared to open up the conversation, because ‘What are we going to do with it?’. We say, ‘Hang on. What is so scary about mental health? You open up those other conversations’.

One of my favourite current messages is on gestational diabetes. No woman will get through her pregnancy without knowing about gestational diabetes; you simply will not. It is actually less common than perinatal depression and anxiety in the antenatal period, but you will not get through your pregnancy without someone having mentioned it. With the antenatal education classes, nurses commonly tell us that women do not want to hear about it. We do not want to hear about mammograms or Pap smears, but we talk about those things for really good reasons. So I think we have still got a long way to go in prioritising mental health as an issue that is at least equal to physical health issues.

Ms McLEISH — And do you ask women why they have not spoken to anyone else about it? Is their first port of call to a helpline?

Ms SMITH — We have that as a conversation; we do not keep it as a data piece. We have a commitment around building the data, but we also want to ensure that our first step is actually providing the service.

The CHAIR — Anecdotally what is your impression?

Ms SMITH — Anecdotally we know that there are two key reasons. The first is that they have not been asked, and that is appalling because we should have universal screening. Universal screening would mean that you are asked those questions.

Dr CARLING-JENKINS — Absolutely.

Ms SMITH — Some women will not answer the questions accurately, but in fact the majority will. In fact very commonly women are dying to be asked. I can tell you about a very, very old friend of mine who, just after I took my job, told me this story. She sat and waited. She wanted to be asked, and the nurse had asked her if she had thought about hurting herself. She said, ‘No. No, I haven’t’. But the nurse decided not to ask the question, ‘Have you thought about hurting your baby?’. This was a professional woman who had made a lot of effort. We often say that if women have made it to the appointment, they are three-quarters of the way. The mask is well and truly up. She was not asked if she had thought about hurting her baby, and she had absolutely thought about hurting her baby. It took her sister, who is 3000 miles away, to ask her the question. She is a midwife in Queensland. She was brave enough to ask her sister the question and got somewhere. That is the first thing.

The second — there is another really obvious one. They just do not get it; they really do not know what is happening, and it does not cross their mind to raise it, because they think, ‘This is just one thing’. It is the stigma. They think they are a bad mother. I mean if you are an Indigenous woman who has seen years and generations of babies being taken away, clearly you will think someone is going to take your baby away from you, but I can tell you that there are women who look like every one of us around the table here who think that too. I mean mental illness is a really serious thing, particularly if you put it together with a lack of sleep and a lack of competence with a new baby. Every single day we hear women talking about ‘Someone’s going to take my baby’. And we are going to make sure that does not happen. It is not logical. It is logical for Indigenous women — do not get me wrong; I think that is a really fair assumption — but for so many of those other women it is not a fair assumption, but it comes from their current understanding of themselves in the world.

Dr CARLING-JENKINS — Thank you very much, Terri, for coming in today. It is fascinating. I love that through the power of the kitchen table 30 years ago it has grown into such a huge service now.

Ms SMITH — Yes.

Dr CARLING-JENKINS — Just with the helpline, are you often, then, the first point of contact for women, or how does that referral pathway work?

Ms SMITH — The first point of contact for their mental health issues?

Dr CARLING-JENKINS — Yes.

Ms SMITH — What we know is the majority of women actually find us on what is called Google.

Dr CARLING-JENKINS — That was the next question I was going to ask — how do they find you?

Ms SMITH — I thought that was the next question. Certainly there is a group who are referred to us by health professionals and by maternal and child health nurses and midwives.

Dr CARLING-JENKINS — And Beyondblue as well? Do you get referrals from Beyondblue?

Ms SMITH — Absolutely. Beyondblue is actually the largest, partly because they are a very large organisation. They are actually the largest organisation we can identify as a single referrer. I am really guessing, but I think on the recent data something like 10 per cent of our calls actually come via Beyondblue.

Dr CARLING-JENKINS — So it is significant.

Ms SMITH — We have a great relationship with Beyondblue, and they are really clear.

Dr CARLING-JENKINS — But a lot come through Google.

Ms SMITH — I should say that in the mental health space this is a very specialised area. It is a really different area, so when we talk about psychologists and psychiatrists it is important that those services are specialist services. So when we are looking for psychologists, for example, to refer our callers to — and we do have a national database that we have developed over the years and we work with Healthdirect as an existing national database — we know that just being referred to a generalist psychologist is not an effective result. You might luck out and find someone who actually understands the perinatal period, but really it is an area that is very specialised, and some of the solutions that you can come up with when you have your time available to you and you do not have a small baby attached to you are really different to what you can achieve.

There have been some really good steps recently with some online programs that we thought the federal health minister was going to launch yesterday. It was the third failed attempt to launch yesterday, but PANDA has been involved, and I really do want to credit the Victorian government across many years. It is across all parties, really, that funding for PANDA; the mutual support and self-help program really has allowed PANDA to develop a particular expertise that has benefited women right across the country.

We have been engaged in developing an app with several other consortium players through a federal government tender that went out last year, but as I say, as soon as the minister launches that it will be available, but there is also an online treatment program — a CBT-based online treatment program for women. So I think there are some great things going on. I think the key step at this stage is that we have some health professionals with some better education and some better resourcing. I understand they are all really busy, but with some better resourcing I think we can still do a lot better by women and children, and that will impact on the children of the next generation.

Dr CARLING-JENKINS — Excellent. Thank you for that. I also noticed in your fact sheet, which we have got a copy of here, the stats around men. It was actually a lot higher than I realised — one in 20 men struggling with antenatal depression and one in 10 new dads experiencing depression. Do you have dads call in?

Ms SMITH — We do.

Dr CARLING-JENKINS — And do you have peer support for dads?

Ms SMITH — We do not. Around 12 per cent of our calls come from men.

Dr CARLING-JENKINS — Twelve per cent?

Ms SMITH — That said, half of those calls are from men concerned about their partners, but half of those are men concerned about their own experience. So you are right about the data, and you are right to be surprised. That is the very common experience. Almost everyone is surprised to know that dads can experience it. Dads will experience it to a lesser severity. There is no question about that, so while it is quite common, the severity is less, but it is still important.

There is a crucial group that we should be looking out for. Dads are much more at risk of perinatal depression or anxiety if their partner has perinatal depression or anxiety, so it is so easy; it is really obvious. We know who they are. They have an increased risk, so if in our system we can identify a father — and it is not to say they are the only ones, and certainly there are dads who will experience it quite independently. It is a really important area. We have developed a separate website for dads called ‘How Is Dad Going?’. We are endeavouring to build our contact with dads. Apparently men are different, which might surprise you. You know, we know so much!

We know a lot about how men engage with the health system. One of the issues with dads being unwell is that traditionally women — still; gosh, the world hasn’t changed much, I reckon! — are often the health-seekers in the family, so if mum is unwell and if dad then gets unwell, it is unlikely that mum is going to be recognising that and intervening in a way that says, ‘I’ve made the optometry appointment for you; could you go and get your eyes checked?’. That is not going to happen, so it is a group we need to watch out for.

We know that children are going to thrive with engagement from multiple parents. There is so much data that says we want to see more engagement of dads or another parent figure, and sometimes that can be grandparents or the same-sex partner. It does not matter. Any child is going to benefit from the involvement of other adults in their life, so if there is a dad there, we want dad to be really well too. So there is a lot of work still to be done there.

Dr CARLING-JENKINS — It sounds like quite a lot.

Ms SMITH — It really is.

Dr CARLING-JENKINS — I guess even if they call up with concerns about their partner, you are also screening them.

Ms SMITH — We absolutely are. We just touched a little earlier on mother-baby units, but in residential units if a mum is so unwell she needs to go into a residential unit, we tend to have sympathy for those parents where there is a baby who goes into a NICU for example. You know, you think you are bringing home a new baby and in fact mum and baby go off to a mother-baby unit. There is some work on our plate at the moment to make sure that those mother-baby units right across the country are aware that — you know, we would want every dad to be referred to PANDA. It is actually really hard to be in a hospital complaining about how tough it is for you being a dad — you know, ‘They’re not the ones having the baby’ — whereas mum is experiencing a severe mental illness. So the staff in those units are not always that sympathetic to needy dads, but we can be a great sounding board because we are external and we are also pretty available. That is the beauty of the telephone, and sometimes a telephone is pretty good for dads. It is not very confronting.

Dr CARLING-JENKINS — And healthier dads means healthier mums.

Ms SMITH — And healthier families, healthier kids.

Dr CARLING-JENKINS — It is just very simple.

Ms SMITH — And it is coming back to that message about early intervention. Some of that work, sometimes it is counselling support, but sometimes it is just education. If someone at the hospital explains to you what has just happened with your wife, partner, but it is really not what you are thinking and you will probably miss 85 per cent of that communication. But you could have follow-up call with us where you are getting someone who has got all the time the world — and we do take all the time we need. We take whatever time we need to manage a call. Basically we meet people where they are. It is a narrative; it is ‘Tell us your story’, and the counsellors know that their job at the end is that they have got to come in and pick up the answers we have not got. We check in around family violence. We check in around drug and alcohol use. We check in around family of origin issues, and we have trauma-informed practice.

It is very common for women who are having a baby, and men too, to go back and touch on issues that they thought they had dealt with a long time ago that they were not expecting to. So childhood trauma — if you talk about birthing, there is a point in your life that you might have lost your mother — maybe when you were five — and you have grown up and you have come to terms with that and you are fine.

Dr CARLING-JENKINS — Until you have your baby.

Ms SMITH — And you can still be fine, but you might need some time to deal with that or you might need to deal with a traumatic birth or you might need to deal with — you might have had anxiety in year 12, and you know, have you got some tools to manage that? Basically you are more at risk if you have had any level of mental illness previously in your life, but you are probably out of contact by now with your mental health team.

Dr CARLING-JENKINS — Thank you very much. I appreciate that.

Ms EDWARDS — I just had a couple of questions in relation to your counselling service. Are they trained grief counsellors as well?

Ms SMITH — They are all trained counsellors I should start by saying, the professional staff are. We absolutely work from a grief and loss model, so some will have been through formal training, but you have touched on the heart of our work. We actually talk about grief and loss all the time, and that might be the loss of your competence as a professional person — and I do not say that in a flippant way at all, but women are having babies much later in life now. It might be just losing — not ‘just’; it might be losing — that previous identity or it might be the loss of your innocence when you were four or the loss of a person in your life, and yes, we talk about the loss of control of your body. We work from that model I think very effectively.

Ms EDWARDS — Yes, I thought so. Also you mentioned women from Aboriginal and Torres Strait Islander backgrounds who fear the removal of their babies. Are your counsellors also trained around and do they sort of have a better understanding of Aboriginal and Torres Strait Islander groups and women from CALD backgrounds?

Ms SMITH — I would say we are doing way better with women from CALD backgrounds. We do very, very well with women from CALD backgrounds. There are some really interesting and some really, really fascinating patterns through different cultural groups where you have a clash of generational values. You might live with those clashes quite well until you bring a baby into the world. There is nothing like a new baby to elicit all those values. Sometimes it is not just your own family; it might be your partner’s family as well. So when you talk about family of origin, it is also making a new family.

So with CALD families I think we are doing really, really well, including working extensively with telephone interpreters where necessary. I would say we are not doing well enough with Indigenous families, but I am very happy to say that just last week we kicked off a formal partnership with the Aboriginal Family Violence Prevention and Legal Service. They came to us some time back and said, ‘We’re going to put in this partnership application. What do you reckon?’, and we said, ‘We’re so excited that you came to us’. We had a gorgeous, really important meeting with them last week that I think has already changed our outlook as an organisation, but there is a long, long way to go. I said to them, ‘Great, you’ve got these national connections’, and they said to me at the end, ‘We’re going to take it slowly, Terri’, and I said, ‘Yes, we are’, because process is important. I hope, if we get to have a conversation in a couple of years time, I can say we are doing a lot better in that space.

We know that our model lends itself pretty well, because we do not make assumptions and we do want to hear stories. We want to hear who is important. We always say, ‘Who is important to you?’. That is actually really important: ‘Who is your family?’, ‘Who are the people that matter right now?’. But we have got a long way to go.

The CHAIR — Thanks for coming in, Terri. Your model is exemplary, I think. Also I love knowing that you are the CEO, because if you are the CEO and the people below are half as exuberant, passionate and committed about this as you are, that is fantastic. Thank you so much.

Ms SMITH — Thank you. It was lovely to talk to you all.

Witness withdrew.