Submission No 50

SUPPORT FOR NEW PARENTS AND BABIES IN NEW SOUTH WALES

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Date Received: 24 November 2017

Response to the Legislative Assembly Committee inquiry into support for new parents and babies in New South Wales

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November 2017

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Dear Committee Members

Thank you for the opportunity to contribute to the Legislative Assembly Committee Inquiry into Support for new parents and babies in New South Wales.

PANDA - Perinatal Anxiety & Depression Australia's interest in this inquiry is in relation to the impact of **perinatal anxiety and depression** and the need for appropriate resources for the **1 in 5 expecting and new mothers** who are directly affected by this illness. We also recognise the 600 Australian mothers (and their families) who are affected by postnatal psychosis each year.

Since 2010 PANDA has provided the only specialist *National Perinatal Anxiety & Depression Helpline* service, underpinned by clinical evidence and informed by the lived experience. In addition to the Helpline service PANDA's websites and written resources provide specialised information and support.

PANDA is committed to raising community awareness of the incidence and impact of perinatal anxiety, depression and psychosis so that families can understand what is happening to them and seek help early. In New South Wales this work is supported by 38 Community Champions who draw on their own experience to help others.

Perinatal anxiety and depression are serious and common illnesses. Recognising symptoms, seeking help and receiving appropriate assessment, education, treatment and support, minimises the risk of potentially devastating outcomes for new parents, infants, the broader family unit and society. These include attachment trauma, relationship breakdown, suicide and infanticide.

PANDA has had over 75,000 conversations about perinatal mental health with expectant and new parents, their loved ones and health professionals since the establishment of the PANDA Helpline. These conversations provide us with a unique and crucial voice on the challenges faced and the barriers to accessing and engaging with universal and specialist services established to meet the needs of parents and infants. Our responses are based on this vast clinical and lived experience.

This submission responds to the following points in the terms of reference:

- The adequacy of current services and structures for new parents, especially those who need extra support, to provide a safe and nurturing environment for their babies
- Changes to current services and structures that could improve physical health, mental health and child protection outcomes.
- Specific areas of disadvantage or challenge in relation to health outcomes for babies
- Models of support provided in other jurisdictions to support new parents and promote the health of babies.Please don't hesitate to contact me if I can be of any further assistance.

Yours sincerely

Terri Smith
CEO

Perinatal anxiety and depression

Maintaining good mental health during and following pregnancy is vital for the health and wellbeing of mothers, their children and families (NSW Health, 2016).

Perinatal emotional and mental health challenges fall across a broad continuum from difficult transition to parenthood (often when expectations and reality are not aligned) to severe perinatal anxiety and depression where daily functioning and capacity to respond to a baby with sensitivity and consistency is significantly compromised.

Difficult transition to parenthood	Mild perinatal anxiety and depression	Moderate perinatal anxiety and depression and / or complex psychosocial risk factors	Severe perinatal anxiety and depression and / or complex psychosocial risk factors

Perinatal anxiety and depression affects up to one in 5 expecting or new mothers and at its most serious can be life threatening. Left untreated, perinatal depression and anxiety is associated with short and long term adverse consequences for the mother, her baby and the family (Marcus et al., 2011).

Perinatal anxiety and depression affects men too, with around 1 in 20 men experiencing depression during pregnancy and up to 1 in 10 new dads experiencing postnatal depression. Anxiety is thought to be as common, with many expectant and new dads experiencing both anxiety and depression at the same time.

During the perinatal period women with depression are at increased risk of **maternal suicide.** Around 30% of pregnant women with depression experience suicidal ideation (Gold et al., 2012) and suicide is one of the leading causes of maternal death in the first year after birth (Austin et al., 2007; Milgrom & Gemmell, 2015).

Puerperal/postpartum psychosis affects up to 1 in 500 new mothers, usually within the first 3-4 weeks post birth. This is a very serious condition that almost always requires hospitalisation.
Effective early intervention can save lives and break the cycle of intergenerational trauma.

PANDA – Perinatal Anxiety & Depression National Helpline

PANDA's Helpline is the only National dedicated perinatal mental health service. Funded in July 2010, it is unique in its purpose: to address the specific emotional and mental health needs of expecting and new parents and to minimise the risks of potentially devastating outcomes associated with unrecognised and untreated perinatal mental illness.

The integrated Helpline workforce of professional counselling staff and extensively trained peer support volunteers, provide a space for expecting or new parents to share their concerns, often for the first time, while a comprehensive perinatal bio-psycho-social and risk assessment is undertaken. This narrative approach reduces stigma associated with mental illness and parenting challenges, minimises the risk of shame, and allows for potentially difficult conversations where risk can be accurately assessed. The assessment informs what referrals and interventions might be helpful, including emergency or duty of care interventions to address suicide, self-harm, risk to child, family violence or an acute mental health crisis.

An initial call to PANDA's Helpline takes an average of one hour and is typically followed with an email outlining discussed coping strategies, referral details and any agreed safe plan. In recognition of the high changeability of need and risk inherent in the perinatal period, outgoing follow-up calls monitor risk and protective factors in a manner that routine appointments do not allow.

As a specialist service with a strong understanding of both clinical presentations and the lived experience of perinatal anxiety, depression and psychosis, we are able to encourage honest conversations to break through barriers and advocate for expectant and new parents to receive the support and care they need.

As a telephone service dedicated to perinatal mental health we have the resources and skill to support discussions that elicit disclosures that enable targeted appropriate referral and care.

PANDA works cooperatively with other services who share our commitment to making a difference for families affected by perinatal anxiety and depression. Our collaborations include but are not limited to:

- *beyondblue*
- Centre of Perinatal Excellence)
- Parent Infant Research Institute (PIRI)
- Paternal Perinatal Depression Initiative
- Pregnancy Birth Baby Helpline
- Queensland Centre for Perinatal and Infant Mental Health
- SANE
- Gidget Foundation Australia

The adequacy of current services and structures for new parents, especially those who need extra support, to provide a safe and nurturing environment for their babies

Limitations of routine perinatal anxiety and depression screening and psychosocial assessment:

The perinatal services and structures currently provided in New South Wales (NSW) to address routine screening to support new parents and their babies are to be commended but there is room for further improvement to support early identification of perinatal mental illness.

Helpline data reveals that of the callers presenting with perinatal anxiety or depression symptoms or psychosocial distress:

67% have not told their GP
87% have not told their midwife or Child Family Health Nurse
50% have not told their partner

Unlike physical health issues, **identification of perinatal mental health issues relies entirely on self-report screening tools** (EPDS - Edinburgh Postnatal Depression Scale) **and psychosocial assessments** and therefore are only as effective as the willingness of the new parent to disclose.

Much faith is held in the 'best practice' administration of the EPDS both antenatally and postnatally, yet insufficient consideration is given to workforce development in having different types of conversations, knowing how to explore sensitive and complex issues and to feel confident in responding when concerns are raised. This gap in confidence and skill sets might be one explanation as to why most cases of perinatal anxiety and depression still go undetected in current best-practice care (Milgrom & Gemmell, 2015).

The environment and skill sets needed to create safety for disclosure of mental health issues, suicide thoughts, child safety concerns, family violence, alcohol and drug use or complex trauma are quite different to the skills required to diagnose physical health issues. Health Professionals (GPs, Midwives, Child and Family Health Nurses) are naturally confident in medical based diagnostic methods such as testing for gestational diabetes, baby growth, feeding difficulties but often less confident in the areas of exploring emotional and mental wellbeing.

Given the first 1000 days are critical for child development, any delay in provision of support to a new parent who is struggling with their own mental health, and therefore meeting the needs of their infant, needs to be taken seriously.

Daily through PANDA's Helpline we hear stories of maternal distress related to 'minimising' comments, or conversely, overreactions to disclosures.

In our secondary consultations with Health Professionals we often hear

"if we don't know… if they won't tell us… how can we help?".

And our callers commonly report

"I felt embarrassed I wasn't coping so I'd pretend everything was OK"

"I was scared that they would think I was a bad mother and take my baby away"

While we understand that health professionals and services have limited resources there are several measures that we believe could be taken to minimise the risk of a new parent being left to make sense of their mental health difficulties and struggle alone without adequate support **(See Recommendations 1, 2 , 3, 4, 6 &11)**

Beyond postnatal depression: Anxiety and antenatal mental health issues

Through our work with health professionals and support of expectant and new parents it is clear that there is a widespread lack of awareness and understanding about the types of perinatal mental health issues, how and when they present, and who they affect. It is important to note:

- **Anxiety** is as common if not more common than depression in the perinatal period
- **Antenatal:** Depression and anxiety commonly occur during pregnancy and mothers can experience an acute mental health crisis in the antenatal period. In fact, 40% of women diagnosed with depression at 12 weeks post birth report having experienced symptoms during pregnancy (Department of Early Childhood Development, 2013).
- **Men** experience perinatal anxiety and depression

Anxiety in the perinatal period is less commonly understood than depression, and is therefore often left untreated. In the absence of greater knowledge, a health professional can minimise anxiety symptoms as 'normal worry' or focus on the source of the anxiety (feeding, settling) while neglecting the anxiety itself. Equally, during secondary consultations, we hear mothers described as 'attentive' when it is likely they are engaging in hypervigilant behaviour driven by anxiety.

Over 65% of Helpline callers report anxiety symptoms including engaging in significant avoidant behaviours related to the care of their baby. A mother who is unaware of the symptoms of anxiety is just as likely to think her anger, agitation, distress and irritability are personal flaws and indicators that she is ill-equipped to be a parent. These are often persistent thoughts and it is not uncommon for callers to the Helpline to state *"my partner and baby would be better off without me".*

Equally, **antenatal** anxiety and depression receive little attention in routine care causing unnecessary extended distress for many expecting parents. Throughout antenatal care there are conversations about physical health complications such as gestational diabetes, however, routine conversations about mental health complications are uncommon.

Only 5% of respondents identified depression or anxiety in PANDA's Community Knowledge Survey when asked about key health issues during pregnancy. 34% named gestational diabetes.

Just 16% of PANDA's callers make contact during the antenatal period.

We regularly hear from midwives that 'women do not want to hear about it' or 'are not interested in mental health issues'. Early identification and invention for perinatal mental illness relies on knowledge of the illness and its symptoms. It is important to find meaningful ways to introduce these important topics. Ultimately this will improve the health of mothers and babies and reduce health care expenditure.

Placing an equal emphasis on mental and physical health of an expectant or new mother aligns with the strong body of research on the importance of maternal mental health on both the developing baby and the first 1000 days of a child's development. Infants need to feel calm, safe and protected (Moore, 2017), this is not possible when their primary care giver is not feeling calm and safe themselves and this is not being recognised as a mental health issue by the parent, their support network or the health professionals providing care.

We need to ensure that universal and specialist health professionals, and expectant and new parents, are aware of perinatal anxiety and depression risk and protective factors, signs and symptoms, and where to go to get help.

There is much work to be done in the areas of community awareness raising and workforce development **(see Recommendations 1,2,3,4 & 6)**

Fathers/Partners

There is limited community awareness that men can experience perinatal anxiety and depression. While paternal postnatal depression is reliably estimated at 1in10 fathers there are less conclusive studies of anxiety. This mirrors the lack of reliable anxiety data for women in the perinatal period. Leach et al., (2016) estimates paternal anxiety at 4.1%-16.0% antenatally and 2.4%–18.0% in the postnatal period.

PANDA's Community Knowledge Survey identified that 60% of the Australian population are unaware that fathers can experience perinatal anxiety and depression. Just 12% of callers to PANDA's National Perinatal Anxiety & Depression Helpline are men. Of this group 65% make contact about their partner's health and the remaining 35% about their own mental health.

In working with fathers seeking support for their partners, PANDA is mindful that father involvement can moderate the intensity of maternal depression (Séjourné et al., 2012). We are also aware that a key risk factor for men for perinatal anxiety and depression is if their partner experiences it.

Currently services that prioritise expecting and new dads emotional and mental wellbeing are limited. There are however some wonderful initiatives (e.g. University of Newcastle, SMS4dads projects) that are driving a conversation and movement to ensure the service sector catches up with the needs and desires of fathers of today. PANDA's www.howisdadgoing.org.au website provides information specifically for expecting and new fathers.

From a routine care perspective, we have a long way to go in providing integrated equal care and support to men in their parenting journey. The challenge is how do we move from a maternal focused system (maternal health, maternal services, mothers' groups) to one that continues to place appropriate significance on the needs of mothers while also seeing fathers, and same sex partners, as more than the 'primary support person'. **(see Recommendation 5)**

Changes to current services and structures that could improve physical health, mental health and child protection outcomes.

Care for parents with pre-existing mental health issues

Over 50% of callers to the National Helpline report a history of mental health issues yet they remain caught off guard and ill prepared when they encounter a mental health decline.

Prior mental illness is a significant risk factor for perinatal anxiety and depression. Over 50 % of callers to PANDA's Helpline report a history of mental health issues yet most express being caught off guard and ill prepared when they encounter mental health decline during pregnancy or after birth.

For some, strategies employed to successfully manage their mental health become impractical or ineffective in the perinatal period. This is generally something that has not been discussed or anticipated.

For others, it is not uncommon for PANDA to hear that, on the advice of their General Practitioner, they recently ceased long term psychotropic medication due to concerns for the potential impact on the developing baby. This commonly results in a rapid mental health decline with high confusion, distress and great shame that they are 'unfit to be a mother'. These actions and consequences commonly occur within the General Practice setting prior to a women being linked into the maternity system or connected with specialist perinatal psychiatric services.

Once in the 'maternity system', obtaining information about a women's mental health history is part of routine practice. However, as stated previously, the psychosocial assessment relies on self-report and calls for the health professional to create a space of safety and trust for such disclosures. It is not unlikely that a newly pregnant women, who is making sense of how her mental health might impact her mothering experience, will choose not to disclose her history. This becomes an obstacle to the provision of preventative and early intervention services.

If we accept that it is likely many women do not disclose mental health concerns in routine screening and assessments, it is critical that the earlier recommendations regarding effective open conversations be pursued.

Conversations about the perinatal period being a period of risk for anxiety and depression, that these illnesses are common and treatable and do not make you a bad mother need to be held in every corridor, office, consulting room, antenatal class and mothers group.

The challenge for all health professionals is to assess and identify mental health issues in the same confident way they manage physical health issues. At the same time we also need to work together to ensure the community knows that having a mental health issue does not preclude you from being an exceptional parent… but it might mean you need some additional specialist care, monitoring and support before conception, during pregnancy and in the early days of parenting. **(See Recommendations 1, 2, 3, 4, 6, 7, 11)**

Specialist perinatal service for mothers facing significant mental health decline in early pregnancy

It is not uncommon for PANDA to receive calls from women experiencing a mental health crisis early in pregnancy (pre 12 weeks) – prior to the commencement of routine maternity care. For some of these women there is a history of mental illness but for others this is a new, unexpected and frightening experience.

Many are distressed about the 'need to terminate their pregnancy' because 'if they cannot manage now how will they manage with a child'. In the absence of understanding that what is being experienced is a treatable mental health issue, the focus is on termination in order to 'make it all stop'. Women who choose to phone PANDA benefit from counselling staff who are able to explore, educate, reassure and advocate for an immediate mental health assessment and treatment through a perinatal lens to ensure the woman can make an informed choice about whether or not to continue their pregnancy.

In these circumstances every women deserves to receive urgent specialist mental health care in the first instance, just as they would physical health care for extreme morning sickness.

The first step in addressing this issue is related to the earlier identified need - increasing community and health professional awareness of antenatal anxiety and depression. The next is to explore how sectors can work together to ensure access to perinatal specific mental health care prior to maternity care when the need arises, including hospitalisation which takes account of the crucial mother / baby relationship. **(see Recommendations 6,7,8 &11).**

Child and Family health services: opt in or opt out?

Child and Family Health Nurses provide an essential service to families across NSW providing essential support in increasing parent confidence through addressing breastfeeding, sleeping or settling concerns. However many of our callers report that they 'do not see' their Child and Family Health Nurse.

While it is clear that Early Childhood Health Clinics offer a vast amount of information and support for families that seek it, it is also clear that those in need (but not within the Child Protection radar) do not necessarily choose to benefit from this service beyond the initial 2 week home visit and early Mother's group.

Due to the nature of perinatal mental health issues there is the potential for double stigma: stigma related to mental illness and stigma related to perception of failure as a parent. Given we know how stigma and shame can prevent expectant and new parents from accessing support when they most need it, it seems important to adopt an 'opt out' service rather than 'opt in'.

Developing a relationship with a child and family health nurse, knowing you have to attend appointments and being asked regularly about how you are going as a mother or father, not just how the baby is going, can assist in breaking down obstacles to accessing support for perinatal mental illness. **(see Recommendation 9)**

Perinatal lens (dyad) applied in acute mental health triage

An assessment of level of risk in a pregnant women or a mother with a new baby always needs to be considered in the context of a dyad i.e, mother and child.

While stated 'intent' is commonly used to assess level of risk in adults this cannot be relied upon in suicide risk for women with very young babies. The revised Perinatal Clinical Guidelines recently released by the Centre of Perinatal Excellence (COPE) provide details about suicide risk assessment and the factor of impulsivity in assessing risk in the perinatal period. There is high changeability in the levels of distress that a parent caring for a new baby can experience and an associated urgency to resolve that distress.

Through the PANDA Helpline we regularly assess and manage suicide risk and risk to child placing us in a very good position to share the challenges faced when trying to convey the level of assessed risk of a parent caring for a very young baby to triage workers on the Mental Health Access line. There is a need for education on the specific challenges faced in the perinatal period and alternative options to ensure safety of a child (eg. by other responsible family members) while addressing a new mother or father's mental health and safety. (**See Recommendation 10)**

Routine support of partner of those with acute mental health challenges

Partners of those with significant mental health issues are critical in the formation of healthy early bonding. This demand often comes at a time when navigating the mental health system (often for the first time), managing other children and processing own transition to parenthood. To maximise infant welfare effective support for their primary care giver at this critical time is crucial. **(See Recommendations 11)**

Specific areas of disadvantage or challenge in relation to health outcomes for babies

Fathers not equally valued as key stakeholders in their infant's wellbeing and therefore not prioritised in maternity and child family health systems

Commentary on the importance of providing integrated equal care and support to men in their parenting journey is covered under 'Adequacy of current services and structures'. Inclusion of fathers here relates to the associated disadvantage that infants of unsupported fathers may face.

We often talk to fathers on PANDA's Helpline who say that their partner has been through so much (pregnancy, childbirth) so they feel ashamed about their own experience of perinatal mental health problems or difficulties with the transition to parenthood. As for maternal perinatal anxiety and depression, paternal perinatal anxiety and depression can impact the child's future development. A study by Fletcher et al (2011) showed children three times more likely to have behaviour problems or twice as likely when controlling for early maternal depression and later paternal depression.

In the absence of universal services providing routine care and support to fathers the risk of paternal perinatal depression being unrecognised and untreated is high. **(See Recommendation1, 4, 5 & 6)**

Models of support provided in other jurisdictions to support new parents and promote the health of babies.

Public Mother Baby Unit beds

As a specialist national perinatal mental health service provider we are acutely aware of the lack of access to public Mother Baby Unit beds in NSW. For new mothers experiencing perinatal mental illness it is important to have access to specialised inpatient care that is inclusive of their baby. General acute mental health beds do not provide a safe and therapeutic option for new mothers and do not accommodate babies. Further generalist mental health staff are not skilled in the specialist area of perinatal mental health. The perinatal period is an extremely vulnerable time for women with suicide one of the leading causes of maternal death in the year post birth.

Currently Victoria has 6 Mother Baby Units, while Western Australia has two, South Australia's MBU has been in operation for more than 20 years and Queensland has opened it's first Unit. These inpatient services are critical to support mothers with severe perinatal mental illness and are also a crucial early intervention measure to support the future wellbeing of the infant. They play an important role in reducing intergenerational trauma for the infant and family unit resulting from separation during a mother's illness. **(See Recommendations 1, & 12)**

Intensive Service Coordination and Support Program (incorporating rural, complex trauma, marginalised communities who slip through the cracks)

PANDA has operated this important and cost effective telephone based service for 5 years in Victoria and more recently in the Adelaide Primary Health network. The program provides support for high need families with moderate to severe perinatal mental illness and / or complex psychosocial risk factors by providing specialised intensive support, service coordination and ongoing risk monitoring and assessment. As a telephone based program it is highly accessible. The program is particularly effective for marginalized groups where there are personal or sector obstacles to engaging with routine care: rural and remote families, LGBTIQ community; CALD community; expectant and new parents with a history of complex trauma.

The program establishes and supports pathways to diagnosis, care and treatment and through assertive advocacy and support ensures access and follow up. This supports high need families that do not access and engage with universal and specialist services.

- This program is all undertaken by telephone making it accessible, non-threatening and infant friendly
- Regular telephone contact monitors risk and facilitates engagement with services
- Regular engagement with services often results in flexibility from services previously unable to meet the family's needs
- A secondary benefit of this service advocacy is incidental capacity building across the health sector (including with GP's, obstetricians, midwives, psychiatric triage and maternal health) through conversations with PANDA's expert team.

Taking a holistic approach we also work extensively with fathers or partners to help them understand and respond to their partner's illness. This work supports the partner but also maximises their positive connection with their baby during the crisis period and assists them manage their own transition to parenthood. **(See Recommendation 13)**

Pre-service and in-service training for midwives, Child family health nurses and GPs

There are a range of consumer informed models for pre-service and in-service training for midwives, Child and Family Health Nurses and GP's to help them to better identify and respond to perinatal mental illness. Notably in NSW Gidget Foundation Australia speaks to medical students, medical professionals and midwifery students and midwives. This work is supported through community and corporate fundraising.

In Victoria the Department of Education funds PANDA to undertake Consumer informed training for Maternal Child Health Nurses (both pre and in-service). This project has operated for three years and is a powerful tool for encouraging Maternal Child Health Nurses (MCHNs) to challenge the values and assumptions they bring to their practice and increase their skills to enquire in an open way that will encourage new mothers to be open about their experiences. PANDA's professional staff, alongside lived experience volunteers, provide this powerful training.

All pre-service Maternal Child Health Nurses in Victoria now undertake a 3 hour core curriculum unit provided by PANDA. Approximately 20% of MCHNs are engaged each year in PANDA training through professional development workshop days and local in-service activities. Over three years we have seen a reduction in Victorian callers to PANDA's national perinatal anxiety and Depression Helpline who have not told their MCHN about their feelings and symptoms of perinatal anxiety and depression. **(See Recommendation 2 & 3)**

Recommendations

1. Involvement of consumers with a lived experience of perinatal anxiety, depression or psychosis in the development (or review) of any service/system established to support the emotional and mental wellbeing of expectant or new parents. PANDA can assist in this work through our Community Champions program.
2. Consumer voice 'heard' alongside theory in the training of health professionals who provide care to expectant and new parents (Midwives, Child Family Health Nurses in particular).
3. Workforce development in building confidence and skills in identifying and responding to the emotional and mental wellbeing of expectant and new parents (rather than just physical health) with a focus on: the grief and loss model of parenting; obstacles to help-seeking; having difficult conversations; risk in the perinatal period; and consumer stories
   This development may be pre-service or in-service.
4. Inclusion of information (clinical and consumer voice) on anxiety, depression and psychosis in antenatal classes, routine maternity appointments, routine Child Family Health appointments, mothers' groups, parenting classes and any environment where physical health issues related to pregnancy and early parenting are discussed. Significant change in levels of awareness and reduction in stigma will only occur with a system wide commitment to routine open discussions of mental health alongside physical health
5. Review of the current universal service model for both maternity and child health care with a view to full integration of fathers/partners throughout the service journey with the intention of moving towards a valuing of co-parenting. This is a paradigm shift and will need champions from both within and outside government.
6. Continued awareness raising by organizations such as PANDA through the sharing of diverse consumer stories of recovery from perinatal anxiety, depression and psychosis. Consumer stories are a powerful way to break down stigma and normalise help-seeking.
7. Regular ongoing professional development for GPs in the safe use of psychotropic medication during pregnancy or breastfeeding: weighing risks of medication versus the impact of untreated mental illness on the mother and baby. In the absence of this training, professional development on the complexity of this issue and the importance of further consultation or referral to support informed choice of the patient.
8. Further training for adult mental health services, general practitioners and pregnancy options services to ask women who present in significant psychological distress to understand the importance of inquiring if the woman is pregnant and to consider urgent specialist mental health assessment if a patient is in the first trimester and has not yet engaged with maternity services (or have, but have not disclosed their mental health symptoms).
9. Consider further exploration of the impact of the opt in model for Child and family Health Services.
10. Workforce development for those on the Mental Health Access line in responding to psychological distress, suicide risk, and risk to child in expectant and new parents. *Risk in the perinatal period* training covers consideration of the safety of mother/father (or other parent) and infant as a unit, assessing for suicide where there is high impulsivity but not intent, collaborating with family members to manage any safety issues to children (and reporting these to Child Protection).

11. Health Professionals or services caring for a mother or father with perinatal mental health should consider a referral for the partner to PANDA's Helpline where counsellors can 'care for the carer', assist in navigating the mental health system, and offer support in their own journey to parenthood. This is an easily accessible, free early intervention to reduce the possibility of a decline in the non-affected partner's mental health.
12. As a matter of urgency ensure availability of public Mother Baby Units for families in NSW.
13. Consider the introduction of an Intensive Service Coordination and Support program in NSW as a cost effective means of supporting vulnerable expectant and new mothers and their families, who face multiple obstacles to accessing and remaining engaged with services.

Closing

Finally, we would like to acknowledge the wonderful work of the following organisations that are dedicated to the support of new parents in NSW. PANDA works in collaboration with each of these universal and specialist services and works towards ensuring families that need support receive it.

- Child and Family Health Services
- Tresilian Family Care Centres
- Karitane
- Gidget Foundation
- Wesley Mission
- St John of God Health Care: Burwood Mother and Baby Unit and
- Raphael Centre Blacktown professional support service
- PIMHS Perinatal and Infant Mental Health Services (PIMS)
- FRS (Family Referral Service)
- Mental health access line

The very real challenge is how do we ensure new parents know what is happening to them, do not feel ashamed about their thoughts, feelings and behaviours, and can share openly so that the right help can be provided, at the right time, to reduce the potentially devastating impact of untreated perinatal mental illness on parent, infant and the family unit.

PANDA brings a unique voice to these conversations and looks forward to making a meaningful contribution to future service development in NSW.

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