

# TRANSCRIPT

## FAMILY AND COMMUNITY DEVELOPMENT COMMITTEE

### Inquiry into perinatal services

Wangaratta — 25 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

#### Witnesses

Ms Jenny Ahrens, operations director, Northeast and Border Mental Health Services;

Ms Fiona Pilkington and

Ms Kerry Dolan, perinatal emotional health clinicians, Albury Wodonga Health; and

Dr Sarah Hancock, GP, Benalla Carrier Street Clinic.

**The DEPUTY CHAIR** — I welcome to these public hearings Ms Jenny Ahrens, operations director, NEBMHS; Ms Fiona Pilkington, perinatal emotional health clinician, Albury Wodonga Health; Dr Sarah Hancock, GP, Benalla Carrier Street Clinic; and Ms Kerry Dolan, perinatal emotional health clinician at Albury Wodonga Health. Thank you all for attending here today. It is fabulous that so many of you can turn up.

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 explored such privilege. It is a contempt of Parliament to provide false evidence. These proceedings will be recorded, and you will be sent a proof copy of the transcript. I invite you to give us about a 15 to 20-minute submission, and then Roma and I will then ask a number of questions.

### **Visual presentation.**

**Ms AHRENS** — Firstly, thank you very much for this opportunity to speak, particularly about a passion for the Northeast and Border Mental Health Services, which is the role of mental health in the perinatal period. Today, just briefly, just a short history — Fiona will talk about the current PEHP program. We will talk about some outcomes and feedback about the program, which is where Dr Hancock will come in. Will then talk about what we would like to see as next steps and finish with a case study from Kerry which indicates the work of PEHP. Starting with the evolution of the perinatal and emotional health program, my early days as a psychiatric nurse saw no acknowledgement really of the mild to moderate mental health disorders that women suffered in the perinatal period. We focused very much on the severe end, which was postnatal psychosis. That was my experience.

Up until about 1988, when a report came out in a local area, the ports in a storm report, and there was a concerted effort to find women who had experienced postnatal depression and to interview them about their experience, what came back was quite concerning. In terms of a lot of the care they received, they either got no care — some got good care, it was very, very haphazard, but most got no care — and struggled through it. Some were still experiencing depression three years later.

Out of that came a bid to our mental health services saying, ‘Listen, this is a really important thing. We really need to be doing something about these women with postnatal depression’. We put in for a grant. We had a very progressive manager, who is still there today, who said, ‘If we don’t get the grant, we’ll do it anyway. We’ll make it core business’. We ended up getting a DHHS grant and that was when I started in the position.

One of the things that I quickly realised was that they are far more about mental health in the perinatal period than postnatal depression. The people I was seeing had antenatal anxiety, had antenatal depression, had obsessive-compulsive disorder and had difficulties just adjusting to the new roles. The role became a lot broader than postnatal depression. There was also the importance of capacity building.

When I look back to my first experience of capacity building, that was attending the maternity ward at North East Health and saying, ‘Would I be able to come and talk at the antenatal classes about mental health?’. And they were going, ‘Absolutely not!’. They nearly bundled me out. They said, ‘Women aren’t interested in that. They just want to know about labour and birth’. This is even though 10 to 20 per cent of them have emotional health problems after birth. So it has come a long way and Julie, who spoke before us, and I have a very close working relationship with the maternity services, the maternal and child health nurses et cetera, which is one of the great strengths of the program.

Around 2010 came the commonwealth’s National Perinatal Depression Initiative. The state also provided funding which evolved into the PEHP program, following an evaluation by the Victorian centre for women’s health, which serves as the template for Victoria. In 2015 the National Perinatal Depression Initiative money sunsetted, and we started a very fraught process with funding tensions that Fiona will talk about a bit more.

Just to put a bit of perspective on the area that we service, we have Kerry and another clinician Lee, who are situated in Wodonga, and we have Fiona and Laura situated in Wangaratta, so you can see that that sort of splits the catchment up. From Mansfield at the bottom to Wagga at the top is a 3½-hour drive. When you put it that women are birthing from all of those areas, and we are a home-based service, it puts into perspective just how much travelling et cetera there is.

In terms of outcomes, since the beginning there has been more than 2000 families receiving service from the PEHP program. Currently we have about 2500 births regionally — 420 referrals a year — which is about 16.5 per cent of the births. So we are hitting the mark pretty much as to how many women need to be seen. We were also recognised in the Victorian healthcare awards.

In terms of health outcomes, which is the really critical thing, when you look at the initial figures, the first blue line is depression, the second, anxiety, and the third is stress. So we measure the levels that women experience as they come into the service and then as they go out, and that is the green and the orange lines. So what those lines mean is that when they come in they are experiencing severe anxiety, depression and stress, and when they go out it is on the mild to moderate level, so there is a significant health improvement. I am going to hand over to Fiona to talk about the current model.

**Ms PILKINGTON** — I am going to discuss the perinatal emotional health program that is based in Wangaratta, which is locally known as the early motherhood service. The early motherhood service is a free home-based specialist perinatal service that provides support from the time of conception up until the infant is 12 months old. We very much pride ourselves on being an accessible, warm and welcoming service with a timely response, which is evidence-based in its interventions.

We are co-located with other maternity services, including the lactation clinic, the community midwife program, the home visiting midwife and the antenatal clinic coordinator. The physical building is a red brick house, which is located behind the main hospital at Northeast Health Wangaratta. Being co-located with generic maternity services reduces the stigma and normalises that we are incorporating mental health into routine maternity care. The early motherhood service provides direct care, which is the bulk of our work, and community and professional education, including antenatal classes and new parents groups. We do an awful lot of secondary consultations, and that includes attending the continuity of care meetings and sitting on the infant high-risk panel with the Department of Health and Human Services. We actively support our colleagues in the midwifery ward, GPs and the maternal child health nurses.

We see women who have high-prevalence, low-severity mental health issues like depression and anxiety. That is our core business. However, in reality we often see women who have serious disabling depression and anxiety. Our core business excludes case management of clients with serious mental illnesses, like schizophrenia or bipolar affective disorders, as they would meet the criteria for being seen as mental health. However, we would provide additional support with some time-limited sessions looking at perinatal support and linking them in with other maternity and child health services.

The staffing is small. It is 1.3 EFT, and both Laura and I are mental health nurses with extensive additional training. Laura has worked in the service for 19 years. I have worked there for 15, and Jenny was the founding clinician and is now our manager, so you can see that we have a great retention rate. Outside of the 1.3 EFT, both Laura and I are employed in other areas of the mental health services. This includes the GP clinics and Kerferd inpatient, which is a psychiatric unit. This enables us to influence the care for perinatal women in Kerferd and in the GP practices.

We very much pride ourselves on the service being accessible. There are lots of mental health services, but often they are difficult to access. Clients can contact us directly, and this is something we encourage. They do not require referrals to be made through the mental health triage. We virtually take referrals from everybody and anybody. Most of our referrals come from the midwives, the obs and gynae medical staff on the maternity unit, maternal child health nurses and GPs, and we have a large proportion of self-referrals. We offer a comprehensive perinatal assessment and access to a psychiatrist. Our interventions include CBT, supportive counselling, mindfulness and behavioural interventions. We encourage women to be socially connected with other mothers, and obviously we talk about the myths of motherhood and validation of their experiences.

We also provide an opportunity for women and their partners to talk about their birth experience when it has been traumatic. We are able to facilitate further medical debriefs and linkages with other support services. Often the clients we see are litigious and angry. However, this usually abates with the timely response from the early motherhood service, explanations for the interventions that have occurred and validation of their experiences. Interestingly, we ask the clients what is most helpful, and it really comes back to the therapeutic relationship, the supportive counselling, the validation of their experience and the practical support, and just knowing that we are accessible and that we will walk the journey with them. In the early days I guess we did lots more — we still

do CBT — but it was lovely on paper. We could say, ‘We’ve done CBT, we’ve done solution-focused’, so it looked like we provided lots and lots and lots, but in fact it was not what the clients were wanting.

The service over time has evolved to meet the needs of the client and not the service. We are very creative in making contact with vulnerable women, including just having to pop into lactation clinic for morning tea, being on the mid ward for routine visits, thus enabling us to provide an impromptu education and again introducing our service to the women. Because of our high visual presence and co-location, it reinforces that emotional health is routinely incorporated into mainstream maternity care.

We mainly see women, but we will also see fathers. This is not something we advertise due to staff and funding limitations. With additional funding this is an area we would definitely consider expanding on. Women have contacted our service worried about their partner, and we have organised a home visit to see the couple together. This has allowed us to engage the dad, offer support and further assessment. When women have contacted us, it is not because their partners are just struggling. Historically the men we have seen have been acutely unwell, extremely high risk, unlikely to ever access help, and our interventions, I believe, absolutely have been lifesaving.

We have a no wrong door policy. With the exceptions of clients with a major mental illness, every client that is referred to our service will be offered an assessment. I guess this is probably only possible because of the quality of the referrals we get and our active attempts to educate service providers. We maintain that we do not know that a client is not for our service until we do an assessment. It is quicker and more effective both in time and intervention just to see a client and assess, then refer elsewhere and say, ‘They’re not for us’.

A classic example of this was when a 23-year-old Filipino lady with a three-month-old infant was referred by her GP because she was lonely and isolated. The referral did not include any other information. At the time I privately questioned the appropriateness of the referral. Because of our no wrong door policy I offered this lady an assessment. Certainly she was definitely lonely and she was very isolated, but 50 minutes into the assessment I completed a routine mental-state examination. This lady was experiencing command hallucinations telling her to kill herself and to kill her baby. She had been experiencing these for 10 weeks since her baby was two weeks old and she had not told anybody. Again, I maintain that the early motherhood service is a lifesaving intervention.

Antenatal education is our core business. We need to provide universal education as we cannot effectively predict who is going to be affected by mental health issues in the perinatal period. It is an opportunity to see the couple and have a conversation about emotional health, adjustment issues, perinatal depression and anxiety. At antenatal education we talk about the realities of parenting and try to reduce the couple’s expectations, because they are often very unrealistic. We talk about strategies to improve or maintain the couple’s relationship, including communication skills, problem solving and how they can support each other during a vulnerable time. But probably most importantly it is an opportunity again to introduce our service. We know that people are more likely to contact if they know who are they going to get on the other end of the phone, and we certainly received lots of self-referrals via the antenatal classes. It is well received by the clients, and that is indicated in the surveys that the antenatal classes send out. We also attend the new parents group and talk about the challenges of being a new parent, strategies to assist, mental health issues, and we actively encourage women, again, to self-refer to our service.

In the past with the looming funding woes it has been very, very stressful for our clients and for the services that refer to the early motherhood service. Our clients have been overwhelmed and made comments like, ‘But who is going to come and visit us at home? Who do we ring? How much is it going to cost us? Will it be a six-week wait? How can we arrange a longer maternity stay?’. Because we certainly will advocate that, and the maternity ward are always very receptive to our recommendations. Service providers were equally nervous. They were asking questions like, ‘Do we still screen for mental health if we have nowhere to send these women? Who are we going to refer them to? Who is going to formulate the maternity inpatient management plans?’. We are quite detailed in our plans, and they look through it word by word and it gives them lots of assurance. ‘Who is going to support the women and their partners after a traumatic birth?’. So we thank the state government for the continuing support and ongoing funding of the perinatal emotional health program. It really does make a difference to the women and their families. We would maintain that prenatal mental health is truly early intervention. So in conclusion, the early motherhood service is a free, home-based service which is well received by clients and referrers. This is evidenced by the consumer feedback surveys and our outcomes. It

prides itself on being accessible, evidence-based and flexible. The perinatal emotional health program is a cost-effective, lifesaving model. Thanks.

**Ms AHRENS** — I will just leave you to read that. We have an ongoing program of giving every client a satisfaction survey so that we can pick up on any areas that need addressing. Overall we get very positive responses. Also I am going to hand over now to Dr Sarah Hancock, who is going to talk about being a referrer to the program.

**Dr HANCOCK** — Just a bit of background, I am Dr Sarah Hancock. I am a GP obstetrician. I no longer do intrapartum care. I no longer deliver babies at Benalla, but I do provide a lot of shared care. I am the only female GP at the clinic I am at in Benalla. I am one of the associates and one of the GP supervisors. We train registrars and interns. I am also a VMO at Benalla Health. We see women in the emergency department there with mastitis, and we see women show up there with babies who do not sleep. They also show up at the clinic. I am also the mother of a three-year-old, so I actually have experience with this service from two perspectives, not only as a referrer and somebody that teaches my registrars to refer but also as a consumer.

As a referrer, the access is impeccable. I can do written referrals and fax them. I can give the phone number to my patients and they can refer themselves — though if they are often unwell enough I do not trust them to do that — or I can just leave a phone message, because we know how much doctors like doing paperwork. Not only do I have great access to Fiona and Laura themselves, but they also give me access to the psychiatrist that works with the adult mental health unit. We as the local GPs do not actually have direct access to the public psychiatrists. We have to go to the triage team or the early motherhood unit. For older persons mental health, we go through those psych nurses to Max Welstead, who is for older persons and aged care. So we do not actually get to call local psychiatrists. If we want consultant input on medication and things, we call a central service in Melbourne. That feels rather depersonalised.

Also, there is good feedback. Laura and Fiona will let me know if somebody has failed to engage. They will try multiple times. They will also feedback the need to escalate and usually give me access to a psychiatrist. We have worked together doing the phone calls round in circles to try and get a particularly unwell lady into a mother-baby unit in Melbourne, because it is pretty hard to care for your newborn when you are scrubbing yourself in the shower for 4 hours at a time. Obviously with the multiple mother-baby units in Melbourne and not much of a central service for that, it was just Laura, Fiona and I making phone calls to them and making phone calls to each other — and you just keep going because you cannot really put a mother and a baby in Kerferd. Well, you can put the mother in, but the baby gets taken away.

One of the things of course the government is interested in is cost-effectiveness. To see me when there is no service available for a mental health patient, particularly a perinatal mental health patient, for 20 minutes with me the Medicare rebate is \$71. For 40 minutes with me the Medicare rebate is \$105. Even if I privately bill these patients, the government will be paying the patients back that much on their Medicare rebate. It would be very rare that I would see any of these women for less than 40 minutes. The problem with that also is access. I am actually booked out until the middle of January. So I may see them when I am at work on Friday and need to see them in one to two weeks. Either I cannot or I take up my lunchbreak, because I am worried if I do not have access to this service.

There are GP mental health plans. Fiona mentioned a six-week wait for the psychologist; I wish it was that short. The GP mental health plan gets 10 visits per year if you are lucky, but you have to get into the psychologist in the first place. There is a lack in this area. Plus you have to have a psychologist that is willing to see or experienced in seeing perinatal patients and have patience for the baby showing up with them.

Postpartum, you cannot drive for six weeks after a caesarean. If your partner is back at work, it is a home-based service. If that is too hard, it can also be a phone-based service intermittently as well, but you have already met them face to face so it is not a nameless, faceless person down in a central phone hotline.

We have had other services from Wangaratta centralised in the past couple of years, including the dementia behaviour unit. It is substandard to what we were getting. We get a person in Melbourne, we leave a message, they call us back and they have no idea about what the services and facilities in our region are. They do not know our area. Like Fiona said, they know the local services and the other links and supports available to the women in Benalla or in Albury or in Yarrowonga, whether that is the maternal and child health.

As a consumer, individualised and flexible, I am on the edge of their service. I was an emergency caesar because that is what happens to a GP obstetrician. However, I had pre-existing anxiety, so I actually engaged with the service in person while I was pregnant, and initially I felt guilt, as most anxious people do, about them spending so long driving to see me, so a lot of my initial postpartum visits were phone appointments. There were even driving to town to do the groceries, panic attacks: pull over, 'I can't breathe', call Laura, who could talk me down from a panic attack. I have almost got over the situation enough with my son turning three recently that we are considering having another child, and the fact that we are even considering it makes me distressed, less so knowing I have the service available.

If the service was not available, it would definitely be another reason to maybe not have another child, because the other supports around are just not there. The similar service in Shepparton is closed. There is no funding. It does not exist. I work in Benalla, so some of my patients live in Violet Town and Euroa and those areas, and previously they would have been picked up by Shepparton; there now is not a perinatal emotional health program there. The breadth of women that we service is huge, from previous mental health issues worsening in pregnancy or feared of worsening postpartum, to the lass that we got into the mother-baby unit in Melbourne turning around and having a high-risk twin pregnancy the next time around but was perfectly well. These ladies helped me monitor her. I think I was more scared than the pregnant woman.

It is a flexible, local, wonderful service, and they do not have high turnover, which makes it even more reassuring to the women because they can have multiple pregnancies with the same support.

**Ms AHRENS** — Hopefully there will be a few of the early motherhood clients coming this afternoon to the community forum.

**The DEPUTY CHAIR** — Fabulous.

**Ms AHRENS** — We never come to anything without our hand out, so this is no exception. We are absolutely thrilled that we now have certain funding for the program, and a big thankyou for that, but we also see areas where, with more staff, we could do so much more in terms of the family unit. Fiona mentioned seeing partners, and the other part of the equation is the infant. I think it is critical that there is a big focus on the attachment. Often that is disturbed when someone has depression. There are various services, maternal and child health et cetera, and a program in Wodonga, but I think that if there were a greater mass of staff we could focus more on working with the infant and the parents together. That would be my hope for the future, because there is nothing better than intervening during pregnancy or in infancy rather than wait until someone has a severe mental illness down the track.

The other thing I see as really important is that the PEHP workers have a support across the state. Even just a couple of sessions a year perhaps could be funded to allow people to get together, talk about their program, share information and do some education. That is my wish list. In conclusion, I am going to hand over to Kerry just to give you a snapshot of a person. This lady is about to have an article in our local *Border Mail* paper.

**Ms DOLAN** — Hello, I am introducing the Hawkes family, Sarah and Scott and their little baby, Spencer. That is me in the red and my colleague Lisa Pascoe, who is an early intervention home visiting worker from the parents and babies service. Sarah and Scott were really looking forward to having a second baby; they were a great team and they worked really well together and supported each other well as parents. Sarah is a busy working mum, but she had a lot of time for her two-year-old, Kayden. She had a very close and nurturing relationship with him. She had a really tough pregnancy. She had quite severe pregnancy sickness and was quite relieved when baby Spencer was born and everything went well. She felt much improved. She was pleased that the feeding was going really well. She found that really difficult with her first baby. However, Spencer became quite an unsettled little baby over his first month of life. Sarah and Scott were both having difficulty getting adequate sleep. Scott had to go back to work, and Sarah was really struggling to cope with the kids at home. She was low in her mood. She was really anxious. She had no appetite, no energy and no motivation to do anything. One thing that really worried her was that she was not developing the bond with Spencer that she had had with Kayden. She was really concerned about that. The other thing that she said was very strong for her was she thought not to tell anyone that she was experiencing all these feelings. However, she was able to reach out to a very trusted maternal and child health nurse, and the maternal and child health nurse referred her to the perinatal emotional health program.

I was able to visit Sarah at home, and after talking to her and Scott, it was really apparent that she was suffering from postnatal depression. I liaised with her GP and she started treatment. Sarah said that PEHP was a wonderful support to help her work on 'me'. I have seen Sarah at home over the last eight months, supporting her to understand her postnatal depression and to build up her confidence and skills as a mum. As I mentioned before, a big concern with Sarah was how the illness would impact on her relationship and her bond with Spencer. We are lucky at the Albury-Wodonga end of our service that we have connections with the parents and babies service and this wonderful program called the early intervention home visiting program, which is a service to support and strengthen the infant-parent relationship. That has been a really helpful service for Sarah.

The other thing that Sarah very keenly became involved with was our local Getting Ahead program, which is a therapeutic program for women with perinatal mental health problems. That is our partnership with the PEHP team and the local health services and the maternal and child health services. It has been very successfully run for quite a few years now. Sarah has just returned back to work, and she is really proud to tell people how far she has come in her journey. She is very pleased to report how close she is feeling to Spencer. She and Scott work well together to manage their everyday ups and downs of being parents, but they are really enjoying family life.

**Ms AHRENS** — That is it.

**The DEPUTY CHAIR** — We will just fire up with a few questions. I might just start with Kerry with the case study that she gave. Will Sarah require ongoing support do you think?

**Ms DOLAN** — At the moment we are starting to talk about discharge. She will continue to receive support through her maternal and child health nurse and her GP, but we will be stopping seeing each other soon. We have cut back on the frequency of our visits, and probably the next time I see her will be the last time.

**The DEPUTY CHAIR** — What percentage do you think that you discharge, if you know, compared to those who require much longer term support and intervention?

**Ms DOLAN** — Most people start to feel that they are back on the road to recovery within that first year of having their baby. Other people have not sought adequate services and/or have not stayed with services and they find the impact of their illness continues over many years.

**The DEPUTY CHAIR** — Yes, there would be a number of those who would have continued issues. Earlier, I think it was right at the start, you mentioned 16.5 per cent of births that were referred. Is that the correct figure?

**Ms AHRENS** — Yes.

**The DEPUTY CHAIR** — Was that higher or lower than you expected, because you said it hit the mark, but I did not know —

**Ms AHRENS** — Depending on how it is diagnosed, between 10 and 20 per cent of women have antenatal, postnatal, emotional health problems. So seeing 16 per cent, you are very —

**The DEPUTY CHAIR** — Smack in the middle.

**Ms AHRENS** — Yes, smack in the middle.

**The DEPUTY CHAIR** — And with regard to the referrals, have you got a breakdown of the referral data, because you mentioned that a large proportion were self-referrals? Sarah mentioned that she did not always trust them to do that self-referral and she would like to do that herself. Have you got a breakdown around that?

**Ms AHRENS** — I do not. I could forward it to you. Just off the top of the head, you guys would have an idea of what the percentage is. Most of them are health professional referrals.

**Ms DOLAN** — Most are. About 10 per cent would self-refer.

**The DEPUTY CHAIR** — And how did they find out about you?

**Ms DOLAN** — Fiona was talking about attending antenatal classes and new mums groups. People largely have met us at some stage in their journey of having their baby.

**The DEPUTY CHAIR** — So they have met you rather than somebody — sister, family member or someone next door — saying, ‘Why don’t you look at this?’.

**Ms DOLAN** — Yes, I had referral this week from a woman who had seen me just recommending to her friend to come and see me.

**Ms AHRENS** — The program has had a lot of publicity, particularly around the time the funding was cut. There was a lot of publicity. There was a lot of people who had used the service, a lot of the obstetricians and GPs around the place, and it got very well known then.

**Ms BRITNELL** — I would just like to thank you all for coming because with everything we have been listening to today this has pulled a lot of it together. It was a very comprehensive presentation and beautifully put from one to the next. I actually do not have any questions, but I would like to thank you.

**Ms AHRENS** — Thank you.

**Ms DOLAN** — Thank you.

**The DEPUTY CHAIR** — I will just plug on; I have got a couple more. With regard to the men that you started to see, what sorts of diagnoses are you seeing there?

**Ms PILKINGTON** — We know that men traditionally do not access help, so, as I said, it is not abnormal that they are just struggling a bit. Major depressive episodes with significant suicidal ideation would be a couple of cases that we have seen.

**The DEPUTY CHAIR** — Pre-existing, or brought on by the birth of the child, do you think?

**Ms PILKINGTON** — The couple that I am thinking of more recently probably had a pre-existing untreated illness; then we assessed them and made a diagnosis and case-managed them for a short period of time. Another gentleman who was really high risk had an obsessive compulsive disorder that was untreated, and it became very apparent postnatally after the baby was born because in the past it had been about germs and cleanliness. Once the baby was born it was about hurting the baby. He thought that the only way to keep his baby safe was in fact to shoot himself. I have no doubt that this gentleman would have done that, but it was actually OCD. He did not have any intent of harming his baby, but that was what he was going to do to keep himself safe.

**The DEPUTY CHAIR** — How many men do you think you have seen?

**Ms PILKINGTON** — Not an awful lot. I think over the time it would be maybe a few a year that we would see, maybe four or five. It is not something that we actively promote, but it is women ringing saying that they are concerned about their partners. They are always, always very unwell when we have seen them.

**The DEPUTY CHAIR** — Are the majority of the people that you see located around Albury-Wodonga and Wangaratta, the main population centres? I mean, your catchment area is large.

**Ms PILKINGTON** — It is the whole catchment area, yes.

**The DEPUTY CHAIR** — You see across the whole catchment area. So picking up the referrals and the classes and things like that, I imagine you do not get to all of that catchment area with the classes.

**Ms PILKINGTON** — No. Certainly with the new parents groups we cover all the catchment areas, so we would do Mansfield, Benalla, Bright, Myrtleford, Yarrawonga and Wangaratta, and the antenatal classes are very much just based in Wangaratta. But if we had more funding we could expand that.

**The DEPUTY CHAIR** — Absolutely. Your contribution today has been terrific and I really thank you for all giving up so much of your time and for a seamless presentation to us. It has been greatly appreciated.

**Dr HANCOCK** — With regard to seeing males there is a mental health service in the area, an integrated primary mental health service. There used to be a male based in Wangaratta. He is gone, isn’t he?



**Ms PILKINGTON** — Russell.

**Dr HANCOCK** — Russell. There is a lot of female integrated primary health services — well, not a lot, a few. There are more female than male integrated primary services. We see lots of women that have husbands or partners that do not think they have a problem or who are not willing to speak to women because women will side with women in this sort of situation. Where future funding could go is for somebody like Russell to have a 0.1, 0.2 in the early motherhood unit, so that there is one day a week that there is a male service available. It is about using those clinicians across multiple areas, which is what Fiona and Laura already do. I think Laura is an integrated primary mental health —

**Ms AHRENS** — She is, yes.

**Dr HANCOCK** — So that is one way that you could have clinicians in the area. You are not going to find somebody to come to Wangaratta for a 0.1 or 0.2 job, but to just —

**The DEPUTY CHAIR** — Blend in with another.

**Ms PILKINGTON** — I think we have got more assertive too in seeing men. In the past I guess we heard the partners say that the father is struggling and you tell them about the services, but these days if I go to a house and the partner is in bed, I will literally say, ‘Can we knock on the door? Can you get your partner up? Can we have a conversation?’. Perhaps he is the solution to our problem, because men like to be solution-focused, and we will get them in the door and get them engaged, and every single time it has happened they will engage.

**The DEPUTY CHAIR** — That is fabulous. Also, thank you for your frankness. It has been greatly appreciated.

**Witnesses withdrew.**