Panda

Post and Antenatal
Depression Association Inc.

Senate Select Committee on Mental Health
Perinatal Mental Health

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Submitted by
Belinda Horton
Director
PANDA
Post and Antenatal Depression Association of Victoria

270 Church St
Richmond VIC 3121
PH: 03 9428 4600
FAX: 03 9428 2400
www.panda.org.au

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Background

In October 2005 I wrote to the Prime Minister John Howard about the needs of Australian men and women who develop mental illness after having a baby (Appendix A). Apart from an automatic email acknowledgement of my letter I have not received any response from him or his government. Senator Lyn Allison responded however and in a meeting with me invited me to make this submission to the Senate Inquiry.

I am the Director of PANDA, the Post and Antenatal Depression Association of Victoria (Appendix B), with extensive experience in the field of postnatal depression as a family counsellor. The recommendations within this submission are founded on the following factors:

- Women are at the highest risk of mental illness in relation to childbirth, for some their first episode of mental illness.
- Women who experience perinatal mental illness are at increased risk of long term mental and physical illnesses and therefore being long term users of the mental health and health systems.
- Men who care for their partners with perinatal mental illness are at increased risk of developing depression (figures unknown) and a further 10% of new fathers will develop postnatal depression.
- Children whose parents have untreated perinatal mental illness will demonstrate learning and developmental difficulties, hyperactivity disorders, mental illness and adult criminal behaviour.
- The relationships of men and women who experience perinatal mental illness are at greater risk of breakdown, resulting in family separation.
- Historically perinatal mental health has consistently failed to gain genuine political, strategic and media attention, despite the enourmous impact and ongoing cost to society and the health system of inadequately managed conditions
- Limited mental health dollars are consistently allocated to low prevalence, acute clinical mental health services to the detriment of the funding for high prevalence, long term community mental health services.
- There are significant inequities across all perinatal mental health service levels in Australian states/territories and between metropolitan and rural and regional areas. For example, inequitable funding and access to support services in the NGO sector, lack of specialist mother/baby units for hospital admissions, inconsistencies in the knowledge and training of mental health professionals such as psychiatrists and obstetricians and gaps in the provision of therapeutic counselling and support group services.

Purpose of submission

It is the aim of this submission to make a constructive contribution to the Inquiry on behalf of PANDA, to address the needs of men and women experiencing perinatal mental illness.

There are two main recommendations made by this submission:

- That a national strategy be established to support all state and territory perinatal health services (with particular focus on rural and regional areas) for the early identification, intervention, prevention and education of perinatal mental illness for men and women having children, that will provide enormous cost savings to the mental health and broader health systems.
- That a national non-government organization be established and adequately resourced that provides **specialist** support, education and resources to consumers, the community, health professionals and policy makers, including a national telephone number.

Definitions:

Perinatal mental illness:	this term is being used to describe the following mental illness diagnoses common to the perinatal period related to pregnancy and childbirth – antenatal depression/anxiety, postnatal depression/anxiety and postpartum psychosis
Caller:	any person who calls PANDA's telephone support service wanting information, referral or resources related to perinatal mental health. It may be the new mother or a third person calling on her behalf – partner, parents, friend or family member.

Recommendation 1:

That a national strategy be established to support all state and territory perinatal health services (with particular focus on rural and regional areas) for the early identification, intervention, prevention and education of perinatal mental illness for men and women having children, that will provide enormous cost savings to the mental health and broader health systems.

The inequities that exist in perinatal mental health services across Australia needs addressing. The establishment and provision of perinatal mental health services is historically left to chance, perhaps dependent upon the energy and commitment of consumers and health professionals. Individual municipalities and regions may have a strategy for addressing perinatal mental illness in their area. Primary mental health services in a particular area may have developed protocols. Committed consumers may have been able to withstand many struggles to establish local support groups or associations such as PANDA.

Perinatal mental health continues to be ignored by state, territory and federal governments when evidence shows that it is a hugely significant health issue and financial cost.

The Federal Government must undertake to address the need for a national strategy that will ensure that new parents throughout Australia will have equal access to support services that will ensure early intervention to reduce perinatal mental illness continuing to take its toll. The national strategy should include the following elements:

- National screening programs for women and their partners in the antenatal and the early postnatal periods for risk factors and symptoms of perinatal mental illness;
- Significant investment in and improvements to the uniformity and sophistication of the content related to perinatal mental illness within the training provided to maternal and child health nurses, general practitioners, psychiatrists and obstetricians to enhance knowledge and recognition of perinatal mental illness;
- Mandated numbers of specialist mother/baby beds in inpatient mental health services;
- More balanced allocation of mental health dollars that addresses the needs of ongoing, community based prevention services as well as acute, clinical services;
- Establishment of counselling and support services across Australia that provide specialist perinatal mental health services that also address indigenous and CALD perinatal mental health needs.
- A national exploration of the experiences and needs of the 1 in 6 men and women who have experienced perinatal mental illness. The voice of the consumer needs to be heard in real terms and to inform a national strategy.
- The establishment of a nation wide support association that would provide new parents with a single contact for information, referral and resources that would aim to ensure their access to early intervention within their local community. See Recommendation 2.

Recommendation 2:

The establishment and adequate resourcing of a national non-government organization that provides specialist support, education, resources and a SERVICE GATEWAY to consumers, the community, health professionals and policy makers, including a national telephone number.

If Australia prides itself as being an equitable society then why is it that a woman living in New South Wales or Brisbane, who is desperately trying to understand why she's not coping with her new baby, and her partner who is terrified about what is going to happen to his wife and baby, cannot access the information and support they need? Fortunately the situation facing a woman and her partner living in Victoria, Western Australia or the ACT is more positive as they can access an active telephone support service. These state and territory organizations receive small amounts of state government funding to support the state/territory based support associations – PANDA in Victoria, PANDSA in WA and PANDSI in the ACT.

Incredibly, there are no like associations in South Australia, New South Wales, Tasmania, Queensland and Northern Territory. Increasingly PANDA receives calls for support and information from throughout Australia.

PANDA's proven sustainability as a state based organisation and its position within existing perinatal mental health services ably equip PANDA to take on the role as lead agency of a national association. PANDA would be the base of the national head office and would work with existing resources and stakeholders within states and territories to establish state/territory branches. This national association would be accessed via a toll free telephone number such as PANDA's 1800 telephone number, available 24 hours a day.

Following is a description of PANDA and its role within Victoria as an outline of the model of service that could be resourced and expanded nationally.

What is PANDA?

PANDA (Post and Antenatal Depression Association) is a community based not for profit, self help organization and services the state of Victoria, established in 1985. In keeping with its founders' commitment to mutual support self help services PANDA provides information to any person who is affected by post and antenatal mood disorders including partners and extended family members, and to any person who wants more information about these conditions.

In addition to a core of paid staff (2.5 EFT) PANDA is 'staffed' primarily by volunteers who are recruited because of their personal experience of or first hand exposure to perinatal mental illness through friends or family. PANDA invests significant time and resources in training and supporting its volunteers to be able to respond to the callers' questions and to be able to assess the caller's situation. PANDA's practice will always be informed by the lived experience of perinatal mental illness through the recruitment and training of volunteers. (See Appendix B)

Some statistics about PANDA:

- supports over 2000 Victorian families per year,
- sends out approximately 500 information packs per year
- receives 3000 website visits per month
- circulates 20,000 pamphlets per year.
- Conducts approximately 50 education/training sessions per year with health professionals and community groups
- Receives approximately 400 calls from service providers, health professionals and students per year requesting information, resources and support for their clients.

The primary aim of PANDA's service is to link the caller into services within their local area that are accessible and affordable. PANDA acts as a gateway for its callers to access existing perinatal mental health and support services by assessing the caller's need for services, providing service contact details and facilitating the caller's access to the services. It is important also for PANDA to assess the factors that have and will continue to prevent the caller from seeking treatment and support, such as their feelings of shame, fear of judgement or losing their children or the impact of depression and anxiety on their self help skills.

What does PANDA do?

PANDA staff and volunteers hear many varied stories from callers everyday, often in between tears and anger. Mostly the calls are made to PANDA when the new mum and dad can no longer tolerate their situation. Many calls are precipitated by an emotional 'melt down', perhaps an episode of suicidal ideation, thoughts of hurting their baby, exacerbation of their symptoms or heightened conflict between the new mum and dad because of the impact of the perinatal mental illness.

Callers ring PANDA when they need answers, immediately, to the following kind of questions:

- What is wrong with me? Why do I feel so terrible?
- Why can't I cope with or enjoy my baby?
- Why do I want to run away from my baby when I really do love him?
- What do I need to do to make these feelings go away?
- I need to talk to someone – where can I go?
- Will I ever get better and be the mum I thought I would be?
- Why doesn't anyone understand that I can't control how I feel?
- Where has my wife that I know gone?
- Will my wife and baby be OK by the time I come home from work?
- Why does my wife scream at me all the time, I can't do anything right?
- How can I keep doing this – working, caring for the baby and worrying about my wife?

PANDA's Support Call Process

PANDA's staff and volunteers have been trained to implement a structure of assessment through a Support Call Process (See Appendix C) with every call. This Support Call Process is predicated on the assumption that the caller will only ring for support once, in recognition of the caller's struggles to ask for help, the knowledge that the call may have followed a period of increased risk to the caller and her baby and the stigma and shame related to mental illness.

The Support Call Process is designed as follows:

Can you tell me what has been happening for you?	**Assessment of the biopsychosocial symptoms**
Describe how you feel when things are at their worst?	**Assessment of the severity of the symptoms**
How long have you been feeling like this?	**Assessment of the duration of the symptoms**
Do you have a history of depression or anxiety?	**Assessment of the risk factors**
Do you have thoughts of harming yourself, your baby or suicide?	**Assessment of risk**
How are your relationships, particularly with partner, baby?	**Assessment of impact of PND**
Who have you been able to talk to?	**Assessment of available supports**
What have you tried to help get better?	**Assessment of existing treatment options**
What would you like to have happen?	**Assessment of the caller's preferences**
What are you going to do from here?	**Assessment of the caller's ability to access her own interventions**

The aim of this Call Process is for the outcome of the call to PANDA for all callers to include:

- The validation of their feelings and their situation
- Accurate assessment of biopsychosocial risk factors, symptoms and risks
- PANDA's role is not to diagnose perinatal mental illness but it is important to identify the likelihood of any of these conditions being present and to inform the caller of their options for support and intervention to ensure that they receive adequate diagnosis and treatment.
- PANDA's role is not to determine the need for medical treatment but it is important to inform the caller of the need for baseline medical assessments, diagnosis and treatment including medication.
- The provision of information to callers about what is post or antenatal depression, what they can expect from these conditions, important interventions and the process of recovery. PANDA posts out approximately 500 information packages throughout the year.
- To function as a **SERVICE GATEWAY** for the caller to access services within their local area. PANDA maintains a statewide database of PND services (General Practitioners, Psychiatrists, Pscyhologists, Counsellors, PND Support Groups, PND Playgroups) and a wide range of generalist community services. Following assessment, each caller is offered contact details for the services that they decide to access as part of their intervention and recovery. The earlier these interventions are accessed the better the recovery process.

- To explore service alternatives for the caller if the PND Services Database does not have appropriate options for the caller. This usually necessitates significant numbers of calls to services in the local area to identify options on behalf of the caller.
- To provide the caller with strategies and information that will support their ability to access the services, including discussing what will prevent them accessing the service, what they can expect and request from the service and what to do if the service does not support them in their recovery (to help prevent the caller 'dropping out' of the intervention plan)
- For some callers, especially those identified as high needs (increased instability of mental health status, at greater risk of self harm, harm to baby or suicide), PANDA staff and volunteers would make contact with the service provider on behalf of the caller to:
    - 'hand over' the outcomes of the call process and the caller's situation, especially in the case of a caller requiring immediate medical intervention by their GP, CAT Teams or Primary Mental Health Service.
    - make an appointment for the caller to attend the service,
    - advocate for the need for the caller to gain immediate access to the service (to bypass lengthy waiting lists) and
    - provide short term monitoring of the intervention plan and the caller's well being until the services and interventions are established and ongoing.

PANDA's work with Health Professionals and Services:

PANDA receives approximately 400 calls (per year) from health professionals, students and service providers with requests such as:

- Can you give me the contact details for a PND Support Group in Geelong?
- Can I refer this mum to you for counselling?
- I've seen a mum today that needs support and I have given her PANDA's number.
- Our area needs a PND Support Group. How do we go about setting it up, can PANDA help us to do this?
- Can you come and talk at our staff inservice program about what is PND, how to recognize it and what helps?
- Can I order 1000 pamphlets for our antenatal clients?
- Can you arrange for someone to come and talk to my first time mums' group about her experience of PND?

Increasingly PANDA produces and distributes accurate information about post and antenatal mood disorders to health professionals, designed to ensure that those affected are identified and receive appropriate help as early as possible. This includes conducting professional development and training for health care workers on a regular basis.

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Appendix A

The Hon. John Howard MP
Prime Minister
Parliament House
CANBERRA ACT 2600

24th October 2005

Dear Mr. Howard

1 in 6 new parents will experience perinatal mental illness.

I read in the paper that you are reviewing the ‘Not for Service’ report released by the Mental Health Council of Australia before embracing any of the recommendations made within the report. I am writing to help you with this review process.

I want to let you know that of the 251,200 births in Australia in 2003 (ABS, Births 2003, Nov 2004) the incidence of perinatal mental illness would have been:

- 42,704 women were diagnosed with postnatal depression (17%),
- 25,120 women were diagnosed with antenatal depression (10%)’
- 502 women were diagnosed with postnatal psychosis (0.2%), and
- 25,120 men were diagnosed with postnatal depression (10%).

This would mean that conservatively 93,446 Australian men and women, that is 1 in 6 new parent, experienced perinatal mental illness in 2003. These conditions cross all cultural, socioeconomic, religious boundaries.

Did you know that:

- Women are at the highest risk of mental illness in relation to childbirth, for some their first episode of mental illness?
- Women who experience perinatal mental illness are at increased risk of long term mental and physical illnesses and therefore being long term users of the mental health and health systems?
- Men who care for their partners with perinatal mental illness are at increased risk of developing depression (figures unknown) and a further 10% of new fathers will develop postnatal depression? **It is not a woman’s issue alone!!**
- Children whose parents have untreated perinatal mental illness will demonstrate learning and developmental difficulties, hyperactivity disorders, mental illness and adult criminal behaviour?
- The relationships of men and women who experience perinatal mental illness are at greater risk of breakdown, resulting in family separation?

When you and your staff are reviewing this report and the mental health system, please ask the following questions:

- The impact and ongoing cost to society and the health system is enormous and yet why does perinatal mental health consistently fail to gain genuine media, political, research and resource attention?
- Why does this benchmark report, 'Not for Service', mention perinatal mental illness in only **2 paragraphs in 1088 pages**? Why does perinatal mental health continue to be ignored by state, territory and federal governments when evidence shows that it is a hugely significant health and financial issue?
- Why are limited mental health dollars consistently allocated to low prevalence, acute clinical mental health services to the detriment of the funding for high prevalence, long term community mental health services? If people are supported in the community by well funded services that focus on awareness (in real terms), prevention and early intervention then the need for high cost acute services is lessened.
- Why is there no national strategy (with particular focus on rural and regional areas) for addressing the perinatal mental health needs of men and women when they are having their children, one that acknowledges that early intervention and prevention of perinatal mental illness provides enormous cost savings to the mental health and broader health systems?
- Why are there inequities across all perinatal mental health service levels in Australian states/territories, eg inequitable funding and access to support services in the NGO sector such as PANDA in Victoria, lack of specialist mother/baby units for hospital admissions, inconsistencies in the knowledge and training of mental health professionals such as psychiatrists and obstetricians and gaps in the provision of therapeutic counselling and support group services?
- How many of those who now have problems accessing mental health services as outlined by the 'Not for Service' report come from backgrounds where perinatal mental illness was a factor?
- Why should men and women be encouraged to have more children (baby bonus, birth rate issues etc) when we cannot support the perinatal mental health of over 93,000 or 1 in 6 new parents?
- Why is there no clear direction from beyondblue for the next stage of the National Postnatal Depression Program after 4 years of screening and research? What is going to happen to the knowledge gained to benefit families in real terms? The stigma attached to perinatal mood disorders continues to prevent men and women seeking help and there have been no increase in investment in services.
- Why does an organization like PANDA, who supports over 2000 Victorian families per year, receives 3000 website visits per month and circulates 20,000 pamphlets per year as a part of promoting awareness of perinatal mental health, have to scrape for finances and rely on donations/fundraising to boost inadequate state government funding?

Australia and your government can no longer afford to fail to address these questions in real terms.

So if you were to ask me, as a key stakeholder in the sector, what I would do with a bucket of money for perinatal mental illness I would respond:

- The establishment and adequate resourcing of a national non-government organization that provides **specialist** support, education and resources to consumers, the community, health professionals and policy makers, including a national telephone number. PANDA as a state based organisation (see attached information), established in 1985, could ably take on this role with adequate resourcing.
- A national exploration of the experiences and needs of the 1 in 6 men and women who have experienced perinatal mental illness. The voice of the consumer needs to be heard in real terms and to inform a national strategy.
- A national strategy within all state and territory perinatal health services for the early identification, intervention, prevention and education for men and women having children, Australia’s future. This could include:
    - National screening programs for men and women in the antenatal and the early postnatal periods for risk factors and symptoms of perinatal mental illness;
    - Significant investment in and improvements to the uniformity and sophistication of the content related to perinatal mental illness within the training provided to maternal and child health nurses, general practitioners, psychiatrists and obstetricians;
    - Mandated numbers of specialist mother/baby beds in inpatient mental health services;
    - More balanced allocation of mental health dollars that addresses the needs of ongoing, community based prevention services as well as acute services;
    - Establishment of counselling and support services across Australia that provide specialist perinatal mental health services that also address indigenous and CALD perinatal mental health needs.

My final question to you Mr. Howard is what are you and your government going to do to respond to my questions about the perinatal mental health needs of all Australian families, particularly the 1 in 6 parent who will experience perinatal mental illness?

Yours sincerely

Belinda Horton

Director

PANDA

Appendix B

Executive Summary

PANDA (Post and Antenatal Depression Association) is a community based not for profit, self help organization and services the state of Victoria. In keeping with its founders' commitment to mutual support self help services PANDA provides information to any person who is affected by post and antenatal mood disorders including partners and extended family members, and to any person who wants more information about these conditions.

Increasingly PANDA produces and distributes accurate information about post and antenatal mood disorders to health professionals and the wider community, to ensure that those affected receive appropriate help as early as possible. This includes conducting professional development and training for health care workers.

The History of PANDA

PANDA began in the early 1980's when two women with postnatal depression (PND) were introduced to each other by their Maternal and Child Health Nurse. Each found it helpful to talk to the other so they continued to meet regularly to share their personal experiences. They increasingly found that there were more women who were interested in sharing their personal experiences and who benefited from the mutual support. Collectively the women decided to establish a support group and over time the organization of PANDA was established to cope with the demand for the need for the group.

At this time, there was very little awareness of, and very little medical information about childbirth related mood disorders. The group decided to approach a medical practitioner with a special interest in this field, from the Royal Women's Hospital, to be available as a consultant and referral source for the women. In response to this the group held an information session at which the psychiatrist spoke about the treatment of PND. A woman who had recovered from PND and a man whose partner had experienced PND also spoke. Several hundred women and their families attended the first information session, eager to learn more about PND and to meet others going through similar experiences.

In 1985 a Committee of Management was formed and in 1986 PANDA became an incorporated association. Becoming an incorporated association came with obligations – the development of a code of ethics and a constitution. As the need for support and awareness grew it became apparent that this type of support was invaluable to women and their families experiencing post and antenatal depression. Over time, however, the nature of PANDA's services became unsustainable as the resources available in volunteers who were able to facilitate the support groups, support unwell women and their families or to bear the demands and intrusion of the telephone support line diminished. This trend paralleled the overall reduction in volunteer resources within the community as there were more women in the paid workforce.

A review of PANDA was conducted in 1999-2000 that resulted in a more sustainable model of operation with minimal recurrent funding from the Department of Human Services. This model saw the establishment of a telephone support Helpline that was office based and available during business hours only, answering machines that provided information to support after hours callers and the cessation of facilitation of support groups by PANDA volunteers, replaced by a database of support groups run throughout Victoria by other facilitators.

In the years that followed PANDA's establishment it has continued to provide services to families and the mental health sector despite periods of difficulties that have threatened its viability. After several re-locations, restructures and the enormous commitment of many staff and volunteers PANDA has now consolidated its position in the mental health sector providing a critical service to the state of Victoria.

Philosophies of PANDA

PANDA's Vision

PANDA is committed to a community where post and antenatal mood disorders are recognised and the impact on women and their families are minimised through acknowledgement, support and education.

PANDA's Mission

PANDA's mission is to:

- Support and inform woman and their families who are affected by post and antenatal mood disorders; and
- Educate health care professionals and the wider community about post and antenatal mood disorders.

PANDA's Beliefs

PANDA's beliefs govern the way it works in the community and with women and their families. They are:

- that all people are important and PANDA's consumers, staff. volunteers and colleagues should be treated with respect and dignity
- that it is important for PANDA to instill hope, that change and growth are possible
- that consumers should be empowered to make informed decisions about their management based on quality information and support
- that consumers and their families are in the best position to determine what helps them and what they can do
- that most of the time, people are doing the best they can
- that services are best delivered to people within their own communities

PANDA's Services

Responding to continually increasing community needs PANDA has evolved into a valuable and critical service, well utilized by the wider community and health professionals. PANDA's services include:

1. **Telephone support, information and advocacy** – PANDA's telephone and referral service is staffed by specifically trained volunteers and supervising staff. Many of these volunteers have experienced antenatal or postnatal depression. On average PANDA receives 200 calls through the Helpline per month, with an increasing prevalence of calls of very high needs (presence of severe PND, suicide risk or at risk infants), of calls from male partners and extended family members and large numbers of callers reacting specifically to current media coverage of PND related issues.
2. **Information packs** distributed to women, their families, friends and general community members. Increasingly health professionals are requesting information about post and antenatal depression.
3. **Resource and referral information about local services** throughout Victoria – the statewide database includes PND groups, health professionals, psychologists, counsellors and support services in the callers' local areas. These professionals have a specific interest and expertise in working with women experiencing post and antenatal depression and their families. Sometimes

this may necessitate PANDA staff or volunteers making contact with these services on behalf of the woman, due to her degree of illness.

4. **Assistance setting up PND Support Groups –** PANDA encourages a 'whole of community' response to post and antenatal depression. The outcome of community meetings, specific training or an apparent community need may be a collaborative effort to establish a new support group for women experiencing PND. PANDA provides information to prospective support group facilitators and ongoing secondary consultation. PANDA also facilitates a peer support and education network for **PND Group Facilitator's Network** from throughout Victoria.
5. **PANDA's website –** although still in an early establishment stage PANDA's website is an increasingly valuable means for the community and health professionals to access information about post and antenatal depression, interventions, research and supports. Plans to upgrade this website are underway in 2004. On average there are approximately 3000 hits on this website per month.
6. **Information, education and training seminars –** customized training can be developed for fee for service for professionals and community groups according to specific requirements for information and skills.
7. **Guest speakers –** PANDA staff and volunteers are available to speak to professional and community groups.

Appendix C

Telephone Support Process

PHASE 1: Opening to the call:

- Identify the caller's name (if appropriate) and engage with the caller
- Allow initial telling / 'unloading' of their story and the reason for their call
- Contain distress and/or enact the Protocol for High Needs Calls

PHASE 2: Assessment process:

- Establishing the needs of the caller – existing diagnosis of PND, who has the caller spoken to about how he/she feels
- Presence and severity of biopsychosocial symptoms that might indicate/confirm possibility of post or antenatal depression
- Risk assessment – suicide (ASIST), self harm, harm to baby or children; also focus on inability to cope and relationship difficulties
- Explore what strategies/supports the caller is currently utilizing and what has been tried already
- Identify what strategies/supports the caller requires

PHASE 3: Support/Education process:

- Active listening and validation of the caller's experience and feelings
- Provide accurate information about post and/or antenatal depression
- Provide information about options for biopsychosocial treatment – balance of medical, psychological and social interventions
- Reinforce the importance of accurate diagnosis (especially if no diagnosis has been made) and intervention

PHASE 4: Establish outcomes of the call:

- Provide the caller with contact details and information about the relevant supports in his/her community that he/she wants to access – eg. General Practitioner, Psychiatrist, Maternal and Child Health Nurse, Counsellors, Support Groups with particular focus on PND; information from generic community directories.
- Provide the caller with strategies for enhancing him/her support networks – partner, family, friends,
- Make suggestions of strategies to assist the caller to manage his/her recovery – time out, practical support, diet, exercise, relaxation
- Offer to send out an information pack relevant to the needs of the caller

PHASE 5: **Review the call:**

- Identify what has been helpful for the caller and what he/she will use
- Reinforce the importance of the caller accessing support services etc. for recovery with a view to gaining some commitment from the caller that he/she will access services as identified, especially where medical assessment and interventions (including medication) are indicated
- Encourage the caller to make further contact if he/she is unable to access the services or if he/she is requiring the Helpline support

PHASE 6: **Conclude the call**

- Offer to make a review call in 1-2 weeks
- Invite further contact from the caller if required
- Arrange the postage of information to the caller
- Shred all notes of the call if contact is concluded
- Put notes into the High Needs / Return Calls folders in locked filing cabinet until shredding at the conclusion of the contact/review process.