



Committee Secretariat
Senate Select Committee on Women's Health
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Submission to the inquiry into women's health (postpartum mental health care)

IN SHORT

We are a psychology practice in Western and South Western Sydney. We see women in pregnancy and in the years after birth, their partners, and their children. Our comments are on the cost and accessibility of postpartum mental health supports and services, the care models and programs behind them, and the data that should tell government whether they work.

Our main point is simple. **A positive screen should start a clock, not a search.** Australia now asks women about their mental health in pregnancy and after birth. What happens next is left to the woman. She has to find a GP who is her usual GP, get a plan, find a psychologist with a free appointment and work out what it will cost, all with a new baby.

- Women with moderate depression or anxiety after birth sit in the “missing middle”. They are too unwell for brief help but not unwell enough for public perinatal teams. The main funded path for them, Better Access, was not designed around a baby.
- Better Access was built around the calendar year and a usual GP, and its rebate has not kept pace with the cost of care. New mothers rarely fit that shape. Community psychology is where most of them can be treated well, if the settings let it.
- No one can say how many women are screened after birth, referred, treated, or left waiting. The national data do not exist.
- We ask for a perinatal care episode that follows the woman rather than the calendar or the GP, a funded clock from screen to first appointment, psychology in-reach to women's crisis accommodation, and national data that can see community care.

WHO WE ARE

Unbound Minds Psychology is a psychology practice with clinics at Gledswood Hills, in the Macarthur growth corridor where many young families are settling, and at the Nepean Health Hub in Kingswood, next to Nepean Hospital, and telehealth across NSW. We see children, teenagers and adults, and run a perinatal and early parenting support service. We are funded through Medicare, the NDIS (we are a registered NDIS provider), workers

compensation and privately. Our psychologists are employees, and we supervise provisional psychologists.

We have made submissions on mental health access before. Our submission to the NSW Legislative Council Portfolio Committee No. 2 inquiry into outpatient and community mental health care (Submission 69, 2023) was cited in the committee's Report 64 (June 2024) at paragraph 2.28, on Medicare rebates not reflecting the true cost of care.

What we describe below are trends across the practice. We do not use client stories or client data.

WHAT WE SEE (POSTPARTUM EXPERIENCES, INCLUDING PSYCHOLOGICAL AND ECONOMIC IMPACTS)

Our clinics sit in communities with many births and few local services. Primary Health Network needs assessments for Nepean Blue Mountains and South Western Sydney both name gaps in community postnatal mental health services and in services for women experiencing family violence.

Many of the women who come to us make contact some months after the birth, once the early support from family and the hospital has fallen away, rather than in pregnancy. Most are dealing with moderate depression or anxiety. They are struggling, but still holding the day together. Some arrive after being screened with no plan and no regular GP, so their first step is paperwork rather than care. Partners often don't come at the start, but some join later sessions when invited.

ON THE COST AND ACCESSIBILITY OF POSTPARTUM MENTAL HEALTH SUPPORTS AND SERVICES

For a woman with moderate postnatal depression or anxiety, the main funded path is a GP mental health treatment plan and Better Access. Four features of it work against new parents.

- **The calendar, not the baby, sets the limit.** Better Access caps sessions per calendar year. Postnatal illness doesn't follow the calendar. A woman whose difficulties start late in the year can reach the end of her allocation, or the reset, at the hardest point of her recovery, and must return to her GP for a review to keep going.
- **The front door has moved.** Since 1 November 2025, Better Access plans and referrals must come from the patient's MyMedicare practice or usual medical practitioner. Women who have moved into a growth suburb late in pregnancy, whose care has mostly been with the hospital, or who have left home because of violence, often have neither. For them the first step is a GP appointment whose only purpose is paperwork.
- **The rebate has not kept pace with the cost of care.** The Medicare rebate sits below what a session costs to provide, as the NSW Legislative Council recognised in Report 64. Families on one income during parental leave feel this most. We see some women space their sessions out, or stop when their sessions or their budget

run out, often just as they begin to improve, and questions about cost before booking are common.

- **The pregnancy item is not treatment.** Medicare's pregnancy support counselling items fund a few sessions of non-directive counselling. They are useful. They are not a course of treatment for depression or anxiety.

The free Medicare Mental Health Check In and Medicare Mental Health Centres are welcome. The Check In is aimed at mild concerns. Moderate postnatal depression and anxiety still fall to Better Access.

ON CARE MODELS AND EXISTING PROGRAMS (THE MISSING MIDDLE)

The national perinatal mental health guideline recommends screening in pregnancy and after birth, and now extends this to fathers and partners. NSW screens through SAFE START, and the 2026-27 Budget funds work toward universal perinatal screening.

Screening only helps if there is somewhere to go. NSW public Perinatal and Infant Mental Health Services are for women with severe, acute or complex illness, and neither public mother and baby unit is in South Western Sydney or Nepean Blue Mountains. Stakeholders told the Commonwealth's evaluation of the Perinatal Mental Health and Wellbeing Program, published in June 2026, that the middle levels of care were underdeveloped, leaving a "missing middle", and the evaluators concluded that "there is a need to bridge the current gap between screening and referral".

That middle is where most women with postnatal depression and anxiety sit, and where community psychology works. The NSW Birth Trauma inquiry reached the same place. Its Recommendation 5 asked for psychological support beyond the immediate postpartum period and for more Medicare-rebatable support for new parents, to reduce gap fees and allow the number of sessions clinically required. The NSW Government supported it in principle.

We think the fix is not more of the same pathway but a door of its own. Medicare already accepts, through the pregnancy support counselling items, that pregnancy is a reason for psychological support without a mental health plan. A perinatal care episode would extend that logic to treatment. It would be one episode from pregnancy until the child turns two, or for a year after the loss of a baby, for mothers and partners, referable from the places women already are (the GP, obstetrician, midwife, child and family health nurse, hospital perinatal team or crisis accommodation), with GP review built in after the first course rather than before it.

Partners belong in this. The guideline now screens them, and the episode should cover them too. So do parents after miscarriage, stillbirth or the death of a baby, who are often discharged from maternity care with no plan for their mental health at all.

ON WOMEN LEAVING VIOLENCE

For a woman who has left violence with a baby or while pregnant, the usual pathway asks for things she may not have, such as a usual GP, a plan, transport, a phone that is safe to use and money to cover the cost of care. The Nepean Blue Mountains PHN notes that

consistent, affordable health care is a particular challenge for women experiencing family violence.

Women in crisis accommodation, many of them pregnant or caring for a baby, need a psychologist who comes to them, without first having to find a usual GP and a plan. The pathway described above does not provide for that.

ON DATA, RESEARCH AND TRAINING

- **No one can count the gap.** The AIHW says there are no national data on perinatal mental health screening, service use or outcomes, and the Commonwealth's evaluation calls the lack of postnatal and partner screening data "a critical gap". Even a complete collection of screening would not show what happens next unless it follows women into community psychology and crisis accommodation, where much of their care happens.
- **Measure the connection, not the screen.** A screening program judged on screens completed will look successful while women wait. The measure that matters is the time from a positive screen to the first attended appointment.
- **Later deaths are not counted.** Maternal death reporting stops weeks after the end of pregnancy, so deaths by suicide later in the first year after birth fall outside it. They should be counted and reviewed, so that services can learn from them.
- **Training follows placements.** Psychologists learn perinatal and family-violence-informed practice best by doing it under supervision. Supervised placements for provisional psychologists in growth corridors and in-reach settings would build that workforce where births are concentrated.

WHAT WE'RE ASKING FOR

1. A perinatal care episode in Medicare that covers psychological treatment from pregnancy until the child turns two, or for a year after the loss of a baby, for mothers and partners. It would count as one episode rather than by calendar year, be referable by a GP, obstetrician, midwife, child and family health nurse, hospital perinatal team or crisis accommodation service without first needing a mental health treatment plan from a usual GP or MyMedicare practice, and include GP review after the first course.
2. A clock on every positive screen. Commonwealth funding for universal perinatal screening should continue beyond 2026-27, on the condition that a named party is responsible for connecting each person with a positive screen to treatment within a defined period, with time from screen to first attended appointment reported as the program's main measure.
3. A perinatal Medicare rebate that reflects the real cost of care and is indexed each year, so cost does not decide whether a new mother finishes treatment.
4. Commonwealth or joint funding for psychology in-reach to women's crisis accommodation for pregnant women and mothers of young children, referable by

shelter staff without a GP plan, with priority continuation in community care, and a published model that Primary Health Networks can commission against.

5. Where a Primary Health Network's own needs assessment names a gap in moderate-level perinatal care, commissioning of that care from local community psychology practices, and plain-language local information for women, GPs and caseworkers on where to go after a screen, how to book, the likely wait and the likely cost.
6. National postnatal data on screening, referral, treatment started and out-of-pocket cost, for mothers and partners, reported by PHN region and including care in community psychology and crisis accommodation, with deaths by suicide in the first year after birth counted in maternal death reporting.
7. Supervised placements for provisional psychologists in perinatal care in growth corridors and in-reach settings, and perinatal mental health counted separately in psychology workforce planning.

CLOSING

We'd welcome the chance to appear at a hearing, including a hearing in Western or South Western Sydney. We consent to this submission being published.

Yours sincerely,



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Chief Executive Officer
Unbound Minds

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