



# **The *beyondblue* National Postnatal Depression Program**

**Prevention and Early Intervention 2001 – 2005**

**Final Report**

**Volume II: State-based Antenatal Intervention Initiatives**

**CONTENTS PAGE**

**Executive Summary ..... 5**

**Victorian Intervention Initiative: “Antenatal Support Following Depression- Enhancing the Parent-Infant Relationship” ..... 8**

**Overview..... 9**

**Introduction ..... 9**

**Methodology..... 12**

        The Idea..... 12

        Program Development..... 12

        Survey ..... 12

        Focus Group ..... 12

        In-depth Interviews ..... 13

        Pilot Study Design..... 13

        Procedure ..... 13

        Outcome Measures..... 13

**Results..... 15**

        Program Development..... 15

        Feasibility and Barriers in the Pilot Study ..... 17

        Recruitment and Retention..... 17

        Consumer Feedback Survey..... 19

        Depression Anxiety and Parenting Stress ..... 20

        Impact on Service Usage..... 22

**Discussion ..... 23**

**Key Recommendations ..... 24**

**Significance ..... 24**

**References ..... 25**

**South Australian Intervention Initiative: "Helping Him to Help Her" ..... 27**

**Overview..... 28**

**Introduction ..... 28**

**Aims ..... 28**

**Methodology..... 29**

**Results..... 29**

        Literature review ..... 29

        The intervention package ..... 29

        Piloting of the project, and attempted methods of recruitment..... 31

        Randomised Controlled Trial of Efficacy ..... 32

        Literature Review of Barriers to Men Seeking Help ..... 33

        Possible Solutions to the Problems Encountered in Recruitment..... 34

**Conclusions ..... 35**

**References ..... 35**

**Appendices ..... 36**

        Appendix A..... 37

        Appendix B ..... 59

        Appendix C ..... 60

        Appendix D..... 61

        Appendix E ..... 62

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**Western Australian Intervention Initiative: “The beyondblue National Postnatal Depression Project for Families with Multiple Birth Children” ..... 63**

**Preface ..... 64**

**Overview..... 65**

**Introduction ..... 66**

**Methodology..... 67**

    Education & Awareness Raising..... 67

    Screening Project ..... 68

    Focus Groups ..... 68

**Results..... 69**

    Education and Awareness Raising..... 69

    Information booklet..... 69

    Presentations and media coverage ..... 70

    Screening Project ..... 70

    Focus Groups ..... 72

    Risk Factors..... 72

    Screening ..... 73

    Support Services..... 73

**Conclusions ..... 75**

**Recommendations ..... 75**

**References ..... 77**

**Appendices ..... 78**

    Appendix A..... 79

    Appendix B ..... 79

    Appendix C ..... 83

    Appendix D..... 91

**Queensland Intervention Initiative: “Education and Training for Regional, Rural and Remote Health Professionals” ..... 93**

**Introduction ..... 94**

**Aims ..... 94**

**Method..... 94**

    Awareness-raising..... 94

        Participants ..... 94

        Procedure ..... 95

    Single-session Education ..... 95

        Participants ..... 95

        Procedure ..... 95

    Multi-session Education..... 95

        Participants ..... 95

        Procedure ..... 96

    Focus-groups ..... 96

        Participants ..... 96

        Procedure ..... 96

**Results..... 96**

    Awareness-raising ..... 96

    Single-session Education ..... 97

    Multi-session Education..... 98

    Focus-groups ..... 99

**Conclusions and Recommendations ..... 101**

**Queensland Intervention Initiative: “Indigenous Women’s Project: Report of Process and Preliminary Results” ..... 104**

**Preface - Specific Contextual Background ..... 106**

**Introduction ..... 106**

**Aims ..... 107**

**The Process: Essential Sequential Steps..... 107**

Choice of Sites ..... 107

Description of Sites ..... 107

Site-specific Indigenous Women’s Reference Groups ..... 107

Process of Iterative Consultation ..... 108

Profile of the Sites ..... 109

Profile of the research process at the three sites ..... 109

The Site-specific ‘Edinburgh Package’ ..... 110

**Hypotheses ..... 110**

**Results (preliminary) ..... 111**

Hypothesis (a) ..... 111

Hypothesis (b) ..... 111

Hypothesis (c) ..... 113

**Conclusion ..... 114**

Ethical Concerns Arising From the Study ..... 114

**New South Wales Intervention Initiative: “Clinical Interventions For, and Preferences of, Women from Vietnamese and Arabic Speaking-Backgrounds” ..... 116**

**Preface ..... 117**

**Overview..... 118**

**Introduction ..... 118**

Design: Overview..... 119

**Part 1 – Research Studies ..... 120**

**A. Arabic and Vietnamese women’s psychosocial intervention uptake study... 120**

Background ..... 120

**Method..... 122**

Procedure..... 122

Interventions..... 122

Measures ..... 122

**Results..... 123**

Comparative analysis among 3 samples of women ..... 123

Participants ..... 123

Helpfulness of Interventions ..... 125

**B. Arabic women’s preferences study: synopsis..... 126**

**Part 2 – Translation And Health Promotion ..... 126**

Method ..... 126

Background ..... 126

Procedure..... 126

**References ..... 128**

**TABLES AND FIGURES**

**Victoria**

**Figure 1** ..... 13

**Table 1. Timing of measure in the pilot study**..... 15

**Table 2. Characteristics of antenatal women in the ‘at-risk’ and ‘low risk’ groups**..... 18

**Table 3. Engagement of intervention women** ..... 18

**Table 4. Consumer feedback survey** ..... 19

**Table 5. Summary of participant feedback coded from clinical notes by therapist**..... 20

**Table 6. Mean values (SE) from 12-week postnatal psychometric questionnaires returned to date**  
..... 21

**Table 7. Patterns of help seeking in women ‘at risk’ and at ‘low risk’ of depression in pregnancy**  
..... 22

**South Australia**

**Table 1. List of common reasons used for lack of attendance to SA initiative**..... 62

**Western Australia**

**Table 1. National distribution of information booklet for parents of multiples by state**..... 69

**Chart 1. Comparison of symptoms of depression from pregnancy to postpartum for mothers of twins and mothers of singletons**..... 71

**Queensland – Education and Training for Regional, Rural and Remote Health Professionals**

**Figure 1. Accurate knowledge questionnaire response** ..... 97

**Table 1. Means and standard deviations of four session evaluation questions** ..... 97

**Figure 2. Single session education evaluation**..... 98

**Figure 3. Influence of *beyondblue* program and training**..... 99

**Table 2. Discussion topics and themes emerging from focus group 1**..... 100

**Queensland – Indigenous Women’s Project**

**Table 1. Comparison of paired Indigenous EPDS and mainstream EPDS in a sample of North Queensland Indigenous women** ..... 111

**Table 2. Community workshop participants perceptions group by risk factors related to increased site-specific EPDS scores ..... 113**

**New South Wales**

**Figure 1. Diagram of the different aspects of the *beyondblue* NESB project ..... 119**

**Table 1. ICMHS psychosocial questions and risk domain ..... 120**

**Table 2. Number of women who speak Arabic or Vietnamese as a primary language and who were referred to social work or PIMHS over a 6-month period at Liverpool Hospital antenatal clinic ..... 121**

**Table 3. Maternal age and gestation and mean (SD) Edinburgh scores at ‘booking-in’ appointment ..... 123**

**Table 4. Percent of referred Arabic and Vietnamese women scoring ‘positively’ (indicating risk) on the psychosocial questions ..... 124**

**Table 5. Take up of interventions offered to referred women ..... 125**

**Table 6. Referred women: Edinburgh scores at recruitment and following birth ..... 125**

## **Executive Summary**

Each State as part of the overall project, sought to build on current expertise and services to expand and evaluate an intervention for perinatal depression. As a result of the breadth of expertise of the State directors and their teams, this section of the project was diverse, but with implications for women across Australia.

In summary:

- ◆ Queensland, Western Australia and NSW all developed information material for specific groups of women that had not been available to them before. With the exception of the Indigenous material (more specific to Palm Islanders/Mt Isa, but has been made available as a base for other Indigenous groups), these have been made available on the web and in hard copy to women in all States;
- ◆ mothers who have a “multiplies” birth are at particular risk and have significant unaddressed needs;
- ◆ in Victoria, a self-help intervention program for pregnant women and their partners, to cope with the emotional transition to parenthood, was found highly acceptable. However, general practitioners and maternal and child health nurses need to be more centrally involved in the program to increase uptake by women;
- ◆ Indigenous women score no differently on the language specific EPDS than on the mainstream EPDS, or on the suicidal ideation question (Q10).
- ◆ an in depth analysis of the issues related to depression in Indigenous perinatal women reveals the high importance of psychosocial stressors;
- ◆ long distance education was successful at increasing awareness and knowledge but like the other education packages, needs ongoing training, and was not without technical difficulties that could be improved with flexible formats;
- ◆ a low-cost, self-help intervention was beneficial and potentially feasible on a large scale;
- ◆ interventions with at risk women, male partners and Arabic women all showed significant issues of reluctance to seek assistance, but with benefits for those who did. Understanding and overcoming these barriers remains the key to increasing early intervention, in association with routine screening;
- ◆ a more in depth analysis and pilot intervention into Vietnamese and Arabic women showed benefits of telephone counselling and psychosocial interventions;
- ◆ despite some difficulties recruiting at risk women, a low cost minimal intervention can be of benefit and if tied in with screening could increase those women receiving appropriate assistance;
- ◆ male partners were particularly difficult to engage (alternatives such as web-based packages should be utilised) and suggests a larger cultural change is required before a primary intervention involving them is likely to be successful.

**Victorian Intervention Initiative:  
“Antenatal Support Following Depression- Enhancing the  
Parent-Infant Relationship”**

**Final Project Report**

**by**

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## Overview

In Victoria alone, more than 10% of pregnant women (>6,000 annually) are at risk of depression, anxiety and/or may be vulnerable to sub-optimal parenting and poor parent-infant relationships with their new baby. Existing antenatal interventions have not been successful in addressing these problems. Using a systematic process of consultation with pregnant women, parents and professionals we developed, in manual format, a self-help antenatal support program *Toward Parenthood* incorporating aspects of content and delivery format that specifically redress the failings of previous programs. Focus group feedback on program content was extremely positive. The feasibility of widespread implementation of this new program was then evaluated in a pilot study including pregnant women ‘at risk’ and at ‘low risk’ of depression. As found in previous studies, there was difficulty engaging women with the intervention program and difficulty retaining participants. ‘At risk’ women were statistically less likely to engage with the program. We recommend a number of specific changes to program implementation designed to maximise uptake and completion of the intervention and to involve GPs and Child Health Nurses more productively. Preliminary psychometric data from the pilot study are consistent with intervention having beneficial effects on postnatal depression levels and on anxiety. Those who attended intervention sessions found the program to be positive, supportive and valuable. The strategies to increase engagement are now in place and the *Toward Parenthood* program is ready for a larger community randomised trial to evaluate its effectiveness and preliminary results suggests it has the potential to be a major public health intervention.

## Introduction

The deleterious effects of postnatal depression (PND) on both mothers and infants have been well documented. Not only does the woman’s mood disorder plunge her into feelings of despair and hopelessness, but also this impacts on her relationship with her infant with long-term consequences on cognitive, behavioural and social development<sup>1</sup>. There is therefore an urgent need for the development of effective methods of prevention and early intervention. In order to intervene effectively, vulnerable women must be identified as early as possible, preferably during pregnancy<sup>2</sup>. We now know that approximately 10-13% of pregnant women experience depression and one half of these women will go on to develop PND<sup>3,4</sup>. The antenatal period is thus a critical time to identify and treat those at risk<sup>5</sup>, thus preventing some of the impact on their new infants.

A brief outline of six existing studies follows. These treatment trials to date have not attempted to treat or identify existing antenatal depression but to teach women skills to prevent the development of postnatal depression. An early attempt at antenatal prevention of PND<sup>6</sup> used a psychoeducational approach. Subsequently, there have been a handful of randomised controlled trials (RCTs) of antenatal interventions aimed at women identified as ‘at risk’ of PND. Elliott et al<sup>7</sup> allocated women to one of two preventive interventions or to a control condition. Their two interventions, ‘Preparing for Parenthood’ (first-time mothers) and ‘Surviving Parenthood’ (second-time mothers), consisted of five antenatal and six postnatal sessions. Women in the Preparing for Parenthood groups experienced a significantly more positive mood postnatally than control participants (Surviving Parenthood groups were unsuccessful).

A similar, but much shorter antenatal intervention<sup>8</sup> was trialled with 73 women allocated to intervention and 71 to routine care. At 6 weeks and 12 weeks postpartum there was no significant difference in depression level between the two conditions. In another small pilot study<sup>9</sup>, 44 nulliparous women ‘at risk’ of PND were allocated between intervention and routine care. The ten sessions were well attended and covered parenting issues, mothercraft skills, anxiety and postnatal depression. At 6 weeks postpartum there were no significant between-group differences in depression or anxiety but the intervention group did report better marital relationships. In a third study, an antenatal intervention designed to reduce risk factors for PND by increasing social support and problem solving skills, was trialled with a sample of 190 women<sup>10</sup>. It consisted of six, two-hour, weekly antenatal classes and the key elements included: acknowledgement/discussion of social/emotional problems of pregnancy; information about PND, social support; learning ways to develop, use and maintain support skills; learning and practicing problem solving; identification/exploration of unhelpful thoughts and beliefs about motherhood. Results revealed no significant impact on PND or its risk factors. These last three studies were variously hampered by poor group attendance, small study numbers and high attrition rate (55% in one case).

More recently, 35 women from ‘financially deprived’ backgrounds were allocated to routine care or to a four-session group intervention, ‘Survival Skills for New Moms’<sup>11</sup>. Based on interpersonal therapy it targeted risk factors for PND. Each hour-long session focused on PND, role transitions and associated changes and on goals for successfully managing transition. At three months postpartum six of the 18 women in routine care had developed PND, compared with none of the 17 women in the intervention but due to the small sample size definitive conclusions were not possible.

In summary, the weight of current evidence appears to show that antenatal programs aimed at reducing PND are not demonstrably successful. A number of problems may have contributed to this negative result:

- (1) Small study numbers making it difficult to test for effects on PND prevalence following intervention. In addition, attrition has been high and it may be that pregnant women do not easily engage in treatment.
- (2) Non-identification of antenatal depression among women participating in interventions.
- (3) A narrow focus on outcome in terms of maternal and partner functioning. Given the serious consequences of PND on the parent-child relationship we need to focus on prevention of not only depression but also parenting difficulties.
- (4) Lack of a cohesive, evidence-driven approach grounded in a clear theoretical framework.

The *Toward Parenthood* program implemented here, as part of the National Postnatal Depression Program, was able to deal with each of these issues respectively in the following ways:

- (1) In order to be accessible to large numbers of pregnant women we developed the intervention in the form of a self-help guidebook for women and their partners, supported by weekly telephone calls by a therapist. This ‘minimal’ intervention can therefore be available to large numbers of women, as it requires less professional time or out-of-home appointments by busy women. We also collected consumer feedback on the intervention to provide valuable information on reasons for attrition and barriers to engagement with the program – essential problems that need to be addressed before larger trials are conducted.

(2) All women who screened as at 'risk' of depression were linked to their General Practitioner (GP) for assessment and management. The program also contains three cognitive-behaviour therapy based units providing self-help skills for coping with anxiety and depression.

(3) Previous interventions have not been designed specifically to address the issue of parenting difficulties but focused on depression alone. In contrast, the *Toward Parenthood* intervention described here has a dual focus on depression/coping and on parenting skills with the purpose of (a) reducing the suffering experienced by women with either antenatal or postnatal depression and fostering access to help (b) preventing postnatal depression and (c) enhancing parenting skills, minimising parenting difficulties and improving infant functioning. The focus on parenting skills is crucial as these skills are often impaired by depression, resulting in disturbed mother-infant relationships that often fail to recover after depression remits. This has the potential for long-term detrimental effects on infants' cognitive and emotional development and family functioning.

It has been argued that the best model for guiding interventions aimed at preventing disorders such as PND, is the reduction of risk factors and the strengthening of protective factors<sup>12</sup>. This approach has been taken by the *Toward Parenthood* program, described here, which tackles the difficulties associated with major risk factors for PND identified in the literature: antenatal depression, anxiety, stressful events, poor social support, marital difficulties, single parenthood, young maternal age, low self-esteem, difficult infant temperament, low socio-economic status, unplanned pregnancy, previous psychiatric history and difficult birth experiences e.g. unplanned caesarean<sup>1,13-15</sup>.

We also took into account known risk factors for parenting difficulties<sup>16</sup>. Some of these overlap, e.g. lack of social support and negative life events, young age, poor education, financial difficulties, mental health problems and a history of substance abuse<sup>17-20</sup>. Women who have endured negative life events (e.g. physical/sexual abuse) are also more vulnerable to parenting difficulties and are more likely to neglect their children and use physical punishment<sup>21</sup>. Poor levels of maternal-foetal attachment have also be linked to maternal violence toward children at 4 years of age<sup>22</sup>. Other risk factors include: difficult/traumatic childbirth, single motherhood, negative parenting role models and anger problems.

Clearly then, several of the main risk factors for PND and parenting difficulties overlap, and these were targeted by the *Toward Parenthood* intervention, through dealing with: couple relationships, family problems, negative life events, rethinking childhood experiences, isolation, anxiety and or depression, coping and parenting skills, expectations of motherhood, and perceptions of and attachment to infants.

(4) In addition, we were guided in the choice of which target risk factors to target by a biopsychosocial model of depression<sup>1</sup> that we developed for understanding PND and which is also helpful for antenatal depression. In essence, we posit that it is the interaction between vulnerability factors in the mother, unrealistic sociocultural expectations and current trigger factors that result in a depressive experience. These are then maintained by negative cognitions and behaviours and negative interactions with significant others. As such, the intervention attempts to reduce maintaining factors, strengthen relationships and teach coping and problem-solving skills to manage the complex demands of parenting.

Finally, it is important to recognise that as not all risk factors are amenable to change or elimination (e.g. negative life events and birth complications), some cases of PND may not be preventable. Nevertheless, antenatal interventions may still have a beneficial impact in such cases. Vulnerable women may still benefit in the targeted areas of social support and relationships and may gain faster access to services. Consequently, they may endure less protracted PND.

The major aims of this study were:

- [1] To develop the *Toward Parenthood* program to a standard ready for implementation.
- [2] To road test the feasibility of delivering this novel self-help antenatal support program to pregnant women (both depressed and non-depressed) by exploring satisfaction levels and barriers to using the program in order to maximize uptake.
- [3] To conduct a pilot study of the effectiveness of the intervention in reducing levels of depression, anxiety and improved parent-infant relations.

## Methodology

### *The Idea*

The original idea for an antenatal *Toward Parenthood* intervention program was conceived at the Parent-Infant Research Institute. Recognising the urgent need for a program of this type, both clinicians and researchers collaborated in a systematic review of the problems and their possible solutions. Selection of intervention targets was on the basis of theory, ‘clinical wisdom’ and an exhaustive empirical review of risk factors impacting on depression and parenting outcomes. Our theoretical and clinical understanding of perinatal depression then informed the approach to managing these risk factors. An extensive review of existing local and international parenting support programs was then conducted to identify key targets for such a program. A ‘skeleton’ program was developed.

The central idea behind *Toward Parenthood* is the provision of an accessible self-help program able to reduce the length and impact of depression when it occurs and to prevent both PND and early parenting difficulties (in depressed and non-depressed women) by supporting couples in the transition to parenthood.

### *Program Development*

This took part as part of the National Postnatal Depression Program, funded by *beyondblue*. Three consultative methods were used in the evaluation of a first-draft prototype of *Toward Parenthood*. Those taking part in surveys, focus groups and interviews had read the program materials.

### *Survey*

Thirty-two women who had screened as ‘at risk’ of depression participated in a telephone survey.

### *Focus Group*

Six pregnant women (32-34 weeks) and six men all of whom were expecting their first or second child took part in a focus group.

### *In-depth Interviews*

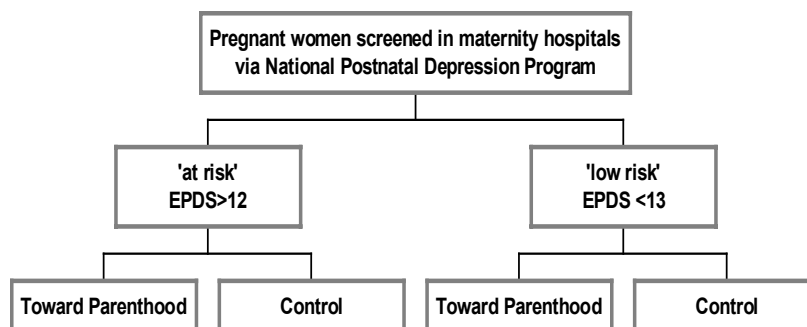
Three extended, in-depth interviews (conducted face-to-face, by telephone and via email) were carried out with new and expectant parents (3 men and 3 women in total). Another set of three interviews was conducted with working professionals in the perinatal health area.

### *Pilot Study Design*

#### Procedure

Women ‘at risk’ of antenatal depression (i.e. EPDS score  $\geq 13$ ) and women at ‘low risk’ (EPDS  $<13$ ) were recruited to the study through maternity hospital antenatal clinics when 26-30 weeks pregnant. This is part of a wider protocol of the National Postnatal Depression Program, funded by *beyondblue*, and as such all women received “Emotional Health During Pregnancy & Early Parenthood” - a booklet about adjustment and postnatal depression. ‘At risk’ women scoring 13 or above on the EPDS were linked to their GP who is notified of the screening result. At two of the screening hospitals in Victoria (Northern Hospital and Royal Women’s Hospital) these ‘at risk’ women were all invited to take part in the pilot study. A concurrent group of ‘low risk’ women with EPDS  $<13$  were selected at random and also offered participation in the study (more were screened than were randomised). Participants continued to access routine primary care services as usual. They were advised that *Toward Parenthood* was an adjunctive intervention to assist in the transition to parenthood and to develop coping skills to deal with its emotional challenges. Prior to commencement, a coded, double-blinded, randomised treatment allocation schedule was produced by computer. The schedule is retained in a secure site and administered by an independent person blind to the coding. The study design is shown in Figure 1.

**Figure 1**



#### Outcome Measures

In addition to questionnaires given to women as part of the National Postnatal Depression Program additional questionnaires were given to allocated women in the *Toward Parenthood* intervention (see Table 1) at 26-32 weeks and at 12 weeks postnatally.

#### *Demographics & Psychosocial Factors*

This self-report, structured questionnaire is one of the basic questionnaires completed as part of the National Postnatal Depression Program and covers: age, ethnicity, education, occupation, employment, marital status, housing; family constellation, socio-economic status; history of

depression, drug/alcohol use, abortion, childhood experiences, extent of prenatal care, expectations of parenthood, and extended risk profile.

#### *Edinburgh Postnatal Depression Scale (EPDS)*

The Edinburgh Postnatal Depression Scale was used to screen women as part of the National Postnatal Depression Program. It is self-rated 10 item scale requires women to read 10 statements and for each choose an appropriate response from a choice of four<sup>23</sup>. It has good validity as a screening instrument (89-90% sensitivity, 82-82% specificity), and has been used extensively with antenatal and postnatal women as a screening instrument for depression. It is particularly useful in postnatal depression because women find it user-friendly, it is short, has separate subscales for anxiety and depression, and does not rely on somatic symptoms, which occur commonly in pregnancy independent of depression. In an Australian sample the EPDS has been reported to have 100% sensitivity and 89% specificity<sup>24</sup>. A cut-off of 12.5 was selected for this study to minimise the false positive rate.

#### *Beck Depression Inventory*

The Beck Depression Inventory (BDI) provides a more accurate clinical measure of depression severity<sup>25</sup>. The BDI is a widely used, well-validated, 21-item clinical instrument that measures cognitive, affective and physiological factors to assess severity of depression. In the last four decades the BDI has been validated on many psychiatric and normative populations, has been applied extensively in clinical settings and its psychometric properties are well characterised. Internal consistency (Cronbach's  $\alpha$ ) ranges from 0.79 to 0.9. Good content, construct and criterion validity are also reported.

#### *Beck Anxiety Index*

The Beck Anxiety Index (BAI) consists of 21 items rated on a four-point scale to yield an overall measure of anxiety symptoms<sup>26</sup>.

#### *Relationships & Additional Treatment*

Part A of this short questionnaire requires participants to respond to two questions by rating levels of social support and levels of happiness in marital relations, on Likert-type scales. Part B inventories the type and frequency of any additional treatments received since allocation to the study.

#### *Information About Birth*

This 18-item proforma asks about the birth, the baby's health, the mother's health and any interactional difficulties.

#### *The Parenting Stress Index*

Measures parent child relations that are under stress and are at risk for the development of dysfunctional parenting behaviour or behaviour problems in the child<sup>27</sup>.

#### *Consumer Feedback Survey*

Once participants passed the primary data collection endpoint of the pilot study (12 weeks postnatal) they were surveyed by telephone and asked to give their open-ended responses to a set list of five primary questions as follows:

- i. If you did not complete all the sessions, what got in the way?
  - ii. Did you like the program and find it relevant to your needs?
  - iii. Was the program helpful?
  - iv. Can you give us feedback on some specific areas? (number of sessions and questionnaires/telephone calls/booklet)
  - v. Did you see your GP or get any other assistance?
- For questions ii and iv there are also pre-set subsidiary queries (e.g. for question ii: were there too many sessions?).

Table 1. Timing of measures in the Pilot Study

	Ante-natal		Post-natal
Questionnaires for National Program		TOWARD PARENTHOOD SESSIONS	
Demographic & Psychosocial Form	X		
Edinburgh Postnatal Depression Scale	X		
Additional Questionnaires for Pilot Study			
Beck Depression Inventory	X		X
Beck Anxiety Inventory	X		X
Relationships & Additional Treatment	X (part A)		X
Parenting Stress Index			X
Consumer Feedback			
• telephone survey			X
• therapist notes		X	

8 antenatal, 1 postnatal

## Results

### Program Development

The evaluation process yielded a number of greater and lesser refinements to the original program, which were implemented prior to piloting. Some of the most important of these were as follows: Those professionals, pregnant women and parents interviewed reported that the program was interesting, useful, thought provoking and meets a need where there is a clear gap in the literature and current service provision. Interviews with women and focus groups revealed there was a common theme that ‘realistic’ portrayal of parenting was presented; booklets were well written with a good mix of text and graphics, but were possibly too much to assimilate in one go. To make the overall package more manageable we separated the sessions into colour coded sections and re-formatted content into a shortened, more approachable layout. There were a number of editorial comments, which were addressed (e.g. larger headings and more correspondence between mother and father manuals). More encouragement for couples to share their responses to activities was suggested and also incorporated to facilitate communication. A more comprehensive referral list was included and language was changed to be more inclusive of various groups who might read the program (e.g. Single parents, same sex

couples etc.) The booklets were reformatted to allow cut out tip sheets to be removed without losing text on the opposite page, as there was a strong conviction that the booklets would be kept as a reference and should be able to remain intact.

Some recommendations were not included in this pilot: having at least one face-to-face consultation with participants; sending out units individually rather than in book form and offering the program earlier in pregnancy. Whilst these were thought reasonable it was not possible to implement these either due to financial or practical considerations.

Thus, the final version of the *Toward Parenthood* program used in the pilot study comprised nine units - eight antenatal and one postnatal. Mothers' and fathers' guidebooks were produced separately and cover similar material. While both guidebooks are provided to each couple, only the mother participates in telephone counseling sessions. Women read one unit per week and then discuss the content with a psychologist from our department. Counseling telephone calls last approximately ½ hour and follow a set format that also allows for tailored discussion and problem solving around the issues of the unit. Session-by-session structure and content was as follows:

#### Unit 1: Making Space for a New Relationship

- Encouragement of maternal reverie using Cranley's Maternal Foetal Attachment Scale.
- Coping with negative feelings about foetus.
- What do babies need?
- Reflective exercises on family of origin & potential impact on parenting.
- Suggestions for play and bonding.

#### Unit 2: We're Expecting!

- Reflective questions about birth, difficult & fun parts of parenting.
- Past experiences of coping with change.
- Specific changes in roles, emotions, finances, relationships, leisure, body image.
- Quiz exploring unrealistic expectations.
- Normalising information re emotions
- Specific training in problem-solving skills.
- Brainstorming exercises for common problems (eg, not enough rest, baby cries constantly, breast feeding problems). Practical suggestions provided in interactive format.
- Cut out "cue card" with realistic messages.

#### Unit 3: Lovers to Parents

- Reflective questions to explore communication style within relationship.
- Interactive exercises to encourage identification of their vision for a "parenting partnership" conceptualised in terms of boundaries, investment, control, and roles.
- Identification of expectations of each other as a "good mother" and "good father"
- Interactive exercises to identify influence of parental relationship models.
- Tips for communication & solving conflict.
- Tips for maintaining intimacy.
- Practical interactive exercise to plan "who will do what" in terms of baby care and household chores.



- Exercises to identify typical ways of coping.
- Influence of parental models of coping style
- Assessing personal life stressors.
- Tips for coping with exhaustion, negative emotions, loneliness, boredom.
- Cognitive behavioural stress management.
- Identifying warning signs of depression.

### Unit 5, 6 & 7: Managing Stress and Depression

These units are based on cognitive-behavioural therapy principles (CBT)

- Start by analysing your behaviour.
- Healthy relationships, healthy self.
- Developing skills in changing your self-talk.

### Unit 8: Caring for Newborns

- Practical advice & normalising difficulties.
- Breastfeeding issues.
- Sleep needs, crying, settling suggestions.
- Quiz to test ideas & engage with material.
- Rehearsal ways of coping with problem scenarios (eg, baby not gaining weight).
- 10 tip sheets for quick reference.

### Unit 9: Welcome to the Club! (Postnatal Session)

- Integrating and reflecting on the birth experience.
- Utilizing problem solving skills to cope with challenges.
- Getting to know your baby: infant communication and temperament.
- Strategies for coping with negative feelings.
- Interactive cognitive therapy exercises to cope with negative emotions.
- Noticing & managing changes in your relationship (based on themes in unit 3).
- Reminder communication tips.
- Ideas to help you nurture your relationship with your child.

Therapist-completed compliance and attendance sheets for each intervention participant detailed which sessions were completed and when.

### *Feasibility and Barriers in the Pilot Study*

#### Recruitment and Retention

Of the women invited to participate in the study 49 ‘at risk’ women consented to random allocation, as did 72 ‘low risk’ women. Of the 49 ‘at risk’ women, 25 were allocated to intervention and 24 were allocated to routine care. Of the 72 ‘low risk’ women, 37 were allocated to intervention and 35 to routine care. Thus, a total of 62 women were allocated to the intervention. Some key demographic and psychometric variables for all the recruited women are given in Table 2.

Table 2. Characteristics of antenatal women in the ‘at-risk’ and ‘low risk’ groups

	EPDS <13	EPDS ≥13
Age (95% CI)	30.0 (28.8-31.1)	29.1 (27.4-30.7)
Number of children (95% CI)	1.3 (1.1-1.6)	1.5 (1.1-1.8)
Weeks pregnant (95%CI)	27.5 (26.6-28.4)	25.3 (22.8-27.8)
University education	28.3%	14.3%
Modal Income (\$Aus)	40 - 60,000	40 - 60,000
History of Depression	15.6%	37.0%
Childhood abuse	9.9%	19.8%
Born in Australia	75.0%	65.3%
BDI (95%CI)	10.8 (6.8-14.7)	23.0 (18.5-27.6)
BAI (95%CI)	12.3 (8.0-16.7)	19.6 (14.5-24.7)
N	72	49

Table 3. Engagement of intervention women\* (session attendance and return of questionnaire data).

	‘Low risk’	‘At risk’
	$\frac{\text{data returned}}{\text{number allocated}}$	$\frac{\text{data returned}}{\text{number allocated}}$
attended sessions	$\frac{10}{14}$	$\frac{2}{6}$
did not attend	$\frac{4}{9}$	$\frac{2}{7}$
totals	$\frac{14}{23}$	$\frac{4}{13}$

\*Note: only those 36 women who have passed the 12-week postnatal time point are included.

Of the 62 women allocated to the intervention a total of 36 have by now reached the 12-week postnatal time point. However, as shown in Table 3, only 56% ( $n = 20$ ) of these attended one or more of the intervention sessions. The current return rate of 12-week postnatal questionnaire packs among these intervention-allocated women was 50%, and was lower for ‘at risk’ women (4/13) than for ‘low risk’ women (14/23).

Logistic regression was used to explore the associations between baseline data and measures of engagement with the program (sessions completed, questionnaires completed etc). This identified some baseline characteristics associated with low return rates of questionnaire packs (46% of those due at the time of writing).

Women in the ‘at risk’ group are over 6 times less likely to return questionnaire packs (Odds Ratio 6.1, 95% Confidence Interval 1.9-19.4). The roles of clinical depression and anxiety levels in generating this result are confirmed by the univariate Odds Ratios associated with baseline antenatal BDI and BAI scores (ORs = 1.13, CI 1.02-1.24 and 1.12, CI 1.03-1.23 respectively). Thus for every 1-point increase on the BDI and BAI, the odds of non-return of questionnaires rose by more than 10%. Questionnaire return rate is influenced positively by increased age (OR 0.84, CI 0.74-0.94) such that younger women are less likely to complete and return the pack. In summary, results suggest that as delivered currently, the uptake of intervention is only 56% even if women agree to partake.

Depressed women are less likely to be engaged. For quantitative analysis of this study we have available only data from 12 women who participated in the intervention (see Table 6 for preliminary evaluation of outcomes for these women compared to women who were not offered the intervention or did not attend but returned questionnaires).

Consumer Feedback Survey

Items in the feedback survey, as well as participants’ session-by-session comments in clinical notes, provide records of a more qualitative nature. Here, we present some preliminary tabulation of the content of emergent themes in these data.

Question	Response
<i>i. Why sessions not completed...?</i>	Too busy (60%) Illness/medical problem (30%) Other (10%)
<i>ii. Did you like the program...?</i>	Yes/positive response (90%) No/negative or neutral response (10%)
<i>iii. Was the program helpful...?</i>	Yes/positive response (95%) No/negative or neutral response (5%)
<i>iv. Your feedback on specific areas...?</i>	<u>Time needed for sessions</u> okay (84%), too many (16%) <u>Time needed for questionnaires</u> Okay (58%), too long 33%), can’t recall (8%)
<i>v. GP or other assistance...?</i>	GP (17%), counsellor (2.5%), none (78%), can’t recall (2.5%)

Table 4 shows a summary of some of the salient responses given by 36 women (10 ‘at risk’, 26 ‘low risk’) interviewed in the telephone feedback survey. All respondents had passed the 12-week postnatal data-collection endpoint when they were contacted. Whole responses have been initially categorised by a simple, emergent coding process. It is immediately noticeable that although the program was apparently well received (questions ii and iii) up to one third of participants thought some of the time demands were excessive (question iv) and the most common reason for non-completion of the sessions was also time-related (question i). Again, in subsidiary queries under question iv, 33% of the respondents who had failed to return the questionnaire pack cited time-demands as the reason and 44% of these indicated they would have found it easier to complete and return the pack had it been shorter.

Therapist Recorded Feedback from Mothers

Coding and analysis of our other qualitative data is still ongoing. The comments so far are overwhelmingly positive. In Table 5 a session-by-session analysis of feedback recorded by therapists is given (n = 11). Women reported being informed and reassured by the content of the program.

They report it to be helpful and interesting. It encouraged them to discuss aspects of parenting with their partner and the outcome was positive. All women that commented on this found their partner’s comments supportive. There were many comments about the booklets guiding them to think about becoming a parent and the associated anxieties and expectations. This was seen to be positive, as was the discussion about this with the psychologist and with their partner if appropriate.

Table 5. Summary of participant feedback coded from clinical notes by therapists.

Session	What the women liked
1. <i>Making Space for a New Relationship</i>	- family of origin issues -expectations/worries/fears of motherhood - opened discussion with husband
2. <i>We're Expecting! Helping you Prepare for Parenthood</i>	-problem solving skills useful -allowed reflection on transition to /responsibility of parenthood
3. <i>Lovers and Parents: managing Relationship Changes</i>	- enhanced communication with partner -communication tips helpful (though less relevant for single mothers)
4. <i>Coping Tips &amp; Stress Busters</i>	-support services list useful resource -distraction and self talk techniques useful
5-7 <i>Managing Stress &amp; Depression:</i>	-model of relationship between thoughts, feelings and behaviours very useful - useful to identify contributors to low mood -recognising passive, aggressive, assertive communication styles -discussion of self-esteem useful in trying to be role model to own children -related to concept of thoughts affecting feelings -helped recognise thinking traps -strategies for increasing positive/decreasing negative thoughts useful
8. <i>Parenting Suggestions for Managing Newborns</i>	- the most helpful unit as it assisted in a practical way -parenting tip sheets good -feeding section good/ non-judgemental/ did not give preference breastfeeding
9. <i>Welcome to "The Club" (postnatal session)</i>	- great review of strategies learnt in program - program helped organise my thinking about my baby

Specific graphics were referred to as being helpful and many women reported the cognitive behavioural therapy techniques (the link between thoughts and feeling) to be helpful as well as the problem solving sessions that have application to their life in general. The phone support was also found to be popular. There were some requests for the content to be offered as a group program or to have a group session postnatally as it is hard to be self-motivated. First-time mothers thought it was very good and second-time mothers tended to report they wished they had access to such a program with their first pregnancy. One mother recommended that all parents get the program.

Effectiveness of Intervention

As end-point data collection is still in progress an interim analysis of primary outcome measures has been conducted. Table 6 shows the results to date for those women who have returned 12-week postnatal questionnaire packs. Whilst numbers are too small for meaningful analyses, current figures are consistent with the intervention being effective as most differences lie in the expected directions.

Depression Anxiety and Parenting Stress

Of the high-risk group the 2 women attending had a lower average BDI score than non-attendees or controls. Similar trends were seen for anxiety.

Table 6. Mean values (SE) from 12-week postnatal psychometric questionnaires returned to date.

			EPDS<13 'low risk'		EPDS≥13 'at risk'	
			Intervention		Routine care	
			Intervention		Routine Care	
attendance Y/N	Y	N			Y	N
BDI	6.1 (1.9)	5.5 (1.4)	8.7 (1.6)		2.5 (1.5)	15 (12)
BAI	3.2 (1.2)	4.0 (0.9)	5 (1.6)		3.5 (1.5)	5 (3)
PSI <i>child domain</i>	173.1 (3.2)	155.3 (21)	170.8 (3.9)		166.0 (4.0)	171.5 (1.5)
<i>parent domain</i>	184.3 (3.2)	144.3 (44.5)	181.8 (3.9)		198 (4)	175.5 (36.5)
<i>total PSI</i>	359.7 (5.4)	302.3 (66.3)	354.1 (6.3)		367 (5)	347.5 (34.5)
<i>N</i>	10	4	12		2	2
						1

Given the small numbers involved it is difficult to interpret the results relating to parenting stress. At present, these appear somewhat mixed (which may of course indicate that no consistent effect is emerging). The PSI total scores for all groups fell within the clinically dysfunctional range (i.e.> 259 as defined by the PSI manual). However, women who were allocated to intervention (especially those 'at risk') and who attended sessions and returned questionnaires had the highest average scores on the PSI (higher scores on the PSI reflect more difficulty and stress in relationships). It is possible that those women who were most concerned about their parenting ability were more motivated to engaged more fully with the program, attend session, return questionnaires etc. If such a systematic effect is operating then scrutiny of returned data from attendees alone may give a misleading impression. Careful, intention-to-treat analyses that account for all of the allocated participants will be extremely important and, for the pilot study reported here, the lack of a baseline measure of PSI will complicate these somewhat. Baseline antenatal Neonatal Perception Inventory scores did not differ significantly between the 'at risk' and 'low risk' groups but nevertheless provide a useful covariate in this regard. Finally, the 12-week postnatal time point may in fact be too early to see a positive effect of intervention of PSI scores. Therefore, if anything, the intervention seemed to have a small positive effect on mood and anxiety but a more complex one on parenting stress.

Table 7. Patterns of help seeking in women ‘at risk’ and at ‘low risk’ of depression in pregnancy.

	Sessions attended	Antenatal EPDS score	Antenatal help?	Postnatal help?	Treatment/treating professional	
Intervention	1 or more	‘low risk’	Yes = 1 No = 9	Yes = 6 No = 4	1 woman sought assistance from GP and received antidepressants; 1 woman sought assistance from psychiatrist and received antidepressants, Valium, counselling/psychological therapy, baby management & herbal/natural remedies 5 women sought help but gave no details	
		‘at risk’	Yes = 1 No = 1	Yes = 0 No = 2	1 woman sought help but gave no details	
	Did not attend	‘low risk’	Yes = 2 No = 2	Yes = 3 No = 1	1 woman sought assistance from GP and received baby management; 1 woman received baby management & herbal/natural remedies; 1 woman sought advice from helpline; 2 women sought help but gave no details	
		‘at risk’	Yes = 0 No = 2	Yes = 1 No = 1	1 woman received herbal/natural remedies.	
	Routine care		‘low risk’	Yes = 1 No = 10	Yes = 5 No = 6	1 woman sought assistance from GP and received counselling/psychological therapy; 5 women sought help but gave no details
			‘at risk’	Yes = 0 No = 1	Yes = 0 No = 1	No women sought help

Impact on Service Usage

Table 7 shows a summary of help-seeking patterns among those women who have thus far returned postnatal questionnaires. More of these women sought additional assistance after the birth of their baby than during pregnancy and more did so in the intervention group than in routine care. Also,

more intervention women who attended therapy sessions sought further assistance than intervention women who did not attend any sessions. No 'at risk' women in Routine Care sought help of any kind

## Discussion

The *Toward Parenthood* program aims to assist parents in the transition to parenthood, particularly by developing coping strategies to emotions such as anxiety and depression and preparing both psychologically and practically for the advent of the newborn infant. Importantly, partners are involved and ways of managing potential relationship conflicts are taught.

We have now developed a program as a 'minimal' intervention package, which consists of self-directed sessions with interactive exercises and tip sheets, supported by telephone contact. It has been refined based on comprehensive consumer focus groups and interviews. A feedback survey on the refined program involved 36 women and was overwhelmingly positive, with 90% of women who participated indicating that they liked the program and giving positive feedback when surveyed by telephone.

Therapist feedback about women's responses was even more encouraging and is outlined in Table 5. Women ( $n = 11$ ) found the content informing, very supportive and interesting. The phone contact with the counsellor was popular with indications further support might increase self-motivation. Involvement of partners and the style of the document were found helpful and antenatal women commented they would keep it as a handy reference postnatally.

We have also established the feasibility of delivering this intervention to a wide community based sample and identified barriers to uptake. This was significant as we found that as in past antenatal programs, attrition was high. Some of the problems can be attributed to the research protocol itself, in that participants found the evaluation questionnaires onerous in terms of length. However, time-demands appear a major consideration and completing sessions was also a problem for reasons such as 'being too busy'. Others cited health reasons as an obstacle.

Most importantly however, it was the 'at risk' women who had the lowest rate of return of questionnaires and attendance at telephone sessions. Odds ratios revealed 'at risk' women were 6 times less likely to return questionnaires, indicating these women may need further support to involve them and treat their depression. Noticeably, very few women (and in particular those 'at risk') accessed additional services despite a notification letter to their GP and it is likely that more intensive referral to GPs is needed. Interestingly, those 'at risk' women who engaged in the intervention were more likely to access help than those in Routine care.

Whilst the final sample of women for whom we have 12-week postnatal psychometric data is modest ( $n = 18$  intervention,  $n = 13$  routine care) results suggest the program is effective at reducing anxiety and depression. Importantly, we reached women who at baseline consisted of a typical group of pregnant women ( $n=121$ ) with those 'at risk' demonstrating significantly higher depression scores on a gold-standard index, the Beck Depression Inventory (BDI 23 versus 10.8). The 'at risk' women also showed a higher prevalence of typical risk factors such as history of depression (37% versus

15.6% for ‘low risk’ women) and childhood abuse (19.8% versus 9.9%). They also had higher antenatal anxiety scores.

Whilst with the current protocol only 56% of women actually partook in the intervention once allocated, nevertheless if offered universally this would still be a significant number of those ‘at risk’ on a *per capita* basis in both Victoria (equal to over 3,000 annually) and in Australia generally (equal to over 12,000 annually). Currently we know that 80% of women do not seek help and so we may be reaching this portion of the population more effectively.

## Key Recommendations

We suggest that the following strategies are likely to increase both access and uptake.

[1] More intensive efforts to recruit and retain high-risk women in the project by:

- reducing time demands e.g. questionnaires
- including incentives, support and time-management as part of the package
- slightly later postnatal follow-up so questionnaires given at less time-demanding period following birth;
- including a fuller section on accessing help and how personal barriers might block this

[2] Involve GPs and Maternal & Child Health Nurses more directly in ‘holding’ women throughout the program, and in treating depression when present e.g. involving shared-care GPs.

In summary, we have developed a refined intervention package for dealing with the challenges of parenthood including depression and anxiety that is well received by women and their partners. Data on small sample of women participating in the pilot study ( $n = 18$  intervention of  $n = 13$  control) reveals trends in the expected direction for improvement in BDI and BAI. We have identified useful further refinements, which are likely to increase uptake. The program is now ready to be evaluated in a larger randomised trial that can be rolled out in community settings.

## Significance

We anticipate that the *Toward Parenthood* program will assist in alleviating many adjustment problems that new parents present with at new baby services. It also has the potential to reduce the incidence of depression, anxiety and related disorders in the perinatal period. Those who need additional care will also be better placed to contact available services such as general practitioners or specialist mental health services.

At present, primary care and general medical specialists come into contact with many women who may be ‘at risk’ of depression and who would benefit from being guided through this program which includes 3 sections on coping and managing thoughts that might lead to depressive symptomatology. This program, if shown to be successful in a larger trial, could be a very cost effective and hugely accessible intervention for Australian families.



## References

1. Milgrom, J., Martin, P. R. & Negri, L. M. *Treating Postnatal Depression. A Psychological Approach for Health Care Practitioners* (Wiley, Chichester, 1999).
2. Beck, C. T. Predictors of postpartum depression, an update. *Nursing Research* 50, 275-285 (2001).
3. Evans, J. et al. Cohort study of depressed mood during pregnancy and after childbirth. *British Medical Journal* 232, 257-260 (2001).
4. O'Hara, M. W., Zekoski, E. M., Phillips, L. H. & Wright, E. J. Controlled prospective study of postpartum mood disorders: comparison of childbearing and non-childbearing women. *Journal of Abnormal Psychology* 1, 3-15 (1990).
5. Spinelli, M. G. & Endicott, J. Controlled clinical trial of interpersonal psychotherapy versus parenting education program for depressed pregnant women. *American Journal of Psychiatry* 160, 555-562 (2003).
6. Gordon, R. E. & Gordon, K. K. Social factors in prevention of postpartum emotional problems. *Obstetrics and Gynecology* 15, 433-438 (1960).
7. Elliott, S. A. et al. Promoting mental health after childbirth: A controlled trial of primary prevention of postnatal depression. *British Journal of Clinical Psychology* 39, 223-241 (2000).
8. Stamp, G. E., Sved Williams, A. & Crowther, C. A. Evaluation of antenatal and postnatal support to overcome postnatal depression: A randomized, controlled trial. *Birth* 22, 138-143 (1995).
9. Buist, A., Westley, D. & Hill, C. Antenatal prevention of postnatal depression. *Archives of Women's Health* 1, 1-7 (1998).
10. Brugha, T. S. et al. Pragmatic randomized trial of antenatal intervention to prevent post-natal depression by reducing psychosocial risk factors. *Psychological Medicine* 30, 1273-1281 (2000).
11. Zlotnick, C., Johnson, S. L., Miller, I. W., Pearlstein, T. & Howard, M. Postpartum depression in women receiving public assistance: pilot study of an interpersonal-therapy-oriented group intervention. *American Journal of Psychiatry* 158, 638-640 (2001).
12. Mrazek, P. J. & Haggerty, R. J. *Reducing Risks for Mental Disorders - Frontiers for Preventive Intervention Research* (National Academy Press, Washington, D. C., 1994).
13. Beck, C. T. A meta-analysis of predictors of postpartum depression. *Nursing Research* 45, 297-303 (1996).
14. Beck, C. T. A meta-analysis of the relationship between postpartum depression and infant temperament. *Nursing Research* 45, 225-230 (1996).
15. O'Hara, M. W. & Swain, A. M. Rates and risk of postpartum depression - a meta-analysis. *International Review of Psychiatry* 8, 37-54 (1996).
16. Gottlieb, B. & Pancer, S. M. in *The transition to parenthood: Current theory and research* (eds.) Michaels, G. Y. & Goldberg, W. A.) 235-269 (Cambridge University Press, Cambridge, 1988).
17. Bailham, D. & Joseph, S. Post-traumatic stress following childbirth: A review of the emerging literature and directions for research and practice. *Psychology, Health and Medicine* 8, 159-168 (2003).
18. Kettinger, L. A., Nair, P. & Schuler, M. E. Exposure to environmental risk factors and parenting attitudes among substance-abusing women. *American Journal of Drug and Alcohol Abuse* 26, 1-7 (2000).
19. Combs-Orme, T., Cain, D. S. & Wilson, E. E. Do maternal concerns at delivery predict parenting stress during infancy? *Child Abuse and Neglect* 28, 377-392 (2004).

20. Baydar, N., Reid, M. J. & Webster-Stratton, C. The role of mental health factors and program engagement in the effectiveness of a preventive parenting program for head start mothers. *Child Development* 74, 1433-1454 (2003).
21. Banyard, V. L., Williams, L. M. & Siegel, J. A. The impact of complex trauma and depression on parenting: An exploration of mediating risk and protective factors. *Child Maltreatment* 8, 334-349 (2003).
22. Tsujino, J. & Higa, M. O. Factors related to maternal violence: Longitudinal research from prenatal to age four. *Journal of Prenatal Perinatal Psychology Health* 18, 241-253 (2004).
23. Cox, J. L., Holden, J. M. & Sagovsky, R. Detection of postnatal depression: development of the 10 item Edinburgh Postnatal Depression Scale. *British Journal of Psychiatry* 150, 782-786 (1987).
24. Boyce, P. M., Stubbs, J. & Todd, A. The Edinburgh Postnatal Depression Scale: validation for an Australian sample. *Australian and New Zealand Journal of Psychiatry* 27, 472-476 (1993).
25. Beck, A. T., Steer, R. A. & Brown, G. K. *BDI-II manual* (The Psychological Corporation, San Antonio, 1996).
26. Beck, A. T., Epstein, N., Brown, G. & Steer, R. A. An inventory for measuring clinical anxiety: psychometric properties. *Journal of Consulting and Clinical Psychology* 56, 893-897 (1988).
27. Abidin, R. R. *Parenting Stress Index Manual* (Pediatric Psychology Press, Charlottesville, VA, 1986).

**South Australian Intervention Initiative:  
"Helping Him to Help Her"**

**Final Project Report  
by  
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**May 2005**

## **Overview**

This project involved the design and implementation of a group intervention for the male partners of women suffering from postnatal depression. The intervention comprised components focusing on education about depression, defining problems which arose in the couple's relationship as a result of the woman's depression, identifying the impact of the depression on the male partner and providing specific strategies which the male could utilise to facilitate the woman's recovery rather than negative interactions likely to impede such recovery.

A considerable amount of knowledge was gained about the approach which male partners and the depressed women found most helpful. A number of important themes also emerged in the small number of groups conducted. It is hoped that this information will be of use to health professionals considering conducting similar groups in the future.

Because of difficulties encountered in recruitment, only a small number of groups could be held which precluded scientific evaluation of the impact of the intervention. However, informal feedback from those who participated indicated that considerable benefit had been gained.

A brief literature review of the possible reasons underlying the recruitment difficulties is provided, together with some proposed solutions, which might assist overcoming these.

## **Introduction**

Good social support is important in the recovery from postnatal depression. The male partner is ideally placed to provide such support. Conversely, inappropriate or unempathetic responses from the male partner are likely to worsen and potentially perpetuate the depression and thus impede recovery.

John Condon had been the chief investigator on the "First Time Fathers Study" funded by the NH&MRC, and had a particular interest in this area, Condon.J.T, Boyce P & Corkindale,C.J. (2004) (Appendix C)

## **Aims**

The main objective of the South Australian initiative "Helping Him to Help Her" was to provide the male partners of depressed women with specific strategies to support their depressed partner, and facilitate her recovery. In addition, it was anticipated that the men's knowledge of postnatal depression would be improved and that they themselves would benefit from contact, and sharing of experiences, with other male partners in the same situation. Thus, the groups would provide a setting where the men could discuss their feelings, and the problems which they had encountered as a result of their partner's depression, as well as consider strategies to minimise or alleviate the distress which both were experiencing.

Given research findings that these male partners may themselves be at risk, the project was also designed to increase their own resilience.

## Methodology

The project was envisaged as comprising five stages:

1. A literature review covering the impact of postnatal depression upon the male partner, as well as the impact upon the couple relationship
2. Design of a specific "package" which could be delivered in a group setting over two sessions to achieve the above objectives
3. Piloting of this package
4. Recruitment of a substantial number of male partners to take part in male group sessions
5. A randomised controlled trial to investigate the efficacy of the intervention in terms of both the woman's depression and the male partners psychological well-being

## Results

### *Literature review*

The literature on the postnatal man is quite limited. However there is considerable evidence to support the "contagion" of postnatal depression within the couple relationship. Thus, the male partner of a depressed woman is himself at risk of depression. This is particularly standard if there is pre-existing dysfunction in the couple relationship.

The literature also suggests that depression in the male is likely to persist for six months or longer, and can have a significant negative impact on the father- infant relationship. Several studies have noted that a father who is depressed is more likely to rate his infant as difficult.

Only one reference could be found which specifically dealt with ways in which the male partner of the depressed woman may facilitate her recovery (Kleiman,2000). This particular reference formed the basis for the initial design of the intervention.

### *The intervention package*

The format of the intervention is two sessions, each of two hours duration, separated by two weeks. The sessions were conducted in a group room of a public hospital commencing at 6.30 pm. There were no crèche facilities, and couples were not encouraged to bring their babies. Light refreshments (but no alcohol) were available.

The first component of the intervention is an education component designed to provide the male partner with factual information about the nature of postnatal depression (Appendix A, Component 1). It was hoped that such information might enable the male partner to facilitate the woman's seeking help with her depression, should she be reluctant to do so. There is good evidence that women with postnatal depression are often quite reluctant to seek professional help

The second component involved in assisting the group to identify and define specific problems, which commonly arise in the couple's interaction with each other. These included difficulties experienced with the infant which were often the issues which the couple felt most comfortable

discussing in the early part of the sessions, before moving on to the impact of the depression on the partner relationship (Appendix A, Component 2).

The third component involved assisting the group to explore ways of handling these difficulties, especially in terms of communication and problem solving (Appendix A, Component 3). Specific interventions were drafted by the facilitators for situations involving:

- Irritability
- Crying / depression
- Hopelessness
- Withdrawal of affection and reluctance to engage in sexual behaviour
- Negative thoughts about self
- Negative thoughts about other issues
- Confusion, forgetfulness, poor concentration
- Anxiety
- For example, for “irritability” issues discussed include;
- Not taking it personally
- Not retaliating

There was considerable emphasis on communication, relationship protection, and recognition of self- help strategies for both partners that were easily employable. Some examples of this are:

- Communication skills, awareness of “risky” dialogue

e.g. the use of “I” statements to communicate feelings versus “You” statements that are accusatory.

e.g. Employ Active listening skills to promote clear and effective dialogue.

e.g. Awareness of body language, and its effects.

- Relationship Protection,

e.g. Problem Resolution, a willingness to negotiate.

e.g. Building intimacy, impact of post natal depression, and demands of parenting.

e.g. Recognition of lifestyle activities that “drain” or “fill” energy levels.

All of the slides, which are utilised in the group sessions, are attached to this report (Appendix A).

*Piloting of the project, and attempted methods of recruitment*

It became apparent, quite early in this project that recruitment of male partners to attend these groups was going to present major difficulties. Invitation to participate was by mail and phone. Initially we made contact with 49 male partners, but only 2 men were willing to put their names down for the initial group.

Given this difficulty, it was decided that the recruitment strategy required modification, and that invitations would now be to both members of the couple to attend as a couple. Whilst this strategy was more successful, recruitment still remained very low. To date 189 individuals have been contacted. Only 4 groups have been conducted, involving 11 couples, this is despite extensive media coverage, including an illustrated article, and an interview with the male partner who had attended, *Adelaide Advertiser*, 25<sup>th</sup> August, 2004 (Appendix D). In addition, all relevant South Australian services were invited to inform women and partners about these groups, this occurred in the way of posters for notice boards and relevant phone contact.

A record was kept of the reasons, which couples gave for their inability to attend when they were personally contacted (Appendix E). For ethical reasons the men were approached via their female partner, and these responses reflect either reasons given by the woman herself or reasons the male gave to her, which were relayed to us.

The format of the groups, which has evolved, has been to have both members of the couple present for the early and final parts of the session, and to split into a male and female group for the middle section. The conjoint groups were co-facilitated by a psychiatrist and a midwife. The male group was facilitated by the (male) psychiatrist while the midwife facilitated the women's group

From the experience gained in running these groups, the following "lessons" have been learned, which may be of value health professionals attempting to run similar groups elsewhere. These are as follows:

- Once the couples become more relaxed, there was only a relatively small need for our didactic input. The couples readily identify the changes and difficulties, which have arisen in their relationships as a result of the woman's depression (and also for some, the transition to parenthood). Our impression was that sharing these experiences was highly therapeutic in confirming, "we are not the only ones".
- It also became apparent that the couples were able themselves to develop sensible and constructive ways of tackling these problems, and again that a less didactic input was necessary from the group facilitator than was initially envisaged. Although there were times when the couples found it useful for the facilitator to suggest specific techniques, for the most part almost all of the techniques, which the facilitators had prepared, emerged in the group discussion.
- The issue of the woman's loss of interest in sex was raised several times, by both male and female participants, however it was clear that the group were much less comfortable discussing this issue, and the facilitators found it helpful to frame this as "expression of affection", with which the group seem far more comfortable.

Although only a small number of groups were conducted, there were some consistent observations that emerged. These were as follows:

- The couples readily related to the "vicious cycle" model (Appendix A), and this was a most useful way of introducing the main issues as it was applicable to almost all of the problems they were experiencing.
- Often, they volunteered the "Catch-22" model. In brief this refers to the male offering to do something helpful, but having the other rejected because the woman's perceives the offer as a statement about his belief that she is incompetent. On the other hand, the male's failure to offer is interpreted as a lack of support and uncaring.
- The couples often mentioned that the most helpful feature of the group was to recognise that other couples were experiencing similar difficulties. i.e.:
- Traditional roles and expectations of parenting, somewhat unrealistic.
- Isolation with a new baby is "deafening", made more so suffering with depression.
- Family of origin, "baggage," reinforces inability to cope.
- Unsupportive family and friends. The stigma of depression always present.
- Life has no fun. Fathers feel guilty if they take time out for sport & recreation.
- The men, especially in the male only sessions, consistently stated that the most difficult aspect for them of their partner's depression was her irritability.
- Both men and women also stated that they found the communication segment extremely helpful.
- The couples offered high levels of support both to each other, as well as to other couples.
- They participated quite actively in the group and this applied even to some of the women who were still quite depressed.
- Some of the men volunteered that their alcohol use had increased since their partner had become depressed, and this was a source of considerable concern to them.
- In the male only groups, the men found it helpful to discuss their own negative feelings and ways in which they needed to "look after" themselves as well as their depressed partner.

#### *Randomised Controlled Trial of Efficacy*

A detailed methodology had been designed for the randomised controlled trial. It was planned to involve both male and female participants before and after intervention, and (in the control group) before and after a two-month period. It was to include symptom measures (depression and anxiety, irritability, positive and negative effect), parent to infant attachment measures, couple relationship measures and a subjective evaluation of the intervention.

Unfortunately, recruitment difficulties rendered it quite impractical to conduct any methodologically sound evaluation study.

The qualitative feedback, which the group provided, was extremely positive. Almost all participants stated that they would like to have more sessions. At the end of the evening session it was often quite difficult to terminate, and it was noted that the couples often continued their interactions outside the group, and one group continued to meet at one of the participants homes of their own accord (Appendix B).



*Literature Review of Barriers to Men Seeking Help*

There is a substantial literature addressing the influence of gender on help-seeking behaviours, and the use of mental and physical health resources. There is a consensus finding from this empirical research that men are consistently more reluctant than women to seek help from mental and physical health care professionals. This reluctance would appear to apply equally to both emotional/psychological distress and physical problems, cardiac disease being the most researched.

There is also a large literature focusing on the reasons, which might underlie such male reluctance. However, in contrast to the empirical data documenting real gender differences, this literature comprises largely theoretical speculation. Very few studies have actually investigated causes.

Sociologists have developed elaborate explanatory models, postulating that men's reluctance arises as a direct result of male socialisation, leading to a male role norm characterised by toughness, stoicism, independence and self-sufficiency. Such attributes do not sit comfortably with help-seeking behaviour, which would potentially equate with weakness or vulnerability.

Other theorists stress the male need to be "in control". Help-seeking inherently involves some degree of relinquishing control. It also involves accepting that another individual has more expertise, and can actually provide help. Some men would appear to have difficulty acknowledging this.

Relationship theorists point out that men, unlike women, get most of their support from their female partners and relatively little from male friends or "outsiders". This is probably another factor contributing to their reluctance to seek "outside" help.

Psychological theorists stress male denial and avoidance, resulting from the need to not confront vulnerability to distress, non-immunity from illness and mortality. There may also be avoidance of recognition that the coping mechanisms (EG alcohol misuse) utilised are maladaptive and potentially hazardous. This may be coupled with a reluctance to relinquish such strategies, and avoidance of situations, which might challenge these.

Feminist theorists have postulated that men tend to detach from the distress around them, carry on their normal activities and recreation, and so are not sufficiently "uncomfortable" to be motivated to seek help or to change.

Many of the above have probably played a role in the difficulties encountered in recruiting men to attend the *beyondblue* male partner support groups. In addition, some men in this situation may fear that they will be blamed for their partners' depression, especially if there are relationship problems. Others may experience guilt or self-blame because they feel that they have actually contributed to the problem through lack of support or punitive attitudes. Finally, the time constraints and stress of handling a full-time job, supporting a depressed partner and doing a disproportionate share of childcare of a young baby may overwhelm the resources of many men in this situation. Attendance at two evening group sessions may be perceived as yet another demand or burden.

*Possible Solutions to the Problems Encountered in Recruitment*

Without the knowledge of the specific factors underlying the recruitment difficulties, possible solutions cannot be evidence-based, but rather must be developed on the basis of experience and opinion

*Inviting men alone to attend groups*

Regardless of how or by whom the invitation is issued (or its format), it is our opinion that this strategy will be unsuccessful

*Inviting couples to attend groups*

Our experience suggests that this is a more successful strategy, although the rates we achieved by mail and phone approaches were still very low. Possibly a face-to-face approach involving an evening home visit to the couple might be more successful, but obviously requires far greater resources. Linkage with routine home visit by the Child and Youth Health Nurse remains a possibility, but in South Australia this occurs at two weeks postpartum which is usually too early for screening or intervention.

*Peer invitations to attend groups*

It was clear from our groups that the men were highly attentive to advice and suggestions offered by other men in the group. Mechanisms of recruitment involving peers who have actually attended would probably be quite successful, but logistically very difficult to achieve.

*Inviting couples to attend groups at an earlier stage (during pregnancy)*

We believe these types of strategies have more potential for success. *Beyondblue* data suggest that antenatal depression is probably as common as postnatal depression. In addition, the majority of first-time expectant fathers attend antenatal classes with their wives. Unfortunately, childbirth educators in most centres are reluctant to focus on negative outcomes, and also prefer to focus on labour, at the expense of addressing psychological issues. However, such classes provide an ideal opportunity to educate couples about perinatal depression. If during one such class, men could be split off, an education session could be held focusing on "fatherhood issues". Research suggests that, unlike women, the majority of men do not want to "follow in the footsteps of their own fathers" in their style of childrearing. Thus, they lack an acceptable role model, and are usually quite receptive to addressing this issue. One format for such a session would be education (and provision of written material) about fatherhood, as well as the possibility of perinatal depression in their partners. This would include an introduction to how they can provide support, and the availability of male support groups. Such a setting also provides an opportunity to "normalise" such help-seeking behaviour in the specific context of perinatal depression.

It might also provide an opportunity to issue an invitation to a male postnatal session.

*Phone counselling*

Many men may be more receptive to one-to-one phone counselling if resources were made available for a male partner support "hot line" to be set up. This phone service could then act as a conduit for group recruitment, or be a stand-alone intervention.

*Web-based education and support*

Most men in this age group (25-30) use the Internet extensively. Provision of information, specifically geared to male partners and based on material we have developed in our groups (see appendix) could be made available on-line. One section of the site could be a public FAQ (Frequently Asked Questions) or a confidential e-mail question and enter service. Again this could be either a stand-alone intervention or provide a conduit to support groups if these were available in the major

## **Conclusions**

We believe that the module designed in this project, and the experience documented in this report should be significantly useful to other health professionals embarking upon the challenging task of implementing support groups for the male partners of women suffering from postnatal depression. It represents a relatively simple and potentially cost-effective intervention, and was very well received by those men who took part.

However, we were unable to develop a method of recruitment to attract a significant number of male partners to take part in these groups. Many other health professionals who have attempted to run support or therapy groups for males in a variety of different settings have reported similar recruitment difficulties, and we have provided a brief review of this literature.

Finally, we have summarised a number of possible ways that the obstacles to recruitment might be overcome. These should be potentially useful for other health professionals who might be contemplating running groups of this kind. .

## **References**

Condon JT, Boyce P, Corkindale CJ (2004). The first-time fathers' study: a prospective study of the mental health and well-being of men during the transition to parenthood. *ANZ J of Psychiatry*; 38(1-2):56-64

Kleiman K, 2000 *The Postpartum Husband: practical solutions for living with postpartum depression* Exlibris Corp, New York.

## **Appendices**

- A. *The Intervention Package:*                      *Components 1, 2 & 3*
- B. *Partners Group Evaluation Form:*            *Example of evaluation responses*
- C. *Reference:*                      *Condon, J.T. & Corkindale, C.J. 2004, First-Time Fathers Study  
Australian And New Zealand Journal of Psychiatry, 38:56-64*
- D. *Media Releases:*    *Adelaide Advertiser: 2004, 25/8. "Fathers help beat the blues"  
Specific copy of article has been sent by mail for inclusion.*
- E. *Table 1:*                      *List of common reasons used of lack of attendance to S.A. initiative*

## **Appendix A**

*The Intervention Package: Component 1*

### **BEYONDBLUE**

#### **◆ NATIONAL INITIATIVE TO COMBAT ALL FORMS OF DEPRESSION IN AUSTRALIA**

**CHILDREN**

**ADOLESCENTS**

**MEN**

**WOMEN**

**OLD**

**PREGNANCY**

**POSTNATAL PERIOD**

## **Appendix A**

*The Intervention Package: Component 1*

### **WHAT IS POSTNATAL DEPRESSION?**

#### **MOOD CHANGES**

- ◆ **SADNESS, “DOWN”, TEARFULNESS**

- |  |
|--|
| ◆ <b>IRRITABLE, “SHORT-FUSED”, ANGRY</b> |
|--|

- ◆ **GUILTY, USELESS, WORTHLESS**

- ◆ **HOPLESS, HELPLESS**

- ◆ **NUMB, NO FEELINGS**

- ◆ **DISTANT AND DETACHED FROM:**

**BABY**

**PARTNER**

- ◆ **MOOD SWINGS**

## **Appendix A**

*The Intervention Package: Component 1*

### **WHAT IS POSTNATAL DEPRESSION?**

#### **BIOLOGICAL CHANGES**

- ◆ **SLEEP (WAKING EARLY)**
  
- ◆ **APPETITE (INCREASE / DECREASE)**
  
- ◆ **WEIGHT**
  
- ◆ **BOWELS**
  
- ◆ **“SLOWED DOWN”**

**THINKING / MEMORY**

**MOVEMENT**

**CONCENTRATION**

## **Appendix A**

*The Intervention Package: Component 1*

### **WHAT CAUSES POSTNATAL DEPRESSION?**

- ◆ **WE DON'T KNOW**
  
- ◆ **STRESS OF PREGNANCY, CHILDBIRTH AND INFANT CARE?**
  
- ◆ **SLEEP DEPRIVATION?**
  
- ◆ **HORMONAL CHANGES?**
  
- ◆ **HEREDITY?**
  
- ◆ **CHILDBIRTH COMPLICATION / TRAUMA**
  
- ◆ **DIFFICULT PAST / CHILDHOOD**
  
- ◆ **OTHER FACTORS**



## **APPENDIX A**

*The Intervention Package: Component 1*

### **WHAT CAN BE DONE?**

- ◆ **INDIVIDUAL COUNSELLING OF THE WOMAN**
  
- ◆ **COUPLES COUSELLING**
  
- ◆ **ANTIDEPRESSANT MEDICATION**

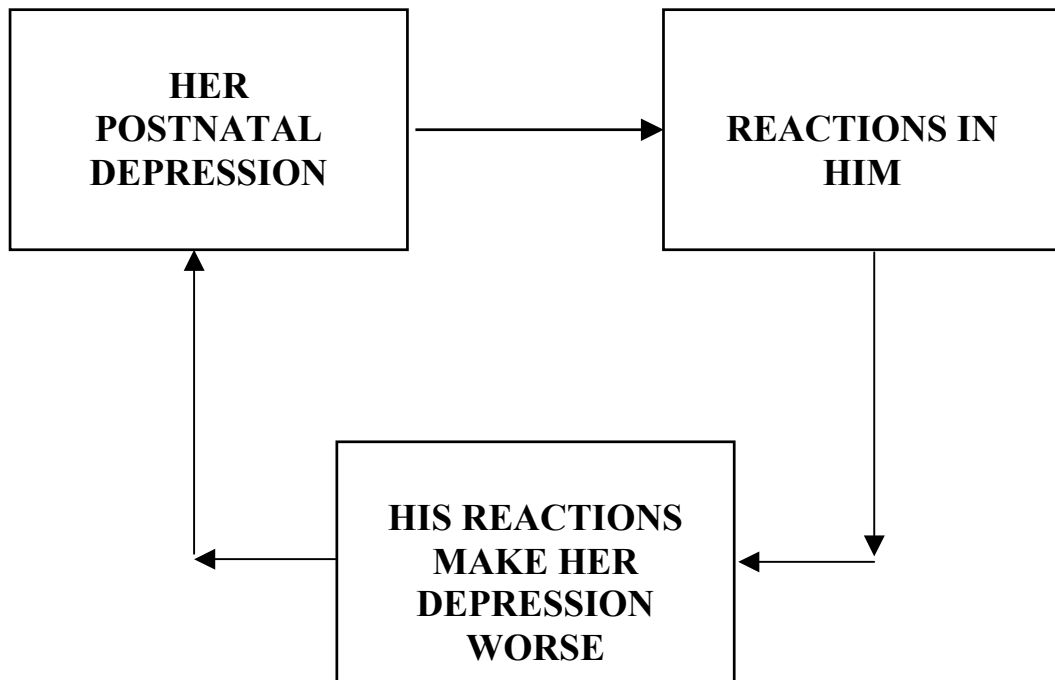
- |  |
|--|
| ◆ <b>THE COUPLE WORKING TOGETHER AS A TEAM TO HELP (NOT HINDER) RECOVERY</b> |
|--|

**APPENDIX A**

*The Intervention Package: Component 1*

**WHAT OTEN HAPPENS**

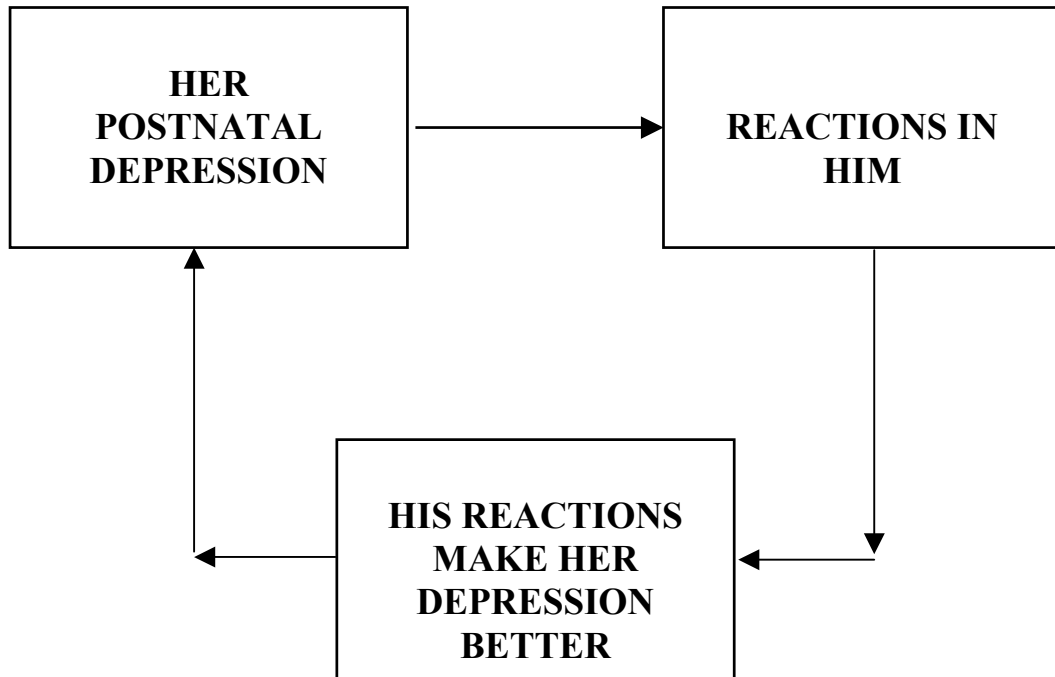
**(NOT DELIBERATELY)**



**APPENDIX A**

*The Intervention Package: Component 1*

**WHAT WE WANT TO HAPPEN**



**APPENDIX A**

*The Intervention Package: Component 2*

**PROBLEM**

**STRATEGY**  
**(PARTNERS ARE NOT THERAPISTS)**

**1. IRRITABILITY**

**2. CRYING / DEPRESSION**

**3. HOPELESSNESS**

**4. WITHDRAWAL OF AFFECTION / SEX**

**5. NEGATIVE THOUGHTS – SELF**

**“EVERYTHING”**

**6. CONFUSION / FORGETFULNESS /  
POOR CONCENTRATION**

**7. ANXIETY**

**APPENDIX A**

*The Intervention Package: Component 2*

**SPECIFIC STRATEGIES**

**IRRITABILITY**

**# NOT TAKE PERSONALLY**

**# NOT RETALIATE**

**LOW SELF-ESTEEM**

**# POINT OUT ACHIEVEMENTS**

**# “DON”T HAVE TO BE PERFECT”**

**# SET SMALL GOALS**

**CRYING**

**# LET HER CRY**

**# ASK HOW YOU CAN HELP**

**APPENDIX A**

*The Intervention Package: Component 2*

**SPECIFIC STRATEGIES**

**PROBLEMS**

**STRATEGIES**

**LOW MOOD**

**# EMPATHY**

**# PLEASANT EVENTS SCHEDULING**

**TIREDDNESS**

**# PRIORITISING**

**# ELICITING SUPPORT**

**# SHARING “NIGHT DUTY”**

**# SHARING HOUSEHOLD CHORES**

**ANXIETY**

**# RESSAURANCE**

**# DISTRACTIONS**

**APPENDIX A**

*The Intervention Package: Component 2*

**SPECIFIC STRATEGIES**

**HOPELESSNESS**

**# REASSURE HER YOU WILL NOT  
LEAVE**

**# REASSURE WILL GET BETTER**

**# ONE DAY AT A TIME**

**CONFUSION**

**# WRITE OUT CARDS WITH SIMPLE  
INSTRUCTIONS / STRATEGIES**

**# POSTPONE IMPORTANT DECISIONS**

**APPENDIX A**

*The Intervention Package: Component 2*

**SPECIFIC STRATEGIES**

**LOSS OF INTEREST IN SEX      # DON'T PRESSURE OR TRY AND  
"SEDUCE"**

**# NON SEXUAL CONTACT**

**WITHDRAWAL FROM YOU      # STRUCTURE AND PLAN TIME TO  
TALK TOGETHER**



**APPENDIX A**

*The Intervention Package: Component 2*

**SPECIFIC STRATEGIES**

**NEGATIVE THOUGHTS**

**# LISTEN**

**# DON'T CONTRADICT BUT DON'T SHARE**

**# AGREE TO DISAGREE**

**DEMANDS ON HER**

**# LIMITS ON DEMANDS FROM HER/HIS FAMILIES**

**# TAKE OVER CARE OF OLDER CHILDREN**

**RELUCTANCE TO ACCEPT TREATMENT**

**# ENCOURAGE**

**# GO WITH HER**

**# WRITE DOWN QUESTIONS**

**APPENDIX A**

*The Intervention Package: Component 2*

**WHAT ABOUT HIM?**

**LIFESTYLE**

**# REACTION**

**# EXERCISE**

**# SELF REWARD**

**SUPPORT**

**# SUPPORT GROUP**

**# NORMALISE**

**# FRUSTRATION**

**# RESENTMENT**

**# ANXIETY**

**# SHAME / STIGMA**

**COGNITIVE**

**# ANTICIPATE “NO WIN” SITUATIONS**

**INFORMATION**

**# BOOKLET / INTEREST**

**HELP**

**# PROFESSIONAL HELP**

## Appendix A

### *The Intervention Package: Component 3*

#### **FACTS ABOUT POSTNATAL DEPRESSION**

Following the birth of a baby, most mothers experience “the blues”. This usually happens within a few days of the birth when they feel tearful and or anxious, and seems to be caused by sudden hormonal changes, tiredness, emptiness and other strong emotions related to becoming a mother. Understanding and support for the new mum helps her to get through this time within a day or two.

In the first months of a baby’s life, both parents can feel that their world has been turned upside down, for better or worse. Women in particular may experience periods of exhaustion, mood changes, from sadness to euphoria, loss of interest in relationships and sex. Sometimes a few good nights sleep does wonders for the woman but for some women, these feelings are there most of the time, regardless of how much sleep they get. These feelings of loneliness, loss of interest in anything, loss of appetite may be symptomatic of depression, and it is important that if they persist, mum talks to someone---a husband, a friend, a relative and most importantly, her doctor/health care worker. It can be very difficult to enjoy the new baby when you are feeling so depressed and this can in turn lead to a feeling of “guilt” at not being a “good wife and mother”

Given time, Post Natal Depression can be treated successfully, but it can take months or even a year for some. Lots of sleep, loving support and care and medication, if appropriate, help mum to be able to experience the joys and good times of being a mother.

#### **Partners can help by:**

1. Not getting angry with your wife/partner. Depression is not a voluntary condition.
2. Being with her. It may be hard to come home every day to a crying mum and baby, but it is important that you do come home.
3. Understanding that your partner may not want as much physical or sexual relating as before. A hug and a cuddle may be all she is able to manage.
4. Understanding that it will get better with time.
5. Listening to her and letting her know you believe her.
6. Sharing the chores and tasks related to caring for the baby.
7. Loving her and the baby unconditionally.

- 8 Making time to deal with your stresses, such as going to the gym, reading, running, walking, meditation, relaxation, etc. so that you too do not become depressed.
9. Not judging, criticising, or advising.
- 10 Make her and the baby a priority.

**DON'T, DON'T, DON'T:**

- Tell her to “pull yourself together”
- “be grateful the baby is healthy”.
- “try and relax, you will feel better.”
- “it can't be that bad.”
- “you'll get over it, we all feel bad at times.”

## **Appendix A**

*The Intervention Package: Component 3*

### **“I” STATEMENTS**

NEED 3 INGREDIENTS.

#### **FEELING & BEHAVIOUR & EFFECTS**

EXAMPLES:

1. I FEEL VERY ANNOYED WHEN YOU DON'T CLEAN THE KITCHEN BENCH AFTER MAKING A SNACK, BECAUSE IT MAKES MORE WORK FOR ME.
2. I FEEL DISAPPOINTED BECAUSE THE DECISION WAS MADE WITHOUT INCLUDING ME.
3. I AM SCARED ABOUT WHAT MIGHT HAPPEN IF YOU LOOSE YOUR JOB.
4. I FEEL EXASPERATED WHEN I TRY AND TALK ABOUT THE CHILDREN AND IT BECOMES A BIG ISSUE.

**Speaking from self enables you to clearly identify the issue by taking responsibility for your feelings thoughts and wants.**

## **Appendix A**

*The Intervention Package:*                      *Component 3*

### **“YOU” STATEMENTS**

These statements have a destructive effect on your relationship  
This is known as “risky” dialogue.

**Avoid using the word “you” when starting a conversation, it automatically refers to accusation.**

#### **Examples:**

- You should have known better.
- You are so untidy.
- You know that you are wrong.
- You are acting just like your mother/father.

#### **Effects of “RISKY” dialogue**

- Makes them act defensively
- Makes them stop talking
- Makes them feel resentful
- Makes them feel they are not being listened to, or understood.
- Makes them feel inadequate

**“YOU” statements block effective communication**

## Appendix A

The Intervention Package: *Component 3*

### Why do you need to “ACTIVELY” listen to your partners?

It promotes clear and effective dialogue.

It displays a sense of “respect” towards each other.

It works more effectively than not.

SENDER RESPONSIBILITIES	RECEIVER RESPONSIBILITIES
Make sure channel is open.	1 Don't assume, let the person finish.
	2
Speak clearly	3 Pick up feeling.
	4
Timing, appropriate time and place.	5 Clarify, ask relevant questions
	6
Tactful tone, do not offend	7 Check it out.
	8
Respectful equality	9 Acknowledge what the person has said
	10
Think first, talk after thinking	11 Make allowances, respectfully tolerant
	12
Be honest	13 Don't think ahead, listen to the “now”
	14
Attend eye contact	15 Attend eye contact
	16
Be aware of body language	17 Remain “body” open
	18
Check if the message has been received.	19 Message received



Remember body language, it says more than any other word!!!!

## Appendix A

*The Intervention Package:*                      *Component 3*

### **ARE YOU WILLING TO NEGOTIATE?**

- |                      |   |
|----------------------|---|
| 1 <sup>ST</sup> STEP | ISSUE/S<br>SITUATION<br>TOPIC<br>DECISION     |
| 2 <sup>ND</sup> STEP | WHAT ARE MY <b><u>THOUGHTS</u></b> ON THIS?   |
| 3 <sup>RD</sup> STEP | HOW DO I <b><u>FEEL</u></b> ABOUT THIS?       |
| 4 <sup>TH</sup> STEP | WHAT ARE MY <b><u>SENSES</u></b> ON THIS?     |
| 5 <sup>TH</sup> STEP | WHAT ARE MY <b><u>INTENTIONS</u></b> ON THIS? |
| 6 <sup>TH</sup> STEP | WHAT ARE MY <b><u>ACTIONS</u></b> ABOUT THIS? |
| 7 <sup>TH</sup> STEP | WHICH ELEMENTS ARE <b><u>NEGOTIABLE?</u></b>  |

This can be used as a checklist when problem solving an issue/situation.

This can be done together in oral or written format.

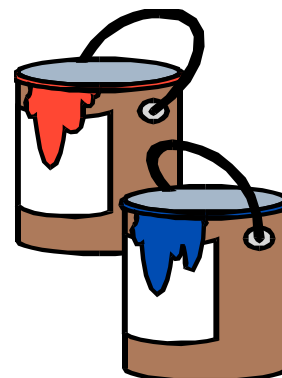
Remember you are both seeking a resolution.

50/50, equal compromise.



## Appendix A

The Intervention Package: *Component 3*



**How full are your energy buckets?**

**What activities of daily living that FILL your bucket?**

**What activities of daily living EMPTY your bucket?**

<b>DRAINERS</b>	<b>FILLERS</b>
KIDS	KIDS
NOISE	LOVE
BILLS	CARE
ANGER	THANK YOU'S
LACK OF SLEEP	CONCERN
ILLNESS	FAMILY LOVE
ACHES/PAINS	FAVOURITE MUSIC
LACK OF EXERCISE	SPORT
LACK OF LOVE	RECOGNITION
LACK OF GOAL	REWARDS
HOUSEWORK OVER& OVER	PRESENTS
DISORGANIZATION	FRIENDS
CUTTING REMARKS	GOING OUT ANYWHERE!
FEAR	SUPPORT
PERSONAL WORRIES	SAUNA
ANXIETY/DEPRESSION	MANAGEMENT
PARTNER	PARTNER

Learn to recognize that when it is nearly empty you cannot function effectively.

## Appendix A

*The Intervention Package: Component 3*

### **HOW TO HELP A MOTHER WITH PND** (beyondbabyblues)

The majority of women with postnatal depression are not good at asking for help. Many women with postnatal depression also experience feelings of guilt and inadequacy and mistakenly believe that asking for help is a sign of weakness. Please remember that when a woman has postnatal depression she may be very sensitive and may view offers of help as a way of saying she “can’t cope”. Sensitivity in implementing strategies may be required.

There are a number of things that partners, family members and friends can do to help a woman who has post natal depression.

Strategies that women have found helpful include:

- Help with practical things, like cooking meals and freezing them.
- Doing some cleaning or ironing or organize a house cleaner.
- Looking after the baby and any older children so that the mother can have some “time out” to relax, go out or spend some time doing something she enjoys.
- Encouraging her to seek professional help if she has not already done so and accompanying her to the doctor, especially if she is anxious or panicky about going out alone.
- Arranging to have someone with her at all times, during the early stages of the illness, when she may be scared of being alone and frightened about how she is feeling or what she is thinking.
- Actively listen to what she has to say and being supportive without judging her or telling her what to do. Ask her how she is feeling each time you see her.
- Developing a support system of friends, family and or counsellors for yourself so that you have some help too.
- Restricting visitors when she is feeling unwell, overwhelmed or tired.
- Organizing small family outings that don’t involve a lot of stress.
- Encouraging her to implement some effective self-help strategies as she begins to recover and or to contact her local state-based consumer organization specialising in P.N.D., that may have regular coffee meetings and offer telephone support services.
- Positively reinforce how well she is managing with the baby.

(beyondbabyblues: the national and antenatal disorders family initiative)

## Appendix B

*Partners Group Evaluation Form: Examples of evaluation responses*

### **PARTNERS GROUP EVALUATION SHEET**

Typical example of evaluation responses:

- *What if anything was most helpful to either yourself or your partner?*

Hearing stories and feelings of other couples experiencing P.N.D and seeing similarities to our own situation.

- *What was least helpful?*

Nothing, everything was helpful.

- *What would you like to have more of, included in the sessions?*

More sessions, I thought the balance was good.

- *What did you take away, where some of your needs met in some small way?*

Some ideas for communicating better with each other, and make the effort to find time for each other.

#### **Please tick one of the following:**

A. I would have preferred more time to talk and listen to other participants in the group, and **less** time listening to the presenters.

B. I would have preferred **less** time to talk and listen to other participants and **more** time listening to the presenters.

C. I thought the balance was about right - *This option was endorsed by almost all respondees*

#### **OVERALL RATING:** Please circle your response.

Excellent      Good      Satisfactory      Poor      Very Poor

All the respondents rated the intervention as either excellent or good.

#### **Your comments:**

{Suggestions for future groups, would you recommend this to your friends?}

The vast majority indicated they would like:

More sessions; highly recommend to others; great, open non-confrontational environment

## Appendix C

*Reference: Condon, J.T. & Corkindale, C.J. 2004, First-Time Fathers Study Australian and New Zealand Journal of Psychiatry, 38:56-64*

### The First-Time Fathers Study: a prospective study of the mental health and wellbeing of men during the transition to parenthood

John T. Condon, Philip Boyce, Carolyn J. Corkindale

**Objective:** In comparison to its female counterpart, the transition of men to parenthood has been relatively neglected in previous research. The present paper argues that men may have gender-specific risk factors for perinatal psychological distress and may manifest distress in ways different from women. The prime objective of this research was to document changes in psychological, relationship and lifestyle parameters in a cohort of first time fathers from pregnancy to the end of the first postnatal year. The present paper reports on these changes.

**Method:** Three hundred and twelve men were assessed at 23 weeks of pregnancy and followed up at 3, 6 and 12 months postnatally, using a battery of self-report questionnaires covering psychological symptom levels, lifestyle variables and relationship/sexual functioning. Two hundred and four men completed all four assessments.

**Results:** The men exhibited highest symptom levels in pregnancy with general, through small, improvement at 3 months and little change thereafter. Lifestyle variables showed small changes over the first postnatal year. Sexual functioning appeared to deteriorate markedly from pre-pregnancy levels with only minimal recovery by the end of the first year. The results highlight that the majority of men anticipated return of sexual activity to pre-pregnancy levels; however, this failed to eventuate.

**Conclusions:** Pregnancy, rather than the postnatal period, would appear to be the most stressful period for men undergoing the transition to parenthood. The results suggest that the most important changes occur relatively early in pregnancy. Thereafter, lack of change (rather than change) is the most noteworthy feature. These men appeared to be ill-prepared for the impact of parenthood on their lives, especially in terms of the sexual relationship. Further research to determine the timing and trigger of stress in pregnancy is recommended.

**Key words:** fatherhood, mental health, postnatal, prospective study, sexual function.

*Australian and New Zealand Journal of Psychiatry 2004; 38:56-64*

The transition to parenthood is a major life event that affects all aspects of psychosocial functioning. Until

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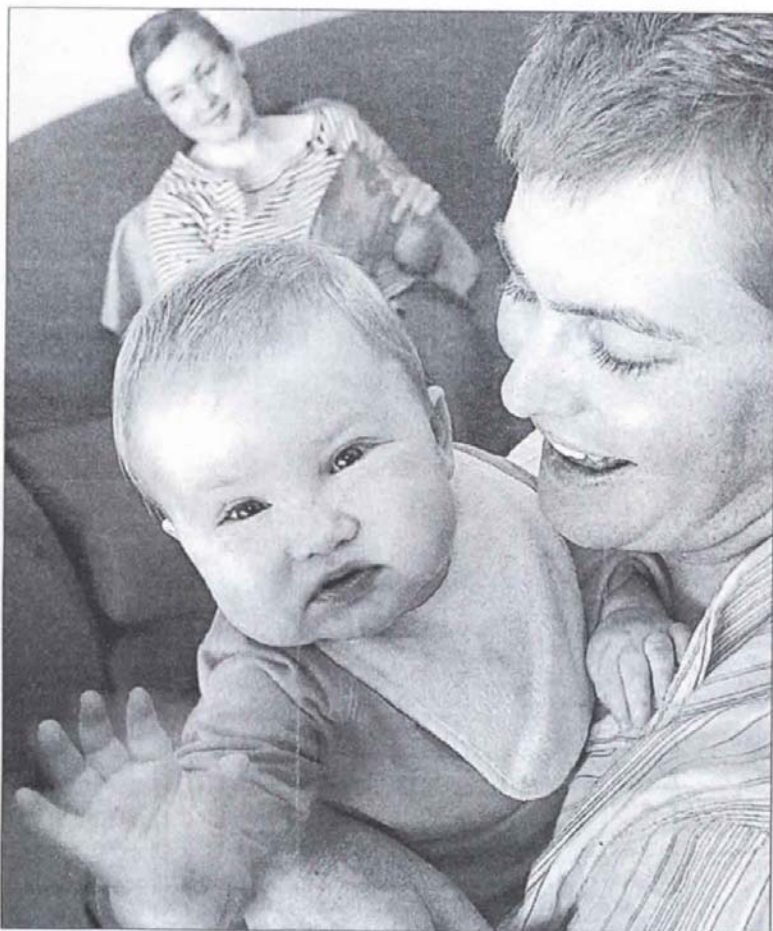
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recently, the transition to parenthood in men has been the focus of a large number of publications based mainly on anecdotal accounts of individual men or surveys of small, non-representative samples (e.g. men attending parenthood classes). Findings are often qualitative rather than quantitative and mostly cross-sectional. In contrast, many prospective studies have collected quantitative data on women through pregnancy, birth and the early postnatal months. These studies focused on psychosocial adjustment, couple relationship, and obstetric and neonatal outcomes, including maternal attachment to fetus

# Appendix D

Media Releases: Adelaide Advertiser: 2004, 25/8. "Fathers help beat the blues"



**DIFFERENT PERSPECTIVE:** Group participant Chris Brice, of Kurralta Park, with daughter Lily and partner Carly Schwerdt.  
Picture: NAOMI JELICOE

# Fathers help beat the blues

By Health Reporter  
LAURA ANDERSON

POSTNATAL depression has been a recognised problem for years, but little support was given to men whose partners were afflicted by it.

Depression support service **beyondblue** has started postnatal depression groups for partners, with the aim of "helping him to be able to help her". A state initiative, the fathers' groups teach men how to cope and how to be supportive when their partner has postnatal depression.

"These groups are more about how the women's postnatal depression affects the relationship and how men start behaving in ways which make the behaviour worse," professor of psychiatry at Flinders University and state **beyondblue** co-ordinator, John Condon, said.

"This is a new way of dealing with the problem, to actually work with the male partners." Three groups of fathers have already gone through Focus On Fathers pilot groups, but now the program is being expanded due to its success.

Professor Condon said the prevalence in SA of postnatal depression in women was 10 per cent, compared with men at about 4 per cent. The classes tried to teach men to accept and empathise with the depression rather than criticise the woman.

New dad Chris Brice, 24, recently attended one of the trial groups with partner Carly Schwerdt, 26, and baby Lily, nine months, and said it was "really reassuring knowing others were in the same situation".

☐ To get involved, phone 8275 1713.

**Appendix E**

*Table 1: List of common reasons used of lack of attendance to SA initiative*

	<b>Month</b>			
	<i>Nov 2003</i>	<i>Mar 2004</i>	<i>July 2004</i>	<i>Nov 2004</i>
<b>Asked</b>	49*	37*	50*	53*
<b>Attended</b>	6*	6*	8*	2*
<b>Did not attended</b>	4*	2*	2*	6*
<b>Confirm</b>	7	4	1	4
<b>No</b>	2	6	9	10
<b>Maybe</b>	5	3	5	2
<b>Message x 1</b>	2	1	2	5
<b>Message x 2</b>	6	3	7	3
<b>Message x 3</b>	5	4	7	4
<b>Message x 4</b>	1	2	5	4
<b>Maternal Illness</b>	0	0	2	0
<b>No partner</b>	0	1	3	4
<b>Send info</b>	4	1	16	3
<b>Separated</b>	3	0	0	1
<b>No voice mail</b>	9	4	7	5
<b>Moved house</b>	3	2	2	3
<b>Phone disconnect</b>	1	2	5	4
<b>On medication</b>	2	6	0	6
<b>No need</b>	2	7	0	5
<b>Psyche help</b>	1	0	2	2
<b>Counselling</b>	1	0	0	0
<b>Baby ill</b>	1	0	0	0
<b>Psyche admission</b>	2	0	4	1
<b>Shift worker</b>	0	1	0	3
<b>Not a bloke scene</b>	1	2	1	3
<b>Gaol</b>	1	0	0	0
<b>Family death</b>	0	0	2	0
<b>Twins, too hard</b>	2	0	0	0
<b>Neo Natal death</b>	1	0	4	3
<b>S.I.D.S</b>	1	0	0	0
<b>Missing person</b>	1	1	0	1
<b>Domestic Violent</b>	1	0	0	1
<b>Father taken baby</b>	0	0	0	1
<b>Inconvenient time</b>	1	2	2	2
<b>No babysitters</b>	2	2	2	1
<b>Maybe next group</b>	1	2	2	0

**Note: \* refers to individuals (not couples)**

**Western Australian Intervention Initiative:  
“The beyondblue National Postnatal Depression Project for Families with Multiple  
Birth Children”**



**Final Project Report**  
by  
**Janette Brooks**

**School of Psychology, Edith Cowan University  
Women & Infants Research Foundation**

**May 2005**

## **Preface**

Over the life of the *beyondblue* PND Program (i.e., 2001 to 2005) certain states have investigated a particular aspect of childbirth related mental health. For the Western Australian (WA) intervention, Dr Sherryl Pope developed a randomized control trial entitled “You, Me and Baby Makes Three”. This trial was aimed at smoothing the transition to parenthood for couples having their first child. Though this intervention was begun and a draft facilitator’s manual produced, Dr Pope was suddenly taken ill at the beginning of 2003, drastically slowing progress. The intervention was put on hold in the hope of Dr Pope’s recovery, with staff energy focused upon the national screening program. Tragically, Dr Pope did not recover and in December 2003 Dr Pope passed away. Without the expertise and vision of Dr Pope to co-ordinate the intervention in WA it was decided after much consideration that an alternative had to be developed that could be completed in the limited time left and with a leaner budget.

The WA Project Manager, Janette Brooks, devised the *beyondblue Postnatal Depression Project for Families with Multiple Birth Children*, focused upon the mental health needs of families expecting or caring for multiple birth children (i.e., twins or higher order multiples). **The new WA Intervention proposal was submitted to *beyondblue* on the 11<sup>th</sup> of February 2004 and was accepted on the 16<sup>th</sup> of February 2004 (leaving 14 months as opposed to the 4 years as originally planned to conduct the state interventions).** Despite the disadvantages, WA has conducted an extremely worthwhile and positive project that, by all accounts, has benefited many new and expectant parents of multiple birth children and will continue to do so thanks to the distribution of booklets, increased awareness in the professional and wider community, significant research findings and information gathered from mothers to guide future policy and clinical practice.

*This Project is dedicated to the irreplaceable Dr Sherryl Pope*



## Overview

Australian research has consistently found that families across Australia are ill-prepared in the prenatal period when they often do not have realistic expectations of how the birth of twins or higher order multiples will affect the family (Hay, Gleeson, Davies, Lorden, Mitchell, & Paton, 1990). Despite consistent evidence that the emotional health and well being of mothers of multiples may be poorer and that they are at higher risk of becoming depressed, anxious and clinically exhausted in the year after childbirth than mothers of singletons (Fisher & Stocky, 2003) there are few resources available to prepare, support and inform expectant or new parents of multiples.

The Western Australian (WA) *beyondblue* intervention conducted numerous educational initiatives to raise awareness of perinatal depression and provide information about emotional health and well-being during the transition to parenthood with multiple birth children. A 45-page information booklet was developed in collaboration with the Australian Multiple Birth Association (AMBA) and 12,000 copies requested and distributed nationally. Articles on perinatal mental health, written specifically to address the unique issues faced by parents of multiple birth children, appeared in numerous publications circulated to professionals and parents. Presentations are still being given, and various forms of media utilized to increase awareness, promote the information booklet and provide information to parents and professionals.

Due to a limited amount of research conducted on depressive symptoms in expectant or new mothers of multiples, and no research to date following mothers through from pregnancy to postpartum, there is currently uncertainty about the prevalence and nature of perinatal depression in this population. This uncertainty makes detection, prevention, and management of depression for these mothers difficult at present. The WA *beyondblue* intervention conducted a preliminary exploration of the emotional experiences of mothers of multiple birth children across Australia by combining qualitative and quantitative methods.

The WA *beyondblue* screening program database was utilized to assess the presence of depressive symptoms in a sample of mothers of twins ( $N = 120$ ) before and after childbirth and compare the results with a sample of mothers of singletons ( $N = 4717$ ). According to scores on the Edinburgh Postnatal Depression Scale (EPDS), 4% of mothers of twins had symptoms of depression during pregnancy (i.e., EPDS >12) and 15% experienced symptoms of depression after the birth (i.e., EPDS >9). An ANOVA revealed a statistically significant difference ( $F(1,4108) = 5.15, p < 0.05$ ) between groups on postnatal EPDS scores, with mothers of twins having significantly higher levels of depressive symptomatology than mothers of singletons (singleton  $M = 4.88, SD = 4.15$ ; twins  $M = 5.83, SD = 4.68$ ). A paired samples t-test was then used with a sample of 3997 participants with a singleton. The mean antenatal EPDS score ( $M = 5.63, SD = 4.38$ ) was found to be significantly higher ( $t(3996) = 10.86, p < 0.05$ ) than the mean postnatal EPDS score ( $M = 4.88, SD = 4.15$ ). In a sample of 101 participants with twins, the mean antenatal EPDS score ( $M = 6.41, SD = 3.74$ ) did not differ significantly to the mean postnatal EPDS score ( $M = 5.83, SD = 4.68$ ).

Statistically significant differences in the mean postnatal EPDS scores, with mothers of twins having a higher prevalence of depressive symptomatology *and* a non-significant reduction in symptoms postnatally, compared to a significant reduction in reported symptoms for mothers of singletons is a clinically significant discovery. Supported by the current research literature these findings warrant further investigation with possible ramifications for prevention, screening, and early intervention strategies.

Three focus groups were conducted with mothers from across Australia to further explore the perinatal experiences of mothers of multiple birth children. Thematic analyses of the focus group data revealed that mothers do not feel their unique and challenging circumstances are adequately acknowledged or supported. Mothers also appear to 'hit a brick wall' emotionally at 4 to 6 months postpartum offering further support for the current quantitative results. Subsequently, it is recommended that future screening policy and provision of support services needs to take into account a possible increased and delayed 'peak' in depressive symptoms in mothers of twins.

It is also recommended that the existing infrastructure of the Australian Multiple Birth Association should be utilised to meet the mental health needs of families with multiple birth children as it would require minimal additional resources and yet provide the necessary connection between families, services and health professionals nationally.

## Introduction

Multiple birth rates have increased dramatically in Australia over the past decade. In 1982 the total number of multiple confinements was 2,476 (i.e., 1.0% of total confinements). This rate has continually increased each year with the number of multiple confinements in 2002 being 4,153 (i.e., 1.7% of total confinements) (Australian Bureau of Statistics, 2003). This is a 59.6% increase in the number of multiple confinements in Australia in the past 10 years. The dramatic increase in the numbers of multiple births is of great concern to health professionals, as the risks for the mother, the infants, and the families are numerous. In addition to traditional indicators of perinatal morbidity and mortality, multiple pregnancies are associated with a number of financial, personal and social costs for their families and multiples themselves (Pettersen, Nelson, Watson, & Stanley, 1993).

Australian research has consistently found that families across Australia are ill-prepared in the prenatal period (Hay et al., 1990) when they often do not have realistic expectations of how the birth of twins will affect the family. Hay et al. concluded that the implementation of the most basic information services remain a problem for this population in Australia.

*No one would deny couples the joy that twins can bring. But the paradox is that, for this to happen, they must be made more aware of the less positive aspects and plan ahead accordingly. The message which they get must not only be realistic, but must be consistent across service providers, which means better education for the many professionals a couple with multiples will encounter (Hay et al., 1990).*

Families with multiple birth children have special needs that are not always fully understood or appreciated. The complications and complexities involved in pregnancy, birth and caring for multiple birth children can add to the misunderstandings surrounding perinatal mental health issues in the community and amongst health professionals. Postnatal depression may remain undiagnosed by health professionals in this population due to the addition of a whole new set of stresses and variables to be considered, particularly sleep deprivation. Parents may also incorrectly attribute depressive symptoms to the inherent stressors of caring for multiple infants and thus not seek help. There is also the volume and constancy of infant's needs to be taken into account when providing services and support for a mother of multiples with postnatal depression. Although mothers of twins undoubtedly experience greater physical challenges during pregnancy than mothers expecting one baby the only study conducted to date on the emotional well-being of women

pregnant with twins found they did not experience poorer emotional well-being (Thorpe, Greenwood, & Goodenough, 1995).

At present, there is limited yet consistent evidence, that the emotional health and well being of mothers of twins is poorer and that they are at higher risk of becoming depressed, anxious and clinically exhausted after childbirth than mothers of singletons (Fisher & Stocky, 2003). Postnatal depression occurs in approximately 14% of childbearing women but there is limited research to date on the prevalence of postnatal depression in women following a multiple birth. It is therefore unclear whether women expecting and then caring for multiple infants have similar patterns of depression as mothers of singletons making screening, early intervention and prevention difficult.

The current project therefore set out to meet the following **aims**:

1. Create an emotional well-being resource specific to multiple births, to be distributed and accessible to the maximum number of multiple birth families in Australia.
2. Increase awareness of antenatal and postnatal depression and the emotional health needs of mothers of multiples through education and awareness raising initiatives.
3. Explore the assertion that mothers of multiple birth children are at higher risk of developing depression during the perinatal period than mothers of single birth children.
4. Provide much needed information on the emotional well-being of mothers of multiple birth children in Australia.
5. Assess the current level of services and support available for families with multiples in Australia and highlight where there is a lack of or increased need for these services.
6. Provide guidelines for prevention, detection and early intervention of antenatal and postnatal depression in mothers of multiple birth children.

## **Methodology**

The Australian Multiple Birth Association (AMBA) is a volunteer organisation established and maintained by multiple birth parents to provide support, resources and education to multiple birth parents. AMBA is the leading resource in Australia for multiple birth families in terms of education, social support, literature and information. With 68 local clubs dispersed throughout every state and territory of Australia, over 5000 families as members and as the main contact point for all parents expecting or caring for multiple birth children it was logical to collaborate with AMBA for all aspects of the WA Intervention.

To meet the aims of this project three components were necessary: (1) education and awareness raising, (2) adaptation and analyses of WA screening database and (3) focus groups. The methodology of these sections is outlined below.

### *Education & Awareness Raising*

The education of parents, parents-to-be and relevant professionals was viewed as the most important aspect of the WA intervention. In addition to calls for information provision and adequate preparation in the Australian research literature, an increase in consumer and carer awareness of antenatal and postnatal depression was one of the core priorities and values of the *beyondblue* Postnatal Depression Program. Presentations, media coverage including print, internet and radio and the production and promotion of a comprehensive written information resource were incorporated within this section of the intervention.

A 45-page information booklet on emotional health during pregnancy and early parenthood for parents of multiple birth children was developed in collaboration with the AMBA and professional stakeholders nationally (Appendix A). An extensive development process was undertaken in order to produce a comprehensive and user-friendly information resource. A total of 37 stakeholders were involved in the review process, including 17 parents of multiples and 20 professionals (Appendix B).

Promotion for the booklet was extensive beginning with a launch on the 20<sup>th</sup> August 2004 at the Western Australian Parents, Babies & Children's Expo, in collaboration with the Australian Multiple Birth Association (AMBA) and Postnatal Depression Support Association. Following the booklet launch an extensive national promotion and distribution process began. This process is now winding down with less than 1000 booklets to be distributed.

### *Screening Project*

The database utilized for the current analysis was the WA screening database, collected as part of the National PND Screening Program. As information on 'number of babies' was not being collected nationally an additional question was added to the WA demographic and psychosocial risk factors questionnaire (i.e., question 20a) to identify participants expecting twins, triplets or higher order multiple birth children. The aim was to assess the presence of depressive symptoms in a sample of mothers of twins before and after childbirth and compare the results with a sample of mothers of singletons.

The final database was comprised of 4,838 English-speaking women, between 18-45 years of age booked to deliver at one of the three centres involved in the program in WA (i.e., King Edward Memorial Hospital, Osborne Park Hospital, Mercy Private Hospital). King Edward Memorial Hospital is a tertiary obstetric facility and subsequently delivers the majority of multiple birth children in WA. In 2002 1.7% of Australian confinements were a multiple birth but as the largest proportion of participants for this sample were recruited from King Edward Hospital this figure was slightly inflated, resulting in 2.5% of the present sample being a multiple confinement (i.e.,  $N = 120$ ). One hundred and twenty sets of twins and one set of triplets were recruited into the WA database. The participant expecting triplets was removed prior to analyses.

Antenatal screening for depression occurred between 26 and 34 weeks gestation to coincide with existing assessment procedures at each of the three obstetric centres involved. Women who were screened antenatally in WA were then followed up between 6 and 12 weeks postpartum.

SPSS version 11.5 was used to conduct all statistical analyses. One-way analyses of variance (ANOVA) and subsequent *t*-tests were used to compare the antenatal and postnatal EPDS scores of mothers of twins with mothers of singletons.

### *Focus Groups*

Three focus groups were conducted with mothers of multiple birth children (i.e., twins and triplets) from across Australia to gather information on (1) the risk factors considered most pertinent by mothers of multiples for developing depression in the perinatal period, (2) opinions on efficacy/validity of screening using the EPDS, and (3) the services, support and information available in Australia to meet the mental health needs of parents of multiples.

In the spirit of this project, the purpose of these focus groups was not only to gather information but also to continue to raise awareness of perinatal depression in the community. Communication among women can be an awakening experience and an important element in the consciousness-raising process.

The focus groups were promoted through the AMBA. The participants were unselected in terms of ethnicity, socio-economic status, education, occupation, marital status, and method of conception. Three focus groups were conducted, involving a total of 17 participants; with representation from each state of Australia (Northern Territory was not represented).

Each focus group took approximately one and a half hours and was audio taped and then transcribed verbatim. Focus group transcriptions were authenticated by taking back a subset to the participants and asking them if they accurately reflected what was said. NVivo software (QSR) was used to conduct a thematic analysis of the focus group transcripts.

## Results

### *Education and Awareness Raising*

#### Information booklet

At the completion of the project, **13,000 copies** of the booklet will have been distributed across every state and territory of Australia with the aim of providing a copy for every expectant/new parent of multiple birth children in Australia for at least a 3 year time frame (i.e., 2004 – 2006). Table 1 displays the distribution of booklets by state. At the time of writing this report, 10,883 booklets had been distributed, with the remaining booklets being distributed over the coming months. In addition, 18 booklets have been requested from international organizations (Canada, New Zealand, UK, USA) that were keen to read this unique resource, which has international appeal and applicability.

Table 1. National distribution of information booklet for parents of multiples by state

	WA	SA	QLD	NSW	VIC	TAS	NT	ACT	TOTAL
<b>No. of booklets requested/ distributed</b>	2104	965	2087	1987	3104	183	30	405	<b>10865</b>
<b>% of total distributed to date</b>	19.3%	8.9%	19.2%	18.2%	28.5%	1.7%	0.3%	3.7%	<b>99.8%</b>
<b>Multiple confinements pa (01/02)</b>	388	286	772	1426	998	100	49	70	<b>4089</b>
<b>% of Australian multiple confinements</b>	9.5%	7.0%	18.9%	34.9%	24.4%	2.4%	1.2%	1.7%	<b>100%</b>

The booklet is being received with overwhelming gratitude from parents and professional stakeholders nationally as demonstrated by the two emails below (excerpts from Appendix C) and the constant influx of orders.

"I would like to order the booklet for women who have had a multiple birth. I am a midwife who also teaches antenatal classes and it would be great for these mums with multiples as they do have different challenges and there is not a lot of information out there just for them.

Thanks (QLD 4221) "

"My name is [REDACTED] I am the President of the Geelong Area Multiple Births Association. I have taken your the information to the committee about the booklets that you are distributing at the present time to clubs just like ours. We would love it if you could please send 150 copies of the booklet to our club. We intend to put it into the information pack that we give to all our new expectants, and also to families that might make contact with the club after the birth of their multiples. This is a wonderful project that you are running. As a mother who suffered and is still suffering PND after the birth of my twins I am sure the information in the booklet will help shed some light on the subject and make it a bit easier for families to cope and realise that it is a very common illness.

Thanking you in advance, GAMBA President"

### Presentations and media coverage

Various forums have been utilized to promote the information booklet and increase awareness of perinatal mental health issues amongst parents, professionals and the general public, including conferences, websites, various multiple birth club publications and radio. For further details please refer to the *beyondblue* **National Postnatal Depression Program Final Report VOL 1.**

### *Screening Project*

Symptoms of depression, as indicated by an EPDS score  $>12$ , were found in 8% of women pregnant with one baby and 4% of women pregnant with twins. Symptoms of postnatal depression, as indicated by an EPDS score  $>9$ , were found in 13% of mothers of one baby and 15% of mothers of twins at 6 to 12 weeks postpartum.

An analysis of variance (ANOVA) was conducted on antenatal EPDS scores. Due to a violation of the assumption of homogeneity of variance a robust test (Welch's ANOVA) was used to compare groups. Results did not show significantly different levels of depressive symptoms during pregnancy between mothers expecting one child ( $M = 5.74, SD = 4.40$ ) and mothers expecting twins ( $M = 6.06, SD = 3.69$ ).

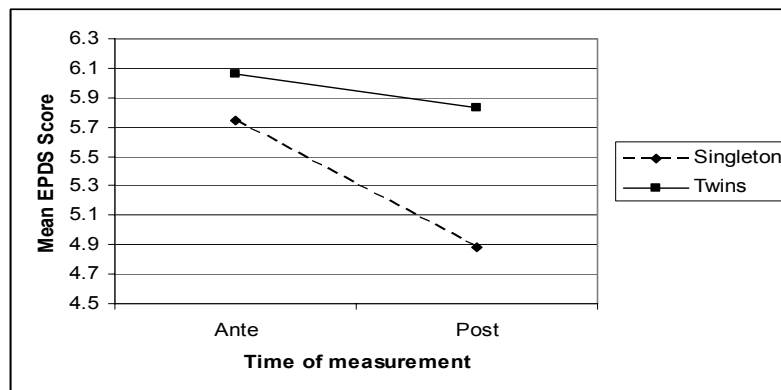
These findings support the only other published research currently available on depression in expectant mothers of twins. That is, that women pregnant with twins experience poorer physical well-being but not poorer emotional well-being than those pregnant with one child (Thorpe, Greenwood, & Goodenough, 1995). The suggested explanation for these results put forward by Thorpe et al. is that the transitory nature of a twin pregnancy, the "special" status of a twin pregnancy, greater social support, and modified expectations about health may buffer the physical effects on emotional well-being during the antenatal period.

An ANOVA was also used to compare *postnatal* EPDS scores of mothers of twins and mothers of singletons. Mothers of twins ( $M = 5.83, SD = 4.68$ ) were found to have significantly higher levels of depressive symptomatology as measured by postnatal EPDS scores than mothers of singletons ( $M = 4.88, SD = 4.15$ ),  $F(1,4108) = 5.15, p < .05$ .

Paired samples *t*-tests were then used to further assess the difference between the antenatal and postnatal EPDS score means for both the singleton and twin groups. Of the 4717 participants with one baby in this sample, 3997 had both an antenatal and postnatal EPDS score available. In this sample of 3997 participants, the mean antenatal EPDS score ( $M = 5.63, SD = 4.38$ ) was considerably higher than the mean postnatal EPDS score ( $M = 4.88, SD = 4.15$ ). This difference is significant ( $t(3996) = 10.86, p < .05$ ).

In the sample of 120 twins, 101 participants had both an antenatal and postnatal score available. In this sample of 101 participants with twins, the mean antenatal EPDS score ( $M = 6.41, SD = 3.74$ ) did not differ significantly from the mean postnatal EPDS score ( $M = 5.83, SD = 4.68$ ). Of particular note, although the mean EPDS score lowered slightly following the birth of twins, the prevalence of participants scoring above the established clinical cut-off (>12 antenatally, >9 postnatally indicating possible depression) increased postnatally (i.e., from 4% to 15%).

**Chart 1.** Comparison of symptoms of depression from pregnancy to postpartum for mothers of twins and mothers of singletons



To ensure the current findings were not being influenced by large differences in group size a random sample of 120 singletons (using SPSS to randomize) was compared with the 120 mothers of twins using ANOVA. Once again, *no* significant difference between groups was found on antenatal EPDS scores (singleton  $M = 5.74, SD = 4.40$ ; twins  $M = 6.06, SD = 3.69$ ) and a statistically significant difference ( $F(1,211) = 4.06, p < .05$ ) was found between postnatal EPDS scores with mother of twins having significantly higher levels of depressive symptomatology (singleton  $M = 4.88, SD = 4.15$ ; twins  $M = 5.83, SD = 4.68$ ).

The limited research available on depression in mothers of twins asserts that mothers of multiples have a higher risk of developing depression after childbirth than mothers of singletons (Hay et al., 1990; Thorpe, Golding, MacGillivray, & Greenwood, 1991; Thorpe, Rutter, & Greenwood, 2003) thus supporting the current results. Higher rates of depressive symptoms in mothers of twins have been documented by Hay, Gleeson, Davies, Lorden, Mitchell, and Paton (Hay et al., 1990) who found that mothers of 3-month old twins had significantly higher rates of depression and anxiety than mothers of singletons, and Thorpe, Rutter,

and Greenwood (2003) who found EPDS scores were significantly higher at 8 and 21 months for twins mothers (and closely spaced siblings <30 months apart) when compared with singleton mothers.

The time at which screening/measurement of depressive symptoms occurs appears to make the difference as to whether the prevalence of depression is higher for mothers of twins than for mothers of singletons (Haigh & Wilkinson, 1989). No differences in scores on the Leeds anxiety and depression questionnaire (Snaith, Bridge, & Hamilton, 1976) were found between mothers of twins and mothers of singletons at three weeks postpartum (Haigh & Wilkinson, 1989). However, subsequent measures at three and six months postpartum, disclosed a trend in which the proportion of mothers of twins experiencing depression and anxiety increased while that of controls decreased (Haigh & Wilkinson, 1989).

As screening for the current study occurred at approximately 6 to 12 weeks postpartum, it may be that the higher rates of depressive symptoms observed in mothers of twins may continue and even become more pronounced as time passes. In light of the current findings, the possible increased risk of depressive symptoms experienced during the postpartum period becoming chronic for mothers of twins must be raised. Thorpe et al. (Thorpe et al., 1991) utilized a large retrospective design to look at maternal depression in a cohort of 13,135 children (139 mothers of twins). It was concluded that both mothers of closely spaced singletons and mothers of twins were at significantly greater risk of depression when the children were 5 years old, with the impact greatest for mothers of twins (Thorpe et al., 1991).

### *Focus Groups*

#### Risk Factors

The risk factors considered most pertinent by mothers of multiple birth children for developing antenatal depression included inflated physical and emotional symptoms of pregnancy, isolation and intimidation by well-meaning family and friends.

*“It’s that chipping away of every single person you meet, ‘oh you poor thing how are you going to cope?’, ‘double trouble’, its constant. How are you going to cope suggests that you won’t cope.” (mother of twins, SA)*

There was strong agreement within and across groups that mothers of multiples may be at greater risk of developing PND due to risk factors such as delivery complications, premature babies, sleep deprivation, the logistical challenges (e.g., carrying, changing, nursing and bathing two babies), guilt of not having enough time for all children, unreal expectations/being unprepared for reality, isolation, additional financial pressures, loss of identity, and the sheer workload.

*“I think for multiples because you’ve got that extra, I was going to say the extra workload but its more than that, its sort of emotional, everything of caring for two babies.” (mother of twins, ACT)*

There were mothers within each of the three groups who had been diagnosed with PND and these participants were in agreement, both within and across groups, on a later time of onset for depressive symptoms. Four to 6 months postpartum were perceived by mothers as the ‘peak period of onset’ as they believed sleep deprivation and the constant workload built to a crescendo at around this time and the realization that there was no end in sight lead them to seek professional help.



*“I’ve heard so many mothers of twins say I just hit a brick wall around the 5 or 6 month mark. And that’s what happened to me. I was so exhausted by that period of time that all those things kind of, it was just like hitting a brick wall, I can’t do this anymore. So if I had done this (EPDS) then it would have got totally different response to say I’d done it at 2 months.” (mother of twins, Qld)*

The ‘brick wall’ theme supports the findings from the current quantitative analysis of the WA screening database which suggest that the significant difference in rates of depressive symptomatology postpartum between mothers of twins and singletons may in fact increase over time, with even more mothers of twins becoming depressed as the months go by.

### Screening

Participant’s experiences with the Edinburgh Postnatal Depression Scale (EPDS) were quite varied across states and territories highlighting the varied protocols and procedures in place throughout Australia at present. A surprising number of mothers had never been screened for depression and had never seen an EPDS. The need for repeated measures over the first 6 months postpartum (at least) was reiterated by mothers with reference once again to the 4 to 6 month ‘brick wall’.

The need for on-going health professional training in the sensitive and appropriate use of the EPDS was highlighted by mothers disclosing numerous incidents where, based solely on the results of the EPDS, they were diagnosed with PND and the results were not dealt with sensitively.

*“I did fill it out actually and that’s when they said yes I’ve got it and I was actually quite shocked...it was very confronting after it was actually filled in because I thought I was actually doing quite well. But I sort of crashed afterwards, after I filled this in.” (mother of twins, VIC)*

### Support Services

There have been numerous calls for specific preparation of parents expecting a multiple birth and for follow-up support to be made available to assist parents to cope ((Hay et al., 1990); (Thorpe et al., 1991). Help from family and friends is often short term and so additional support is usually needed. A lack of consistent physical and emotional support is commonly reported as a contributing factor to postnatal depression in mothers of multiple birth children.

The AMBA provides the bulk of information and support nationally to families expecting or caring for multiples. The South Australian MBA lobbied for and received a grant to provide limited home help to families on a needs basis. Elsewhere all support is provided by volunteers (i.e., families of multiples) without government funding. The AMBA provides various services but most importantly a place where mothers can share their feelings, realize they are not alone and obtain useful advice from those who understand.

*“Just knowing that I could, there was a soft pace to fall. I mean I know it’s not a hugely fantastic organization because it isn’t plush with all this money and can’t offer all these things but there are lots of little things you can go and do if you want to. I knew I could go and talk to someone and just have someone to listen to me.” (mother of twins, WA)*

Other services utilised by families were: the Red Cross Family Respite Service (WA), a volunteer catholic church service for families at risk (Canberra), Charlton Brown nanny training college (Qld), paid

sleep consultants (i.e., QE2 in Canberra and Ngala in WA), Women's Health Care House Northbridge (WA), and health care professionals including GPs, child health nurses, and obstetricians (nationally). Families were discussed as providers of support but often the complexities of family support were often raised as potential stressors.

*"I love my family but they can be one hell of a double edged sword. The amount of expectation and the insistence of doing things their way." (mother of twins, Qld)*

From the focus group transcripts it was evident that mothers of multiples believe the services, support and information available in Australia does not adequately meet the mental health needs of expectant parents and parents caring for multiple infants.

*"There are huge gaps I think in services for multiple families." (mother of twins, ACT)*

Women suffering from depression during the perinatal period often report feeling isolated and may not seek help due to the perceived stigma and subsequent shame they feel. For mothers of multiples the isolation experienced is understandably even greater as they are a minority within a minority.

*"I was diagnosed with postnatal depression. I was actually referred to a hospital where they had group therapy discussions and things like that and I'd never felt so alone as when I was in this group therapy because I was the only one in there with twins and no-one understood what I was talking about and I did it for one day, I just couldn't go back. And I just think at the time if there were four or five mothers with similar problems to mine that would have been fantastic. I felt isolated, very isolated." (mother of twins, Qld)*

Providing support to and linking these women together poses a challenge but is possible by utilizing the infrastructure already in place with the AMBA. The potential to link women together and to available support services and health professionals is there but requires a concerted and professionally guided effort to put into place and run (see recommendation 10).

*"What's coming out sometimes when AMBA new mums get together is that its not uncommon at all to be depressed and there not upset about the fact they're depressed they're just so pleased that there not the only one." (mother of twins and local AMBA club president, NSW)*

A common theme amongst mothers of twins was the overall lack of recognition of their unique needs and thus inadequate provision of information and services due to the increased frequency of twin births in Australia today.

*"There wasn't really any sort of special consideration or any additional support offered. If I wanted anything I felt like I really had to get on the phone and put a good case for why I needed like a child health nurse to visit me, or you know, so it was a bit of a battle." (mother of twins, WA)*

Mothers who are struggling to cope and/or suffering from depression usually do not have the energy/capability to be asking for help, never-mind having to put forth a good case for why they should get additional support.

*“...you’re depressed, you haven’t got the energy to actually refer yourself to appropriate services, and that’s where there is a big gap in actually people diagnosing and then being able to refer to support.” (mother of twins, Qld)*

## Conclusions

The current intervention project explored the experiences of mothers of multiple birth children in Australia today, developed and distributed resources nationally and assessed the prevalence of depressive symptoms during the perinatal period. One clinically significant discovery of this project was that mothers of twins were found to have a significantly higher prevalence of depressive symptomatology *and* a non-significant reduction in symptoms postnatally, compared to a significant reduction in reported symptoms for mothers of singletons. Supported by the current research literature these findings warrant further investigation with possible ramifications for prevention, screening, and early intervention strategies.

Through its education and awareness raising initiatives this project has succeeded in producing a ‘groundswell’ of energy and enthusiasm to engage in preventative strategies and develop early intervention and support initiatives amongst the community networks utilized by expectant and new families caring for multiples (i.e., AMBA). The project has received overwhelming support over the last 14 months from multiple birth families nationally and the WA AMBA President and National AMBA President have expressed their gratitude for the Project in writing (Appendix D). From these letters it is evident that the project has indeed succeeded in increasing awareness and knowledge of perinatal depression amongst this influential and far-reaching community group.

The WA intervention was met with gratitude and enthusiasm from parents and professionals who expressed that this had previously been an area of need that had gone widely unrecognized.

## Recommendations

1. Continue printing and distribution of information booklets developed for families expecting or caring for multiple birth families.
2. Future screening policy and provision of support services needs to take into account a possible increased and delayed ‘peak’ in onset of depression in mothers of multiples (i.e., 4 to 6 months postpartum).
3. Further longitudinal research is required to ascertain the prevalence and course of depressive symptoms over the first 12 months postpartum for mothers of twins, possible causes and links to chronic depression.
4. There were numerous comments made during focus groups about initial difficulties learning about the AMBA – how to make contact and realizing what they offer. As this is such a valuable service, it is crucial that families are given the opportunity to make use of its services. Supporting AMBA to improve their promotional activities and establish links with health care providers and obstetric services nationally would ensure health professionals and thus families are aware of AMBA and what they offer.

5. The AMBA is the first contact point for 1000's of multiple birth families and the major organization nationally providing information, support and services for families with multiples. But as a volunteer run organisation with limited government support/funding they can not provide screening, referral or counselling services that would benefit families struggling with depression, anxiety, and grief across Australia. The association provides a valuable forum for mothers to share their experiences and subsequently realize they are not alone. The association, however, currently lacks the knowledge to provide any further referral or counselling services. As an established organization with infrastructure in place nationally AMBA is the logical place to provide such services. It is therefore recommended that funds be allocated (i.e., a grant) to employ a professionally trained consultant (i.e., 0.5 FTE psychologist/counsellor with expertise in perinatal mental health) to provide on-going support and structure to the AMBA nationally. As part of this role, the consultant would establish and maintain links between local AMBA clubs, mental health services and obstetric services in each state, provide information, advice and support to committee members to facilitate their roles within AMBA, establish links between mothers within and across states (i.e., facilitate group therapy/support), develop referral guidelines and liaise with health professionals as required, provide an internet and phone based support/counselling service to families, and be responsible for the updating, printing and distribution of the information booklets as well as developing additional information resources/packages.

## References

- Australian Bureau of Statistics. (2003). *Births 2002* (No. 3301.0). Canberra: Australian Bureau of Statistics.
- Fisher, J., & Stocky, A. (2003). Maternal perinatal mental health and multiple births: implications for practice. *Twin Research, 6*(6), 506-513.
- Haigh, J., & Wilkinson, L. (1989). Care and management of twins. *Health Visitor, 62*, 43-45.
- Hay, D., Gleeson, C., Davies, C., Lorden, B., Mitchell, D., & Paton, L. (1990). What information should the multiple birth family receive before, during and after the birth? *Acta Genet Med Gemellol, 39*, 259-269.
- Petterson, B., Nelson, K., Watson, L., & Stanley, F. (1993). Twins, triplets and cerebral palsy in Western Australia in the 1980's. *British Medical Journal, 307*, 1239-1243.
- Snaith, R., Bridge, G., & Hamilton, M. (1976). The Leeds scales for the self assessment of anxiety and depression. *British Journal of Psychiatry, 128*, 156-165.
- Thorpe, K., Golding, J., MacGillivray, I., & Greenwood, R. (1991). Comparison of prevalence of depression in mothers of twins and mothers of singletons. *British Medical Journal, 302*, 875-878.
- Thorpe, K., Greenwood, R., & Goodenough, T. (1995). Does a twin pregnancy have a greater impact on physical and emotional well-being than a singleton pregnancy? *Birth, 22*(3), 148-152.
- Thorpe, K., Rutter, M., & Greenwood, R. (2003). Twins as a natural experiment to study the causes of mild language delay: family interaction risk factors. *Journal of Child Psychology and Psychiatry, 44*(3), 342-355.

## **Appendices**

*A*            *Information Booklet*

*B*            *Stakeholders*

*C*            *Positive Feedback*

*D*            *Letters*

## Appendix A

*Emotional Health During Pregnancy & Early Parenthood: An Information Booklet for Parents of Multiples* - see attached

## Appendix B

### Stakeholders

#### Stakeholder Feedback Process

Each Stakeholder posted a booklet 'Feedback Package':

- ◆ Covering Letter
- ◆ *Stakeholder Feedback Form*
- ◆ Draft Information Booklet
- ◆ Reply-paid envelope
- ◆ 2 x reminders sent

Name	Position	Organisation	Contact & Postal details
Dr Elizabeth Kaczmarek	Clinical Psychologist, Academic	ECU, School of Psychology	e.kaczmarek@ecu.edu.au School of Psychology Edith Cowan University 100 Joondalup Dve, Joondalup WA 6027
Dr Justin Bilszta	bb National Project Manager	beyondblue	justin.bilszta@armc.org.au ARMC Repat Campus, Building 129A, Locked Bag 1, West Heidelberg, 3081, Victoria
Prof Jeanette Milgrom	Clinical Psychologist, bb Chief Investigator	beyondblue	jeanette.milgrom@armc.org.au ARMC Repat Campus, Sth Wing Centaur Building, Locked Bag 1, West Heidelberg, 3081, Victoria
Jennie Erickson	Clinical Psychologist, bb Associate Investigator	beyondblue	jennifer.ericksen@armc.org.au ARMC Repat Campus, Sth Wing Centaur Building, Locked Bag 1, West Heidelberg, 3081, Victoria
Prof Bryanne Barnett	Psychiatrist, bb Chief Investigator	beyondblue	Maribel.Thomas@swsaha.nsw.gov.au Park House, 13 Elizabeth Street, Liverpool, NSW 2170
Dr Delphin Swalm	Chief Clinical Psychologist	KEMH, Psychological Medicine	Delphin.Swalm@health.wa.gov.au Psychological Medicine, Agnes Walsh House, King Edward Memorial Hospital, PO Box 134, Subiaco, Western Australia 6904
Rosie	Senior Clinical	KEMH, Psych	Rosemary.Hagan@health.wa.gov.au

<b>Name</b>	<b>Position</b>	<b>Organisation</b>	<b>Contact &amp; Postal details</b>
Hagan	Psychologist	Medicine, PNDPA	Psychological Medicine, Agnes Walsh House, King Edward Memorial Hospital, PO Box 134, Subiaco, Western Australia 6904
Ass Prof Jan Dickinson	Associate Professor of Obstetrics and Gynaecology, Head, Maternal Fetal Medicine, (specialist in multiple births)	Maternal Fetal Medicine, KEMH	karen.reid@health.wa.gov.au Maternal Fetal Medicine, King Edward Memorial Hospital, PO Box 134, Subiaco, Perth Western Australia 6904
Marie Hill	Midwife	Parent Education KEMH	Parent Education King Edward Memorial Hospital, PO Box 134, Subiaco, Perth Western Australia 6904
Prof David Hay	Prof of Psychology, Multiples researcher, AMBA Ambassador	Curtin University AMBA	d.hay@curtin.edu.au School of Psychology, Curtin University of Technology GPO Box U1987 Perth WA 6845
Cathy Vellacott	National President, AMBA, Mental Health Nurse, (mother of twins)	AMBA	fivealive@ozemail.com.au 43 Harold Street, Stafford, Qld 4053
Marie Bennett	WA President (mother of twins)	P&DMBA	bennetz@bigpond.net.au 51 Whitfeld Terrace, Winthrop, WA 6150
Ass Prof Karen Thorpe	Clinical Psychologist, Ass Prof of Psychology, Multiples Researcher	Queensland University of Technology	k.thorpe@qut.edu.au School of Early Childhood Queensland University of Technology Victoria Park Rd, Kelvin Grove, QLD 4059
Julie Watts	Clinical Psychologist, PND Researcher	SJOG, Raphael Centre	c/o St John of God Health Care Raphael Centre PO Box 14 Subiaco 6904



<b>Name</b>	<b>Position</b>	<b>Organisation</b>	<b>Contact &amp; Postal details</b>
Trish Sullivan	Manager	St John of God Health Care, Raphael Centre	Trish.Sullivan@sjog.org.au St John of God Health Care Raphael Centre PO Box 14 Subiaco 6904
Hilda O'Callaghan & Alice	Hilda - Manager Alice - Respite Coordinator	Red Cross Family Support Service	hocall@wa.redcross.org.au Australian Red Cross 110 Goderich Street, East Perth. WA 6004
Dr Ann Hodge	Psychiatrist, State Perinatal Ref Group Director	OPH	Ann.Hodge@health.wa.gov.au Osborne Park Hospital Osborne Place, Stirling WA 6021
Christina Down	State Perinatal Ref Group Co-ordinator	OPH	<a href="mailto:Christina.Down@health.wa.gov.au">Christina.Down@health.wa.gov.au</a> Osborne Park Hospital Osborne Place, Stirling WA 6021
Rebecca Godin	President	PNDSA	rebecca@thecomputerteam.com PNDSA Agnes Walsh House, KEMH PO Box 548, Subiaco WA 6904
Dr Margo Norman	Obstetrician, Gynecologist	Joondalup Health Campus & Fertility North	C/o Fertility North Suite 213, Specialist Medical Centre, Joondalup Health Campus, Shenton Ave, Joondalup 6027
Dr Mark Umstad	Obstetrician	Head, Multiple Pregnancy Clinic, Royal Women's Hospital	mark.umstad@maynegroup.com Suite B, Level 10 Multiple Pregnancy Clinic Royal Women's Hospital 132 Grattan Street, Carlton, Victoria 3053
Staff	Midwives	Fertility North	C/o Fertility North Suite 213, Specialist Medical Centre, Joondalup Health Campus, Shenton Ave, Joondalup 6027
Gerry Ferguson	Child Health Nurse	North Metro Health Service & NEST	North Metro Health Service, Mirrabooka Population Health Program 4/14 Chesterfield Road, Mirrabooka, WA 6061
Alison Motherwell	Health Promotion Officer	North Metro Health Service & NEST	Alison.Motherwell@health.wa.gov.au North Metro Health Service, Mirrabooka Population Health Program 4/14 Chesterfield Road, Mirrabooka, WA 6061

<b>Name</b>	<b>Position</b>	<b>Organisation</b>	<b>Contact &amp; Postal details</b>
Mary Vlahov	Child Health Nurse	North Metro Health Service & NEST	North Metro Health Service, Mirrabooka Population Health Program 4/14 Chesterfield Road, Mirrabooka, WA 6061
Elizabeth Buckton	Child Health Nurse	North Metro Health Service & NEST	North Metro Health Service, Mirrabooka Population Health Program 4/14 Chesterfield Road, Mirrabooka, WA 6061
Leonora MacTavish	Child Health Nurse	North Metro Health Service & NEST	North Metro Health Service, Mirrabooka Population Health Program 4/14 Chesterfield Road, Mirrabooka, WA 6061
12 AMBA members	Not in WA (expecting or multiples age < 36 months)	'Consumers'	c/o Cathy Vellacott
5 P&D MBA members	In WA (expecting or multiples age < 36 months)	'Consumers'	c/o Marie Bennett
Colleen Ball Jocelyn Bristol Sandy Clarke	3 WA Midwives/ CHN's	beyondblue	c/o WIRF

**Total returned N = 37**

## Appendix C

*Positive Feedback (received via email for the Information Booklet for Parents of Multiples)*

Hi

>I would like a copy of the booklet for women who have had a multiple  
>birth. I am a midwife who also teaches antenatal classes and it would be  
>great for these mums with multiples as they do have different challenges  
>and there is not a lot of information out there just for them.

>Thanks

>

QLD 4221

**From:** [REDACTED]  
**Sent:** Wednesday, September 08, 2004 12:05 AM  
**To:** Janette BROOKS  
**Subject:** Information booklet for multiple families

Hi Janette,

My name is [REDACTED] I am the President of the Geelong Area Multiple Births Association. I have taken your the information to the committee about the booklets that you are distributing at the present time to clubs just like ours. We would love it if you could please send 150 copies of the booklet to our club. We intend to put it into the information pack that we give to all our new expectants, and also to families that might make contact with the club after the birth of their multiples.

This is a wonderful project that you are running. As a mother who suffered and is still suffering PND after the birth of my twins I am sure the information in the leaflet will help shed some light on the subject and make it a bit easier for families to cope and realise that it is a very common illness.

My postal address is:

[REDACTED]  
[REDACTED]  
[REDACTED]

Thanking you in advance

[REDACTED]  
GAMBA President  
Ph) 03 52823294

Hi Janette,

How are you?

The PND multiple birth booklets look great - I'm looking forward to hearing more about your work at Convention. If possible, I'd also like to get some copies of the PND booklet to send out - we've currently got 11 members, so maybe about 20 booklets (to cover new members) if that is ok? I've already sent one copy to one of our members who is currently suffering PND - it was fantastic to be able to put my hands on something to give her. [REDACTED]

[REDACTED] QLD 4157.

Thanks!

Catch ya  
[REDACTED]

Hi Janette

I have received these booklets - thank you. I was suggesting to my club that we make them available to local Doctors, hospitals, baby clinics and the IVF clinic in Coffs Hbr. Is that OK?

I was pleased to see the comments acknowledging the feelings that accompany the birth of multiples after a long period of infertility and subsequent fertility treatment. When my twins were born after 6 years of trying and finally IVF treatment, everyone kept on telling me how blessed and lucky I was. I was unprepared for the sleep deprivation, impact on my life with my partner and the sheer exhaustion and there were times I did not feel very lucky at all. I felt very reluctant to complain to anyone, even close friends and family and my partner! Now my boys are three and are the great, yet still challenging, light in my life!!

I think the booklet is very useful - thanks  
[REDACTED]

**From:** [REDACTED]  
**Sent:** Wednesday, October 27, 2004 12:37 AM  
**To:** Janette BROOKS  
**Subject:** Hello Janette,

Hello Janette,

I am the membership secretary of our multiple birth club(rockhampton) and received your letter and booklet "Emotional Health During Pregnancy and Early Parenthood: an information booklet for parents of multiple birth children".

Thankyou, it is an excellent read and one that I personally will find of assistance. We are delighted to distribute this information and request 60 books. With these books we can supply to our obstetric hospitals who have increasing numbers of multiple birth deliveries and of course our own members. with many thanks

[REDACTED], membership secretary RMBA

Hi Janette,

Thank you again for sending out the extra booklets. Could we please have another 50, that should be the last request for awhile! Still a great response from the people who are receiving them AND giving them out.

Regards

[REDACTED]

Knox MBA Vic

PO Box 4021  
Knox City  
Wantirna South 3152

Good afternoon Janette,

This is [REDACTED] from Knox Multiple Birth Association.

Thank you for the 30 PND booklets you sent to us, we've had a great response to them and would like to order some more please. We're sending them out in our enquiry packs so even if they don't join the club, they have that information with them.

Could we please have thirty more?

Much appreciated

[REDACTED]

KMBA President/Gemini editor

--Original Message-----

From: [REDACTED] <mailto:Verna.Fisher@dhs.vic.gov.au>

Sent: Friday, October 15, 2004 1:02 PM

To: Janette BROOKS

Subject: health and well being booklet - multiples

Hi

Is it possible to have a copy please so as to support new parents through my role with the Australian Multiple Birth Association (Vic)?

thanks heaps, can really see a lot of use coming out of it.

[REDACTED]  
[REDACTED]

Dear Janette,

Thankyou for those brochures on new parents of multiple babies. They will be beneficial to the patients.

[Redacted]

Hello,

Thank you for sending me the booklet, it is very helpful. Could you please send me another five so I can give them to some of my friends. My postal address is below.

Thank you, [Redacted]

----- Original Message -----

**From:**  
**To:** j.brooks@ecu.edu.au  
**Sent:** Monday, December 13, 2004 8:28 PM  
**Subject:** booklet

Hello,

I have just been looking at the beyond blue website. COuld you please send me a copy of the booklet it mentions on PND for parents with multiples. My postal address is below.

Thank you,

[Redacted]

~~~~~

[Redacted]

I am one of the childbirth educators at the Women's and Children's Hospital in Adelaide, my primary focus is on multiple birth's and I was excited to see your information. Is there any possibility that I can access this information to give to expectant mother's. Kind Regards [Redacted]

Janette,

Yes I am one of the research officers in Canberra working on the bb PND program. The booklets have been a huge hit here and there are calls for more. If you can spare another 40 they will be quickly absorbed. [Redacted]

[Redacted]

[Redacted], Academic Unit of Psychological Medicine, The Canberra Hospital

Hi,

My name is [REDACTED] and I am the Secretary of the Newcastle Multiple Birth Club. On receiving your booklet we were very excited and would like to order 200 copies for our club.

Thank you so much for this important support document, I know it will be of great value to many of our families.

Yours sincerely

[REDACTED]

Dear Janette,

Today I received the Australian Multiples Magazine from AMBA and have read with great interest about the information booklet Emotional Health during Pregnancy and Early Parenthood: An information booklet for Parents of Multiple Birth Children.

I am a new mum to 7 month twins - [REDACTED] and [REDACTED] and would like to receive a copy of the booklet.

I have recently been diagnosed with PND and am very interested in the management strategies for parents who have multiples.

My contact details are:

[REDACTED]  
[REDACTED]

I look forward to hearing from you.

[REDACTED]

Hi

Janette

My name is [REDACTED] and I am from the Sunshine Coast Multiple Birth Assoc. I am writing about the booklets on PND. If possible we would like to have around 100 for our club. I think that it is a wonderful idea for all our new and expecting mums. If there are any problems or this is too many just send what you can.

Thanks for your time

[REDACTED]  
[REDACTED]  
[REDACTED]

Dear Sir/Madam,

I am a nurse working in a large maternity ward in a NSW hospital. I am responsible for parent education and was hoping you could send me the postnatal depression booklet, which particularly relates to parents of multiple babies so I can make them available to parents who need them.

My name is [REDACTED] and my address is [REDACTED]

Thankyou for your assistance in this matter, look forward to receiving more booklets. Congratulations on such a successful Program, in providing families with useful information to help through trying times.

Yours truly

[REDACTED]

President

Metropolitan West Multiple Birth Club

I am writing on behalf of the Wagga Wagga Multiple Birth Association. We would love to order 150 of your booklets,

**Emotional Health During Pregnancy & Early Parenthood: An Information Booklet for Parents of Multiple Birth Children**

These will be a fantastic resource for our Ante-Natal Co-ordinator to use. She sees many people at our hospital from Wagga and many outlying country towns. Thank you for the effort you have put into the books. I'm sure the mums who receive them will also appreciate it.

Thank you once again.

[REDACTED]

**Vice-President Wagga Wagga Multiple Birth Association.**

From [REDACTED]  
Sent: Monday, September 06, 2004 2:20 PM  
To: Janette BROOKS  
Subject: Beyond Blue Booklet for Multiple parents/families

Hi Janette

I am writing on behalf of Coffs Harbour and Districts Multiple Birth Association for which I am the newsletter editor. I would like to obtain 30 copies of the booklet Emotional Health During Pregnancy and Early parenthood: An Information Booklet for Parents of Multiple Birth Children.

I think this is a fantastic idea and I wish it was available in the months proceeding the birth of my now nearly 4 year old twins.



We plan to provide a booklet to each of the families who are currently members of our association and also to have one available in our club Library. If you can spare more for future members, that would be welcome. Would you also mind confirming that the booklets and postage are free please?

My address is

[REDACTED]  
[REDACTED]  
[REDACTED]  
[REDACTED]

Kind Regards and thank you

[REDACTED]

From: [REDACTED]

Sent: Tuesday, September 07, 2004 2:44 PM

To: Janette BROOKS

Subject: Information booklet

Hi Janette, the booklet looks really great!!!! Congratulations. We would love to have some stock of it so we can distribute to our multiple families. How shall we work it - I suppose I can collect some from you one afternoon? Please let me know what you normally do.

Thanks, [REDACTED]

[REDACTED]

Family Support Administrator  
Red Cross Family Support Service

[REDACTED]

Hello Janette,

When I received the email of the free booklets on PND for multiple birth families I was excited!!!! Our club is the largest in Queensland with a membership of 180 families at the last count. and growing. We also run Expectant Parent Information Nights which we try to cover everything in 2 nights (these are held every 2 months) for members and non members. I know this booklet will be of benefit to so many, multiple birth families out there. I would like to place an order of 500 BOOKLETS ASAP and we will distribute these to our expectant parents and our member families. postal address  
BRISBANE MULTIPLE BIRTH ASSOC (NORTHSIDE) INC.

PO BOX 481

STRATHPINE QLD 4500

attention [REDACTED]

Many Thanks

[REDACTED]

Club President BMBA Northside QLD

**From:** [REDACTED]  
**Sent:** Thursday, September 02, 2004 9:12 PM  
**To:** Janette BROOKS  
**Subject:** Information Booklet for Parents of Multiple Birth Children

My name is [REDACTED] and I am the President of the Gold Coast Multiple Birth Association Inc. I would like to order 100 booklets to be used in our information packs, our new parents and the six hospitals that we work closely with. Thankyou so much for this generous gift. Our address [REDACTED]  
[REDACTED]

Hello Janette,

My name is [REDACTED] and I am the resident of the Brisbane Multiple Birth Association - Westside in QLD, part of our national organisation - AMBA. We think your booklet is a wonderful idea and much needed. We currently have 40 new and expectant mothers within our membership (with a total membership of 110. We would also receive between 3 and 5 new members a month and would be very interested in including this information in what we call our New Enquiry Pack.

Booklets can be mailed to our PO Box Address - PO Box 198, Kenmore, QLD 4069.

Thank you very much  
[REDACTED]

**From:**  
**To:** j.brooks@ecu.au  
**Sent:** Wednesday, September 01, 2004 1:26 PM  
**Subject:** Emotional Health During Pregnancy & Early Parenthood Booklet

Dear Janette,

I have received an email from Cathy Vellacot of the Australian Multiple Birth Assc. regarding your new booklet, and would like to request some copies for our Library. All existing and new members have access to this valuable resource within our Club, and I feel that your booklet will be a very useful addition.

If possible, please send five copies to:

WOLLONGONG MULTIPLE BIRTH ASSOCIATION  
P.O. BOX 417  
UNANDERRA  
NSW, 2526

Many thanks,  
[REDACTED]  
Secretary, WMBA

## Appendix D

### *Letters*

April 18, 2005

Janette Brooks  
WA Project Manager  
The *beyondblue* National Postnatal Depression Program  
School of Psychology  
Edith Cowen University  
100 Joondalup Drive  
JOONDALUP WA 6027

Dear Janette,

Thank you for your outstanding work on The *beyondblue* National Postnatal Depression Program. Through your efforts and generous funding from *beyondblue*: the national depression initiative, multiple birth families have benefited greatly. In collaboration with the Australian Multiple Birth Association (AMBA) your work increasing awareness of post natal and emotional health and wellbeing issues has covered:

- ◆ Families and professional staff being able to freely access your informative booklet 'Emotional Health During Pregnancy & Early Parenthood: An Information Booklet for Parents of Multiple Birth Children'
- ◆ A series of articles in our AMBA National magazine, Australian Multiple Magazine (AMM), with a circulation of approx 900 copies per edition.
- ◆ Reproduction of the above articles in most of the local AMBA club newsletters (68 clubs in Australia)
- ◆ Access to these articles by international Multiple Birth organizations via the Australian Multiple Magazine (12 overseas subscriptions)
- ◆ Access to these articles by members of the International Society for the Study of Twins (ISTS) via AMM
- ◆ Guest speaker presentation at the AMBA National Convention in Brisbane October 2004
- ◆ Focus groups with AMBA members
- ◆ Liaison with local AMBA clubs and the Board of Directors

Judging by the informal feedback I have received, I credit the 'Emotional Health During Pregnancy & Early Parenthood' booklet with meeting several of the project's initial goals by providing information which is user friendly, free, easy to access and contributes to the protective factors families need when faced with the complex task of parenting multiple birth children.

I would like to take this opportunity to thank *beyondblue*: the national depression initiative, for supporting multiple birth families throughout Australia.

Yours sincerely,

Cathy Vellacott  
Chairperson, AMBA Board of Directors



# AUSTRALIAN MULTIPLE BIRTH ASSOCIATION (WA)

ABN 25 180 917 476

PO Box 1766 Canning Vale WA 6970 Telephone (08) 9487 8825 Email: [ambawa@hotmail.com](mailto:ambawa@hotmail.com)

Monday, 11 April 2005

Janette Brooks

WA Project Manager

The *beyondblue* National Postnatal Depression Program

School of Psychology, Edith Cowan University

100 Joondalup Drive,

Joondalup WA 6027

Dear Janette

I am writing to thank you for the work you have undertaken with the *beyondblue* National Postnatal Depression Program. Our organization prides itself on working in collaboration with institutions and individuals carrying out research projects of particular benefit to multiple birth families.

The work you have done in the past year has done much to increased the awareness of Postnatal Depression and emotional health amongst our member families and the articles published in the various newsletters and journals of AMBA, its State Committees and Clubs has been invaluable in communicating findings from your research.

The focus groups and individual interviews has resulted in wonderful presentations on your behalf at a national level, during the AMBA Convention in Brisbane, and a State level – during the 2004 State Seminar of AMBA (WA) in Bunbury. We are delighted that you have agreed to present once again at our 2005 State Seminar in Perth on May 21.

The booklets have been well received and are distributed as a matter of course to new members.

On behalf of Western Australian members, I congratulate you on your efforts and look forward to continuing our association.

Yours sincerely

Marie Bennett

PRESIDENT

**Queensland Intervention Initiative:  
“Education and Training for Regional, Rural and Remote  
Health Professionals”**

**Final Project Report  
by  
Barbara Hayes & Beryl Buckby**

**School of Nursing Sciences  
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## Introduction

Queensland Health includes 38 health districts partitioned into three zones, which includes rural and remote regions. Each district exercises authority regarding the implementation policy and, until recently, had direct oversight of all research ethics applications and projects within their areas of responsibility. One consequence of this structure is that districts differ with respect to whether screening of women occurs antenatally and/or postnatally for perinatal depression. A second consequence is that health professionals across the state have widely varying levels of knowledge, experience, and/or skills with screening women for perinatal depression. A third consequence is that the educational needs of health workers across districts require targeted intervention appropriate to prior knowledge and experience.

The Queensland State Education Intervention for health professionals, unlike other state involved remote regions and was approached through a systematic multi-layered intervention designed as a broad outreach and education initiative to increase awareness, knowledge and screening skills. Multi-session education targeted health professionals directly involved in preparation for screening or without prior assessment experience and knowledge; single-session education targeted health professionals with some prior knowledge, not currently screening, and; health professionals without previous experience or knowledge were targeted in an awareness raising and educational materials distribution. General Practitioners (GPs), who were nominated by women with high EPDS scores as their preferred GP, were also targeted for awareness-raising and received educational materials with referral letters throughout the follow-up process. Finally, health management-professionals' knowledge and awareness of antenatal and postnatal screening was targeted in focus groups. The multi-layered strategy is depicted in Appendix A.

## Aims

The education intervention had two aims: (1) to increase awareness of health professionals generally regarding antenatal and postnatal depression and screening; (2) to increase knowledge and skills for health-professionals working directly with women in the perinatal period.

## Method

### *Awareness-raising*

#### Participants

Two hundred and sixty-five GPs, 731 child health nurses, other 232 health professionals (e.g. social workers, psychologists) and 106 individuals from other programs (parenting, mental health programs, educational guidance) received Emotional Health Booklets in Pregnancy and Early Parenthood, EPDS and Management Guides, Brochures and a Letter with details of the *beyondblue* website and other language resources. GPs receiving referrals for women in the program, and child health nurses in rural areas across the state were especially targeted for awareness-raising. All areas of the state were represented amongst the 95 respondents in the awareness raising initiative including Cape York, South West Queensland, North West Queensland, the Central Highlands farming communities and the mining towns of Central Queensland, the Atherton Tableland farming communities, regional centres along the coast, and some metropolitan based health professionals.

## Procedure

Packages of materials were posted or couriered to participants around the state. The distribution of education materials was weighted toward regional, rural and remote regions. However, many areas (e.g. border regions in the far west, Gulf of Carpentaria, Cape York, and smaller rural communities across the state) have few established localised services and rely on mobile clinics such as the Royal Flying Doctor Service (RFDS) to provide or supplement health care. In these instances, centres identified as providing mobile services to rural and remote communities received education resources. Amongst the awareness-raising group, knowledge questionnaires and reply paid envelopes were also distributed. All areas of the state were represented amongst the Ninety-five questionnaires that were returned.

### *Single-session Education*

#### Participants

Three hundred and eleven post-graduate or undergraduate university students (Nursing, Psychology, Social Work), 26 mental health workers, 283 health professionals (CHNs, Midwives, Social Workers, Psychologists), and 440 others (nursing educators, academics, administrators, volunteers, antenatal group, and community members), attended short education (e.g. one x three-hour session). Format and content varied across sessions dependent on the context and participant mix.

#### Procedure

The education session content incorporated information on reliability and validity of the EPDS, administration of the EPDS, symptoms of postnatal depression, grief and loss, and referral pathways. In some sessions, sub-groups were formed for participants to practice skills and formulate responses to a series of questions. The sessions were evaluated through short reports compiled by each sub-group and a short (4 questions) end evaluation questionnaire. Sessions were conducted in face to face mode during formal gatherings of health professionals and consumers (e.g. women's' health forums), by invitation (e.g. Queensland Health funded mental health program of the Migrant Resource Centre who support NESP communities in Townsville and surrounding rural districts; invited lectures/tutorials of students in health stream education courses), during visits around the state (e.g. Mount Isa, Cairns, Mackay), or by co-opting and resourcing nurse educators or research midwives in regional centres (e.g. Rockhampton and Mackay).

### *Multi-session Education*

#### Participants

One hundred and twenty-three health professionals (midwives, child health nurses, community health workers, community health nurses) participated in six hours of education over two to six separate sessions delivered in face-to-face mode, or via videoconferencing in eight centres throughout the state. Multi-sessions were conducted in face-to-face mode in 4 locations.

In all, 13 videoconference sessions across 4 locations (2 regional and 2 rural/remote) were scheduled totalling approximately 20 hours of education and discussion. A minimum of three educators also attended each videoconference and sessions were conducted with one site at a time.

## Procedure

Session content (for videoconference or face to face mode) incorporated information about the *beyondblue* National Postnatal Depression Program, background research, clinical and behavioural indicators of antenatal and postnatal depression, rationale for screening, administration and interpretation of EPDS, referral pathways, and self-care for professionals. Participants were offered an evaluation questionnaire at the end of the final session and certificates of attendance were issued.

Videoconferencing to rural and remote areas of the state encountered scheduling and technical difficulties that are discussed further in the conclusions.

## *Focus-groups*

### Participants

Health-managers involved in women's, family, and mental health were targeted in 4 health districts to attend and participate in focus group discussions via videoconference. Discussion points were developed around screening and management of postnatal depression within existing structures and policies. At the time of writing two focus groups had been conducted which included 8 managers from public and private hospitals, and 3 discussants from the Queensland *beyondblue* program (focus group 1), and 8 health district managers and 4 discussants (focus group 2). The remaining focus groups are scheduled to meet before the end of June at time convenient to individual health districts.

### Procedure

Participants completed an initial questionnaire focused on the assessment and management of women with depression and identification of the appropriate referral pathways within their district. The *beyondblue* National Postnatal Depression Program research midwife then presented her perspective on the research midwife role and the perceived impact of the program within the district. The topic was then opened for discussion. Following the discussion the participants completed a final questionnaire reflecting on the management of postnatal depression.

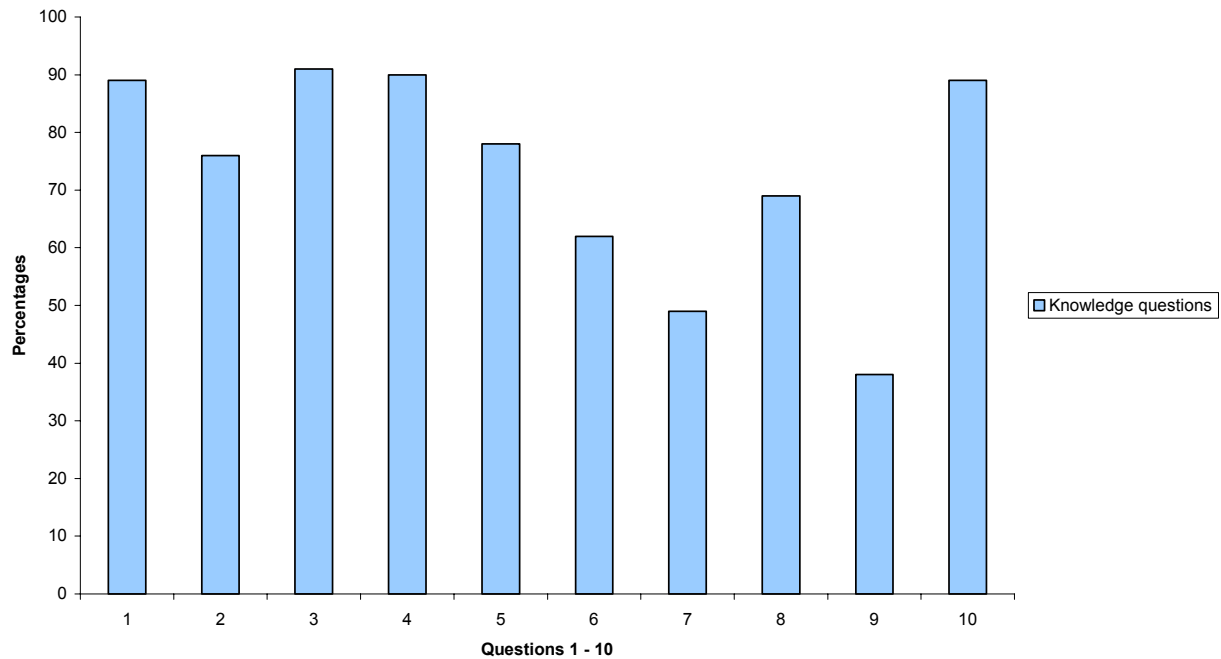
## **Results**

### *Awareness-raising*

Knowledge questionnaires (Pope & Watts, 1998) returned following the distribution of information resources were assessed for accuracy of responses. Participants omitted responses to 35 questions overall. Eight participants did not respond to Question 9 (Which statement is true about the Edinburgh Postnatal Depression Scale?), all other questions varied between 2 and 5 missing data points. Respondents in the awareness raising initiative represented health professionals from all areas of the state. Figure 1 describes percentages of accurate responses for each of 10 questions about postnatal depression and screening.



Figure 1. Accurate Knowledge Questionnaire Responses



*Single-session Education*

A sample of the small group reports is appended (Appendix B). Participants completed a short evaluation at the end of the session that asked for a rating on 4 aspects of the education session: intellectual challenge, connections with professional practice, recognition and consideration of special talents and resources and, supportive, comfortable learning environment. The combination of small group intensive work rather than testing knowledge following teaching was hypothesised to contribute more to retention and later application of subject content.

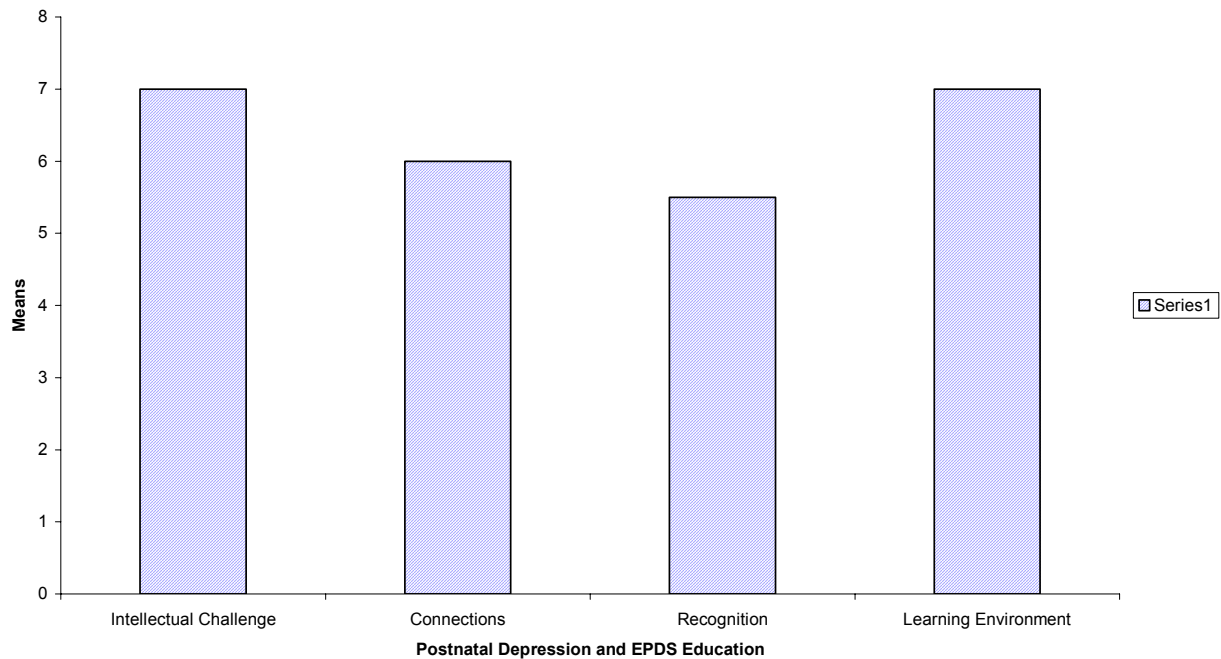
Participants responded on a 10-point scale where 1 was very low and, 10 very high. Descriptive statistics are set out in Table 1 and Figure 2.

Participants also recorded their perceptions that reflected on the ratings shown in Figure 2. Participants reported feeling challenged (e.g. Felt like we didn’t have enough information to do the task, so we had to think more), but also found the material was related to professional practice (e.g. very relevant to my personal/professional life), and that the learning environment helped engagement (e.g. was great to choose our own groups-very comfortable working with them; comfortable working in group-speaking freely and openly).

**Table 1**  
*Means and Standard Deviations of Four Session Evaluation Questions*

|                                              | <i>M</i> | <i>SD</i> |
|----------------------------------------------|----------|-----------|
| Intellectual challenge                       | 7        | 1.65      |
| Connections with professional practice       | 6        | 2.22      |
| Recognition of special talents and resources | 5.5      | 2.09      |
| Comfortable learning environment             | 7        | 2.65      |

Figure 2. Single session education evaluation

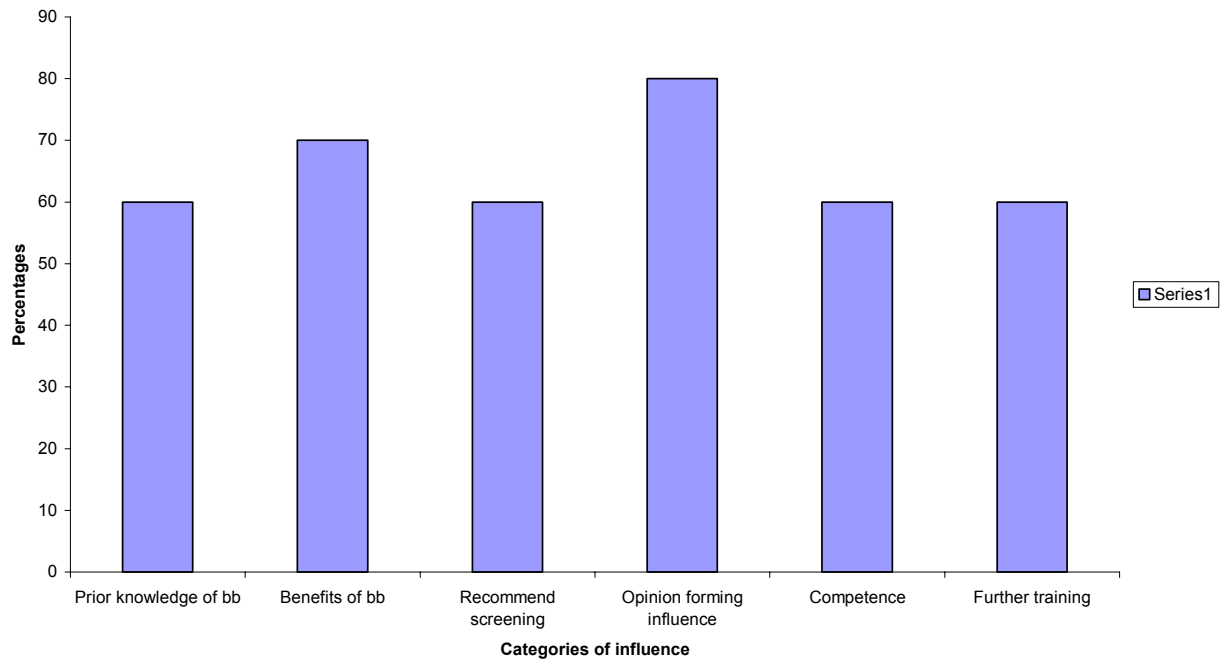


*Multi-session Education*

Participants responded to an evaluation questionnaire at completion of the education sessions. The average years of practice for participants were 20.20 (*SD*=2.86). Eighty percent of participants reported currently using the EPDS in current practice and using a cut-off score as a referral criteria. When asked to self-report the score or other clinical indicators that would prompt a referral, 60% responded stating a score of 13 or more and made a reference to checking Question 10 for suicidality. However, 40% either did not respond to the question or made uninterpretable comments. Eighty percent thought nursing professionals were the most appropriate group to screen using the EPDS, and 20% thought any professional group (GPs, Nurses, Psychologists, Social Workers) could screen. Sixty percent of participants thought it was important to screen women several times during pregnancy and in the postnatal period. Forty percent also thought that hospital based screening was most appropriate.

The impact of the *beyondblue* program was also assessed in the evaluation. Respondents were asked to report their opinion on the principal benefits of the program, and any negative outcomes of screening. Most participants (80%) did not respond to the question regarding negatives, however, 20% reported no negatives to the program. The majority of participants were strongly supportive of the program, recommended routine screening to others, and stated that the *beyondblue* program had helped them to form their opinion about screening. Participants were also asked to report on their feelings of competence after training, and whether they felt the need for further training. Participants reported feeling generally competent to screen women, and being interested in further training around the emotional health of women in pregnancy and early parenthood. Figure 3 depicts participants' responses to the *beyondblue* program and training.

Figure 3. Influence of beyondblue program and training



*Focus-groups*

Ending Well focus groups commenced in April and at the time two groups were awaiting a mutually suitable time and date to be negotiated. Two groups had been conducted by the time this report was written. Group 1 discussed Health District policy, identification, and management of postnatal depression. Questionnaires and discussion addressed the following topics: referral pathways, the Health District’s responsibility toward women and health professionals affected by antenatal/postnatal depression, and interfacing care and referral pathways. Major themes and specific solutions for Group 1 are summarised in Table 2.

**Table 2**

*Discussion Topics and Themes Emerging from Focus Group 1*

| Topic                                                           | Discussion Themes                                                                                                                                                                                                                                                                                                                                                     |
|-----------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Referral Pathways                                               | <i>Patient consent and confidentiality<br/>Involvement of partners<br/>Patient education,<br/>Women’s Mental Health Liaison Service</i>                                                                                                                                                                                                                               |
| Health District’s responsibilities towards Women                | <i>Help the patient, protect the baby,<br/>Role of Child Safety for at risk children<br/>Adequate and timely follow up of woman and baby<br/>Main responsibility lies with education of staff</i>                                                                                                                                                                     |
| Health District’s responsibilities towards Health Professionals | <i>Provision of Employee Assistance Scheme<br/>Support from line managers, HR<br/>Adequate education for relevant staff<br/>Debriefing opportunities, support for emotional trauma<br/>Build in supervision and debriefing system</i>                                                                                                                                 |
| Identification and Management of Perinatal Depression           | <i>Screening in pregnancy and early postnatal period to engage early support<br/>Early detection and support provision<br/>Recognition of importance of sensitive questioning by HP (instead of /or in addition to formal screening) that links into nurturing role of nurses and midwives.<br/>Need for further education and skill around perinatal depression.</i> |

The discussion generated insights into the effects of the *beyondblue* screening program and potential benefits to be gained through refining referral processes. Recognition was made of the consistency of the EPDS in systematically identifying women at risk of depression rather than the less reliable clinical interview that was dependent on observation of a woman’s distress.

The group also acknowledged the relative paucity of referral options in regional areas by comparison with major metropolitan centres. Overall, the group viewed screening as complementary to care of women that fitted in well with existing processes, and did not burden participants. In group discussion the program was generally recognised as having raised awareness of a need for systematic screening, and having increased the depth of knowledge of associated health professionals.

The process of screening and follow-up also increased awareness of the discussion group of the need for interfacing psychiatric liaison and a screening program. Psychiatric liaison was discussed as providing two essential benefits to the care of at risk women; firstly through involving the screening midwife in regular case reviews and thereby providing case supervision and debriefing, and secondly through a clear pathway to further care for women with an identified need. As an indication of the frank level of the discussion one discussant disclosed an initial personal scepticism that the program would generate substantially increased referrals, however, this person reported that referrals did not increase, but women may have been identified earlier than without a screening program in place. Thus, systematic screening of women antenatally and postnatally was now viewed positively within the Health District as facilitating more effective use of resources for women.

Interfacing women's health and mental health was discussed in terms of extending existing role boundaries. The role of the *beyondblue* research midwife in particular was discussed as a template for care of perinatal depression that required skill to assess coping abilities and to appropriately refer beyond the usual scope of responsibility for midwives in antenatal or birthing contexts.

Focus Group 2 differed from Group 1 in that existing referral pathways to Child Health established for the domestic violence initiative had effectively created a structure for pregnant women to be followed-up postnatally that did not need refinement due to the *beyondblue* screening program. EPDS screening was not part of the booking in process prior to the *beyondblue* program and Group 2 discussed at length the impact on the health district and antenatal women of commencing a routine screening process.

Participants viewed the *beyondblue* screening program positively and thought there were benefits to women, however voiced reservations about continuing under the auspices of their Health Service District. The concerns raised by the group included; (1) increasing the already heavy demand on women attending antenatal clinics to provide extensive personal and family information, (2) utilising scarce staffing resources on "non-core" business of midwives, (3) increasing the operating expense through the time involved in screening and referral. The group saw resolution of these barriers as one of adequate resourcing and refinement of intake policy and procedures at two levels Queensland Health and Health Service District.

## **Conclusions and Recommendations**

The education intervention was a multi-level intervention that included distribution of information resources, one three-hour education session, a six-hour multi-session education package, and a series of four focus groups of which two had been conducted prior to writing. One consequence of the geography of Queensland with a relatively small population is that Health Professionals work in a culture accustomed to travelling long distances for education and professional development purposes. This report should be read with this understanding in mind, as education sessions for rural and remote health professionals were not all conducted in rural and remote locations although many participants came from rural and remote locations (e.g. in one session conducted through JCU participants included participants from Alice Springs, Mount Isa, Weipa, Normanton, Charleville, Moranbah, Richmond, Innisfail, Proserpine).

Thirteen video-conferenced education sessions were conducted to 2 regional and 2 rural/remote locations. While video-conferencing has great potential and is currently used extensively within Queensland Health there were problems that inhibited more extensive use for the *beyondblue* Queensland education initiative. Due to demand, co-ordinating scheduling between availability of video-conferencing facilities at The Townsville Hospital and destination sites was problematic. Secondly, remote destination sites had poorer quality video-conferencing facilities and less reliable phone connections. These problems affected the vision and sound quality for both the delivery of education material and for discussion at the end of the sessions. Thirdly, the video-conferencing equipment at The Townsville Hospital from which the *beyondblue* team conducted education sessions was limited to one connecting site at a time. Effective use of the video-conferencing strategy in future requires more control over time schedules and video-conferencing equipment as well as a capability to connect to multiple sites at one time.

**Recommendation: Improve capability to deliver education in regional, rural and remote communities through more flexible formats e.g. self paced modules, CD or DVD, internet, or hosted through Queensland Health Web Site.**

The first aim of the education intervention was to increase awareness of perinatal depression and screening amongst health professionals. A distribution of materials to 1334 health professionals directly engaged in the care of childbearing women was assessed through a knowledge questionnaire sent out to one third of the sample with the education materials. Figure 1 shows that of those who responded to the questionnaire, rates of accuracy ranged from 50% to 90% on all questions where missing data was less than 5% of the responses.

Health managers also showed awareness of screening and referral processes in the focus group discussion that found potential benefits to early identification of women at risk of depression. Based on the knowledge and awareness of the *beyondblue* program Focus Group 1 discussed developing a new case review and supervision process that links women's health into mental health. Furthermore, this focus group endorsed the development of a role based on that of the research midwife role to interface or bridge between mental health and women's health.

The second aim to increase knowledge and skills for health-professionals working directly with women in the perinatal period was achieved through education delivered in single or multi-sessions. In total, 1183 individuals received the education packages. Of those who completed single session evaluations, a mean of 70% found the material intellectually challenging and a mean of 75% were approving of the learning environment, while a mean of 60% found the material relevant to their workplace. Eighty percent of participants who completed multi-session evaluations reported that the *beyondblue* program had helped influence their view of screening, and 70% thought there were benefits to screening. While 60% felt competent to screen, 60% also felt the need for further training in the area of perinatal mental health.

**Recommendation: (1) Provision of further or follow up training particularly for health professionals working in small communities, to increase confidence in screening, conduct risk assessments, refer and follow up with women when referral pathways are limited. (2) Provision of training with respect to managing work related stress for health professionals.**

In summary, the Queensland state intervention has raised awareness across the state of the program and EPDS screening in the antenatal and postnatal period. A need for further education and training around screening and perinatal depression has been identified through the intervention. Future education for Health Professionals working in relatively isolated positions in rural and remote locations needs to take into account the paucity of referral pathways available for women at risk of depression and prepare this group of workers for self-managing work related stress. Finally, health managers in one focus group identified benefits to early identification and a new role that interfaces women's health with mental health in one Health District. A second focus group identified barriers to implementing routine screening due to the impact such a program would have on present resourcing levels.

**Queensland Intervention Initiative:  
“Indigenous Women’s Project: Report of Process and Preliminary Results”**

**Final Project Report  
by  
Prof Barbara Hayes, Lynore Geia, Beryl Buckby,  
Margaret Egan & Janese McCulley**

**School of Nursing Sciences  
James Cook University  
Townsville QLD**

**May 2005**



*The Queensland Indigenous Women's Project is a component of the beyondblue National Postnatal Depression Program. From the outset, this project differed somewhat in the methodology of the study from that of the main study because of the nature of the cultural groups participating in the project.*

*This report is dedicated to all the women who participated in the project and to those who facilitated the process – both Indigenous and non-Indigenous.*

*The results are restricted to this report only until negotiation with relevant Indigenous Reference Groups, Councils and Boards for publication; agreement regarding publications was part of the Ethics approval for these sites.*

## **Preface - Specific Contextual Background**

The *beyondblue* Indigenous Women's Project was possible because of a partnership between the Queensland State Director – Professor Barbara Hayes and Ms Lynore Geia. Barbara Hayes is a skilled midwife, paediatric and mental health nurse and, as Foundation Professor of Nursing at James Cook University and Foundation Head of the School of Nursing Sciences in Townsville, has been resident in the area for fifteen years and has built strong links between the local Indigenous Community through her unwavering commitment to university education for Indigenous people in the area. Lynore Geia is a highly skilled Aboriginal midwife who is master's prepared in public health from James Cook University and who belongs to one of the large Indigenous families of Palm Island (off the coast of Townsville). Both these researchers were skilled in research and in group processes. As the research process intensified, Margaret Egan, an Aboriginal Liaison Officer in health for twenty years at Mt Isa, joined the project in 2003 and brought to the group invaluable skills in interpersonal communication and cultural sensitivity.

From previous research, the researchers were aware of specific issues that would impact upon the success of the project. Some of these are as follows: that all Indigenous health personnel in the practice fields of maternal and child health feel 'over-researched'; and that many Indigenous health personnel report that they have experienced no direct benefit for sharing information about themselves, or the women who sought their services. In addition, those researched feel that they had been exploited by not being named or recognized in any way, in the final outcomes of research and having no influence about the way the findings of research were reported.

Therefore, the Queensland *beyondblue* research group believed that the issues identified above could be addressed in the following two ways: (1) by adhering to the strict operational detail of the National Health and Medical Research Council (NHMRC) Guidelines for Research with Indigenous Communities (1987); and (2) by ensuring local ownership of some palpable outcomes while still ensuring that the *process*, itself, was generalisable.

## **Introduction**

Beginning in 2002, the *beyondblue* National Postnatal Depression project established multisite screening of antenatal and postnatal women in all states of Australia and the Australian Capital Territory (ACT). In addition, each state was funded for state-specific projects according to local needs. The *beyondblue* Indigenous Women's Project was part of the Queensland state initiative and, thus, was a small but significant part of the overall national project. The overall aim was to explore women's perceptions of their perinatal needs in emotional and mental health through conducting culturally sensitive focus groups, and then to match those needs with the current services available. Specific education of selected Indigenous women in perinatal emotional and mental health was part of the reciprocity inherent in the negotiations relating to participation and co-operation in the project. Simultaneously with the Indigenous Women's Project, five separate sites in five different Health Service Districts were established for antenatal and postnatal screening of women in mainstream health services by the Queensland team and a wide-ranging education initiative was conducted for health professionals and childbearing women. Both these projects are reported separately.

## **Aims**

The overall aims were as follows: (1) to explore women's perceptions of their perinatal needs in emotional and mental health through conducting culturally sensitive focus groups and then to match those needs with the current services available; (2) to provide specific education to Aboriginal Health workers, Aboriginal Liaison Officers, and other Indigenous women selected by the specific communities, around early recognition and appropriate referral of women with perinatal emotional and mental health issues.

However, much more was achieved as the research evolved.

## **The Process: Essential Sequential Steps**

### *Choice of Sites*

Choice of the sites was purposive in that they were located in the areas where Barbara Hayes and Lynore Geia were known, and respected, by both the Indigenous Communities and by practitioners employed by Queensland Health and by the private health care sector. Barbara Hayes has conducted two previous studies in postnatal depression using the Queensland Health facilities during the 1990s. Margaret Egan, as an experienced Aboriginal woman, was known and accepted at the three sites.

### *Description of Sites*

(1) Townsville, 1200 kms north of Brisbane, is the second largest city in the state. The Townsville Aboriginal and Islander Health Service (TAIHS) is a purpose-built, Community Controlled outpatient health facility in suburban Townsville with a specific 'Mums and Babies' stand-alone facility serviced by non-Indigenous medical officers and experienced Indigenous Health Workers. TAIHS has close links with the Women's and Children's Health Institute at both the Townsville Hospital and in Community Maternal and Child Health. Aboriginal, Torres Strait Islander and other Islander women attend the 'Mums and Babies' Unit for antenatal and postnatal care.

(2) Mt Isa is a large mining town (approx 1000 kms west of Townsville) with discrete, identifiable Aboriginal tribal groups who identify as 'desert people'. Health services are delivered by the state health service (Queensland Health) and by a Community Controlled Indigenous Health Service operating on a clinic (8am-5pm) basis.

(3) The Palm Island Health Service is directly controlled by Queensland Health with close consultation of the Palm Island Council elected by the people of Palm Island. The people of Palm Island were forcibly settled in the early 1900s by the government of the day and, by and large, have no original connection with that particular country. However, over the last several decades, the community people on Palm Island have developed a strong attachment to the land and now identify, with pride, as *Palm Islanders*.

### *Site-specific Indigenous Women's Reference Groups*

Convening the site-specific Indigenous Women Reference Groups was one of the crucial events in the project. Once convened, these groups developed both authority about, and ownership of, the outcomes. Membership of the Reference Group was a sensitive issue and became a community based

selection task in each of the sites. Thus, membership of the Reference Group varied according to the individual 'culture' of each site and, in summary, was as follows:

(1) *TAIHS*: Following an initial workshop of all staff involved in maternal-child care at TAIHS (including 'peer counsellors' who are recent mothers who were offered extra training to assist in maintenance of maternal lactation) in April 2003, the Reference Group was reduced to the senior Medical Officer, the Senior Health Care Worker, other Health Care Workers and a Peer Counsellor;

(2) *Mt Isa*: The reference group was drawn from Queensland Health employees in Child Health Services and Aboriginal Health Workers and Aboriginal Liaison Officers from the Mt Isa Hospital, as well as Aboriginal Health Workers and other health personnel from the Community Controlled Indigenous Health Service called Yaptajarra;

(3) *Palm Island*: All women of Palm Island were invited to an initial workshop. After the initial workshop, the reference group was drawn from Queensland Health employees and Aboriginal Health Workers in Child Health Services and other Aboriginal and Palm Island women who wished to be involved.

#### *Process of Iterative Consultation*

Prior to the launch of the *beyondblue* National Postnatal Depression project, agreement in principle had been given by the, then, Minister of Health via the Northern Zonal Manager, Mr Terry Meehan, upon the request of Professor Hayes; the actual operational process of consultation, again, varied according to each site:

(1) *TAIHS*: the first step was informal consultation with the staff at the 'Mums and Babies' Unit followed by a formal application to the governing Board of TAIHS. Close, ongoing consultation with the "Mums and Babies" staff and referral to the Board, as necessary, was continued throughout the project;

(2) *Mt Isa*: the first consultation was with the CEO and Director of Nursing of the Queensland Health Mt Isa Health Service District and with the Community Controlled Indigenous Health Services. The turnover of personnel in these positions is high so ongoing consultation was conducted at each visit by the researchers;

The above initial consultation was followed by iterative consultations with the many levels of hospital and community based services such as antenatal clinics, postnatal in-services, maternal and child health services, Health Worker Services (both inpatient and community based), mental health services and with the staff at the Community Controlled Indigenous Health Service. Many staff changes occurred throughout the life of the project so iterative consultation and re-briefing were essential;

(3) *Palm Island*: the first consultation was a formal letter to the Palm Island Council who wished to interview the researchers before giving permission. The Palm Island Council was dissolved for over a year and the project was recommenced when a new Council was established. Iterative

consultation with the changing personnel in Queensland Health continued and operational connections were developed.

### *Profile of the Sites*

(1) *TAIHS*: population of Townsville is 150,000; number of births: 3,200; number of indigenous births: 1,200 – most of the Indigenous women would use the TAIHS services at some time in their childbearing event (many of these women are not Townsville residents but are from other outlying areas);

(2) *Mt Isa*: population of Mt Isa is 50,000; number of births: 1800; number of indigenous births: 900 – most of the Indigenous women would use the Yaptajarra services or the maternal child health services – many of these women are from remote communities in the region;

(3) *Palm Island*: Population is 3,000; number of births: 150 – all of whom would be Indigenous women; unless there is a qualified midwife and/or a resident doctor with appropriate experience, all the women would birth in Townsville.

### *Profile of the research process at the three sites*

In summary, at each of the sites, the following research instruments and resource materials, which were in use in the *beyondblue* National Postnatal Depression project, were made site specific: (1) The Edinburgh Postnatal Depression Scale (EPDS); (2) the Women's Information Sheet; (3) the Women's Consent Form; (4) the resource booklet titled: *Emotional Care in Pregnancy and Early Parenthood*.

(1) After approval by the appropriate Ethics Committees, the research process commenced with a workshop at each site focusing on perinatal emotional and mental health issues. Barbara Hayes and Lynore Geia conducted the workshop. The reference group was formed after each workshop. Each group on site arbitrated membership of the reference group.

As a result of that workshop, and with the willingness and interest of each reference group (TAIHS = 5 members; Mt Isa = 12 members; Palm Island = 5 members), the Edinburgh Postnatal Depression Scale (EPDS) was modified at each site by iterative consultation with the reference group, and piloting with antenatal and postnatal women. The EPDS is a 10-item screening tool used widely in many countries to screen both antenatal and postnatal women and was used for this purpose in the mainstream *beyondblue* National Postnatal Depression project (Cox, Sagovsky & Holden, 1987). The stems of each item was expressed in language which was more meaningful to the women at each site so that two primary purposes of the research would be achieved – that is (a) the tool would be both more reliable and valid for screening anxiety and depression and (b) each site would take ownership of the instrument as an outcome of their own work. Forms, and filling forms in, is onerous for an oral culture but is necessary for the recording of data and delivery of services. Thus, the women welcomed the thought of their 'own Edinburgh Package' and their 'own Booklet'.

(2) Minor changes were made after the pilot work; for example, in Mt Isa, after piloting the tool with ten women each at Maternal and Child Health and at Yaptajarra, facial expressions depicting

emotions replaced the numbers in the scoring of the tool but, after further use of the EPDS, these were removed as women tended to tick the 'smiling face'.

(3) An important part of the ownership process was to ensure that appropriate cultural images, and colours, were incorporated in all of the materials. Special consideration was given to the Women's Information Sheet, the Women's Consent Form and the resource booklet titled: *Emotional Care in Pregnancy and Early Parenthood*—all of which the women would keep (a copy of the consent form was also given to each woman). A timely addition here is that the cultural symbols, images and colours served not only an aesthetic and ownership function but also served as a vehicle for Indigenous women, in a small way, to 'take back their culture' in this core area of 'women's business'.

(4) At each site, those who were going to administer both the site-specific EPDS and the mainstream EPDS were given onsite training and ongoing follow-up supervision and information.

#### *The Site-specific 'Edinburgh Package'*

The 'Edinburgh Package' consisted of the following specific to each site:

- A site-specific Women's Information Sheet;
- A site-specific Consent Form;
- A site-specific EPDS;
- A mainstream EPDS.

Examples of the three packages are available in the Education Materials package, due to space constraints in this report.

## **Hypotheses**

The following hypotheses were derived from discussions and interaction in the reference groups. It was expected that:

(a) Indigenous women would report higher scores on the Indigenous EPDS than on the mainstream EPDS.

(b) Psychosocial stress would be significantly related to increasing EPDS scores on the site-specific Indigenous EPDS and mainstream EPDS.

(c) Site-specific Indigenous EPDS, and information booklets, workshopped in reference groups would lead to greater ownership by health workers and Indigenous clients, and a high response rate by Indigenous women at each site.

Testing of the package was achieved fully at just one site (TAIHS) (see Results section) due to limitations of time and funding. However, use of the site-specific EPDS and the *Emotional Care in Pregnancy and Early Parenthood* booklet is underway at the other two sites with strong encouragement from the health services at two sites and co-operation at the third site.

To our knowledge, the EPDS has not been normed for Indigenous women. Thus, to elicit responses from women, using both mainstream EPDS and the site-specific EPDS, has the following

two functions: one of norming an established instrument and the other of comparing scores on the mainstream EPDS and the site-specific EPDS.

## Results (preliminary)

### *Hypothesis (a)*

Hypothesis (a) that Indigenous women would report higher scores on the Indigenous EPDS than on the mainstream EPDS was not supported. Indigenous women did not report significantly higher EPDS scores on the language specific version of the EPDS than on the mainstream EPDS. Antenatal ( $N=141$ ) and postnatal women ( $N=127$ ) completed the language specific EPDS. Of those, 125 also completed the mainstream EPDS. Comparison of the scales shows that antenatally ( $r=.92$ ,  $p<.01$ ) and postnatally ( $r=.93$ ,  $p<.01$ ) the scales were highly correlated, and no significant differences were observed.

**Table 1**

***Comparison of paired Indigenous EPDS and Mainstream EPDS in a sample of North Queensland Indigenous Women***

| <i>Source</i>          | <i>N</i>   | <i>t</i>     | <i>df</i>  | <i>p</i>   |
|------------------------|------------|--------------|------------|------------|
| <b>Combined sample</b> | <b>125</b> | <b>-1.38</b> | <b>124</b> | <b>.17</b> |
| <b>Antenatal women</b> | <b>47</b>  | <b>-1.21</b> | <b>46</b>  | <b>.23</b> |
| <b>Postnatal women</b> | <b>75</b>  | <b>-.75</b>  | <b>74</b>  | <b>.46</b> |

In addition, a separate comparison of responses to Question 10 with respect to suicidal ideation showed no significant difference. Within the Indigenous EPDS sample 82% of participants scored below 13, approximating estimates of PND within the wider population. However, although the overall EPDS scores did not differ, in this first analysis, there may still be some differences in responses to specific questions, which will need further exploration.

### *Hypothesis (b)*

Hypothesis (b) that psychosocial stress would be significantly related to increasing EPDS scores on the site-specific Indigenous EPDS and mainstream EPDS was supported. Preliminary analyses show that psychosocial stress related to increased EPDS scores. High levels of 'daily hassles', problems in the family, history of depression and emotional problems, financial insecurity, major life events, a history of physical and emotional abuse, relationship problems with a current partner, were significantly related ( $p<.01$ ) to increased risk of perinatal depression as assessed by the Indigenous-site-specific EPDS. A history of sexual abuse was also significant ( $p<.05$ ) to increased scores on the site-specific version of the EPDS. Concerns about managing the baby and age of the new mother were not significant predictors of increased risk. However, younger women may be at increased risk in some respects (e.g. personal psychosocial problems) than older mothers, and older women may be more affected by deaths in close family than younger women. These nuances of age effects amongst Indigenous women need further investigation.

Nevertheless, increased risk of depression amongst perinatal women in this study was supported by qualitative data gathered from reference groups on Palm Island and other sites. During a workshop the group separated into three small sub-groups and focused on issues specific to the community that they perceived as contributing factors to postnatal depression in the community. The following factors identified by the women of Palm Island, were generally consistent across the three Indigenous sites.

Group responses to their perception of factors contributing to postnatal depression were as follows:

- *Domestic Violence, women getting bashed by partners*
- *Family Violence, jealousy between families*
- *Relationship problems, jealousy, sharing of partners*
- *Unsafe sex ending in women getting STDs*
- *Pressure of expectations placed on women from men, family pressures and conflicts*
- *Stress in the workplace and at home*
- *Housing shortage and overcrowding*
- *Men not understanding what is involved with caring for a new baby*
- *Substance abuse of alcohol and drugs*
- *Loud parties in the house where mother and baby are living*
- *Problems with the law and police*
- *Unemployment and money problems*
- *Past history of depression*
- *Lack of support groups for mothers and families, relationship counselling, play groups*
- *Limited access to child care*
- *Not enough skills and knowledge in caring for child or children.*
- *Not being ready to have a child*
- *Lack of support from father and others [e.g. family organisation]*
- *No time out for self*
- *Limited leisure activities for women*
- *Negative self image, women feeling out of shape, feeling ugly and overweight.*

Table 2 categorises the stressors identified during the workshops according to stressors identified in the preliminary analysis.



**Table 2**

***Community Workshop Participants Perceptions Grouped by Risk Factors related to increased Site-Specific EPDS Scores***

| <b><i>'Daily Hassles'</i></b>                                            | <b><i>Problems in the Family</i></b>                                                            |
|--------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|
| <i>Stress in the workplace and at home</i>                               | <i>Family Violence, jealousy between families</i>                                               |
| <i>Men not understanding what is involved with caring for a new baby</i> | <i>Housing shortage and overcrowding</i>                                                        |
| <i>Loud parties in the house where mother and baby are living</i>        | <i>Pressure of expectations placed on women from men, family pressures and conflicts.</i>       |
| <i>No time out for self</i>                                              | <i>Substance abuse of alcohol and drugs</i>                                                     |
| <i>Limited access to child care</i>                                      | <b><i>Depression and Emotional Problems</i></b>                                                 |
| <i>Problems with the law and police</i>                                  | <i>Past history of depression</i>                                                               |
| <b><i>Major Life Events</i></b>                                          | <b><i>History of Physical, Emotional and Sexual Abuse</i></b>                                   |
| <i>Unemployment and money problems</i>                                   | <i>Family Violence, jealousy between families</i>                                               |
| <b><i>Relationship Problems with a Partner</i></b>                       |                                                                                                 |
| <i>Relationship problems, jealousy, sharing of partners</i>              | <i>Lack of support groups for mothers &amp; families, relationship counselling, play groups</i> |
| <i>Domestic Violence, women getting bashed by partners</i>               | <i>Lack of support from father and others [e.g. family organisation]</i>                        |
| <i>Men not understanding what is involved with caring for a new baby</i> | <i>Unsafe sex ending in women getting STD's</i>                                                 |

*Hypothesis (c)*

Hypothesis (c) that site-specific Indigenous EPDS, and information booklets workshopped in reference groups would lead to greater ownership by health workers and Indigenous clients, and a high response rate by Indigenous women at each site, was supported. Of the 274 Indigenous women who participated, 271 (99%) completed the language specific EPDS. This strong response rate was

supported by observations during workshops within the communities in which ample opportunities were provided for storytelling by the participants utilizing the usual small group ethical ground rules.

The telling of stories led into a discussion on the strengths of Indigenous women, how women prevailed in current socio-economic circumstances in the community. Most of the participants talked about identifying themselves with a particular Indigenous language group and its cultural mores and values. Their connection to the shared collective experiences of that group's history of colonization and survival was also a source of strength, even though a great part of the experience was sadness.

For example, at the workshop on Palm Island, the concept of identification as Palm Islanders was very important to the group, resulting in the naming of the *beyondblue* project specific to Palm Island as "Bwgcorman Mambarra, Jalbu and Bubba Care Program". The word "Bwgcorman Mambarra" means Palm Island, "Jalbu" is a language name for woman and "Bubba" the colloquial term for baby. Giving the project a name identifying it with the community of Palm Island has given the participants an ownership of the project and has placed a positive emphasis on the project.

Working together in small groups produced a twofold result. It gave the participants an opportunity to tell their stories and identify and clarify issues that they too had experienced or were currently experiencing. In addition, it also set the scene to launch into discussion of the EPDS and the appropriateness of the language for use in screening Indigenous women.

## **Conclusion**

The important findings of the Indigenous State Intervention are that Indigenous women score no differently on the language specific EPDS than on the mainstream EPDS, or on the suicidal ideation question (Q10). However, ownership and engagement appear to be enhanced by the language specific EPDS and information booklets. This is evidenced by the extremely high completion rate amongst the sample group of 99%.

Psychosocial stressors identified through workshops in the communities were confirmed by a preliminary analysis that showed perceived risk factors identified through these workshops were related to high EPDS scores. This is consistent with previous research in the wider community and provides some evidence for the validity of the site-specific EPDS.

In summary, meticulous application of the NHMRC Guidelines for Indigenous Research in this women's health project demonstrates that high levels of energy, time, patience and skill are required for the detailed operationalisation of the guidelines. However, such application reflects that teaching and mentoring Indigenous health personnel in the research process itself as well as their feeling ownership of the outcomes can achieve significant outcomes. These people are a vital key to the delivery of services, which are congruent with their culture and life-style.

### *Ethical Concerns Arising From the Study*

The emergence of a clear 'Duty-of-care', implicit in recruiting Indigenous women to assist in decision-making integral to the delivery of direct health care of childbearing Indigenous women, is an outcome that needs to be reported. One of the issues which arose slowly but inevitably was that

Indigenous women (irrespective of the level of professional preparation) need professional supervision, including de-briefing, when involved in the direct emotional and mental health care of childbearing women. All Indigenous women continue to experience the cumulative loss of culture, country and the effects of the Stolen Generations and often have not had the opportunity to process their own issues when they are confronted with the experiences of providing professional services to contemporary new mothers. *Funding for such supervision needs to be built into health service funding.*

**New South Wales Intervention Initiative:  
“Clinical Interventions for, and Preferences of, Women from Vietnamese and  
Arabic-Speaking Backgrounds”**

**Final Project Report  
by  
Bryanne Barnett, Stephen Matthey & Janan Karatas**

**Infant, Child & Adolescent Mental Health Service  
Sydney South West Area Health Service**

**May 2005**

## Preface

The *beyondblue* National Postnatal Depression Program was implemented across three area health services in NSW, all of which were, at the time, at very different stages in the implementation of perinatal psychosocial assessment. We are therefore provided with a unique cross-sectional analysis of what the *beyondblue* program has achieved for health services at opposite ends of the spectrum in terms of perinatal psychosocial assessment becoming routine clinical practice within health services of NSW.

The *beyondblue* program at Northern Sydney Area Health Service, based at Royal North Shore Hospital (RNSH), not only provided the resources, but also the coordination to change the ethos to commence routine antenatal psychosocial assessment across three hospital sites in Northern Sydney. Where the previous focus had been on effective treatments of perinatal mood disorders, it now includes prevention and early intervention. The implementation of *beyondblue* provided a large-scale training program for midwives, the commencement of routine psychosocial assessment and distribution of resources to community women and among health professionals from more than three public health services in the Northern area. Without the input from *beyondblue* this would not have been achieved. It is therefore with great regret that the *beyondblue* universal psychosocial assessment has come to an end with the rest of the National Postnatal Depression Program.

South Eastern Sydney Area Health Service (SESAHS), namely Royal Hospital for Women (RHW), was also part of the *beyondblue* program. Prior to the inception of *beyondblue* at SESAHS, Associate Professor Marie-Paule Austin had developed a psychosocial assessment process which in conjunction with the Liverpool IPC model went on to inform the NSW Health Department models of Integrated Perinatal and infant Care (IPC) and the Families First program. Psychosocial assessment and IPC has been part of routine clinical practice since 2000 at RHW. *beyondblue* provided the funding to further the work already achieved by Prof Austin and her team across SESAHS. This was achieved by employing a project co-ordinator for the three years *beyondblue* has been involved at SESAHS – Dr Susan Priest. Dr Priest was able to provide also large scale training of midwives and nursing staff, implement an early form of psychosocial assessment at another major Sydney hospital - St George Hospital at SESAHS, establish connections between obstetric and gynaecology services to mental health providers and distribute the many *beyondblue* resources to new mothers and other health professionals.

Where RNSH had no foundation for universal psychosocial assessment, on the other end of the spectrum was South Western Sydney Area Health Service where routine psychosocial assessment had already commenced. The Integrated Perinatal and infant Care (IPC) program had been introduced to SWSAHS in early 2000. The IPC program is grounded in the philosophy of prevention and early intervention not only for perinatal depressive and anxiety disorders but also for all psychological and social difficulties that might impair wellbeing and parenting capacity for new mothers and their families. The implementation of IPC brought with it the training of all midwives, routine psychosocial assessment in antenatal clinics, clinical therapies for distressed women, training for health professionals across NSW and by the time *beyondblue* had been implemented in SWSAHS, had begun evaluating the usefulness of certain aspects of the service. Therefore, perinatal psychosocial screening was in operation in SWSAHS when *beyondblue* was introduced to the area. It was, however, only in

operation for English-speaking women, and a considerable proportion of the population falls outside this definition. A universal service required that CALD communities be included. The IPC service acted as a springboard for *beyondblue* to conduct some much needed research into the mental health of women from non-English speaking background during the perinatal period. This project was to become the unique aspect of the *beyondblue* NSW State intervention study. The State study also (1) collected extensive data on English-speaking women, and the knowledge and attitudes of relevant professionals and distributed *beyondblue* Information Booklets to many thousands of women at the participating and other hospitals around the State. The NESB-focused project aimed to

1. Examine the rates of uptake of psychosocial intervention by Arabic and Vietnamese women and the perceived usefulness of the interventions.
2. Further examine the preferences for psychosocial interventions of Arabic women.
3. Translate the existing *beyondblue* resources into Arabic and Vietnamese in the hope of increasing knowledge and changing attitudes about postnatal depression for Arabic and Vietnamese women and their families

## Overview

Two research studies were undertaken to explore appropriate psychosocial interventions for Arabic and Vietnamese-speaking women during the antenatal period. In addition, across the various sites in NSW a variety of material was rigorously developed and then distributed to all Arabic and Vietnamese speaking women, and considerable training and education of staff were undertaken.

The first research study provided a variety of psychosocial interventions to women from the above-mentioned non-English speaking backgrounds that were assessed as being either currently distressed, or at risk of becoming distressed postnatally. Fifty-six women were offered a variety of interventions, with the greatest uptake being for telephone support (both groups), individual counselling (Vietnamese women), and antenatal classes (Arabic women). All women rated the interventions as helpful, and there was some evidence of a significant lowering of self-report distress scores following the birth.

The second study explored Arabic women's stated preferences for psychosocial interventions. Results from a sample of sixty Arabic women indicated that approximately a third of those with concerns or worries would not take-up the usual psychosocial interventions offered by health professionals, but would rely on their own resources. Information indicates that such interventions are, however, considered acceptable and appropriate by many women from this ethnic community.

## Introduction

Postnatal depression (PND) may be more prevalent within the immigrant communities in Australia. There is ample evidence that migration is associated with increased incidence of mental illness, particularly depression (Jenkins et al. 1991, McDonald and Steel, 1997). The South Western suburbs of Sydney house a considerable percentage of the migrant population, in particular those from Arabic and Vietnamese backgrounds. By being both geographically and linguistically isolated they do not have the social support network and rituals that are part of the normal postpartum period practice as in their homelands (Rice, 1994). As early research suggests, some aspects of social support may be

more crucial to NESB mothers than Anglo-Celtic mothers (William and Carmichael, 1985) these women may therefore be possibly more at risk of postnatal depression than the general community.

Added to these two pertinent risk factors of previous depression and poor social support is a general lack of knowledge and understanding of mental illness within parts of these communities. Some cultures do not have a word for depression and mental illness of any sort carries such stigma that it is denied wherever possible (Barnett et al. 1999). Mothers may also refrain from expressing any emotional distress as they fear being labelled a bad or incapable mother in a societal culture where the female role within society is so clearly defined.

The deleterious consequences of PND are severe and far-reaching and as explained above, the prevalence may be higher among migrant communities. These women have become dislocated from the normal social support network they would have traditionally received in the homelands, and are therefore devoid of the normal rituals of new motherhood. This coupled with linguistic problems and a general misunderstanding of perinatal mood disorders creates a public mental health issue for health professionals.

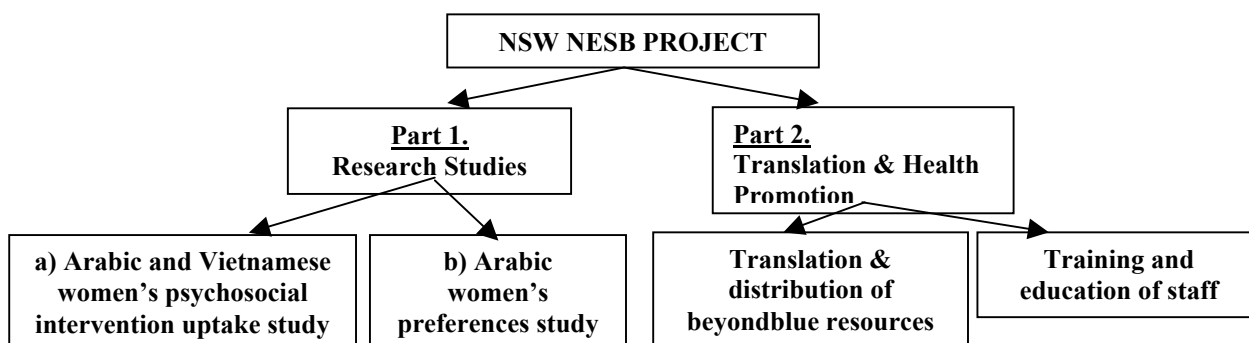
*Design: Overview*

There were two parts to the NESB psychosocial intervention project; (1) the two research studies and (2) the translation and health promotion.

The first research study examined the uptake of antenatal interventions offered to Arabic and Vietnamese women who, as part of routine clinical practice at Liverpool Hospital in SWSAHS, were identified as either currently, or at risk of becoming, emotionally distressed during their pregnancy or postpartum. Subsequent to the uptake of services the women’s perceptions of the usefulness of the interventions was also examined. The second study looked at Arabic women’s preferences among antenatal interventions.

The second part of the NESB project was the training and education of staff and the meticulous translation of *beyondblue* resources. These two parts will be described in separate sections. Figure 1 therefore displays the different components of the *beyondblue* NESB projects.

**Figure 1.** Diagram of the different aspects of the *beyondblue* NESB project



**Part 1 – Research Studies**

**A. Arabic and Vietnamese women’s psychosocial intervention uptake study**

*Background*

South Western Sydney Area Health Services’ (SWSAHS) Infant, Child and Adolescent Mental Health Service (ICAMHS) developed a psychosocial assessment process that is now part of routine antenatal clinical practice. The two-step process involves the use of (a) psychosocial questions (PSQ) and (b) an antenatal version (EDS) of the Edinburgh Postnatal Depression Scale (EPDS; Cox, Holden & Sagovsky, 1987).

First introduced at Liverpool Hospital, the psychosocial questions have now been placed on the ‘OBSTET’ database used by obstetricians and midwives across the whole of SWSAHS and indeed many other NSW hospitals. The original version of the PSQ consisted of 31 questions but underwent review in June of 2002 to assess the acceptability of the questions to both women attending the antenatal clinic at Liverpool Hospital and the midwives asking the questions (Matthey et al, 2002). As a result of this review and NSW Health Department changes to the antenatal domestic violence screening protocol, 12 questions remain (see Table 1 for these questions and the corresponding risk domains). The evaluation of this routine psychosocial assessment has been reported elsewhere (Matthey et al., 2004; Matthey et al., in press).

**Table 1.** ICAMHS psychosocial questions and risk domains.

|    | <b>Question</b>                                                                                | <b>Risk domain</b> |
|----|------------------------------------------------------------------------------------------------|--------------------|
| 1  | Will you be able to get practical support after the birth of the baby?                         | Practical support  |
| 2  | Do you have someone you can talk to about your feelings and worries?                           | Emotional support  |
| 3  | Have you had any major stressors, changes or losses recently?                                  | Stressors          |
| 4  | Generally do you consider yourself a confident person?                                         | Personality        |
| 5  | Does it worry you a lot if things get messy or out of place?                                   | Personality        |
| 6  | Have you felt anxious, miserable, worried or depressed for more than two weeks?                | Mental health      |
| 7  | If yes, was that related to a previous pregnancy or birth?                                     | Mental health      |
| 8  | Are you currently receiving or have you in the past received treatment for emotional problems? | Mental health      |
| 9  | As a child were you hurt or abused in any way (Physically, emotionally or sexually)?           | Childhood abuse    |
| 10 | Have you been hit, slapped or hurt by your partner/ex-partner over the last 12 months?*        | Domestic violence  |
| 11 | If yes, are you safe to go home when you leave here?*                                          | Domestic violence  |
| 12 | If yes, would you like some assistance with this?*                                             | Domestic violence  |

Note: \*NSW mandated domestic violence (DV) questions replaced the ICAMHS DV questions in early 2004.



The EDS is a modified version of the EPDS, an internationally renowned scale developed to screen for postnatal depression (Buist et al, 2002). The EDS is a brief (10-item) self-report measure validated for use during the antenatal period (Murray & Cox, 1990). The only difference between the two versions is the introductory statement referring to the women as either ‘as you are about to have a baby’ or ‘recently had a baby’. The PSQ are used in conjunction with the EDS. This assessment process identifies women as either ‘at-risk’ (AR) or ‘not at risk’ (NAR) of perinatal distress. The identification of women as either AR or NAR of distress is based on responses to both the PSQ and the EDS. A score of 10 or above on the EDS was chosen to warrant identification of AR. Question 10 of the EDS is related to self-harm ideation and any score on this question will also necessitate AR identification. Either alternatively or additionally, women endorsing problems in any of the domains of the PSQ are identified as AR (e.g. no practical support, not confident person, previous depression).

Women identified as AR are offered a referral to either the Perinatal and Infant Mental Health Service (PIMHS) or Social Work (SW) teams. The PIMHS or SW teams then provide referral or services for the women according to their specific needs. Examples of these services include individual counselling, group counselling sessions or antenatal classes. Women who score 9 or below on the EDS and indicate no concerns on the PSQ are identified as NAR and are not offered any intervention. Arabic and Vietnamese cultures were chosen for this study as people from these backgrounds make up the two most significant cultural groups in South Western Sydney – the area in which the study was conducted.

A random sample of Obstet data was analysed to ascertain the number of women from Arabic and Vietnamese backgrounds who (1) speak Arabic or Vietnamese as a primary language, (2) identified as AR, and (3) were referred to some sort of psychosocial intervention at Liverpool Hospital over a 6-month period in 2004. Table 2 shows the results.

**Table 2.** Number of women who speak Arabic or Vietnamese as Primary Language and who were referred to Social Work or PIMHS over a 6-month period at Liverpool Hospital Antenatal Clinic.

| Sample     | Primary Language | Referred to SW or PIMHS |
|------------|------------------|-------------------------|
| Arabic     | 142/1576 (9%)    | 11/1576 (0.70%)         |
| Vietnamese | 130/1576 (8.2%)  | 16/1576 (1%)            |
| Everyone   | N/a              | 437/2839 (15.4%)        |

These figures indicate that over an 18-month period approximately 33 Arabic and 48 Vietnamese women would be referred to IPC or SW from the psychosocial assessment process.

Ethics approval was given to follow up a sample of women who met the following selection criteria – 1) Arabic or Vietnamese background 2) from the psychosocial assessment were identified as either currently, or at risk of becoming, emotionally distressed during the pregnancy or postpartum.

## **Method**

### *Procedure*

The Arabic and Vietnamese women who accepted a referral to SW or PIMHS over an 18-month period were sent an information letter at four to six weeks postpartum. This letter detailed the purpose of the current study and a copy of the EDS in the woman's respective language for reference during the phone interview. The letter also outlined that women would be contacted in 1-2 weeks via phone by a bilingual *beyondblue* researcher of the same ethnic background as the women. At this time the women were informed they could either accept or decline participation in the study. The women who chose to participate undertook a semi-structured telephone interview and were administered the EDS.

The follow-up of women continued from early 2003 to mid-2004.

### *Interventions*

A variety of interventions were made available to the women. Wherever possible all were offered to women in their preferred language, and by a health professional from a similar ethnic background, to ensure cultural appropriateness. These interventions included face-to-face counselling; telephone support; home visiting; referral to appropriate groups (eg anxiety management) and antenatal classes. Considerable work went into sourcing the variety of interventions provided by the numerous government and non-government organisations in South West Sydney. The decision as to which interventions were offered to each woman was made by the PIMHS and SW teams at weekly meetings.

### *Measures*

#### Antenatal Intervention Interview

The NESB Antenatal Intervention interview was a semi-structured telephone interview specially developed for the present study. It examines the interventions offered to women, whether they were taken up, and the perceived usefulness of each intervention. Questions are also asked about reasons for not taking up the offered services where applicable. All interviews were conducted by a health professional from a similar ethnic background to the women, and in their preferred language.

#### EPDS

English, Arabic and Vietnamese antenatal versions of the Edinburgh Depression Scale (EPDS) (Cox, Holden & Sagovsky, 1987) were used. The EDS is a self-report measure, whereby women indicate, using a 4-point scale (0, 1, 2, 3), how they have been feeling over the last seven days with respect to 10 statements. Individual items are summed to give an overall score. The lowest severity of symptoms scores zero while the maximum possible score for worst severity of symptoms is 30. An affirmative answer on question 10 (1, 2, or 3), indicates the presence of suicidal/self harm thoughts. The original EPDS was validated and confirmed as both reliable and sensitive in screening for postnatal depression in English speaking women (Cox et al., 1987) and more recently in Arabic speaking women in the United Arab Emirates (Ghubash, Abou-Saleh & Daradkeh, 1997), as well as Arabic and Vietnamese speaking women in the Australian context (Matthey & Barnett, 1997).

## Results

### *Comparative analysis among 3 samples of women*

Table 3 shows maternal age at time of the booking in appointment, gestation at the booking in appointment and antenatal Edinburgh scores for all Arabic and Vietnamese women attending the clinic during an 18-month period. In addition comparative data are provided in some of the following Tables for all other women seen at the hospital clinic (N ≈ 2,600).

**Table 3.** Maternal age and gestation and mean (SD) Edinburgh scores at ‘booking-in’ appointment.

| <i>Characteristics of the population</i> | <b>Arabic<br/>(n = 129)</b> | <b>Vietnamese<br/>(n = 262)</b> | <b>All women<br/>(n = 2,345)</b> |
|------------------------------------------|-----------------------------|---------------------------------|----------------------------------|
| Maternal age (years) at booking in appt  | 27.8 (5.3)                  | 29.7 (5.1)                      | 27.7 (5.4)                       |
| Weeks pregnant at booking in appt        | 20.4 (6.3)                  | 18.6 (5.4)                      | 18.7 (6.2)                       |
| Mean Antenatal Edinburgh Score           | 6.6 (4.8)                   | 6.6 (4.7)                       | 6.4 (4.8)                        |
| 0-9                                      | 74%                         | 73%                             | 76%                              |
| 10-12                                    | 10%                         | 16%                             | 13%                              |
| 13 or more                               | 16%                         | 11%                             | 11%                              |
| Score 1, 2 or 3 on Q10                   | 1.6%                        | 5.4%                            | 4.2%                             |

Note: There were no statistically significant differences among the three groups of women on any of these variables (See footnote 1).

### *Participants*

Participants were 56 women who had attended an antenatal clinic in South Western Sydney Area Health Service and had undertaken a psychosocial assessment at the first ‘booking in’ appointment. Subsequent to this the women were identified as either currently distressed, or at risk of becoming distressed, and were offered, and accepted, some sort of antenatal intervention. Of these 56 women, 29 were Vietnamese and 27 were Arabic. Of the Arabic women 15.4% were primiparous, of the Vietnamese women 26.9% were primiparous.

There were no significant differences between the two referred groups on maternal age, gestational age, or antenatal Edinburgh score (Arabic mean: 14.5; Vietnamese mean: 13). In addition, referred women were not different on the first two of these variables to the population of Arabic and Vietnamese women presenting to the clinic (cf Table 3). By definition the EDS scores were higher in the referred women than the population of women, given that a high EDS score puts them into the AR category.

The countries of birth for the Arabic sample of women include Lebanon (n=11 - 40.7%), Iraq (n=10 - 37%), Australia (n=2 - 7.4%), Syria (n=2 - 7.4%), Kuwait (n=1 - 3.7%), Sudan (n=1 - 3.7%).

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1 Caution should be applied to interpreting these EDS scores. There is evidence that different cut-off scores should be applied for women from different cultures (cf. Barnett et al., 1999), as well as different cut-off scores being appropriate for the antenatal and postnatal periods. (cf. Murray & Cox, 1990).

Of the Vietnamese women, 27 (93.15%) were born in Vietnam, 2 women (6.9%) countries of birth were not known.

Table 4 shows the percentage of referred Arabic and Vietnamese women scoring positively – in a way that indicates risk – on the individual psychosocial questions. This shows that nearly all of these women had experienced previous depression or anxiety, this therefore being the most frequent psychosocial risk resulting in a referral to PIMHS or SW.

**Table 4.** Percent of referred Arabic and Vietnamese women scoring ‘positively’ (indicating risk) on the psychosocial questions.

| <b>Risks</b>                             | <b>Arabic</b> | <b>Vietnamese</b> |
|------------------------------------------|---------------|-------------------|
| No postnatal practical support           | 12%           | 9%                |
| No postnatal emotional Support           | 0%            | 13%               |
| Has had recent major stressors           | 20%           | 35%               |
| Lacks confidence                         | 20%           | 17%               |
| Is a worrier                             | 48%           | 30%               |
| Has history of depression/anxiety        | 100%          | 83%               |
| Experienced some form of childhood abuse | 6%            | 2%                |
| DV - Does she hit partner?               | 3.7%          | 3.4%              |
| DV – Does partner hit her?               | 7.4%          | 0%                |
| DV – Partner hit her since pregnant?     | 0%            | 0%                |
| EDS score 10 or more                     | 96%           | 87%               |
| Scoring 1,2 or 3 on EDS Q10              | 26%           | 39%               |

Note: These percentages are not mutually exclusive.

PIMHS and SW were able to contact 89% (n=23) of Arabic and 62% (n=18) of Vietnamese women who had been referred to them. Of these women who had been contacted by PIMHS and SW to be assessed for their specific needs, 39% of Arabic and 50% took up further services that had been offered to them. The reasons women gave for not accepting referrals the services offered to them by PIMHS or SW include difficulties with transport, childcare, or language, as well as some women stating that they were too busy.

Without knowing the uptake rates for pregnant women from other cultural backgrounds (e.g., English-speaking) it is difficult to know whether or not these rates are exceptional for women identified as potentially ‘at-risk’ of current or future psychosocial difficulties.

Table 5 shows which services these women accepted.

**Table 5.** Take-up of interventions offered to referred women.

| <i>Service</i>          | <b>Arabic</b> | <b>Vietnamese</b> |
|-------------------------|---------------|-------------------|
| Individual counselling  | 2/12 (17%)    | 5/10 (50%)        |
| Volunteer home visiting | 2/6 (33%)     | -                 |
| Antenatal classes       | 3/5 (60%)     | 1/5 (20%)         |
| Ongoing phone support   | 12/16 (75%)   | 2/3 (66%)         |

Note: Women could be offered more than one intervention

These data indicate that ongoing telephone support was the intervention that was most likely to be taken up by both Arabic and Vietnamese-speaking women.

*Helpfulness of Interventions*

Women were asked to rate the helpfulness of any interventions they received – from ‘very helpful’ to ‘not helpful’. All women from both ethnic groups reported that they saw the interventions as being helpful, with just one woman reporting that one of three of the interventions she received was not helpful.

In addition the EDS was administered to all the women during the telephone interview. Table 6 shows the mean antenatal and postnatal scores for each ethnic group. These data show a significant drop in the number of the referred women having high EDS scores postnatally, a further indication that the interventions provided were helpful not just antenatally but also for the women’s postnatal psychological adjustment.

**Table 6.** Referred women: Edinburgh scores at recruitment and following the birth (see footnote 2).

| Group      | Mean (SD)<br>Ante EDS | Mean (SD)<br>Post EDS | % scoring 13<br>or more - ante | % scoring 13<br>or more - post |
|------------|-----------------------|-----------------------|--------------------------------|--------------------------------|
| Arabic     | 14.4 (2.8)            | 8.4 (5.4) ***         | 77%                            | 27%                            |
| Vietnamese | 13.4 (4.5)            | 9.7 (6.3)*            | 68%                            | 12%                            |

\*\*\* p < .001; \* p<.05

2 Caution should be applied to interpreting these EDS scores. There is evidence that different cut-off scores should be applied for women from different cultures (cf. Barnett et al., 1999), as well as different cut-off scores being appropriate for the antenatal and postnatal periods. (cf. Murray & Cox, 1990).

## **B. Arabic women's preferences study: synopsis**

A small study was undertaken to ascertain which type of psychosocial services are preferred by Arabic speaking women (Taouk, 2004). The summary of this study is as follows:

Sixty Arabic-speaking women were interviewed in person at the antenatal clinic, prior to their interview with the midwife. This interview in part asked them about their, or Arabic women's, preferences for psychosocial interventions (using more colloquial language to describe this). Specifically, they were asked about their preferences for group counselling or individual counselling.

Almost a third of the women said that if they had major concerns or worries they would not use either type of counselling service, with the impression being that they would first use their own informal support networks. The remaining two-thirds of women reported a preference for either type of service. Again, without knowing the preferences of women from other cultural groups it is difficult to know whether these rates are exceptional to Arabic-speaking women. However, these findings would indicate that i) the uptake rates are in line with what might be expected given their stated preferences for services; and ii) that the offer of counselling is seen as acceptable by the majority of these women.

## **Part 2 – Translation And Health Promotion**

### *Method*

#### Background

The English version of the *beyondblue* published booklet 'Emotional Health during Pregnancy and Early Parenthood' was prepared by drawing material principally from two sources – 'Childbirth Stress and Depression' written by Sherryl Pope and Julie Watts and 'Postnatal Depression – The Inside Story' written by Jeanette Milgrom, Carol Richards and Jennifer Ericksen. The booklet was painstakingly constructed with the main focus on being a user friendly resource that would be easily read and understood by mothers, their partners, friends and families and later kept for the local emergency and helpline contact numbers on the back page.

The 15-page booklet covers many topics related to the emotional health of new parents, for example adjustment, depression during pregnancy, causes of depression, treatment options and coping strategies.

This particular aspect of the project aimed to increase knowledge and change attitudes of Arabic and Vietnamese women, their families and, hopefully, their respective communities, and indicate where help might be available.

### *Procedure*

The many difficulties experienced in producing the Arabic and Vietnamese translations of the 'Emotional Health during Pregnancy' booklet had not been fully anticipated by the NSW *beyondblue* staff. The Arabic and Vietnamese project officers (PO) expended considerable time and energy in the production of the booklet and many unpredicted issues arose during all stages of its translation. For example, obtaining permission from women, husbands or families for use of appropriate photographs on the cover of the booklet was complicated by differing traditional structures in various families and the way in which images were seen as acknowledging authority. Obtaining a husband's permission

was sometimes appropriate, but not always, and a husband might give permission but request that he himself be excluded from the picture. Problems also arose in the publication process, for example when the publisher decided to use a different language version from the one selected by the researchers.

Focus groups with samples of Arabic and Vietnamese women and health workers were organised at several stages in the process to discuss the translation/languages, cover photographs and design, and appropriate resources to be detailed in the back of the booklet.

Once the booklets had finally been printed they were distributed to community women mainly from the antenatal clinics of 10 major hospitals in Sydney. The booklets were handed out to Arabic and Vietnamese women during the first 'booking-in' appointment. To date, approximately 10,000 booklets (5,000 Arabic and 5,000 Vietnamese) have been distributed from these clinics.

Requests for the booklet also came from many government and non-government agencies across Sydney, for example, community health centres, migrant resource centres, local GP/medical clinics, private psychology practices and even an Arabic childhood clinic. The *beyondblue* resources were quick to become known as a high quality product and as the booklet became more widespread through Sydney, and NSW, requests became more frequent.

The third reprint of 6000 of each booklet is currently underway; these will be distributed to Arabic and Vietnamese women across New South Wales. The resource is also available now on a national basis.

During the study, collaboration with the NSW Multicultural website ensured that many different translations of sections of the booklet and the internationally listed translations of the EDS were made widely available. These included an Assyrian audiotape and written resources, launched by *beyondblue* and Karitane at the Assyrian Cultural Club in Fairfield.

## References

- Barnett, B., Matthey, S., & Gyaneshwar, R. (1999). Screening for postnatal depression in women of non-English speaking background. *Archives of Women's Mental Health*, *2*, 67-74.
- Buist, A.E., Barnett, B.E.W., Milgrom, J., Pope, S., Condon, J.T., Ellwood, D.A., Boyce, P.M., Austin, M.P.V., Hayes, B.A. (2002) To screen or not to screen – that is the question on perinatal depression. *Medical Journal of Australia*, *177*: S101-S105
- Cox, J.L., Holden, J.M., Sagovsky, R. (1987) Detection of postnatal depression – development of the 10-item Edinburgh Depression Scale. *British Journal of Psychiatry*, *150*, 782-786
- Ghubash, R., Abou-Saleh, M.T., Daradkeh, T.K (1997) The validity of the Arabic Edinburgh Postnatal Depression Scale. *Social Psychiatry and Psychiatric Epidemiology*, *32*(8), 474-476
- Jenkins, J.H., Kleinman, A., Good, B.J. (1991) Cross cultural aspects of depression. In: Becker J, Kleinman A (Eds) *Psychosocial aspects of depression*. Lawrence Erlbaum, New Jersey.
- Matthey, S. & Barnett, B. (1997) Translation and validation of the Edinburgh Postnatal Depression Scale into Vietnamese and Arabic. In: Ferguson, B. & Barnes, D. (Eds) *Perspectives on transcultural mental health*. Transcultural Mental Health Centre, Sydney.
- Matthey, S., Phillips, J., White, T., Glossop, P., Hopper, U., Panasetis, P., Petridis, A., Larkin, M., & Barnett, B. (2004). Routine psychosocial assessment of women in the antenatal period: frequency of risk factors and implications for clinical services. *Archives of Women's Mental Health*, *7*, 223-229.
- Matthey, S., White, T., Phillips, J., Taouk, R., Chee, T. T., & Barnett, B. (in press). *Acceptability of routine antenatal psychosocial assessments to women from English and non-English speaking backgrounds*. *Archives of Women's Mental Health*.
- Matthey, S., White, T., Panasetis, P., Hopper, U., Larkin, M., Glossop, P. & Barnett, B. (2002). *Evaluation of the routine psychosocial assessment at the Liverpool Hospital Antenatal Clinic: June 2002*. Infant, Child & Adolescent Mental Health Service, South West Sydney Area Health Service: Sydney Australia.
- McDonald B. & Steel, Z. (1997) *Immigrants and mental health*. Transcultural Mental Health Centre, Sydney.
- Murray, D. & Cox, J. L. (1990). Screening for depression during pregnancy with the Edinburgh Depression Scale (EPDS). *Journal of Reproductive and Infant Psychology*, *8*, 99-107.
- Rice, P.L. (1994) *Asian mothers, Australian birth – pregnancy, childbirth and childbearing*. Ausmed Publications. Melbourne.



Taouk, R. (2004). What women want: tailoring antenatal interventions to the preferences and needs of Arabic speaking women. Unpublished Masters Dissertation, Macquarie University, Australia.

Williams, H., Carmichael, A. (1985) Depression in mothers in a multi-ethnic urban industrial municipality – Melbourne. *Journal of Child and Adolescent Psychiatry*, 26, 277-288