Midland Women's Health Care Place Inc.

# PERINATAL MENTAL HEALTH SERVICE CAPACITY BUILDING

## PROJECT REPORT


Jill Cameron and Associates
April 2012

## Acknowledgements

*My sincere thanks to the women and their partners who willingly shared their stories, views and ideas.*

*Thanks also to staff at Midland Women's Health Care Place who helped make this project happen. Without all of these people, this project could not have been completed.*

***Jill Cameron***
30th April 2012

## Executive Summary

In 2011, Midland Women's Health Care Place Inc (MWHCP) received a Mental Health Capacity Building Grant from the Western Australian Mental Health Commission to assist in the measurement of perinatal depression services provided by MWHCP to the region with the aim of improving service quality.

The project recognised that Women's Health Centres in Western Australia are key providers in the delivery of regional perinatal mental health services and the importance of working towards the development of a best practice model of service delivery.

Jill Cameron and Associates were contracted to undertake the project. The core elements of the project were:

(i) feedback from participants in MWHCP individual counselling and group programs for women experiencing perinatal mental health issues

(ii) identification of outcomes as perceived by participants

(iii) identification of factors participants perceived as contributing to successful or positive outcomes.

The people who participated in focus groups and telephone interviews identified the following factors that were important to them and the success of the PND service provided by MWHCP.

- The place where the service was delivered
- The people
  - The staff generally
  - The counsellor/s
- The program
  - Structure and organisation
  - Tools, reading material and handouts
  - Opportunity for partners to participate
  - Cost – affordability
  - Availability of the onsite crèche
  - The PND Program timing and length
  - Availability of follow up and support.
- Participants identified personal outcomes such as gaining confidence, normality, relief, support, reassurance, friendships, becoming more in control, assertive and understanding that they were not 'the only one' and no longer feeling consumed by problems and the challenges of motherhood.

**The project found that:**

- the service activity met MWHCP's internal standards, and for the individual women from across the East Metropolitan region who participated, the outcomes sought by and for them had been achieved
- feedback from participants in the project indicated that the service delivered by MWHCP reflected the organisation's commitment to the principle of social inclusion
- participants in the project provided feedback that the following outcomes had been achieved or partly achieved:
  - to minimise personal anxiety, stress and depression and feelings of helplessness associated with the birth of a child and early parenting and changed life circumstances
  - to have 'meaningful others' understand the challenges, changing life circumstances and feelings associated with the perinatal experience
  - to be and be seen as a well functioning adult and parent
  - to have opportunities to be included in social networks and social activities, and
  - that outcomes not achieved in full for all participants reflected community attitude to and understanding of, factors external to the individual participant
- the service activity met external standards such as those defined by beyondblue and the Western Australian Mental Health Commission, including being woman centred and based in the community.

**Some other issues identified were that:**

- women found out and came to the perinatal mental health service at MWHCP via a number of pathways which is important to understand given that awareness, understanding and acceptance of the need to access information, support and/or therapeutic services can be a significant barrier for women experiencing perinatal mental health issues
- there remains a stigma or perceived stigma associated with perinatal stress, anxiety and depression
- the level of awareness and understanding about PND among the partners of the women who participated in the project is limited as are the opportunities available for men to participate in programs that deal with PND.

**Conclusion:**

The important 'high level' elements identified in this project were:

- the place where the service activity took place
- the people who interacted with participants (including professional counsellors providing the service directly as well as all other staff), and
- all aspects of program design and delivery and appropriateness for both individual participants and the group.

The review suggests that measurement of outcomes of PND programs such as those delivered by MWHCP should include:

- pre and post quantitative data collected through instruments such as the EPDS and/or other relevant reliable validated instruments
- qualitative data collected through focus groups and interviews
- follow-up three months after completion of a program.

Adoption of a rigorous approach to collection of data using standardised data collection instruments and a standardised procedure will advance knowledge in this important area of service delivery.

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## 1. ABOUT THE PROJECT

In 2011, Midland Women's Health Care Place Inc (MWHCP) received a Mental Health Capacity Building Grant from the Western Australian Mental Health Commission to assist in the measurement of perinatal depression services provided by MWHCP to the region with the aim of improving service quality.

The project design identified focus groups as the methodology for carrying out the project.

Project outputs were identified as a strategic report for the Board and a final report for community dissemination through local and regional networks such as the Eastern Region Mental Health Agencies network, the newly established Mental Health Professionals Network and the Ellenbrook PND Committee, as well as through the MWHCP website.

The project recognised that Women's Health Centres in Western Australia are key providers in the delivery of regional perinatal mental health services and the importance of working towards the development of a best practice model of service delivery.

Jill Cameron and Associates were contracted to undertake the project.

## 2. APPROACH TO PROJECT

The core elements of the project were:

(i) feedback from participants in MWHCP individual counselling and group programs for women experiencing perinatal mental health issues

(ii) identification of outcomes as perceived by participants

(iii) identification of factors participants perceived as contributing to successful or positive outcomes.

Participants' views were obtained in focus groups. Where attendance at a focus group was not possible, telephone interviews were conducted. Twenty women who had participated in the MWHCP perinatal mental health program and two partners provided input to the review. Factors identified from the views expressed by participants were reviewed against a range of practice elements identified in key policy documents that provided context for the review.

# 3. THE CONTEXT

## 3.1 Women's Health Centres

Midland Women's Health Care Place Inc is one of eleven organisations in Western Australia providing "quality, holistic healthcare services to enable women to make informed decisions regarding their health and lifestyle. Women are provided with information, advice, counselling and therapeutic support. Some clinical services are provided at most centres"[1].

Services provided in women's health centres across the State generally include individual and group therapeutic programs. Some services funded through the Mental Health Commission specifically address perinatal mental health, although they may be branded and publicised differently.

## 3.2 Midland Women's Health Care Place

MWHCP is a non government not-for-profit organisation whose purpose is to provide services that promote the total health and wellbeing of women and their families in the East Metropolitan Region of Western Australia.

MWHCP provides services for women across the lifespan, recognising that individual women can be vulnerable at different times because of factors including social and economic disadvantage, disability, ethnicity and age.

[1] *http://kemh.health.wa.gov.au/services/women%27s_health_centres*

**MWHCP believes in the right of people to:**

- be valued as individuals
- make choices in their own lives
- dignity, respect, privacy and confidentiality
- access services on a non-discriminatory basis
- safe, comfortable and reliable services
- accountable and responsive services.

**MWHCP upholds the principle of social inclusion and is committed to:**

- providing friendly, responsive, evidence-based services
- respecting and valuing diversity
- achieving high professional standards
- teamwork, productive partnerships and collaboration
- accountability and transparency
- providing services designed to provide a holistic approach to overall health incorporating all aspects of a woman's life and health over the lifespan, including emotional health, education, exercise, family, work and community inclusion.

### 3.3 The Mental Health Reform Agenda

A number of significant documents have signalled a new era in the delivery of mental health services in Western Australia.[2] Key elements of the reforms include a person focused, whole of government approach to mental health and a strengthened community sector that is well placed to deliver individualised supports and services.

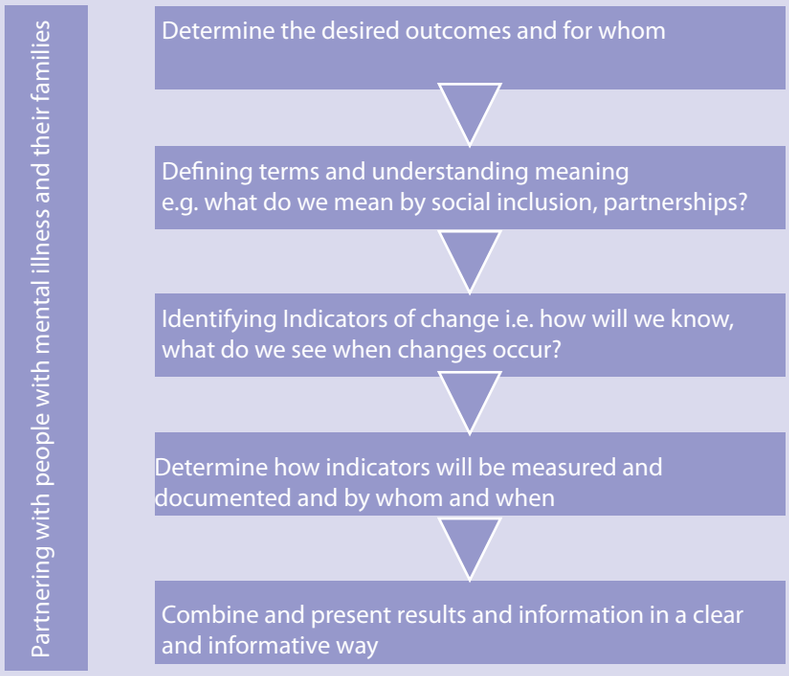
[2] *"Mental health 2020" Making it personal and everybody's business. Reforming Western Australia's mental health system, Mental Health Commission October 2011*

*DRAFT DISCUSSION PAPER FOR THE NON GOVERNMENT MENTAL HEALTH SECTOR Developing Outcome Statements Paper prepared by the Mental Health Commission in conjunction with the Western Australian Association for Mental Health, November 2011*

*Partnership Forum for Not-for-Profit Sector Leaders: Fact Sheets 1-7, December 2011*

*Proposed Reforms: Improving Services and Supports Provided by the Community Mental Health Sector in Western Australia Briefing Paper Feb 2012*

In the future non government organisations will be required to demonstrate how they are assisting people with a mental illness and their families to identify and achieve their own personal goals that support people to live better lives in communities in which they live. This is a systemic shift from an output driven system to one that recognises the quality and difference services make to peoples' lives.




DISCUSSION PAPER FOR THE NON GOVERNMENT MENTAL HEALTH SECTOR Developing Outcome Statements

This approach is consistent with the shift from the delivery of outputs to delivery of outcome as articulated by the Economic Audit Committee.[3]

### 3.4 Perinatal Mental Health

"It is well established that the year after giving birth is one of heightened vulnerability for women with regard to social and emotional adjustment and mental illness, especially mood disorders (Evans et al, 2001). One in five Australian mothers of full term infants experience a perinatal mental health disorder within the first year of delivery (Priest et al, 2005). However, many are not diagnosed or treated (Buist et al, 2005). Antenatal anxiety and depression occur frequently and often together and may lead to postnatal depression and anxiety (O'Connor et al, 2002; Heron et al, 2004). A small number of women will develop an acute psychotic illness (one in a thousand), which significantly increases their risk of harm to themselves or others (Chaudron & Pies, 2003).

[3] *Putting the Public First: Partnering with the Community and Business to Deliver Outcomes. Economic Audit Committee, 2009.*

Whilst recent developments have seen an expanded focus and interest in the broader field of perinatal mental health, historically, the study of childbirth and mental health has been largely limited to postnatal depression (PND) (Austin, 2004).

Women who are particularly at risk for perinatal mental health disorders are those with:

- A history of mental illness (particularly affective disorder);
- Limited emotional and social support;
- Stressful life events or losses;
- Change in role and identity;
- An unwanted or unplanned pregnancy; and
- Those women from a lower socioeconomic status (O'Hara & Swain, 1996; Beck, 2001; Abou Saleh & Ghubash, 1997).

An increasing body of literature now supports that maternal depression and other psychological disorders during the perinatal period negatively impacts on the infant, partner and other family members as well as the mother (Herring & Kaslow, 2002; Murray et al, 1999; Glover, 1997; Lovestone & Kumar, 1993). Disturbed maternal/infant attachment can result in a significant influence on the cognitive, emotional, social and behavioural development of the infant both short term and long term (Murray et al, 1999; Murray et al, 1996).

Management of PND consists primarily of psychosocial support and both individual and group psychological interventions (Milgrom et al, 1999; Pope et al, 1999). Whilst outcomes of these are varied, there is some evidence to support certainly the short term benefits of such intervention (Boath et al, 2005)".[4]

The *beyondblue* Perinatal Mental Health Consortium (2007) based the National Action Plan 2008-2010 firmly within a health promotion and early intervention framework. Since publication of the plan, beyondblue has added significantly to research, evaluation and resources specific to perinatal mental health.

*beyondblue* has identified 'robust mental health for both mother and family in the perinatal period (pregnancy and the following year) as critical for emotional and physical development in infants and to optimise parenting, nurture and care capacity, and family formation (Perinatal Mental Health Consortium, 2008).[5]

[4] *State Perinatal Reference Group and the Western Australian Perinatal Mental Health Unit (2007). State Perinatal Mental Health Initiative: Report 2003-2007. Perth: Department of Health WA.*

[5] *www.beyondblue.org.au*

*beyondblue* has also developed comprehensive guidelines with the aim of providing evidence-based recommendations that support early identification and effective management of mental health problems in the perinatal period and improved mental health outcomes for women and their families. The guidelines were approved by the Chief Executive Officer of the National Health and Medical Research Council on 11 February 2011, under Section 14A of the National Health and Medical Research Council Act 1992. In approving the guidelines the NHMRC stated that it considers that they meet the NHMRC standard for clinical practice guidelines. The approval is valid for a period of 5 years. The guidelines include 'Good Practice Points'. [6]

The Guidelines identify key aspects of the therapeutic relationship as the development of trust confidence, mutuality, active listening and empowerment:

"It is important for health professionals to:

- understand the normal range of emotions common to various stages during the perinatal period so they can better
- identify distress and depressive symptoms if they occur
- allow adequate time to assess, listen and build rapport
- ascertain and address any misconceptions or needs for information
- encourage women to express their feelings about pregnancy and motherhood, validate any concerns and support their emotional state
- maintain a non-judgmental attitude; and
- assess women's support systems, including the attitudes and availability of her significant other and support network.

The relationship should be based on an open, collaborative process. Where mental health treatment is required, the collaborative process continues, with the setting of mutually agreed goals and tasks and regular support to help the woman to achieve those goals. If referral is necessary, the process should be managed in an empowering, supportive way.

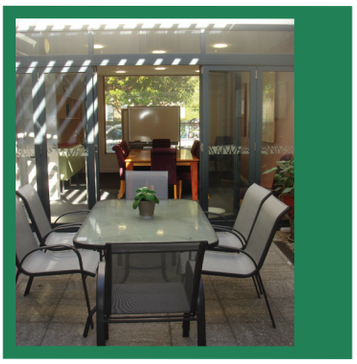
**A good practice point**
Health professionals should ensure that communication with women in the perinatal period is empathic and non-directive, and that discussions are woman-centred". [7]

[6] *Clinical Practice Guidelines for Depression and Related Disorders – Anxiety, Bipolar and Puerperal Psychosis – in the Perinatal Period. A guideline for primary health care providers, February 2011.*

[7] *Clinical Practice Guidelines for Depression and Related Disorders – Anxiety, Bipolar and Puerperal Psychosis – in the Perinatal Period. A guideline for primary health care providers, February 2011.*

A new study published in the journal of Social Psychiatry shows 'postnatal depression hits fathers and mothers equally in the first 12 months of a newborn's life. Young fathers are particularly vulnerable, with those aged under 30 facing a 40 per cent increase in the risk of developing postnatal depression compared with fathers aged over 30. Co-author Professor Jan Nicholson, of the Parenting Research Centre in Melbourne, says the study shows 9.7 per cent of fathers suffer postnatal depression in the first year of their child's life compared with a rate of postnatal depression among new mothers of 9.4 per cent…..

"As the birth of a baby can result in profound changes for lifestyle and recreation, sleep patterns, couple relationships and identity, it is not surprising that adjustment difficulties may arise for fathers at this time, the researchers note." [8]



## 4. ABOUT THE MWHCP SERVICE

- Prevention and early intervention are the overall goals of the service activities.
- The service activities (inputs) are:
  - individual and group counselling
  - group programs
  - complementary activities
  - on-site crèche.
- The target client group for the service activities was women at risk of, or who have, perinatal anxiety, stress and/or depression.
- Funding sources for the service activities were:
  - Mental Health Commission funding for the perinatal group program
  - Department of Health core funding for MWHCP holistic services.
- Service activity outputs were:
  - the number of women who participated in individual counselling, group programs and complementary activities
  - the number of opportunities for partners to participate in a PND program
  - the number of children who attended the crèche while their mother participated in a group program.

8 *On www.abc.net.au/news/2012-2014/fathers-post-natal-depression*

- Expected outcomes for clients are:
  - to minimise personal anxiety, stress and depression and feelings of helplessness associated with the birth of a child, early parenting and changed life circumstances
  - to have 'meaningful others' understand the challenges, changing life circumstances and feelings associated with the perinatal experience
  - to be and be seen as a well functioning adult and parent
  - to have opportunities to be included in social networks and social activities.

- At an organisational level, the project was expected to inform the development of the 2012-2017 Strategic Plan.

- Internal assessment (monitoring/evaluation tools used)
  - Edinburgh Postnatal Depression Scale (EPDS) during 1:1 counselling on a regular basis, approximately every five weeks. NOTE: There is an extensive body of evidence that the EPDS, while not providing a diagnosis of depression, will identify people who have symptoms that are common in women with PND[9]
  - EPDS in group programs at Weeks 1, 5 and 9
  - Variable Analogue Scale (VAS)[10] – an overall emotional assessment in which the client marks on a line where they fit between the worst they have felt and the best
  - Depression, Anxiety and Stress Scale (DASS) – 42 questions which help to tease out whether depression, anxiety or stress are the main concerns.

NOTE:

The EPDS and DASS are standard assessments tools. The widely used EPDS is a screening tool which, together with the VAS, has been found to provide an accurate picture. MWHCP Senior Counsellor has found over time that if the EPDS is low, the VAS will be high and vice versa and that if the EPDS is low, and the VAS is low, then it is less likely that PND is the issue and there is something else going on for the client, for example, relationship issues, domestic violence, childhood issues.

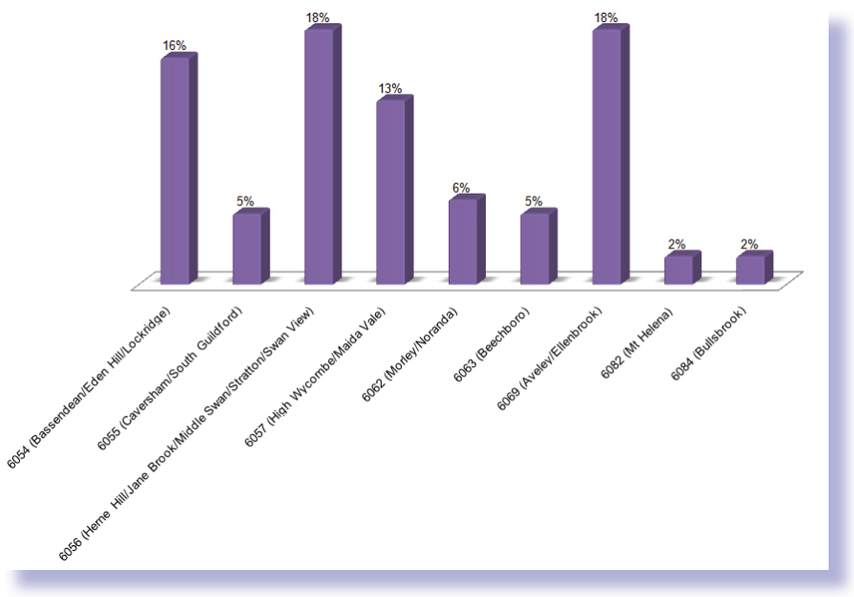
The size of PND groups ranged from 3 to 10 and each group ran for nine sessions.

9 *www.beyondblue.org.au*

10 *Developed by Madeleine Hicks, Senior Counsellor, Midland Women's Health Care Place The VAS has not been subjected to validity or reliability testing.*

# 5. THE PARTICIPANTS AND THEIR PERSPECTIVES

**PND Program Participants' Demographic**
**Jan - Dec 2011**




## 5.1 Participants

A sample of 20 participants in the MWHCP PND program was interviewed in small groups following an informal lunch provided by the centre or by telephone. The sample included:

- women who had been referred by a Child Health Nurse, a GP, Swan District Hospital or had found out about the PND program from a friend or family member, a Mums group or playgroup
- women with vastly different life experiences
- women who had a history of depression and those who had no previous experience of depression
- women with different experience of childbirth
- women with fly-in fly-out partners, women with partners who worked in jobs involving long hours away from home (eg 5.30am-7.00pm daily or 2-3 nights away from home) and women with partners working regular/standard hours.

Two partners of participants were interviewed by phone.

Some participants said: it was hard initially not knowing what to expect when they started in the PND program. They were not keen on the idea of a group. Thought it would be 'scary exposing yourself in front of other people' but came because they were 'so desperate'.

Other comments included:

- You know you're there to learn how to make a better life
- My mother suffered PND, so I had a clue – I didn't want to accept it, but friends and the child health nurse said to go. I didn't want to be rejected by the group. It was daunting to come
- I was freaking out and didn't recognise I had a problem
- I didn't want to come and be with depressed people but it was a humbling experience
- It was significant that everyone was like me – the check list was really helpful
- I was sinking and in denial – then the group was my support network
- I didn't tell anyone – just my husband
- My husband doesn't believe in PND – my friends said I should do something
- People didn't want to talk about it or didn't know - because of shame in family
- There's a huge number of 'shoulds' that say what a mother should be and should do that I was trying to live up to
- 'I'm afraid I'll have my child taken away if people know I'm depressed. If something happens at school I'd be worried if I say anything that they will take the kids away'.

## 5.2 What participants said about the PND program

### 5.2.1 The place

- It's easy to get to – and local
- There are not a lot of places and programs like this for women
- Everything out there is too fast. Here you can slow down and think. You're made to feel welcome
- MWHCP is good for the Midland community – it's good that there's a PND program in Ellenbrook now
- Having the crèche available at the centre was fantastic
- It's a relaxed and helpful environment


### 5.2.2 The people

Staff generally:

- They're really helpful, friendly, discreet, good people
- No-one judges you
- Everything about the Centre – everyone who's there – they don't look and judge you
- The crèche staff were welcoming and you could trust them
- 'There was a 10 week wait at the Mental Health Commission even though I was suicidal. The person I spoke to first at MWHCP understood straight away and managed to fit me in'
- 'I was desperate. The GP couldn't help and gave me three phone numbers. I was in tears but no-one could offer an appointment or help. I left a phone message when MWHCP had closed for the day and someone phoned back at 8.30am the very next morning and I was able to see a counsellor straight away…later I asked to do the group twice'
- Staff will fit you in for an appointment as soon as possible if they know the situation is urgent.

The counsellor/s:

- They're organised and knowledgeable
- They have different styles and different ways of helping
- I was afraid of what other people think of me. At least here I have the counsellor
- In a group with a counsellor, you have someone to back up – that's important
- Things the counsellor taught about how I'd got stuck in a cycle. She gave activities to try
- The counsellor works on one issue at a time and helps you work through the issue
- The counsellor has a way of getting you to go further
- The counsellor takes off the sugar coating
- The counsellor is approachable and really hears what you say. She's also very down to earth – there's no mucking around
- The counsellor peels away the onion layers – she gets to the nitty gritty
- The counsellors challenge you
- The counsellor's amazing, so easy to get along with, dedicated, sincere, caring and blunt
- Sometimes people pussy-foot around. The counsellor wants you to change and is therefore blunt
- The counsellor's fun and sometimes a bit crazy. She uses humour but presents everything in a positive way that makes sense
- You sometimes think the counsellor is harsh but you go home and think, "no, she's right"
- The counsellor has an amazing talent – always has the right flyer on hand. She's not at all like a teacher preaching to you
- Having to wait for the next group to start was awful for me personally but I had one individual counselling session in which the counsellor made sure I was getting help elsewhere given the length of the waiting time for the group to start.

### 5.2.3 The program

Things that were identified as good or helpful about the program:

- The way the sessions are organised – the first part listening to each other and chatting about what's been happening and the second part information and strategies with something new introduced each week that helps
- I had counselling to start with. It was really helpful – I needed to do it. It was good to talk to someone who doesn't know or judge you – to talk things out that are in your head and work out why you're feeling the way you are
- Finding out that others care
- It helped me stop thinking and get stuff onto the table and deal with it
- The support and getting into the group. I was anxious, but once I was there the other girls helped and were supportive
- It's comforting to know others are going through similar issues – and to hear different approaches
- It made me realise I was not the only one
- I heard stories that made me feel my life was not so bad
- That the feelings are normal
- Finding what to do….finding answers to questions about what you're feeling – so the questions are not just in your brain
- Thinking of things to do – talking about goals and coming back and talking about how it all went
- Being able to debrief with the counsellor each week about what you've faced since last week…offloading troubles
- Having a safe place to debrief about my week was the best thing for me and learning about unhelpful thinking styles, core beliefs about myself and hearing other's stories and how they think about themselves
- Understanding the Parent/Adult/Child concept was an eye opener
- Having reading material to take home and look back at between sessions was a good refresher
- The whole course itself – the pampering day good
- Knowing someone else cares – a group you can come to or phone – "we're very lucky to have MWHCP here"
- You can say what's in your head
- Being able to be blunt without judgment
- Being able to clear emotions
- Being able to cry and not be looked down on or feel like an idiot
- Being able to yell and scream and get it out of your system in one of the sessions
- Good to get 'shoulds' into the open – my husband doesn't get it
- There's no way I would change the program - it's pretty good the way it's organised and run and the ideas you get to work with are really good
- I gained so much I couldn't fault it.

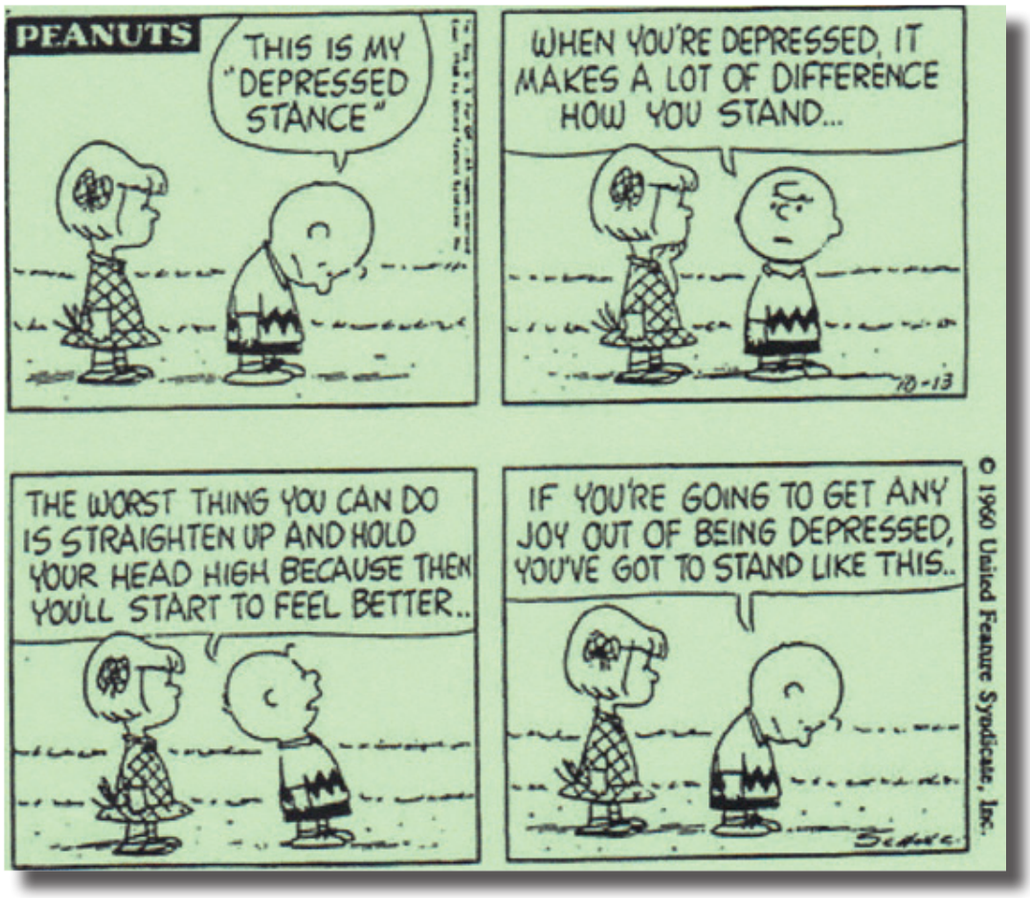
The tools:

- Having good tools to use
- Tools are really good for 'outside'
- Delaying technique
- Parent/Adult/Child concept
- Helpful thinking
- Handouts for the fridge
- Learning to say 'No', 'Stop'
- Reading material to take home

Some examples of 'handouts:'

## CHARACTERISTICS OF WOMEN WITH PND

- Overly responsible
- Worriers (A – Z Thinking)
- Perfectionist
- Lack of nurturing or ability to take in nurturing
- No permission to take time out for self
- Internalised anger (often)
- Very self-critical
- Lots of "shoulds" around mothering, being a wife etc
- High self-expectations (birth, parenting, families, breast feeding, self etc)
- Low self-esteem
- May lack outside supports or not allow themselves to use these supports


PEANUTS
THIS IS MY "DEPRESSED STANCE"
WHEN YOU'RE DEPRESSED, IT MAKES A LOT OF DIFFERENCE HOW YOU STAND...
THE WORST THING YOU CAN DO IS STRAIGHTEN UP AND HOLD YOUR HEAD HIGH BECAUSE THEN YOU'LL START TO FEEL BETTER..
IF YOU'RE GOING TO GET ANY JOY OUT OF BEING DEPRESSED, YOU'VE GOT TO STAND LIKE THIS..
© 1960 United Feature Syndicate, Inc.


DON'T
LET
ANYONE
"SHOULD "
ON
YOU

Partners – their participation in the program from the women's perspective

- Information for partners is good – it helps them to understand the situation
- Partners group definitely needs to be a part of the program
- It's good that there's a chance for partners to come along – they learn that it's more than just girls getting together
- There were three sessions for partners – two provided information and one was a celebration
- Some joint sessions would be good so you can work on things together
- My partner partly understood.
- The partners' night is important even if it turns out to be a 1:1 session – partners' adjustment has to be part of it
- The partners' group didn't run because of the small number who could attend. It would be good to run a session for partners even if it's 1:1.

## A partner's perspective:

*"I missed the first partners' session because of work but was there for the second and third sessions. I asked work if my roster could be reorganised and that was ok. Partners' nights are really helpful but it was hard to know what to tell (in the group)….you need to keep an open mind….walk in and be prepared for anything and take whatever comes your way. The topics brought up and discussed are really relevant and helpful. It's comforting to know others are going through the similar issues but may have had a different approach. We could use the information to figure out our own circumstances. We write little notes for each other. I would recommend it to a friend. I've seen the difference it made in my partner and to our lives."*

A Fly-In Fly-Out worker - 14 days on and 7 days off.

Cost

- I felt guilty about it being so cheap
- I'd paid $300 for counselling before and got nothing out of it
- It's a good service at a discounted rate – counsellors are expensive and I couldn't afford it
- $5 per session for child care was too good to be true

Onsite crèche

- It's great that the kids are taken care of while you're learning so much
- Having the crèche available at the centre was fantastic
- Having the crèche available is a massive help.

## PND Program timing and length

- I wasn't ready at the beginning but now when skills are being given I can use them
- It was the right length. I finished and moved on
- For amount of effort involved in getting here with the children it was perfect
- Nine sessions were not enough. I was just building bonds, just creating friends
- At the end of the ninth week I thought "what now?"
- Nine weeks is not enough time to break down and rebuild and get skills which you start to get in the sixth week
- After nine weeks of the program there's a level of wellness and the group drops off anyway
- I asked to do group twice
- The time was right – any shorter I would have felt left in the lurch. We talked about the group coming to an end and professional and non professional support and we were given strategies to use. Any longer would have been too difficult to fit in with the kids.
- I would love to come to a second group but a part of me says I have to stand on my own two feet.

## Follow up and support

- Even though they're booked out (for counselling) 2-3 weeks, you can rock up if you're desperate – and she'd help you
- It would be good to have an ongoing support group – to go from the group to a support group
- We tried to meet when the group finished but it's easier when it's an organised group with a set time and place
- We haven't met up. The group's fallen apart. We were all very different (eg. age, where we live, life experience) with only the PND group in common
- We kept a support group going when I was the leader but I couldn't do it anymore because of family commitments
- There's no-one to guide the group if it's placed out in the big wide world – in these four walls there's safety
- Afraid of what people might say in a support group – at least here we have the counsellor to turn to if something comes up
- There's no support group for after hours
- After the PND program I did the African Dolls craft project at the centre
- Facebook is good for keeping in touch
- It would be a good idea to check in with people if the centre hasn't heard from them for a while
- I finished and moved on.

### 5.2.4 Outcomes for participants

Participants said the group gave them confidence, normality, relief, support, reassurance and made comments such as:

- I can have a bad day but will never go back to where I was before
- My husband noticed the difference – I still have off days but I'm dealing with issues better
- Meeting each other in the group – we've stayed friends and have a friend from another group
- Friendship from the group – I see some of the girls regularly
- Knowing I'm not the only one – before I thought I was batty
- Able to say 'no'
- Able to say don't 'should' on me!
- I don't feel consumed by problems in my life and the challenges of being a mum. I'm more in control and able to cope. Others have definitely noticed the change in me and comment on it
- It helped me to stop thinking and get stuff onto the table and deal with it. It changed my train of thought
- I've become a crèche worker and coordinator of playgroups.
- I got my life back.

### 5.2.5 Would you recommend MWHCP to a friend and if so, what feedback would they offer?

All participants said they would recommend the PND program at MWHCP to a friend and would tell their friends about the good friendship you form at a hard time in your life, that it's a good support group, that they've experienced it and are doing better.

Some examples of what participants said:

- There needs to be much greater awareness
- We'd tell our friends – and we're already telling mums at playgroup
- It's an opportunity to meet other mothers in a similar position in a comfortable setting. If you feel you need extra support it's definitely what they provide
- I'm grateful I did it
- I got a lot out of it
- I have experience of it (but I'm still not telling husband)
- MWHCP is a nice place - friendly and I could bring my daughter and they cope

Some examples of what participants said (continued):

- It's a really helpful, friendly place. The people are really good
- Come to MWHCP – see the program
- Get on the mailing list – they'll post out the programs
- It's easy to get to – and local
- I've told other people about individual counselling – it's a good way to start – it's less scary being in a group – a group is another step
- I could have my baby daughter in the room with me when I went to counselling
- It's a very safe place, there's no judgment, other services and classes are available – there are lots of things that can get you out of the hole. Some of the other activities are craft, tai chi, belly-dancing, mums and bubs exercises with baby massage, budgeting and food, self awareness ('I've grown in confidence in leaps and bounds')

### 5.2.6 Some other issues raised

#### Medication

- The GP was only about medication
- Medication is a GP thing
- PND is like a wound – medication stops the bleeding
- We had a brief session on medication to help us to understand the combination of medication and CBT and counselling
- Talking about anti-depressants was good. 'I'm still on anti-depressant – to know it's OK to take medication. The family and others don't get it'
- 'I'm on medication and scared to come off it'
- 'I'm on medication now and after 2 months my child is toilet trained.

#### Support for men

- My husband doesn't believe in PND
- There's a need for more support and information for men
- One joint counselling session to explain to your husband what PND is would be a good idea – perhaps tie in with a male counsellor? 'My husband is at a loss'
- Adjustment for men just as much as for women
- Men's Health needs to be addressed – men are alienated and don't have the tools
- There could be a Men's Health Centre where it's safe for men to talk in a group

Suggestions for promoting the PND program

- Advertisements in local paper
- Prenatal classes at Swan District Hospital – information about what might happen
- Information at all maternity hospitals including KEMH – counsellors there didn't know about the PND program
- Pamphlets for GPs and clinic sisters
- On-Line information

The people who participated in focus groups and telephone interviews identified the following factors that were important to them and the success of the PND service provided by MWHCP.

- The place where the service was delivered
- The people
  - The staff generally
  - The counsellor/s
- The program
  - Structure and organisation
  - Tools, reading material and handouts
  - Opportunity for partners to participate
  - Cost – affordability
  - Availability of the onsite crèche
  - The PND Program timing and length
  - Availability of follow up and support.

Participants identified personal outcomes such as gaining confidence, normality, relief, support, reassurance, friendships, becoming more in control, assertive and understanding that they were not 'the only one' and no longer feeling consumed by problems and the challenges of motherhood.

The project found that:

- the service activity met MWHCP's internal standards, and for the individual women from across the East Metropolitan region who participated, the outcomes sought by and for them had been achieved
- feedback from participants in the project indicated that the service delivered by MWHCP reflected the organisation's commitment to the principle of social inclusion
- participants in the project provided feedback that the following outcomes had been achieved or partly achieved:
  - to minimise personal anxiety, stress and depression and feelings of helplessness associated with the birth of a child and early parenting and changed life circumstances
  - to have 'meaningful others' understand the challenges, changing life circumstances and feelings associated with the perinatal experience
  - to be and be seen as a well functioning adult and parent
  - to have opportunities to be included in social networks and social activities, and that outcomes not achieved in full for all participants reflected community attitude to and understanding of, factors external to the individual participant
- the service activity met external standards such as those defined by *beyondblue* and the Western Australian Mental Health Commission, including being woman centred and based in the community.

Some other issues identified were that:

- women found out and came to the perinatal mental health service at MWHCP via a number of pathways which is important to understand given that awareness, understanding and acceptance of the need to access information, support and/or therapeutic services can be a significant barrier for women experiencing perinatal mental health issues
- there remains a stigma or perceived stigma associated with perinatal stress, anxiety and depression
- the level of awareness and understanding about PND among the partners of the women who participated in the project is limited as are the opportunities available for men to participate in programs that deal with PND.

## 6. FINDINGS

6.1 Did the service activity meet MWHCP's internal standards and achieve the outcomes sought by and for individual women?

| **Values:**<br>**Midland Women's Health Care Place believes in the right of people to:** | **Question:**<br>**Were these values reflected in feedback from participants?** |
|---|---|
| be valued as individuals | Yes |
| make choices in their own lives | Yes |
| dignity, respect, privacy and confidentiality | Yes |
| access services on a non-discriminatory basis | Yes |
| safe, comfortable and reliable services | Yes |
| accountable and responsive services | Yes |

| **Principle:**<br>**MWHCP believes in the principle of inclusion and is committed to:** | **Question:**<br>**Were the principle and social commitment reflected in feedback from participants?** |
|---|---|
| providing friendly, responsive, evidence-based services | Yes |
| respecting and valuing diversity | Yes |
| achieving high professional standards | Yes |
| teamwork, productive partnerships and collaboration | Yes (Teamwork) |
| accountability and transparency | Yes |
| providing services designed to provide a holistic approach to overall health incorporating all aspects of a woman's life and health over the lifespan, including emotional health, education, exercise, family, work and community inclusion. | Yes |

6.1 Did the service activity meet MWHCP's internal standards and achieve the outcomes sought by and for individual women? (continued)

| **Expected outcomes for clients participating in the service activities were:** | **Question: Did all or some of the participants provide feedback that this outcome had been achieved for them?** |
|---|---|
| To minimise personal anxiety, stress and depression and feelings of helplessness associated with the birth of a child and early parenting and changed life circumstances | Yes |
| To have 'meaningful others' understand the changing life circumstances and feelings associated with the perinatal experience | Yes for most, but not all challenges, participants eg not all family members understood PND |
| To be and be seen as a well functioning adult and parent | Generally yes |
| To have opportunities to be included in social networks and social activities. | Yes |

| **Expected organisational outcome:** | **Question: Was the organisational outcome achieved?** |
|---|---|
| Information and learning from the project will inform the development of the MWHCP 2012-2017 Strategic Plan | Yes - The values, principles, philosophy articulated in the strategic plan reflect information and learning from the project. The target group, core services, objectives and activities including monitoring and evaluation in the strategic plan are also consistent with the findings of the project. |

## 6.2 Did the service activity meet external standards, for example, as defined by *beyondblue* and the Western Australian Mental Health Commission

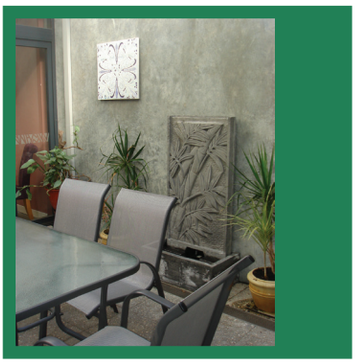
The following are among the key elements of quality perinatal mental health programs identified in the documents referred to in 3.3 and 3.4 above. Of particular relevance are some of the *beyondblue* guidelines.

- Professionals trained in woman-centred communication skills and psychosocial assessment
- Use of EPDS as a component of assessment in the prenatal and antenatal period
- Cognitive behavior therapy for women with mild to moderate post natal depression
- Assessing the mother-infant interaction in the postnatal period
- Support for emotional health and well-being in the perinatal period
- Locally relevant strategies
- Involvement of members of women's support network
- Psychoeducation for women and, where appropriate, their significant other(s) including discussion of mental health and provision of educational material
- Woman centred, empathic, non directive communication

| OVERVIEW OF SIGNIFICANT ELEMENTS IN MWHCP SERVICE ACTIVITY IDENTIFIED AND VALUED BY PARTICIPANTS | | EXTERNALLY IDENTIFIED QUALITY FACTORS |
|---|---|---|
| **PLACE** | | |
| Accessibility | Local, in the community | Yes |
| Physical environment | Welcoming | |
| | Non threatening | |
| | Safe | |
| | Pleasant | Yes |
| Human environment | Non judgmental | |
| | Friendly | |
| | Welcoming | |
| | Responsive | |
| | Safe | Yes |
| **PEOPLE** | | |
| Professional skills - assessment | Skilled | |
| | Knowledgeable | Yes |
| Professional skills - delivery | Knowledgeable | |
| | Skilled | |
| | Tailored to needs of individual women and group dynamics | Yes |
| Therapeutic relationship | Trusting | |
| | Confidential | |
| | Empowering | |
| | Challenging/thought provoking | |
| | Fun | Yes |
| **PROGRAM** | | |
| Length | Number of sessions | Yes (most) |
| | Individual support if needed | Yes |
| | Follow up | Some |
| Focus | Woman-centred | |
| | Affordable | |
| | Secure | |
| | Tailored to individual needs and group dynamics | |
| | Information | |
| | Collaborative | Yes |
| Mode of delivery | Individual counselling | |
| | Group programs | Yes |
| Breadth | Partners' program | |
| | Crèche | |
| | Complementary activities and programs | Yes |
| Social inclusion | Range of services and activities available and accessible | Yes |

### 6.3 Some issues identified

- Women found out and came to the perinatal mental health service at MWHCP via a number of pathways which is important to understand given that awareness, understanding and acceptance of the need to access information, support and/or therapeutic services can be a significant barrier for women experiencing perinatal mental health issues.
- There remains a stigma or perceived stigma associated with perinatal stress, anxiety and depression.
- The level of awareness and understanding about PND among the partners of the women who participated in the project is limited as are the opportunities available for men to participate in programs that deal with PND for their partners and themselves.



## 7. CONCLUSION

- The important 'high level' elements identified in this project were:
- the place where the service activity took place
- the people who interacted with participants (including professional counsellors providing the service directly as well as all other staff), and
- all aspects of program design and delivery and appropriateness for both individual participants and the group.

The review suggests that measurement of outcomes of PND programs such as those delivered by MWHCP should include:

- pre and post quantitative data collected through instruments such as the EPDS and/or other relevant reliable validated instruments
- qualitative data collected through focus groups and interviews. Interviews can be conducted face to face or by telephone
- a short follow-up telephone interview three months after completion of a program.

It is considered likely that the data collected through personal contact with participants will provide a richer source of information than data collected electronically and that this will help to inform a better understanding of the key factors that contribute to the most positive outcomes.

Adoption of a rigorous approach to collection of data using standardised data collection instruments and a standardised procedure will advance knowledge in this important area of service delivery.

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"It made me realise I was **not the only one**"

"I don't feel consumed by problems in my life and the **challenges of being a mum.** I'm more in control and **able to cope**"

"I'm **afraid I'll have my child taken away** if people know I'm depressed. If something happens at school I'd be worried if I say anything that they will take the kids away"

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