

Australasian Marcé Society for Perinatal Mental Health 2015 Conference

SOS: Stresses, Outcomes, Solutions: working in perinatal mental health

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PROCEEDINGS



The
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Friday 23 October 2015

1A Screening

Evidence-based practice in screening psychosocial assessment and management

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Background: Pertinent issues are currently being debated internationally to guide those involved in active identification of perinatal depression and anxiety. Aims: In this paper, current issues in identifying perinatal depression will be reviewed. Methods: The purpose of screening will be defined and a minimum set of elements necessary in a perinatal depression screening program will be described, including the important distinction between screening tests and a screening program. We describe a current challenge: what would be needed to make screening programs more viable? Results: There exists a tension between the limited evidence for the clinical efficacy of perinatal depression screening and the general consensus that early identification is paramount. The balancing of benefits and potential harms, the utility of depression and anxiety screening tools, issues of broader assessment, diagnosis, treatment, and pathways to care, adjunctive assessment of infants and fathers, evolving international guidelines, health economic issues, professional training and the prospects for the use of information technology in perinatal screening will be summarized. Conclusion: These issues have been expanded in a new book and several recent publications. The National Perinatal Depression Initiative in Australia is proving to be an international leader in the identification of perinatal depression. However, there remain challenges in implementation and increasing treatment rates. Further research regarding the effectiveness of screening in reducing morbidity is necessary. We present a summary of current opinion on how to best guide practitioners in the perinatal mental health field given the current evidence base.

Implementing brief universal screening for depression, anxiety and other emotional difficulties in a maternity hospital setting

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Despite current guidelines recommending universal antenatal screening for depression and anxiety using the Edinburgh Postnatal Depression Scale (EPDS), lack of time for administration makes this impractical in a busy metropolitan hospital. The Perinatal Emotional Health Program (PEHP) at Sunshine Hospital implemented two brief measures (Patient Health Questionnaire-2, Matthey Generic Mood Questions) over 15 months as an alternative to the EPDS. Patients were offered a referral to PEHP mental health team for further assessment if they screened positive. Midwives were trained to use the tools, provided onsite support and surveyed to gather feedback. Midwives report the tools as clinically useful, easy to administer and interpret, although time pressure was still reported as an issue. Of completed screening assessments (N = 2750), 15% (n = 400) were positive for symptoms of depression, anxiety and/or of being unable to cope on either one or both measures. Of those women subsequently assessed by PEHP mental health clinicians at a later time point (n=124), 90% received a psychiatric diagnosis. Seventy-one percent scored in the moderate – extremely severe range on the self-report Depression, Anxiety and Stress Scale-21 in at least one symptom area or >13 on the self-report EPDS. Reasons for patients not taking up a full assessment appointment after screening positive (70%) are unknown. These findings suggest the application of brief tools can act as a useful and practical first step to screening in busy settings. Despite a high proportion of women not following through with a full assessment after screening positive, those who did were very much in need of help. In order to further address time challenges, digital screening could be trialled in waiting rooms, to provide automated tailored information for patients and staff with referral pathways.

A comparison of two brief screening measures for antenatal depression, anxiety and other emotional difficulties in a maternity hospital setting

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The validated Patient Health Questionnaire-2 (PHQ-2), and the newer 2-item Matthey Generic Mood Question (MGMQ), are brief mood screening tools assessing how a person has felt over the past 2 weeks. While the PHQ-2 screens only for depression, the MGMQ screens for a wider range of negative emotions (stress, anxiety, unhappiness, or difficulty coping). The PHQ-2 determines possible caseness based upon how often a person has felt 'bothered' ('more than half the days' or more); whereas the MGMQ uses the severity of bother ('moderately bothered' or more). The Perinatal Emotional Health Program, conducted at Sunshine Hospital, Victoria, administered the two measures to 2330 pregnant women as part of routine antenatal care. The majority of screening was self-administered, with 25% administered verbally by a midwife. The data show that 38% of those scoring as 'possible cases' on the PHQ-2 (N=269) report nil or minimal bother on the MGMQ. And of the women on the PHQ-2 who do not meet caseness criteria (N = 2052), around 6% report they are feeling substantially bothered on the MGMQ. Examination also shows that 90% of 'possible cases' on the PHQ-2 (N=269) say 'Yes' or 'Possibly' to experiencing distress on the MGMQ, though 31% of these then say that the distress is not bothering them substantially. These findings indicate that if the degree of bother with emotions is considered a clinically important dimension in offering follow-up services, then the PHQ-2 will misclassify a large portion of women. The MGMQ, however, detects the majority of cases on the PHQ-2 but contextualises findings by asking about severity of bother. In addition, the MGMQ captures a wider range of negative emotions, making it overall a more clinically useful brief screening tool. These data will be discussed with particular emphasis on their clinical implications in routine screening.

Transient vs Enduring Distress – does trimester make a difference?

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A single high score on the Edinburgh Depression Scale (EDS) during pregnancy is often used to report on rates of possible depression in research studies. In addition, it is often used within clinical settings to make triage decisions regarding further mental health assessments. Recent work in Australia, however, showed that about 50% of high scoring women during the early part of their pregnancy no longer scored high on the EDS just a few weeks later – that is, they had 'transient' distress. The remaining 50% continued to score high, and thus had what is termed 'enduring distress'. The women with transient distress often had face-valid reasons for this, due to the early stage of their pregnancy. Reasons included morning sickness subsiding, receiving good news from specialist tests or ultra sounds in the intervening period, and feeling reassured at their initial visit that their pregnancy was progressing normally. But many of these transient reasons will no longer apply in the third trimester as the birth approaches – thus a high score on the EDS in the third trimester may be more indicative of enduring distress. This hypothesis was investigated in an Italian-Australian project, which consisted of two components: i) A survey of 116 perinatal health professionals, from four countries (Sweden, Italy, Finland and Australia), asking whether they expected the 50% transient finding in the early second trimester study would be replicated if women were screened in their mid-late third trimester; ii) A total of 86 women, in an Italian health service, completed the EDS on two occasions in their mid-late third trimester, a few weeks apart. Findings will be presented, with emphasis on the clinical implications for services screening women routinely with the EDS at different time points of their pregnancy.

The 'Emotional Wellbeing Program': psychosocial assessment and depression screening in a private hospital setting

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Background: Despite recommendations that universal psychosocial assessment, including depression screening, be integrated into routine antenatal care across Australia, implementation and research in the private sector has lagged. The aims of this study were to (1) describe the demographic, psychosocial and obstetric characteristics of women participating in the Gidget Foundation's 'Emotional Wellbeing Program' (EWP), an NIB-funded antenatal depression screening and psychosocial assessment program at Sydney's North Shore Private Hospital (NSPH), and (2) explore psychosocial and obstetric correlates of elevated Edinburgh Perinatal Depression Scale (EPDS) scores in this private obstetric sample.

Method: A consecutive series of 1000 pregnant women participating in the EWP at NSPH were recruited to participate in this cross-sectional study. Participants provided demographic information and consented for details from their EPDS and psychosocial assessment interview to be included in the study.

Results: The average maternal age was 33.9 years (range 22-49) and most women (71%) were primips. The cohort was socio-demographically advantaged with less than 1% being un-partnered, 90% having undergraduate/post-graduate tertiary qualifications and 63% reporting an annual family income >\$150,000. Depressive symptoms were also present in many cases, with 6% scoring ≥ 13 on the EPDS and 14% scoring 10-12. Obstetric issues were also common with 30% reporting difficulty falling pregnant and 18% conceiving using artificial reproductive techniques. The strongest independent predictors of EPDS score were history of depression ($\beta = 3.2, p < .05$), anticipated lack of practical support after the birth ($\beta = 3.1, p < .05$) and previous caesarean delivery ($\beta = 2.05, p < .05$).

Conclusion: Despite being socio-economically advantaged, depressive symptoms and psychosocial risk factors in this cohort were common. Psychosocial correlates of antenatal depressive symptoms in this study align with findings from previous studies, and the identified association between previous caesarean delivery and elevated EPDS scores adds to the literature about potential adverse impacts of caesareans.

What are the barriers to implementing psychosocial assessment in the private sector?

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Approximately 30-40% of obstetric women choose to deliver in the private sector⁴ in Australia. Compared to the public sector, women in the private sector are more likely to have an induction of labour, a caesarean section, an instrumental delivery and a longer postnatal stay. Obstetricians and midwives in the private sector note that the role of obstetricians in postnatal care is minimal.

Psychosocial assessment, including depression screening, as part of perinatal care has been deemed good practice in the national clinical guidelines for perinatal depression and anxiety. However, little is known about psychosocial assessment in the private hospital sector. The primary aim of this study was to establish what is known about such assessment for women who choose private obstetric/maternity and postnatal care, particularly the availability and appropriateness of referral pathways and barriers to implementation. The study included implementing psychosocial assessment as part of the booking-in process at a regional private hospital in NSW.

This presentation reports on the barriers encountered in introducing psychosocial assessment to the pilot site. Recommendations for how to identify and overcome some of these barriers will be presented, with the aim of facilitating the introduction of this assessment at other private hospitals.

Access to information on risks to maternal and infant health is considered a fundamental privilege of antenatal care. Routinely assessing and measuring psychosocial risks and mental disorders are essential activities in evaluating the need to provide appropriate and timely responses to identified risks, to reduce infant mortality, preterm births and low birth weight infants. The perinatal period provides a unique opportunity to identify and intervene in perinatal anxiety and depression, partner violence, substance use problems, unresolved loss and other traumatic history. There is an increasing move internationally to standardise and make routine the psychosocial assessment and depression screening of all pregnant women.

The EPDS for women and men in the perinatal period – some cautionary considerations

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The EPDS is the most well-established self-report mood measure to screen for possible depression in English-speaking women in the perinatal period. In addition it has been validated for use for women from many non-English speaking countries (eg., France, Italy, Nigeria, Malta, Germany, Saudi Arabia). In the last few years there have also been several studies validating it for fathers. Understandably it has become the instrument of choice within many screening programmes, and it is possible that it may also become the instrument of choice for screening men in the perinatal period. While it has unquestionably been an excellent instrument that has helped highlight the importance of maternal – and to a certain extent paternal - mental health over the past 25 years, we would like to discuss some of its limitations. Awareness of these is particularly important for clinical services considering its suitability for men, and for women and men from different cultural groups, across the perinatal period, as well as for researchers reporting on rates of possible depression or anxiety, or investigating risk factors for such mood disorders. These limitations include: i) exclusion of certain types of distress; ii) item ambiguity; iii) a high rate of false positives; iv) validation focus just on depression; v) questionable item suitability for men; vi) confounding respondents with transient distress and those with enduring distress; vii) multiple valid cut-off scores; viii) scoring difficulties. A brief discussion will also be given about alternative mood screening questions that overcome many of these limitations.

1B Fathers

An exploration of negative thoughts and fathering experiences in recent fathers

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The importance of positive and actively involved fathering is becoming well-established in parenting literature (Carlson, 2006; Astone & Peters, 2014). Warm, caring and engaged father-infant relations have demonstrated significant benefits for fathers, mothers and infants alike (Gere et al., 2013; Leahy-Warren, McCarthy, & Corcoran, 2012). However, very little is known about the psychological factors influencing paternal involvement. This study surveyed recent fathers ($n=361$) recruited through social media using well-established measure of depressive symptoms and parental self-efficacy, along with a researcher modified version of Hall and Wittkowski 's (2006) Postnatal Negative Thoughts Questionnaire (PNTQ) designed to investigate postnatal negative thoughts. Findings suggest negative thoughts, such as negotiating professional and family commitments, understanding infant communication and dissatisfaction with intimacy and sexual activity, are typical during the transition to fatherhood. An exploratory factor analysis of the modified PNTQ revealed a six factor model with good reliability, validity and internal consistency. The factors include remorse/frustration, interpersonal relationship, hopelessness, harmful, negativism and self-consciousness. To our knowledge, this is the first study that explicitly explores and provides information of paternal postnatal thoughts. Importantly, evidence suggests that a baseline of paternal postnatal negative thoughts may be functional and healthy in promoting a successful transition to fatherhood.

What do men who call the PANDA - Perinatal Anxiety & Depression Australia (PANDA) need?

Richard Fletcher

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In a 12 month period approximately 1,000 calls are received by PANDA from men who are seeking information or assistance with their own or their partner's distress. A sample of cases selected randomly from the case notes of PANDA counsellors was used to identify presenting issues and service outcomes. An a priori framework was developed to extract presenting issues, anxiety symptoms, underlying risk factors, relational vulnerabilities, service responses and intervention outcomes from the case notes. This presentation will give an account of the interchanges addressing the men's relationship with their infants and their partners and their anxieties and concerns. Lessons for professionals engaged with families over the perinatal period will be suggested.

Strategies for supporting the mental health of new fathers: The Healthy Dads project

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This paper will report on the results of recent *beyondblue* research into the mental health and wellbeing of new fathers. New fathers are at an increased risk of experiencing psychological distress, however, their distress is mostly unidentified and does not receive tailored support. In depth interviews and focus groups were conducted with fathers, mothers, couples and experts; and 1500 fathers throughout Australia were surveyed. Results identify the information and support needs of new fathers, perceptions of psychological distress and the barriers and facilitators of help seeking, and appropriate communication concepts for engagement. The results of this research will inform the development of specific campaigns to increase education and community awareness of perinatal mental health for fathers. The research will also lead to the development of projects applying best-practice in engaging new fathers, including pilot projects focused on managing stresses in the co-parenting relationship and using technology to reach fathers at heightened risk of psychological distress who may be harder to engage through traditional services. Information from this research has implications for professionals working with expecting and new parents to assist them in developing programs and services inclusive of the needs of fathers during the perinatal period.

Developing and testing the acceptability of text messages to support and influence new fathers in the perinatal period

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The perinatal period presents an important opportunity to help fathers develop positive and long-lasting relationships with their partners and their children. However, fathers are at higher risk of depression and anxiety during the transition to parenting and this has important implications for fathers, mothers and the social/emotional development of the parents' children. Fathers are often difficult to access, poorly linked to services and poorly equipped to identify their own psychological distress or provide support to effected partners. Mobile phone text messaging presents a cost effective and powerful way to access, influence, and link fathers to services. A text messaging project with over 360,000 parent users has reported that 75% of users found that text messages gave them important medical information and a recent RCT has found that text messaging was associated with hoped for changes in targeted health beliefs. Importantly for the present project, a study with disadvantage men has found that 88% responded to questions contained in health related text messages. These studies indicate that text messaging could be an effective way to access and influence fathers in the perinatal period. However, there are no clear guidelines on what issues should be addressed in these messages or what information should be contained in messages to fathers at this time. SMS4dads has worked with fathers, mothers, clinicians and other sources of evidence to develop and trial a range of text messages and the subject areas that these messages could address. This presentation will describe the process

of message development, the outcomes of this process and report on preliminary data concerning the acceptability of these messages for new fathers.

Factors associated with poor father-to-infant attachment at 6 months postpartum: a community study in Victoria

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Father-to-infant attachment is the emotional tie between a father and his infant. It is essential for the child's healthy growth and development. If it is not well established in early infancy, children are at risk of subsequent emotional and behavioral problems. The aim of this study was to identify factors associated with poor father-to-infant attachment. English-speaking men were recruited in six diverse local government areas in Victoria, Australia. Participants (n=270) completed computer-assisted telephone interviews at approximately 4 weeks and 6 months after the birth of the couple's first infant. Data were collected on demographic characteristics, unexpected pregnancy, mental health, quality of intimate partner relationship, and infant crying and fussing. The Parental Attachment Questionnaire (PAQ) was administered at 6 months postpartum. The outcome was "poor" father-to-infant attachment identified as PAQ scores in the bottom quartile. Controlling for relevant factors in logistic regression, quality of relationship with intimate partner was the factor most significantly associated with father-to-infant attachment. Men who experienced their partners as sensitive, kind and affectionate were less likely to have poor father-to-infant attachment. Men who reported that their partners were critical of the way they looked after the baby were > 2.5 times more likely to have poor father-to-infant attachment than men who reported that their partners never criticized their baby care. Although a father's own attachment style is likely to be reflected in his relationships with both intimate partner and infant, these results suggest that the quality of the intimate partner relationship may be a promising site for facilitating father-to-infant attachment. Routine primary care should focus on both parents in order to promote these interlinked relationships. Raising parents' awareness of the benefits to each family member of affirmation and affection and the adverse impact of criticism, may contribute to healthier family functioning and better outcomes for children.

Fathers' distress and parenting self-efficacy in the postnatal period, later parenting behaviour and children's emotional-behavioural functioning: longitudinal evidence from an Australian cohort

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Fathers' distress has been associated with emotional and behavioural outcomes for children in early childhood. The aim of this study was to explore the complex, long-term relationships between fathers' psychological distress and parenting self-efficacy in the postnatal period, later parenting behavior, and emotional-behavioural outcomes for children at age 8-9 years. Structural equation modelling with a large representative cohort of Australian father-child dyads ($N = 2,045$) indicated that high paternal distress and low parent self-efficacy in the postnatal period was associated with lower levels of parental warmth, higher levels of hostile and inconsistent parenting, and poorer child emotional-behavioural functioning at 8-9 years. Findings underscore the important contribution of fathers' postnatal mental health to later parenting behaviour and child outcomes. Implications for policy and practice focused on improving mental health and parenting support to fathers in the early parenting period are discussed.

1C Perinatal Therapy Services 1

Recognising and disrupting gender-based stereotypes: promoting a comprehensive biopsychosocial approach to perinatal clinical practice

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Stereotypes are over-simplified generalisations about the characteristics of a group of people, which sometimes have positive consequences but are frequently pejorative. Most people adhere to some form of stereotyped attitude that may exert adverse effects on others but remains outside their own conscious awareness. Stereotypes based on gender can exert a powerful impact on women's sense of themselves, their worth and their confidence, especially when they are communicated by authority figures such as clinicians. By becoming aware of their own attitudes, clinicians can choose to reinforce or disrupt these stereotypes by their choice of language, by understanding how they assess their priorities and by examining how they interpret disclosures.

In the perinatal period, pervasive gender-based stereotypes presume that women who are pregnant or have recently given birth are prone to mental illness, that infant care is instinctive in women rather than a set of learned skills, that caring for an infant and managing a household are not work, and that unsettled infant behaviour is caused by a woman's poor emotional regulation. These attitudes contribute to women's feelings of guilt, inadequacy and anxiety about their performance of motherhood.

In this presentation, 'gender-competence' will be described, in which unconscious stereotyped attitudes are recognised, and gendered risks are identified, challenged and addressed. The perinatal period for women can then be conceptualised as characterised by multiple losses of income, independence and autonomy, substantial increases in unpaid household work, and severe sleep disruption and fatigue associated with managing unsettled infant behaviour. Unrecognised loss and profound fatigue contribute to depression and anxiety and all of these risks accrue disproportionately to women compared with men.

Clinicians are in an influential position to disrupt gender based stereotypes, act as agents for social change and promote women's mental health. Gender competent clinicians contribute to a comprehensive biopsychosocial approach to care.

Utilisation of health services for mental health during the postpartum period

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Mental health problems are common for women during the postpartum period. Yet, we know relatively little about women's use of health services for their mental health at this time. The current study reports findings from the Living with a Young Baby Survey (LYBS), an Australian community-focused study of 1093 postpartum women recruited online during 2014. The findings show that two thirds (60.8%) of the women had utilised health services for their mental health. The most common sources of help were a GP (18.2%) or the Internet (14.8%), followed by a psychologist (7.8%). Engaging services was clearly related to symptom severity, such that 93.5% of those with very high psychological distress (K-10) had sought help, compared to 69.3% of those with medium-high distress and 45.4% of those with low (or no) distress. The main reasons distressed women did not seek help included: they didn't think they had a serious mental health problem, they preferred self-management, or they were afraid what people might think. The results suggest many women are engaged with health services for their mental health during the post-natal period, particularly women with very high psychological distress. The findings support previous studies demonstrating the importance of GPs in the management of mental health, and emphasise the widespread use of the Internet to seek mental health information. Continued efforts are needed to communicate accurate, information about postnatal mental health as many women appear to be actively seeking information and assistance.

Five years on: A unique view of front line care from PANDA's National Perinatal Depression

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Since 2010 PANDA (Perinatal Anxiety & Depression Australia) has run the only specialised Australia-wide perinatal depression and anxiety support line. The large volume of calls through the service has provided a unique understanding of the experience of perinatal mental illness faced by families across Australia. An independent review of the first three years of the service, undertaken by the Judith Lumley Centre, in addition to service data from the subsequent 2 years, documents important information. PANDA's biopsychosocial assessment framework together with active risk assessment provides rich data. PANDA's service model of optional follow up calls provides insight into the behaviour and experiences of callers in the period after their initial helpline contact. From the 2013 data the most common presenting condition among callers, was postnatal depression/anxiety (50%), followed by 'transition difficulties' (12%), and antenatal depression/anxiety (10%). The two most common interventions PANDA provided to the majority of callers during their initial call were support (94%) and information (76%). The majority of callers received at least one referral (80%), and 40% received three or more referrals. This presentation will build on the 2013 results and review data resulting from more than 45,000 inward and outgoing calls. The presentation will review the increased reporting of presence or risk of family violence since the introduction of this risk category in 2012. It will also review calls to PANDA from men seeking support for their partners and those seeking support for their own experience of perinatal depression or anxiety. The presentation will review levels of risk identified through assessment (self harm, suicide and harm to baby) and the extent of child protection reports, ambulance or mental health crisis team interventions. The presentation will also consider the implications of the data for future service delivery and emphasize the need for comprehensive screening and support services.

A model of care: Providing future solutions in perinatal mental health

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The Raphael Service Blacktown NSW was established in response to the ever increasing demand for affordable, equitable services for woman (across all cultures) and their families, experiencing perinatal anxiety and depression and other related mood disorders. This unique, community based specialist secondary level service provides early identification and intervention from pre-conception up until 4 yrs of age at no cost to the client. The highly credentialed multidisciplinary team provide interventions including medication, individual psychotherapy, couple therapy, groups and parent-infant therapy.

Women accessing the service undergo a comprehensive mental health assessment and are assigned their individual therapist. Providing a safe and secure environment is essential in developing a trusting therapeutic relationship. Care is provided in a collaborative manner with all those involved as well as partners and significant others. It includes preparing care plans for the birth, liaising with referring agents and advocating for additional high level services such as in-home care. Women and their families continue with the service until their treatment is completed or they are ready to "graduate".

Referral pathways have been established across a broad range of private and public sector services including maternity units, child and family health, mental health (inpatient and outpatient), GP's, obstetricians, paediatricians, psychiatrists and NGO's etc. Undertaking extensive networking and providing education and training to health professionals has been instrumental in developing this coordinated approach to care. The Raphael Service Blacktown also provides outreach clinics within metropolitan and rural areas through partnerships with external agencies. This model of care reaches out to vulnerable and "at risk" families who otherwise may go undetected. It is anticipated that current research being undertaken by the Raphael Service Blacktown is likely to inform the future expansion of perinatal and infant mental health services and provide solutions for those working in the field.

Managing pregnancy-related stress: Reported impact of the Mindfulness in Pregnancy Program (MiPP) and the Pregnancy Support Program (PSP)

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Background: Prenatal stress appears to be associated with perinatal anxiety and depression. Mindfulness training offers a non-invasive, non-pharmacological, evidence-based intervention for managing stress. Few studies have been conducted on the effects of mindfulness with pregnant women, and none have used a face-to-face active control group. This paper reports the qualitative findings of a pilot randomised controlled trial (RCT).

Methods: The Mindfulness in Pregnancy Program (MiPP) and the Pregnancy Support Program (PSP) were conducted for 2-hours, weekly, for 8-weeks. Data collection included summative program evaluation (MiPP n=9; PSP n=11), facilitator field notes (n=2), MiPP daily records (n=8), and follow up telephone interviews (MiPP n=9; PSP n=11). Content and thematic analysis was conducted.

Results: Seventeen women (73.9%) attended 4 or more sessions (MiPP n=8; PSP n=9). Women in the MiPP reported learning how to manage stressors, feelings of fear and anxiety and how to be more present. Women in the PSP reported learning how to calm down when stressed, increased confidence, and valued connecting with other participants. Identified impact themes for the MiPP included: *managing stress, become aware, accepting, having options and choices, and connecting and being compassionate*. Impact themes for the PSP included: *managing stress, increasing confidence, connecting, focussing, being accepted and preparing*. We noted that many pregnant women work and experience tiredness which impacts on their entry into, and completion of wellbeing programs. Once they commence however, they value such programs.

Conclusions: While both programs decreased stress, women in the MiPP accepted their emotions, body sensations and situations, 'as they are' resulting in increased wellbeing. Women in the PSP gained their acceptance primarily from external sources, such as others in the program. Further research would include longitudinal RCTs, with an active control group and cost-benefit analysis.

1D Mother-Baby Unit I: Stress, Outcomes and Creative Solutions in Mother Baby Units

Examining the design and therapeutic milieu of a purpose built mental health unit: with specific emphasis on a mother-baby facility

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This paper presents the findings of the first part of our study into the efficacy on a newly designed acute mental health unit for mothers and babies. This initial stage of a larger project draws upon 30 hours of observational ethnography, which examines how clients, families and staff respond to the designed spaces. We will present the major themes that emerge from the movement and use of specific spaces. We will also discuss the balance between functionality and aesthetics of all spaces observed and comment on their ability to facilitate interactions between staff and clients. Our discussion will include what a therapeutic environment might mean in the discourses of architectural design and post natal mental health care.

This study builds upon a previous study into the purpose built design of open and closed adult mental health wards in a large public hospital in Australia. Here we broaden the research to include mothers, babies and families where

design demands are arguably more complex and varied. The overall aim of the project is to provide information to designers, clinicians, mental health clients and government on the success and efficacy of designs for purpose built

mental health units. This short paper aims to provide a work in progress account of the design functionality in order to receive feedback and move forward to the next stage of the project which includes personal interviews with staff and architects.

Outcomes for mothers and their babies admitted to a mother-baby unit with postpartum psychosis: a retrospective audit of all cases 2012-2014

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Postpartum psychosis is a severe and debilitating condition that is life-threatening to both mother and baby, and may have substantial effects on the entire family system. Fortunately it is also readily responsive to specialised treatment, usually warranting immediate inpatient care. The research literature concerning postpartum psychosis, particularly in the Australian context, is scant. Infant outcomes have received very little attention to date. Helen Mayo House (HMH) is the only facility in South Australia where mothers experiencing severe mental illness can be admitted with their infants. Assuring optimal treatment for dyads affected by postpartum psychosis is therefore a high priority for our service. The aims of this study are to investigate the nature and severity of symptoms, the types of treatments received, and the associated outcomes for mothers with postpartum psychosis and their babies who receive an admission to HMH. With ethics approval we are therefore carrying out a systematic audit of the individual medical records of all identified patients, both mother and baby, admitted with the diagnosis during the period between 1st January 2012 and 31st December 2014. Postpartum psychosis is defined here as any psychotic and/or manic episode with onset within 6 weeks of parturition, where there is no history of non-postpartum episodes. Data to be extracted will include features at onset, medications used, duration of inpatient treatment, time to remission, infant health and factors relating to maternal caregiving and the mother-infant relationship. Data will be presented descriptively, and scrutinised for trends and themes. Comparison with published European cohorts may highlight differences specific to Australia. We anticipate that the findings will improve our understanding of the women and babies referred to our unit, form the basis of a larger prospective study, and inform the development of local best-practice guidelines.

Birth, Breasts and Beyond: Traumatic birth, breastfeeding rates and the impact on post-natal mental health. A retrospective case note audit.

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Research demonstrates that feeling traumatized by a birthing experience is not uncommon and that trauma symptoms can develop. A history of previous trauma predisposes women to further experience trauma or distress during the perinatal period. Women who have experienced child sexual abuse are more likely to experience childbirth as traumatic. Does having a difficult or traumatic birth increase a woman's risk of post-natal mental health difficulties requiring inpatient care? Is a woman less likely to breastfeed if she experienced childbirth as traumatic? These questions and others were being raised during clinical case discussion in our mother baby inpatient psychiatric unit, Helen Mayo House (HMH). To begin to address such questions, a retrospective case note audit was done. The audit examined consecutive admissions of mothers and their babies to HMH. Mode of birth, complications, perceived birth trauma, mental health diagnosis and how the baby was fed were reviewed. This paper will present findings of the audit. These results will be compared to rates of difficult or traumatic births and to breastfeeding rates in the general population. Reflections on what these findings may mean for our work will be presented.

Peek-a-Boo Clinic: Infant-parent therapy after mother-baby unit admission to improve relationship outcomes

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Mothers and babies who experience an admission to a Mother Baby Unit (MBU) constitute a unique and heterogeneous population. Such mothers typically continue to experience residual symptoms of their mental illness for some time after discharge. It is clear from decades of research that such symptoms can have a large impact on the quality of their relationship with their infants and on the infant's attachment and emotional development. The severity of symptoms during the MBU stay can limit these mothers' participation in infant-parent therapy, and it can then be difficult to source therapy after discharge, due to ongoing illness and adverse social circumstances. Many of these mothers decline referral to unfamiliar services, but are accepting of treatment at the MBU site. For these reasons, a time-limited (4-8 sessions) outpatient infant-parent therapy clinic for selected dyads following discharge from our MBU was established in 2014. The therapeutic approach aims to boost parental reflective function and increase interactions that provide secure emotional experiences for the infant. All sessions are filmed and some sequences of film are used in session to facilitate the mother's reflections about herself and her baby. Two therapists work in the room and most sessions are viewed through a one-way screen by the other therapists. Measures of mood and attachment are completed at commencement and cessation. Many of these mothers have personal childhood experience of trauma, and their babies often exhibit markers of disorganised attachment. We are therefore considering use of the AMBIANCE (Atypical Maternal Behaviour Instrument for Assessment and Classification) scale to better define problematic interactions and to guide the therapeutic focus. We will present an overview of the clinic's genesis and progress, as well as a discussion of the themes, challenges, and proposed future directions. Illustrative video footage of the dyads will be shown.

Experiences of motherhood, mental illness, and community service use after discharge from a mother-baby unit.

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Women admitted to a mother-baby unit (MBU) during the postnatal period often experience severe mental illnesses that significantly impact their functioning and wellbeing. Despite intensive and tailored treatment within these facilities many women continue to experience residual symptoms and difficulties after discharge and require ongoing support in the community. Although accessing these services is considered integral to increasing their functioning and wellbeing, many studies have found that there is low engagement in these services. In order to explore the experiences of women following discharge from a MBU and their use of services and supports in the community semi-structured interviews were conducted with eight women, who had been discharged from a MBU. These interviews were analysed using Interpretive Phenomenological Analysis to gain a comprehensive understanding of the lived experiences of these women. The themes identified, related to the research question, focused on the transition home as a significant event, how life in the community as a mother with a mental illness is experienced, the process of service use in the community, and the complex decision-making involved in this use. Through an exploration of these themes we are able to provide a greater insight into women's experiences of life following discharge and their service use practices. Future directions in research are also proposed to encourage further exploration into the way in which services in the community are presented, recommended, and chosen by both MBU and the women themselves.

Retrospective review of physical factors contributing to vulnerability in infants admitted to the Mothers and Babies Service Christchurch.

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Introduction: The Christchurch Mothers and Babies Unit is a South Island regional service offering inpatient and outpatient multidisciplinary support to mothers with mental health issues in the first year of their baby's life. In

September 2013 a liaison paediatrician was appointed to the service. The infants of mothers admitted to this service often have multiple vulnerability factors at a critical time for physical, social/emotional and cognitive development. The service is currently developing a framework for identifying the vulnerability and resilience factors for this group of infants. As part of this project we have collected data on our in-patient

Objective: To review factors in the antenatal period and first year of life that may affect infant mental health in a population of infants admitted to a regional Mothers and Babies Service.

Methods: Participants – mother-infant dyads admitted to Christchurch Mothers and Babies Service between September 1 2013 and 1 March 2015.

Study type –retrospective review

Data collected by retrospective review of clinical notes.

Data variables:

MOTHER	INFANT
Psychiatric diagnoses	Gender
Ethnicity	Age at admission
Age	
Proxy for socioeconomic status	Gestation at delivery
Household structure – one parent alone	Inutero complications
Mother without current partner	Delivery type
Household structure - two parents alone	Admitted to neonatal unit
Household structure- Parent(s) with extended family	Z score weight, length, HC on admission
Household structure - Parent(s) living with non-kin	Breastfeeding on admission
Number of other children	If no longer breastfeeding at what age was this stopped?
Involvement with mental health services prior to this pregnancy	Breastfeeding on discharge (exclusive/mixed)
Referral service	Formula feeding on admission
Region of origin (eg Living in Canterbury or regional referral)	Documented sleep difficulties
Documented concern regarding mother-infant attachment	Documented feeding difficulties
Smoked during pregnancy	Inutero exposure to psychotropic medications
Current Smoker	In-utero exposure to alcohol
History of alcohol abuse	Diagnosis of neonatal withdrawal syndrome
History of drug abuse	On anti-reflux medications on admission
Current concerns about family violence	CYFS involvement
Duration of admission	Discharged to the care of someone other than their parents
Admitted under mental health act	Developmental concerns raised during admission
	Living in a smoke-free household
	Cobedding with adult (not in own sleep space)
	Mostly sleeping on their back
	Mostly sleeping on their side

	Mostly sleeping prone
	Involved with a paediatrician
	Enrolled in early intervention service
	Enrolled in early childhood education
	Immunisation status(unimmunised/partially immunised, fully immunised)
	Concern about infant-mother attachment

Results: TBA. These data will be presented alongside data from the Growing up in New Zealand Study for national context. The Growing Up in New Zealand Study is a longitudinal study tracking the development of approximately

7000 children from before birth until they are adults. Reports are currently available for the first two years of these children's lives.

Discussion: The factors contributing to vulnerability in the first year of life will be discussed. The implications of our centre results in terms of future infant mental health service development will be discussed.

1E Song and movement symposium

The Acorn Initiative: Working on the intersubjective space of the parent - infant dyad

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Acorn is a model of intervention for the early parent - infant relationship. The Acorn groups support parents of children aged birth to three years who have diagnosed mental health difficulties by fostering their ability to accurately and appropriately read, interpret and respond to their infant's cues.

Acorn is designed to focus on the intersubjective space of the parent - infant dyad, through experiences of shared play, music and movement and time for reflection. The intent is to provide a therapeutic environment whereby "... every utterance of pleasure or joyfulness can give some guidance to feed the dyad with feelings of self-efficacy and trust" (M. Van Puyvelde et al., 2014)

The Acorn program outcomes relating to the parent - infant relationship include:

- To foster the enhancement of parent competencies
- To enhance parent coping skills, resilience and self-efficacy (empowerment)
- Expand and strengthen Social/Community supports (Build Social Connectedness/ Social Capital)
- To strengthen (and sustain) security of attachment for parents in their relationship with their infant
- To enhance family relationships, independence and resilience
- To strengthen and expand inter-sectoral partnerships in order to facilitate the recruitment, engagement and support of targeted parents engaging with the evolving Acorn program

Reported outcomes for mothers who have attended Acorn include experiencing more joy in their relationship with their child, more joy in their parenting role and sensing they are not alone in their experience of mental health and relationship struggles.

This experiential and interactive workshop will provide an overview of what is unique about the Acorn model. The workshop will explore how each of the three interpersonal processes of Dance-Play, Journaling and the reflections inspired by the content of each week's Therapeutic Letter functions to scaffold attunement to improve attachment.

2A At the Coal Face

Providing interdisciplinary care for women with mental health needs – midwives' experiences of specialised antenatal clinics as part of a perinatal psychiatry service

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Mental illness, such as depression, affects 1 in 5 women during the perinatal period. It can lead to inadequate nutrition, substance abuse and poor antenatal clinic attendance. There exists many barriers to effective treatment of a patient suffering from mental illness during pregnancy, and have shown to include poor recognition of symptoms by care-givers, stigma, limited or absent health provider skills in the area of mental health and an overall lack of mental health providers.

The Perinatal Emotional Health Program (PEHP) was established as a pilot program at Sunshine Hospital, Victoria Australia. It was designed to serve as a specialist perinatal psychiatry service staffed with psychiatrist, psychiatric registrar and mental health clinicians able to provide psychological treatment. Patients could be referred by any staff from within Sunshine Hospital and from Maternal Child Health Nurses, GPs, Psychologists, Psychiatrists & local mental health services. A key component of the program was the establishment of dedicated PEHP midwife clinics. These clinics were staffed by midwives with an interest in mental health who had received additional training from PEHP. These clinics enabled women with complex mental health needs to see the same midwife during their antenatal care. PEHP midwives were provided regular supervision and access to a member of the PEHP team to discuss any concerns about patients.

This presentation aims to provide a discussion of the challenges faced by front line maternity staff and their experience working within a specialist perinatal psychiatry service. It will provide an insight into how to improve the integration of a new perinatal psychiatry service into existing midwifery services.

Group Antenatal care for young women

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Since May 2015, Centering Pregnancy Group Antenatal care has been offered to young women under 21 and their partners/support people at the Women's Children's Hospital. This presentation will talk about the successes and learnings of the facilitators in their work with young women.

Psychological consequences of traumatic vaginal birth

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Somatic trauma to levator ani and external anal sphincter muscles after vaginal birth trauma are major etiological factors for fecal incontinence and pelvic organ prolapse, affecting 20-30% of primiparae. Such injuries are likely to be associated with psychological trauma and even post-traumatic stress disorder (PTSD) due to overlap in risk factors and somatic consequences. Aims of this research were to examine associations between somatic and psychological trauma after low-risk vaginal birth at term. 40 primiparous women with known major pelvic floor trauma, identified in

two perinatal imaging studies were analyzed. Mothers were approached 1-4 years postpartum. Telephone/face-to-face interviews were collected with a focus on interpreting personal experiences. The interviewer was a midwife with

extensive professional experience. Written consent was obtained prior to interview. Thematic, purposeful analysis was undertaken. The designed template comprised open-ended questions on antenatal, intrapartum and postpartum care. Duration of interviews was 35-40 minutes. Approval was obtained from local Human Research Ethics committee. Results identified 10 themes: inadequate antenatal education/ absent 'informed consent' causing poor preparedness for birth; nil information on potential morbidities; conflicting advice from clinicians before, during and after birth; partners traumatized by unexpected events; long term sexual dysfunction/relationship issues; nil postnatal assessment of injuries; multiple symptoms of pelvic floor dysfunction, including: urinary, fecal incontinence, prolapse, dyspareunia; 'putting up' with injuries; symptoms of PTSD: poor bonding, flashbacks, anxiety, dissociation, numbness, avoidance; dismissive reactions from staff regarding injuries/ PTSD.

Conclusions noted that major somatic pelvic floor trauma suffered during vaginal childbirth seems to be a marker for psychological trauma. Both forms of trauma provide major opportunities for practice improvement in maternity services worldwide. Mothers are likely to have reduced quality of life and psychological impacts that are more immediate. There is a great need to acknowledge women's concerns and provide optimal diagnostic and therapeutic services.

Child protection in the perinatal period: the value of home visiting nurses.

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Families referred into the Targeted Intervention Service (TIS) have undergone statutory investigation and child protection concerns have been substantiated. A decision has been made not to remove children and the TIS aims to address precipitating factors. Each family is allocated a case manager for 12 months, as well as access to the nurse. Susan and Lynn are pioneer clinical nurses in a field traditionally managed by social workers. The addition of nursing skills into case work, and in particular to families with babies, has changed the outcome of health and well-being for

many. Issues such as post-natal depression, failure to thrive, developmental delay, insecure attachment, poor home hygiene, exposure to drugs, alcohol and violence, can remain undetected in out of home health assessments. Regular home visiting uncover layers of disadvantage, providing more accurate health assessments and ensures the most authentic environment in which to implement strategies. The nurses can present multiple case studies demonstrating the process of change as a direct result of in home nursing intervention, while working in partnership with the allocated case manager and maintaining connection and collaboration with traditional health services.

2B Aboriginal families

Aboriginal women caring for Aboriginal women

Deanna Stuart-Butler

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This model of care for Aboriginal women caring for Aboriginal women is founded on the principles and success of the Anangu Bibi Birthing Program in Port Augusta, SA. This program has now expanded to Women's and Children's Hospital.

The model does 'break the mould' of convention in order to achieve excellence in maternity services for Aboriginal women. Within this model a team of Aboriginal Maternal and Infant Care (AMIC) workers, midwives, and other health professionals deliver high quality, culturally and clinically safe antenatal, birthing and post-natal care to Aboriginal women and their families. Mutual respect for individual role expertise is a critical aspect of the model. Within this team AMIC workers provide most of the primary health care. Continuity of a known care provider is paramount as is a primary health care focus

The Aboriginal Health Council of South Australia Inc (AHCSA) is engaged as a key project partner to guide the development of the AMIC workforce. There is a nationally accredited course that aligns to the qualified AMIC job role.

Aboriginal Family Birthing Programs network across SA with WCHN acting as a “hub” that provides expertise and support to other services. Reorientating health services to meet the needs of Aboriginal women is essential to improve engagement and better health outcomes. The program aims to provide holistic and culturally safe care to Aboriginal women and their families.

A scoping of current practice surrounding the screening, assessment and management of perinatal mental health across Australia's New Directions: Mothers and Baby Service Program.

Nicole Highet, Andrea Goddard

COPE: Centre of Perinatal Excellence, VIC

Whilst there have been significant developments under the NPDI in the public sector of the general population, less is known about its application for the Aboriginal and Torres Strait Islander population specifically. In response, this Mapping Project sought to scope the degree to which screening and assessment is being undertaken across New Directions Mothers and Babies Services. Through deploying both qualitative and quantitative methodologies, the Project identifies barriers and enablers to the provision of screening, assessment and culturally appropriate care. The Project makes a series of recommendations for the more comprehensive and successful integration of practice under Australia's NPDI.

Kalyakool Moort- Always Family. Perinatal mental health screening for Aboriginal mothers and fathers

Jayne Kotz

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There is a complex cultural interface between Western and Aboriginal beliefs and notions about perinatal mental health and screening in the perinatal period. This area is particularly difficult to research as methodological and conceptual difficulties arise when utilising western systems of illness categorization and ‘risks’ for mental health. This paper will

1. Describe an assessment of the process and the impacts of current perinatal depression and anxiety screening practices among Aboriginal families across Western Australia, and secondly
2. Summarise emergent recommendations for practice for agencies and practitioners.

Kalyakool Moort-Always Family illustrates the challenges and emphasises the importance of collaboration between Aboriginal Elders and community members, agencies and disciplines. Importantly, this research has been driven by priorities set by the potential users of the outcomes of the research, including Aboriginal mothers and fathers, nurses, midwives, child health nurses, Aboriginal health workers and general practitioners. A detailed assessment of other screening tools, has been undertaken and consideration given to the knowledge drawn from the recent Kimberley Mums Mood Scale validation study.

This process of negotiation through the complex maze of intercultural and philosophical differences between these key people and agencies will ultimately result in the development of a joint strategic body of work which will inform both practice for agencies and a resultant screening process and tool with potential for widespread use among Aboriginal mothers and fathers during the perinatal period.

The role of supervision in the development of an integrated perinatal and infant mental health service- within Maari Ma Health Aboriginal Corporation

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This presentation will reflect on and describe the experience of supervision to staff working in a primary care setting for mothers, infants, young children and families "Healthy Start" within Maari Ma Health over a number of years. Child and Family Health nurses, Midwives, Aboriginal Health Workers and Perinatal Mental health clinicians are all offered supervision every two months which is the frequency of visits, and monthly for the two perinatal mental health staff (once a month via phone link) Supervision was initially offered to not only build clinical skills and knowledge in perinatal and infant mental health, but offer a reflective space for staff to discuss matters impinging on their work and practice, many of which relate to the difficulties of engaging hard to reach and at risk mothers and infants in a remote region, cultural considerations especially with regard to child protection, high staff turnover and shortages and building working relationships within and across teams and agencies. Supervision will be discussed in the face of these difficulties and dilemmas but also alongside developing competencies and confidence through staff being encouraged to pursue further training. This is reflected in nearly all of the supervised staff having completed certificates in introduction to perinatal or infant mental health in Adelaide.

2C Mother-Baby Unit II: Domestic violence focus

Clinical presentation of post-partum relapse of bipolar I illness complicated by undisclosed domestic violence

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The case of A is presented. Relapse of well-established bipolar 1 illness one week postpartum, compulsory admission to psychiatric unit with separation from infant for 2 weeks followed by transfer to mother baby unit. Recovery was slower than anticipated until the unexpected disclosure after 7 weeks by A of significant, recurrent domestic violence during pregnancy. The partner had presented regularly on the unit and had impressed staff with his caring attitude and willingness to undertake care of the infant. The disclosure was met with disbelief by some staff who had determined the partner was potentially the more capable parent. Re-analysis of the presenting information and behaviour of the patient and partner, exposes the pervasive manipulation that is a hallmark of partner inflicted domestic violence. This manipulation extends into the community and professional contacts that women experiencing violence may encounter. The vulnerability and risks of women and children exposed to violence exemplified through the experience of A is explored in this case presentation.

The infants early experience of in utero exposure to domestic violence with a mother with bipolar I illness and post-partum relapse

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Baby X was exposed to recurrent physical and emotional abuse via her mother's experience of abuse in pregnancy. This is likely to have altered the foetal environment via mechanisms of increased pervasive stress in the mother +/-

physical impact. Physical assaults were experienced every two to three days in addition to daily emotional stress via controlling and emotionally abusive behaviour of the partner. Physical assaults could occur without warning or prediction and there was a state of chronic hypervigilance in the mother. There was no history of relapse of Bipolar I symptoms in pregnancy but this occurred soon after delivery requiring the use of the mental health act and compulsory hospitalisation for mother and baby. The mother ceased all medications prior to pregnancy and was not clinically monitored by any mental health professional at this time. Due to her deteriorated mental state the mother was unable to breastfeed. The clinical progress of baby X is presented, who spent the first three months of life in a psychiatric inpatient unit.

Navigating a road to recovery from post-partum relapse of bipolar i with disclosure of domestic violence. The pathway and the system constraints encountered.

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Post-partum mental illness recovery usually involves an algorithm that is inclusive of mother, child, partner and wider family/community networks. Domestic Violence disclosure presents challenges to patients and professional staff alike as these relationships are distorted but still connected. In addition, ongoing stress can be a barrier to mental illness recovery. Domestic Violence can alter familial supportive relationships, which may need re-negotiation. The perpetrator wants to negotiate ongoing relationships with the child and the partner. Child Protection and Legal systems have their unique perspective of priorities and terms. The victims (mother and child) are trying to make

sense of their experience through a filter of trauma and an unknown future. Simultaneously, the mother and infant are establishing an attachment that is not independent of all these factors. The case of A will illustrate the complexity of such a system and a negotiated pathway. Discussion about how women who experience Domestic Violence and major mental illness may be better served by the wider community and professional services is invited.

The neurodevelopmental impacts of domestic violence on infants

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Sharron presents an easily understood explanation of the impacts of living with domestic violence on infant development. The presentation is built via a series of stories about children and infants she has worked with and links this to theories of brain development, attachment, neurodevelopment, and post traumatic stress disorder. The presentation is designed to be able to be shared with parents of infants living with domestic violence either currently or in the past as well as other workers. This presentation draws on the work of Dr Bruce Perry, Peter Mertin, Natalie Worth, Alan Jenkins and others.

2D Symposium: Primary care intervention for first time parents: What were we thinking

Changing practice to implement an innovative primary care mental health program for parents of first babies: Translational formative evaluation

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A comprehensive mental health system requires primary prevention as well as early identification and treatment. We developed What Were We Thinking (WWWT), a manualised, structured, gender-informed psychoeducation program for parents that addresses known but neglected risks in primary postnatal health care. WWWT is successful in preventing mild to moderate anxiety, depression and adjustment disorders in primiparous women six months after giving birth. The objective of this translational formative evaluation was to establish the practitioner, organisational and health system changes necessary for WWWT implementation in usual care. Following the UK Medical Research Council (MRC) Guidance for evaluating complex interventions, we conducted a translational formative evaluation using mixed methods, including collection and analysis of government documents and the academic literature, semi-structured interviews, an online survey and group discussions with parents, clinicians, health service managers and

government policy makers. The findings documented current clinical practice, barriers to change, staff training needs, necessary service modifications to standardise advice to parents and include fathers, the WWWT Training Program, key priorities and drivers of government health policy, and informed a model of costs and expected health and social outcomes for an economic analysis of WWWT. Implementation of WWWT into routine postnatal care requires adjustments to clinical practice and has economic implications for the health system, including staff training and changed service opening hours. The results informed the protocols for a cluster RCT and health economic evaluation and will be essential in considerations about scaling up WWWT to make this innovative mental health promotion program available to all Australian new parents and support positive outcomes for families.

Demoralisation: a novel and useful construct for understanding postnatal mental health problems among women in the community

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Demoralisation is a psychological state occurring in stressful life situations where a person feels unable to respond effectively to their circumstances, characterised by feelings of distress, subjective incompetence, helplessness and hopelessness. Although demoralisation is a well established construct in research and psychosocial interventions among people with serious physical illnesses, it is a novel construct in postnatal mental health. The period after the birth of a first baby is a time of great changes and disruptions to many aspects of the mother's physical, psychological and social functioning. This can lead to feelings of distress, a sense of incompetence and helplessness. This study examined the prevalence and determinants of demoralisation symptoms among primiparous women in the community in the early postnatal period. Primiparous women attending community maternal health centres (n=400) were recruited. Data were collected using telephone interviews in the baseline phase of the What Were We Thinking (WWWT) trial. High levels of demoralisation were uniquely associated with lower confidence on going home from the hospital after birth, lower self-ratings of mothers' global health, more than three hours of infant crying and fussing in

the last 24 hours and a controlling partner, after symptoms of depression, anxiety, vulnerable personality characteristics, and psychiatric history were controlled for. Demoralisation is a detectable and recognisable construct, distinct from depression and anxiety, and is associated with potentially modifiable risk factors. The relevance of demoralisation to postnatal health practitioners in the community is in better understanding of women's experiences and intervening in a way that is more meaningful and less stigmatising to women, rather than exclusively focusing on reducing symptoms of depression. In population based postnatal programs this brings the focus on helping first time parents to acquire the necessary caregiving skills together, in order to increase their competence, decrease helplessness, and reduce critical and controlling behaviours.

A gender-informed, psychoeducational program to prevent postnatal common mental disorders among primiparous women: assessing mechanisms for change

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What Were We Thinking (WWWT) is a psycho-educational program for couples to prevent perinatal common mental disorders (PCMD) in primiparous women. The aim of this analysis was to establish (a) whether the prevalence of PCMD at 6 months postpartum is associated with two modifiable risk factors targeted specifically in WWWT, namely

unsettled infant behaviour (UIB) and quality of intimate partner relationship; and (b) whether *WWWT* is associated with significant changes in these two proposed mechanisms for change. In a cluster RCT, maternal and child health centres from 6 diverse Local Government Areas in Victoria were allocated to usual care (control), or usual care + *WWWT* (intervention). English-speaking primiparous women (n=364) completed computer-assisted telephone interviews at 6 weeks and 6 months postpartum. Standardised and study-specific measures were used to assess infant crying and fussing and aspects of intimate partner relationship. At 6 months postpartum, PCMDs were significantly associated with UIB, and with fewer empathic and affectionate and more critical and abusive partner behaviours. Overall, there was no significant difference in these factors between trial arms. However, babies unsettled at baseline had significantly fewer unsettled behaviours 6 months postpartum in the intervention than the control group. Thus infant behaviour management strategies to reduce UIB appear to have been more salient and therefore applied by this group of parents than those whose babies were more settled at baseline. Among those whose intimate partner relationship was optimal at baseline, participation in *WWWT* was associated with significantly fewer abusive partner behaviours at 6 months postpartum. Couples who are less affirming and encouraging and more critical of each other in early parenthood may need more than a single session to change these interpersonal interactions. Thus the behaviours targeted by *WWWT* were associated with PCMD, and were modifiable, although flexible implementation of *WWWT* may be required.

A gender-informed, psychoeducational program for couples to prevent postnatal common mental disorders among primiparous women: findings from a cluster randomised controlled trial

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Interventions for unselected populations of women who have recently given birth, to prevent postpartum common mental disorders (PCMD) have had limited success. We aimed to determine whether What Were We Thinking (*WWWT*) a gender-informed, structured, psycho-educational program for couples and babies can prevent PCMD in

primiparous women at six months postpartum. We conducted a cluster randomised controlled trial in which maternal and child health centres (MCHCs) from 6 Local Government Areas (LGAs) were allocated randomly to usual care, or usual care plus *WWWT*. *WWWT* is a manualised program, which comprises primary care from a trained nurse, print materials and a face-to-face seminar. Participants were English-speaking primiparous women receiving primary care at trial MCHCs. Data sources were standardised and study-specific measures collected in blinded computer-assisted telephone interviews at baseline (6) and endline (26) weeks postpartum. The primary outcome was PCMD. We also assessed clinically-significant symptoms of depression and anxiety not meeting diagnostic criteria. Forty-eight MCHCs were allocated randomly to trial arms (24 per arm) and 204 participants were recruited to the intervention and 196 to the control conditions. Of these, 187 (91.7%) intervention and 177 (90.3%) control participants provided complete data. The Adjusted Odds Ratio (AOR) of PCMD was 0.63 (95%CI:0.30;1.30, not statistically significant), and of clinically-significant psychological symptoms was 0.57(95%CI:0.33;0.97) favouring the intervention arm. The *WWWT* seminar was appraised as salient and comprehensible by >85% participants. No harms were detected. *WWWT* is readily integrated into primary care, enables inclusion of fathers and addresses modifiable risk factors for PCMD directly. At the 'dose' tested in this trial PCMD were reduced, but not significantly. However, *WWWT* appears to be a promising program for preventing clinically significant symptoms of depression and anxiety, optimising family functioning, and as the first component of a stepped approach to mental health care.

2E Children of Parents with Mental Illness

Let's talk about the children

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A practitioner with a child and parenting focus recognises the interconnection between parental mental health and child mental health and development. Let's Talk is a structured discussion with parents who experience mental illness, about parenting, the well being and development of their children and how the mental illness is understood by them. The impetus for the development of Let's Talk emerged from recognition that parenting responsibilities are an important consideration and that parents experiencing mental illness can actively prevent the emergence of mental health difficulties and support the positive development of their children. Let's Talk was originally developed by Professor Tytti Solantaus as a short intervention for the Finnish public mental health sector. The method involves a series of thematic discussions between a practitioner and parent(s) about children and parenting. A body of evidence has been developed around the Let's Talk method as a preventive and health promotion intervention for children of parents with a mental illness. Key benefits for children of parents who participate in the method include decreased emotional symptoms and anxiety, improved pro-social behaviour and an increased sense of hope. The method has also been shown to contribute to the parent's recovery. This presentation will look at the Let's Talk intervention; discuss the rationale for its development and the associated research evidence. Video clips from the COPMI e-learning modules will demonstrate this technique.

Saturday 24 October 2015

Bipolar disorder and childbirth – understanding risk

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NCMH Deputy Director and Clinical & Research Specialist in Perinatal Mood Disorders, UK

It has long been recognised that childbirth is a time of considerable risk for women with bipolar disorder, with postpartum episodes (including postpartum / puerperal psychosis) occurring following up to 50% of deliveries. Childbirth is therefore a very potent trigger for bipolar episodes and highlights the importance of considering issues regarding pregnancy and childbirth in women with bipolar disorder. In this talk I will review the evidence confirming that women with bipolar disorder are at very high risk of episodes of severe postpartum affective disorder and examine what is known about the factors that influence this risk. Studies from our group have demonstrated that familial (genetic) factors influence vulnerability to the puerperal trigger and based on these findings we are conducting molecular genetic studies to identify the genetic variants that confer risk. This line of research has the potential to uncover the nature of the puerperal trigger, allow a more individualised estimation of risk for women with bipolar disorder, and provide further information relating to the aetiology of mood disorders in relation to childbirth and at other times

3A Parent-infant issues

The clinical significance of early co- regulation for both parent and infant and system effectiveness

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The capacity of parents and infants to achieve mutually rewarding moments that build to solid partnership is essential for healthy maturational development. The implications of considering the significance of co regulation within perinatal health systems will be explored through case examples.

Case examples will highlight

- the importance of mutual regulation for the infant's development of self, neurobehavioural presentation and approach/ defensive behaviours
- internal and external stressors that influence early parental approach, reward, child reading and meaning making capacities within a parent
- the complexity of clinical presentation of dysregulation between parent and infant

The presentation will identify multiple points of entry and strategies to influence the states of both parent and infant. Approaches aim address both immediate needs and longer term relational and developmental trajectories. Strategies will include instances of timely, reparative relational experiences between therapist and parent, whilst simultaneously assisting the parent to tolerate and meet the infant's needs in the present moment. The authors will discuss their experience of assisting health systems to acknowledge and utilise the significance of parent infant regulation in their efforts to achieve desired system outcomes.

Addressing mother-baby attachment in a communication framework for women with depression

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There is a complicated relationship between a mother's behaviour with her child and her experience of postnatal depression (PND). Maternal depression has an potential effect on her child in a number of ways, putting a child of a depressed mother is at risk in a range of areas including in cognitive, social, emotional, and psychological development. Researchers in the attachment field have developed a number of interventions with postnatally depressed or other at-risk mothers aimed at improving attachment, in the hope of providing better outcomes for the child. Attachment interventions do not typically have an effect on postnatal depression, and vice versa.

This presentation details the development of a manualised group therapy which adapts a gold-standard depression treatment to incorporate the mother-child relationship. Interpersonal psychotherapy (IPT) is a depression treatment designed to address a patient's communication style, thereby affecting the way they ask for and use social support. Lack of social support is a known precipitator and exacerbator of depressive symptoms.

IPT does not traditionally target the mother-child relationship despite the disruption to this relationship in postnatal depression. It has been assumed that IPT should focus on relationships with other adults in the patient's life in order to meet her attachment needs and build social support. The issue of whether the child can be a social support, or whether a better relationship with the child will help improve the mother's mental health and increase her sense of adjustment to the role, has not been explicitly addressed. Neither has the issue of whether it is possible to buffer against the risk of negative attachment outcomes in the mother-child dyad using a communication framework. Yet IPT appears suited to being able to conjointly address attachment issues due to its interpersonal focus.

Experiences in the conduct of pilot groups for this intervention are described.

Antidepressants and long-term developmental outcomes for infants

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Aim: To evaluate the association between prenatal antidepressant exposure and behavioural problems at 7-years of age.

Methods: Information on exposures was obtained from the Danish National Birth Cohort. We studied the children of 210 mothers who had used antidepressants during pregnancy (exposed) and compared these to 231 children of mothers with prenatal depression but no use of antidepressants during pregnancy (untreated depression) and 48,737 children of mothers with no prenatal depression and no use of antidepressants during pregnancy (unexposed). Childhood behavioural problems at 7-years of age were examined using the validated Danish parent-report version of the Strengths and Difficulties Questionnaire (SDQ).

Results: No associations were observed between prenatal antidepressant exposure and abnormal SDQ scores for overall problem behaviour (aRR 1.00; 0.49, 2.05), hyperactivity/inattention (aRR 0.99; 0.56, 1.75), or peer problems (aRR 1.04; 0.57, 1.91). While prenatal antidepressant exposure appeared to be associated with abnormal SDQ scores on the subscales of emotional symptoms (aRR 1.68; 1.18, 2.38) and conduct problems (aRR 1.58; 1.03, 2.42), these associations were significantly attenuated following adjustment for antenatal mood status (aRR 1.20; 0.85, 1.70 and aRR 1.19; 0.77, 1.83 respectively). Untreated prenatal depression was associated with an increased risk of all behavioural outcomes evaluated compared to unexposed children, with significant attenuation following adjustment for antenatal mood status.

Conclusion: The results of this study suggest that independent of maternal illness, prenatal antidepressant exposure is not associated with an increased risk of behavioural problems in children at 7-years of age.

A Review of the First Touch Infant Massage Program embedded in a Community Development Setting

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High-quality interactions and relationships between babies and parents are crucial for life-long mental and social health. Maternal stress introduces risks that can impede these interactions, affecting infant mental health development. First Touch™, a low-cost, evidence-informed program, aims to protect/restore these early interactions in the face of significant stress. It fosters the development of healthy parent-baby interactions by assisting parents to respond sensitively and appropriately to their babies through a range of modes, including touch, massage, voice, facial expression, eye contact, and movement. Parents' increased awareness of, and sensitivity to, their baby's cues is then used as a basis for regulating, comforting, stimulating and soothing their baby. Whilst not necessarily concerned with preventing trauma, First Touch™ potentially prevents the *consequences* of early trauma on development.

Piloted at Relationships Australia South Australia (RASA), First Touch™ has demonstrated effectiveness in increasing parenting confidence and decreasing depressive mood in families with moderate risk of early mental health issues. Since this pilot study, RASA, together with the International Association of Infant Massage, has provided professional development training, educating communities in the skills required to facilitate First Touch™ programs. The resultant

peer (mother-to-mother) education that such training affords effectively engages so-called "hard-to-reach" families, providing greater accessibility to intervention and skill-building programs. In this paper, we report on how the community application of First Touch™ works towards broadening community-level infant mental health literacy, resulting in substantial economic savings and enabling more vulnerable, at-risk families to benefit from low/no-cost approaches to reduce risks from problematic parent-infant relationships.

Exploring parents' experiences and perceptions of singing and using their voice with their baby in a neonatal unit: An interpretative phenomenological analysis

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Music Therapy practices with premature and medically fragile infants and families have been widely researched and documented across the globe. Despite such a plethora of discourse, there remain many questions within the evidence base. In particular, exploring and understanding parents perceptions of musically engaging with their baby, the role of

the music therapist when working with the infant-parent dyad and understanding where music therapy practice is best placed to intervene within such a multifaceted and acute health care continuum.

This qualitative inquiry, adopting Interpretative Phenomenological Analysis (IPA) methodology explored how parent's experience and perceive interactions with their baby through moments of singing and using their voice in a Neonatal Unit (NU). Findings emerged across four waves of analysis with recurrent themes including the intrinsic role of singing and voice to support the developing identity of parents and act as a fundamental bridge of connection to their premature baby; the powerfully supportive role of voice to meet the emotional needs of parents; and accessing voice as a self-soothing coping tool for parents. Moreover, the concept of time across differing stages of the acute neonatal journey and its influence on parents' experiences and perceptions of voice inductively emerged across cases. Moreover, findings highlighted singing and voice interactions as a critical dialogical encounter of perceived connection and recognition that validated the parent's developing relationship with their baby. Finally, the role of the music therapist was explored with dialogue emerging acknowledging the importance of this role in supportively educating and facilitating parents to find their voice and connect with their baby in the NU.

This exploratory study has contributed a novel perspective within the music therapy and broader neonatal community, illuminating the powerful potential of parental singing and voice interactions for the parent of a hospitalized infant in a NU, and the way in which family- inclusive music therapy practice can work towards wellness for both the parent and infant dyad in acute care.

3B Postnatal therapies 2

Best beginnings: An integrated response to mothers/ families experiencing feeding issues and anxiety in the first 6 weeks post-partum

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Anxiety and depression in the neonatal period, and the early cessation of breastfeeding are significant and interlinked public health issues. High prevalence mental health problems are among the most common complications of pregnancy and can be an important factor in the cessation of breastfeeding. Further, when mothers experience difficulties and/or cease breastfeeding, it can compound pre-existing mental health problems. Interestingly, integrated responses to breastfeeding and parent's mental health in the early post-partum period are not standard practice and there is limited research in this area. In the experience of the authors the limited recognition of the overlap between infant feeding difficulties and parental mental health lead to difficulties for families accessing appropriate support. In response to this gap in service Bendigo Health Maternity and Psychiatric Services developed Best Beginnings: a single session support group for parents in the first 6 weeks after birth. The aim of Best Beginnings is to support

parents in developing feeding and settling routines and recognise and respond to the interplay between parents' mental wellbeing and their infant's behaviours. The program is co-facilitated by a mental health clinician and lactation support clinician and aims to normalise the range of infant feeding and settling behaviours in the early weeks and support parent develop strategies to manage these, through the use of newborn behavioural observation techniques. The program also encourages parents to reflect on their own states of mind and psychological wellbeing, changes to relationships and sense of identity during pregnancy and after birth. In this presentation we will describe the rationale, implementation and outcomes of the program, which has been running for the last twelve months, and discuss recommendations for further development of the program.

Implementing a perinatal emotional health program in a metropolitan maternity hospital

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In addition to the high personal costs of perinatal mental health disorders, a report undertaken by PricewaterhouseCoopers for births in 2013 estimated that the cost to the economy for not identifying and treating perinatal depression are estimated to be well in excess of \$538M. The Perinatal Emotional Health Program (PEHP) implemented within Maternity at Sunshine Hospital aimed to create a sustainable, collaborative and improved service

system model that could ultimately be replicated across other metropolitan sites. PEHP has achieved success through:

- Implementing universal antenatal mental health screening
- Employing a specialist perinatal mental health team who are co-located at the hospital working alongside maternity staff
- Providing mental health capacity building, education and secondary consultation and advice to midwives
- Appointing dedicated midwives to run a high risk mental health antenatal clinic. These midwives are paired with mental health clinicians who provide mental health mentoring and support.
- Instigating the development of Guidelines for Maternity Length of Stay and Mental Health. These guidelines are intended to help midwives make a decision about an appropriate hospital stay for mothers with a pre-existing mental health condition as a part of their holistic treatment and care plan.

This paper aims to demonstrate for health professionals and health services how holistic maternity care which incorporates mental health can be delivered in maternity hospital settings. Key enablers and challenges as well as considerations for future implementations are discussed.

Clinical decision making from postnatal psychosocial assessment

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The use of psychosocial assessment can facilitate early identification and appropriate intervention for women at risk of postnatal mental illness. However, the assessment is only as effective as the underpinning decision-making.

Method: This qualitative study provides a description of the clinical decision making undertaken for psychosocial assessment of women during the postnatal period. Critical incident technique was utilized to encourage twelve experienced child and family health nurses to recount recent assessment experience as part of admission to an early parenting centre. Content analysis was undertaken to determine the specific domains that the nurses drew the information from. Template analysis, based on Fonteyn's Thinking In Practice study, was undertaken to describe the specific thinking strategies that the nurses used within each domain of information.

Results: This presentation details the twenty four domains of information that the nurses draw information from and explains the use of seventeen specific thinking strategies that the nurses use to undertake this complex task. The

three most commonly utilized information domains; Parenting and Care of the Child, Assessment Tools (Post Natal Risk Questionnaire and the Edinburgh Postnatal Depression Scale) and Women Determined Issues or Goals are presented in terms of the most commonly used thinking strategies; Searching for Information, Recognising a Pattern in the Information and Judging the Value of the Information.

Conclusion: A description of clinical decision-making by experienced clinicians conducting postpartum psychosocial assessment may be useful to other clinicians providing similar assessment and may benefit women, their babies and their families.

Are we there yet? The stages of early parenthood and how they impact on family mental health and relationships

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At a time couples expect to be closer together than ever, 92% report more conflict in the first year after the birth of their first child, 67% a decline in relationship satisfaction over the first three years of family and 17% of Australian couples go as far as saying having a baby together caused the end of their relationship. Relationship distress is the single biggest factor in antenatal anxiety and one of the top three factors in postpartum depression. An attachment injury from a partner also increases the risk for a traumatic birth experience. The good news, thanks to Adult Attachment Theory, is we also know that a secure emotional attachment between partners inoculates them against anxiety and depression during the perinatal period and also sets them up for a positive birth experience. In fact, in the

Gottman's Pilot for their U.S. program Bringing Baby Home, the researchers found that just two 40 minute sessions on relationship preparation could reduce Postnatal Depression in mothers by 60%. However, despite this potential and despite recommendations from the Australian Federal Government's 1998 To Have and to Hold Report, no formal

program of relationship preparation for the transition into parenthood has been rolled out. This presentation introduces a unique developmental model approach to the transition into parenthood and the author's observations and

independent research on the process of emotional disconnection between partners during the perinatal period, the effects of this on mothers' and fathers' perinatal mental health, the marital relationship, each parent's ability to bond with their baby, to support the partner/baby bond and to form a harmonious co-parenting relationship. Participants will come away with a new understanding of the links between parenthood, relationship quality and maternal and paternal mental health that may support the need for new research, promote alternative ways of working with parents and inspire strategies for prevention and early intervention approaches.

No woman should ever feel alone in her role as a mother

Michelle Kornberg

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Caring Mums is a unique program that fills a much needed gap in services for pregnant women and mother's with new babies. Through an on going relationship with a trained volunteer, mothers are given emotional support from an older, experienced mother. This connection has been shown to help new mothers with the biggest adjustment a woman makes in her life (outside of chronic illness) -that of having a child!

Volunteers see mothers weekly in their own homes where they are able to bear witness to the mother in her new role. It is during these visits that the mothers are able to speak about everything and anything, without fear of being judged.

It is often during the intake done by the coordinator of the program, that the mothers first talk about some of their disappoints, losses, sense of grief and often guilt that they are unexpectedly feeling. With the establishment of an honest, trusting, and empowering, stable relationship with their volunteer, these feelings can be discussed, normalised or validated. Where necessary, intervention by professionals can be encouraged at an early stage, thus, possibly diverting increasing anxiety or depression, as well as promoting secure attachment relationships with their babies.

From collating the intake information, it is apparent that many mothers feel that they are not prepared sufficiently for motherhood post birth. The majority of mothers feel alone in the negative feelings they have in regard to being a mother and believe that there is no one they can talk to about it. Caring Mums volunteers play an enormous role in supporting mothers in bridging the gaps between their dream of motherhood and its reality.

Caring Mums is a non-denominational program of the National Council of Jewish Women (Vic). It is a free service making it available to all women within its catchment area.

3C Perinatal therapy

Antipsychotics and gestational diabetes – Outcomes for women attending an Australian Perinatal Psychiatry Service

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Gestational diabetes (GDM) is associated with an increased risk of maternal morbidity and adverse birth complications. In Australia, the rate of GDM has been reported as being between 4.7 - 13.0%, depending on criteria used. Atypical, or second-generation antipsychotics are well known to induce metabolic disturbances such as hyperglycaemia, insulin resistance and type 2 diabetes (T2DM). They have also been recognized as a risk factor for hyperglycaemia during pregnancy, and there are some reports in the literature of higher rates of GDM among pregnant women who are taking antipsychotic medications, then those who do not. Despite the risk of increased

metabolic disturbances, antipsychotic medications are often still required for the treatment of severe mental illness during pregnancy. Current guidelines recognise the increased risk of hyperglycaemia and GDM in women taking

antipsychotic medications, and as such recommend that these women undergo an early screening with an Oral Glucose Tolerance Test (OGTT) along with a repeat test later in pregnancy.

This presentation aims to report on the rate of early OGTT screening and diagnosis of GDM in women taking an antipsychotic medication who attended the Perinatal Emotional Health Program (PEHP) at our hospital. Rates will be

compared with a matched cohort of women who attended PEHP but did not report antipsychotic use. A retrospective audit will be conducted from 31st October 2013 to 11th February 2015, of women who were documented as taking an antipsychotic medication in early pregnancy. Further information regarding medication type, dose, psychiatric diagnosis, additional GDM risk factors and GDM birth complications will also be reported. The results of this audit will provide information on the rates of GDM, birth and neonatal complications among Australian women taking antipsychotic medications, as compared to a control group. Further, it will also provide information on the rates of women who undergo recommended early OGTT screening during pregnancy.

Anti-depressants in pregnancy – prescribing trends in women presenting to an Australian perinatal psychiatry service

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There remains much interest and controversy surrounding the use of antidepressants in pregnant women. Despite this, antidepressants remain recommended for the treatment of moderate to severe depression occurring in the perinatal period. Non-mental health clinicians and patients can be confronted with a vast amount of conflicting information about the safety of these medication in pregnancy. While rates of antidepressant use during pregnancy have increased, there has been an observed trend of women ceasing their antidepressant when discovering their pregnancy or during the course of their pregnancy. In some cases women had not been given the option of continuing their antidepressant. This is worrying as women who cease their antidepressant treatment during pregnancy are at an increased risk of relapse. Given these observed trends, tracking prescribing practices of primary care providers is

important in understanding the treatment pregnant women receive when suffering depression. We undertook a naturalistic observational study recording medication of women referred to an Australian Specialist Perinatal Mental Health Service. The service is based within a maternity department of an Australian hospital. All women referred planned to birth at the hospital and had current psychiatric symptoms or a history of psychiatric illness.

Effects of common perinatal mental disorders and micronutrient deficiencies among women on infant development in rural Viet Nam

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The effects of exposures to maternal symptoms of ante- and post-natal common mental disorders (CMD) and micronutrient deficiencies on early childhood development in resource-constrained settings are unclear. A prospective community-based investigation of a systematically-recruited cohort of women followed from early pregnancy, and with their infants until six months postpartum. Psychosocial and biological data were collected in two pregnancy and two postpartum assessment waves. The outcome was six-month old infants' cognitive, motor, and social-emotional scores on the Bayley Scales of Infant and Toddler Development (BSID). Direct and indirect effects of the exposures on the outcome were tested simultaneously with Path analysis. Complete data were available for 378 mother-infant dyads. Antenatal CMD had direct adverse effects on BSID cognitive scores of six month old infants when controlling for antenatal micronutrient deficiencies, postnatal CMD, and socio-demographic characteristics (path coefficient -4.80 points, 95% CI: -9.40 to -0.20). There was also a direct adverse effect of CMD in early pregnancy on infant BSID

motor scores (-7.13 points, 95% CI -11.13 to -3.13). There was an indirect pathway (path coefficient -1.11, 95%CI -1.79 to -0.42) in which antenatal CMDs were associated with increased likelihood of postnatal CMDs, which were associated with reduced parenting self-efficacy and less affectionate, warm parenting practices, which were associated with lower infant Social-Emotional scores. These data indicate that in addition to the risks conferred by micronutrient deficiencies, maternal mental health may be crucial to the development of infants in resource-constrained settings. They provide further evidence that interventions to optimise all domains of early childhood development in these settings should address maternal mental health.

Maternal caregiving and parent-infant interaction: the roles of maternal oxytocin and adult attachment

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Background: Animal data suggest that the neuropeptide oxytocin, a neurohormone of affiliation, mediates mother infant bonding through maternal grooming and contact (Francis, Young et al., 2002) and emerging evidence implicates a role of oxytocin in human mother-infant bonding and caregiving (Eapen et al, 2014). This study investigated the roles of maternal oxytocin, adult attachment, maternal mood and infant behaviour in predicting the quality of maternal caregiving and parent-infant interactions under stressful and non-stressful conditions.

Methods: One hundred and nine mothers-infant dyads participated in the still-face procedure at 3 months postpartum. Maternal and infant behaviours were rated using Murray's Global Rating Scales (Murray et al, 1996) during conditions of low stress (free play before the still face) and higher stress (reunion following the still face). Mothers completed self-

report measures of adult attachment pattern and current depressive symptoms, and blood samples were taken immediately before and after the procedure to determine oxytocin levels.

Results: In the free play interaction ('low stress' condition), positive parenting behaviours (warm, accepting, responsive, non-demanding, sensitive behaviours) were predicted by older maternal age and positive infant behaviours (attentiveness, communicative, positive vocalisations). Remote/withdrawn parenting was predicted by an avoidant adult attachment style; maternal intrusiveness was predicted by adult attachment anxiety. The overall quality of the mother-infant interaction was predicted by the degree to which the infant's behavior was positive. In contrast, during the reunion ('high stress' condition), positive parenting behaviours were predicted by positive infant behaviours and higher levels of oxytocin. Remote/withdrawn parenting was predicted by lower oxytocin levels and intrusive parenting was predicted by infant gender (female). The quality of the mother-infant interaction was predicted by positive infant behavior and maternal oxytocin level.

Conclusions: This study highlights an association between maternal oxytocin and positive parenting behaviours and parent-infant interactions, particularly under stressful conditions.

Antenatal Depression Treatment: Impact on Early Child Developmental Outcomes

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Aim: Substantial evidence links antenatal depression and anxiety with negative effects on fetal development, resulting in enduring negative impacts on child development. Despite this, there is a paucity of research on intervention programs designed to address depression and anxiety in pregnancy and whether active treatment can prevent longer-term adverse child outcomes. We aim to evaluate the efficacy of a brief treatment for maternal depression and anxiety in pregnancy in a sample of women with a diagnosed depressive disorder. **Design and Methods:** We developed a

cognitive behavioural therapy treatment for antenatal depression and anxiety and evaluated it in a feasibility trial (*Beating the Blues before Birth*). This was followed by a pilot randomised controlled trial (RCT) collecting data on the efficacy of the brief intervention (Beck Depression Inventory [BDI] and Beck Anxiety Inventory [BAI]), and follow-up data on infant development (Ages & Stages Questionnaires and Revised Infant Behaviour Questionnaire). **Findings:** The feasibility study (n = 25) yielded promising results for adherence, acceptability and improvements in depression and anxiety (BDI and BAI). The RCT (n = 54) again showed excellent adherence and acceptability and supported the efficacy of the treatment. Strong reductions in anxiety were observed during pregnancy and improvements in depression were maintained at nine months representing a moderately large effect size. Nine-month infant outcomes

showed several medium-to-large effects favouring the intervention in domains including problem solving, self-regulation, and stress reactivity, which were statistically independent of maternal postnatal mood. **Conclusions:** Treating severe depression and anxiety during pregnancy with a brief CBT intervention appears feasible and effective. This is the first published study showing a positive effect of treatment on infant outcomes to 9 months. The cohort is being followed longitudinally and preliminary data on child outcomes at 2 years of age will be presented. Larger RCTs are likely to be required.

3D Workshops Cognitive behaviour therapy

Use of Cognitive behavioural therapy (CBT) in perinatal mental health: Two case studies highlighting positive clinical outcomes when used in perinatal bereavement and post natal anxiety

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Having a baby is usually a rewarding experience. For at least 15-20% of women it will be an extremely challenging emotional time. It may be heightened if the woman experiences unexpected perinatal loss. If she decides to have another baby, the ambivalence and the parental coping mechanisms during the subsequent pregnancy may be troublesome. Furthermore, if the woman is overly stressed and develops a distorted view of motherhood, she may become seriously anxious postnatally. These clinical situations may potentially impact on the infant. These women need support provided in a careful way with consideration of different methods of treatment.

CBT is a form of psychotherapy which helps the individual understand the impact of their situation on what they think, do, and their physical feelings and emotions. It helps individuals modify their emotions and improve coping behaviours by assisting them to identify their dysfunctional beliefs, test these beliefs against reality, and replace them with more realistic beliefs. It is evidenced based in clinical practice. Mothers, who have experienced loss and grief, or extreme anxiety, have responded well to the structure of CBT. Particular attention is given to active learning of stress management strategies. It can be used sensitively and is useful immediately and long term.

Two case studies will be presented which will provide a brief overview of CBT and how it was beneficial to these clients. The first is about complicated loss – a mother of a 2 year old who terminated her second pregnancy due to foetal anomaly, and the second is a mother with high anxiety postnatally. The stress and anxiety management interventions will be described together with the positive treatment outcomes. Delegates will take away useful screening tools and brief CBT interventions for loss and anxiety.

3D Workshops Post-traumatic stress disorder

Naming and exploring the elements of perinatal PTSD

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Perinatal post-traumatic stress disorder (PTSD) remains poorly defined with a limited and imprecise knowledge base. The aim of this workshop is to enable participants to explore possible definitions and nomenclature for perinatal PTSD as well as consider possibilities for guidelines for practice and research options.

3E Perinatal Education

The changing landscape of perinatal education: Introducing the “PEPP Talk” (Preparing Emotionally for the Perinatal Period)

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To introduce and walk through Peach Tree’s PEPP Talk concept, providing an overview of current research and inviting workshop attendees to discuss the changing landscape of perinatal education. Existing challenges in emotional preparation for parenthood will be explored, and the impact such challenges present to the perinatal

wellness of families in Australia. Attendees will also have the opportunity to hear “lived experience” stories from PEPP Talk creators, Viv and Rani, and engage in an example of the activities asked of participating parents. Peach Tree’s overall goal is for delegates to gain a) insight into the emotional transition realities for new parents during the perinatal period, and b) understanding of the emotional preparation requirements of couples during their transition to parenthood.

Our workshop outline is as follows:

1. Introduction & Overview
2. Brief Background & Summary of Peach Tree Perinatal Wellness
3. Personal Accounts of Perinatal Mental Illness

4. Recent research and findings that reinforce why the current landscape of Perinatal Mental Health needs to change.
5. Introduction of PEPP Talk and Parenting Partner concepts, including discussion and workshop activities about:
 - a. Couple relationship quality and communication tools
 - b. Parent psychopathology
 - c. Father Involvement
 - d. Parent-Infant relationship
 - e. Infant development and temperament
 - f. Creating the Village
6. Special showing of documentary “Because Parenting Isn’t Always Peachy” with follow up comments and discussion.
7. Q & A Time

Family wellbeing: using a codesign process to support parents with ‘mental illness’

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Co-design is an integral component of the Children of Parents with a Mental Illness (COPMI national initiative) consumer working framework and has been the key in the development of resources designed to support families and professionals. The process of co design will be introduced through the voice of ‘lived experience’ as we hear from a mother, wife, parent, community member. We will hear how and why this contribution is acknowledged as being as important as any professional in the development of products to support families where there is ‘mental illness’.

A ‘tool kit’ co designed in partnership with parents who live with mental illness, their children and supporters will then be presented. Understanding that many services focus on the adult as an individual, this ‘tool kit’ is designed to support parents to reflect on being a parent living with mental illness. It offers practical ways to strengthen the parent child relationship and promotes the concept of a family living well.

This ‘tool kit’ acknowledges

- the shared and interdependent nature of child – parent relationship
- that considering the family as a whole can promote parent recovery and support child well being
- the parenting role as an important part of any parents life
- the best person to talk to a child about a parents mental illness is the parent the child needs
- to feels safe and nurtured
- be provided with emotional support

- be supported to develop and thrive
-

The ‘tool kit’, bringing together the voice of ‘lived experience’ who have shared their knowledge and stories will be demonstrated.

4A More from the Coal Face

How can partners support one another to help prevent perinatal depression and anxiety? A Delphi consensus study with professionals and consumers

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Systematic reviews have established that partner support protects against perinatal mood problems and is therefore a key target of prevention efforts. However, the extant literature has not been translated into specific actions that partners can implement. Interventions aiming to prevent perinatal depression and anxiety by facilitating partner support need to provide partners with specific guidance on how they can best support one another. Two panels of experts in perinatal mental health (21 consumer advocates and 39 professionals) participated in a Delphi consensus study to establish how couples can support one another to reduce their risk of developing depression and anxiety during pregnancy and the postnatal period. A total of 214 recommendations were endorsed as 'important' or 'essential' in reducing the risk of perinatal depression and anxiety by at least 80% of both panels. The study established consensus between consumers and professionals on how partners can support one another other to prevent depression and anxiety during pregnancy and following childbirth. The resulting guidelines will inform the development of perinatal depression and anxiety prevention efforts.

How kids tell us that Mum's depressed; thinking about toddlers in a perinatal and infant mental health service.

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The importance of addressing perinatal mental health for the benefit of both parent and infant are well recognised. Additionally, behavioural disturbance in infants and toddlers may be an indicator of parental mental ill health. While it is recognised that such behavioural disturbance left unaddressed may lead to long term mental ill health for parent and child, there are gaps in services for toddlers and pre school age children. The Raphael Centre Bendigo is a Tier 2 specialist perinatal and infant mental health service, providing mental health care to parents and their children in the perinatal period, up to the index child's fourth birthday. The Raphael Centre Bendigo aims to address the mental health needs of toddlers by engaging them in their parents' care, with the aim of improving mental health outcomes for these children and their parents.

In this session, Tina Winzar will present a clinical case of parent-infant psychotherapy to illustrate a potentially helpful model for working with parents, infants and toddlers.

Managing pregnancy-related stress: Reported impact of the Mindfulness in Pregnancy Program (MiPP) and the Pregnancy Support Program (PSP)

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Background: Prenatal stress appears to be associated with perinatal anxiety and depression. Mindfulness training offers a non-invasive, non-pharmacological, evidence-based intervention for managing stress. Few studies have been conducted on the effects of mindfulness with pregnant women, and none have used a face-to-face active control group. This paper reports the qualitative findings of a pilot randomised controlled trial (RCT).

Methods: The Mindfulness in Pregnancy Program (MiPP) and the Pregnancy Support Program (PSP) were conducted for 2-hours, weekly, for 8-weeks. Data collection included summative program evaluation (MiPP n=9; PSP

n=11), facilitator field notes (n=2), MiPP daily records (n=8), and follow up telephone interviews (MiPP n=9; PSP n=11). Content and thematic analysis was conducted.

Results: Seventeen women (73.9%) attended 4 or more sessions (MiPP n=8; PSP n=9). Women in the MiPP reported learning how to manage stressors, feelings of fear and anxiety and how to be more present. Women in the PSP reported learning how to calm down when stressed, increased confidence, and valued connecting with other participants. Identified impact themes for the MiPP included: *managing stress, become aware, accepting, having options and choices, and connecting and being compassionate*. Impact themes for the PSP included: *managing stress, increasing confidence, connecting, focussing, being accepted and preparing*. We noted that many pregnant women work and experience tiredness which impacts on their entry into, and completion of wellbeing programs. Once they commence however, they value such programs.

Conclusions: While both programs decreased stress, women in the MiPP accepted their emotions, body sensations and situations, 'as they are' resulting in increased wellbeing. Women in the PSP gained their acceptance primarily from external sources, such as others in the program. Further research would include longitudinal RCTs, with an active control group and cost-benefit analysis.

Supporting infant's to find sleep – in a respectful sensitive way.

Helen Stevens

Safe Sleep Space

It is unquestioned that infants benefit from consistent, predictable and tender caregiving to ultimately achieve a self regulated state, such as sleep. What our society asks of infants it to be able to have the capacity to separate and self regulate for sleep and when they cannot we consider them as having sleep problems. In Australia, up to 40% of families reported their infants and children had sleep problems (Quach J., Gold L., Hiscock H., Mensah FK., Lucas N., Nicholson JM., Wake M. 2013) which often sees parents searching for help. Behavioural sleep interventions such as modified controlled comforting are often offered as a 'solution'. These interventions train infants to settle to sleep without caregiver attention. Although successful in extinguishing infants' crying at transition to sleep, research has shown that the cessation of this behavioural indication of distress is not associated with a decrease in infants' physiological stress response during the time of intervention (Middlemiss, Granger, Goldberg, & Nathans, 2012). Infant sleep patterns can be changed without compromising the infant's emotional wellbeing. Rather than focussing on interventions to extinguish behaviours, caregivers can be encouraged to notice and respond to infant behaviours at sleep time. In this presentation, infant needs and abilities surrounding sleep will be examined as well as the rationale behind response-based sleep interventions that focus on helping caregivers understand normative sleep patterns, identify sleep signs, and to learn responsive approaches to help infants achieve a healthy sleep, all without extinction based programs. Based on Safe Sleep Space (2009 & 2104) evaluation data, 87% - 92% of families who engaged in a response-based, sleep intervention with their infants [aged 2 to 36 months] reported being happy with their participation at the time of intervention and 2 weeks later, had reduced symptoms of anxiety and had babies who slept for longer periods. By responding to the communication of infants and considering them in the process of finding sleep, both infants and children were able to sleep without needing to be exposed to behavioural interventions such as controlled crying.

4B Postnatal therapies 3: Modern technologies and approaches

Communication around perinatal mental health: the rationale for a new approach to positioning information outside of a mental health context

Nicole Highet

Extensive qualitative research with women with a history of perinatal depression, revealed a number of barriers to identification of symptoms, accessing of information and treatment. Following, the extent to which these themes were

reflected across the population was then evaluated through an online survey of over 1045 women who had a personal history of perinatal depression/anxiety. This paper outlines research methodologies and outcomes to demonstrate the extent to which these initial findings are represented across a broader population. The relevance of these outcomes to future approaches to communication in the context perinatal mental health is discussed.

Telephone Based Counselling and Service Coordination to improve service access and engagement in cases of moderate to severe perinatal mental health

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The importance of consistent antenatal care and early intervention in perinatal mental health is widely understood and accepted. However, those most in need are often least able to access and engage with universal and specialist services. Overcoming barriers to access is vital to achieve greater outcomes in mother, infant and family wellbeing.

The question is how do we increase accessibility and engagement when services have limited resources and limited flexibility in modification of service delivery parameters? This presentation will discuss the physical, psychological and social/cultural barriers to access and engagement with perinatal mental health services, and examine an extended Perinatal Telephone Counselling and Service Coordination Program as a solution. Based on outcomes and lessons learned through work with Victorians with moderate to severe perinatal mental health and/or complex psychosocial

risk factors, we will examine the role of ongoing risk assessment and service coordination in the prevention of loss of life; prevention of child abuse; minimization of the consequences of family violence, AOD use and self-harm; minimization of the risks associated with undiagnosed and untreated mental illness and the provision of an accessible, responsive point of contact for families and services. Telephone Counselling and Service Coordination Program data collected in Victoria in 2014 indicates that of the 4,149 calls 1089 were advocacy or service coordination contacts to manage risk to baby/child (46% of clients); risk to self (44% of clients); family violence (38% of clients) or self harm (25% of clients). Taking a case study approach this presentation will also look at the value of counselling that targets identified obstacles to care and health professional consultations to maximise understanding and hence responsiveness to our most vulnerable families in the perinatal period. Lessons for future collaborations and practice will be explored.

Smartphones, parents, babies and young children: Implications of a systematic review for our practise

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The use of smartphones is a recent, rapidly growing, socially acceptable interactional habit. Frequent use by parents while with their infants and children is common. There is anecdotal evidence of negative effects on children's social/emotional development, safety and wellbeing. Social researchers have investigated positive and negative effects of technology use on adults and teenagers. There has been little consideration of the effect of parents' use on young children. Given the wealth of literature on the importance of secure attachment and consistent, emotionally available, well attuned parenting it is important this knowledge gap is investigated. A systematic review was conducted to assess current knowledge about parents' smartphone use and potential effects on child development. The few relevant studies were of mixed methodological type and quality. Studies investigated neurocognitive/developmental outcomes, IQ and epilepsy with no association found to parental mobile phone use, but the effects on child behaviour were variable. There was some evidence that maternal phone use changed foetal physiology and that the amount of smartphone use may increase with parental anxiety, depression, negative self-assessment of parenting and social isolation. Qualitative studies and grey literature raised concerns about parental absorption in devices affecting parenting availability and physical safety of children. Further research is indicated given the; ubiquitous use of smartphones during pregnancy and around children; minimal empirical data; problematic design of studies and

variability of findings. Research should be directed towards understanding the mechanism of potential effects and investigating effects on; the foetus; attunement of parents to children; parent/child relationships and infant/child behaviour. In the absence of clear evidence about effects of parents' smartphone use on children, parents and clinicians should consider problematic smartphone use may, be a risk factor for behavioural and emotional issues in children, affect attuned parenting, be a marker for mental health problems in parents.

4B Postnatal therapies 3: The Business End

A novel service – 3 years on

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Background: Previously, we presented the rationale, set-up and early stages of operation of NEST Clinic, a unique multidisciplinary perinatal health clinic. Then, the clinic was just one year old. Now in operation for 3 years we have learnt a great deal and the service has evolved appreciably.

Objective: Our objective has always been maintaining high levels of clinical care as well as building our service in breadth and depth. However, whilst we set out to establish a *Clinical* service of excellence, little did we appreciate the *Operational* issues that lay ahead. Therefore, our objective in the last 2 years has turned to dealing with these operational challenges and overcoming them, whilst maintaining and expanding the high level clinical care.

Method: Whilst we intended to simply draw upon previous experiences and body of knowledge to meet our goal of clinical service development and expansion, with operational challenges becoming apparent, our limited experience in the arena of service development was exposed.

New learning was required. Our method was not reading books or studying case notes but by learning on the job. Listening to the needs of staff and colleagues, compromising solutions, leading when required and humbly following when alternately advantageous.

Results: Aspects of the service not perceived to be challenging were, and issues thought problematic weren't. When hardships were experienced, management principles of collaboration, consultation and delegation with interpersonal qualities such as, listening, understanding, and directing were invaluable.

Conclusion: Despite, being blindsided by non-clinical aspects of service management, we learnt how to overcome operational challenges whilst developing and expanding clinical services.

Our original vision of a leading multidisciplinary perinatal health service was not compromised. However, to meet our objective of expansion, new skills had to be mastered to overcome operational challenges. The outcome is better than we had imagined.

Reaching 'Generation XYZ' - delivering the message about perinatal attachment via smartphone application

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Background: Parent-child attachment or bonding is essential for a baby's wellbeing and woman's health following birth. Research confirms that the quality of pre and post-natal attachment is key to a range of developmental outcomes for children; and that attachment quality is amenable to change via a range of specialised and community-based parent-focused interventions. Yet, barriers exist that limit access to these services such as cost of provision and access, parental knowledge, mental health, comorbidity. Given the ubiquitous use of Smartphones and other hand-held devices among women of current child-bearing age, there is potential to exploit this phenomena and practicability and feasibility of accessing information via smartphone application that may contribute positively to adaptive parent-child attachments.

Method: Babicare, a smartphone application, consisting of information, images and links to additional resources relevant promoting pre-natal and post-natal attachment from conception to the first 24-months of life (babicare app can be seen on itunes and google play) was developed and commercial viability will be assessed via parenting groups, field experts, focus group interviews.

Results: Although attachment issues within families are prevalent and smartphone has been deemed a novel way to deliver the educational program. Concerns were raised about the preparedness to pay for access and trustworthiness of smartphone application.

Conclusion: Ongoing evaluation of the women who participate in using the 'babicare' and health care professionals who are likely to refer women to such an app is required. New ways need to be forged to meet the needs of the current technologically adept group of young mothers. There is nothing specifically Australian or that can developed for a particular culture or Country.

4C Workshop: Mindfulness

Minding your mind- Mindfulness self care for the busy clinician

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Most of us know what it is like to feel "too busy" with accompanying feelings of fatigue, bodily tension, even pain, not noticing when we need to eat or over eating for distraction, not sleeping enough or knowing when we need to rest, losing concentration, constantly facing the demands of others and our own expectations and in clinical work holding risk and anxiety. In addition there are the demands of balancing our personal/family needs with professional life, coping with change especially in the public sector, and being assailed by constant information and questions via emails, and on line media- all being common experiences in contemporary life.

This workshop hopes to provide the busy clinician, researcher, administrator or conference goer with some practical ways to "change mental gears" in the midst of the above through the experiential practices of mindfulness and self compassion. Cultivating more mental space and awareness of the physical body and emotions, gives an opportunity for greater perspective taking and can promote more discerning decisions and priorities day to day and in life generally which in turn can lead to more balance and less reactivity in the face of stressful and unpredictable daily events.

The workshop leaders are all mindfulness teachers with many collective years teaching mindfulness groups to perinatal women. They offer this workshop as an introduction to taking better care of ourselves and hope you will be encouraged to use some of the practices in an ongoing way or be reminded to continue or refresh your commitment if you already have a meditation/mindfulness practice.

These approaches cost nothing but a small amount of time, are available 24 hours a day and have an evidence base!

4D Mother-Baby Unit III: Disrupted Emotions and Thoughts: BPD and all that

Borderline personality disorder and its effects on infants: Overview

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Borderline personality disorder (BPD) has been recognized as a condition for more than 50 years but only in the last 2 decades has there been substantial progress in identifying its main characteristics, understanding aetiology, providing effective pathways and documenting effects on offspring of people with this condition. When the first wave of research into BPD in a mother-baby unit identified the frequency of this condition as close to 50% (either by self-report or by clinical interview), efforts were made to better coordinate care for women presenting with features of this condition, including the development of ward protocols for staff, psychoeducational material for women and their

families and further training for staff. This first presentation will provide information on several of these topics, including a pictorial summary of what is known about the neurobiology of BPD and how it may be transferred from one generation to another, the results of the first wave of research, training and the effects for staff, and the effects on

children and families of this condition and general information about how to provide early intervention. There will be some discussion of the effects of this condition for families and staff.

Borderline personality disorder (BPD) symposium: A dialectical behaviour therapy informed skills group for mother with BPD and their infants.

A dialectic behaviour therapy informed group for women with BPD and their infants

Chris Yelland, Sharron Hollamby

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Borderline personality disorder is common in an inpatient mother-baby unit and at Helen Mayo House, protocols have been developed for helping women and their infants when this condition is diagnosed. Once the diagnosis is made, a two week inpatient stay is defined with precise plans for discharge and community follow-up. Staff in the unit have all had some training with dialectical behaviour therapy and in addition have had some training in how to help mothers with reflective functioning in relation to their infants.

During admission most women are offered referral to a specialized dialectical behaviour therapy (DBT) informed group which begins after discharge. Approximately 30% of women are ready to take up this offer. The group strategy has been developed by the team specifically to address the effects of this personality disorder on the woman and her infant. The skills group targets mother/infant interactions to provide the woman with a range of skills to help her with her own emotional dysregulation which is often triggered by her crying infant, and also with her engagement and management of her infant. Both mothers and their infants attend the group, with the mothers initially separating for the skills training whilst the infants are cared for in a separate room. The mothers are then given an opportunity to start practicing new skills with their infants, with the support of the workers. Techniques used with the infants are also informed by infant mental health principles and ideas, including Lynne Murray's *The Psychology of Babies*. Work from these DBT-informed groups will be presented, initially by sharing the techniques involved, then by showing video work of mother-infant dyads and then preliminary outcomes.

4E Symposium: Engaging midwives in infant mental health

Engaging Midwives in Infant Mental Health: The Development of a Typology of Looking - a clinical tool for midwives

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This paper outlines PhD research that explores how mothers' look at their newborn babies. The overall goal of the project is to use this to intervene early in the mother /infant relationship where indicated. A typology of looking has been developed that demonstrates that midwives' intuitive knowledge can be codified. It also provides an opportunity to enhance midwives' capacity for early intervention in the actual mother-infant relationship

Research occurred in two 2 phases. In the first phase, videotapes were made of mothers with their newborns on the post-natal ward. Video of mothers being with their babies and their responses to a brief semi-structured interview were analysed to identify key characteristics of looking. Using an iterative process, behavioural descriptions were developed under three broad classifications. This yielded a one-page typology of looking.

The second phase of the study engaged midwives in an inter-rater reliability process. Thirty midwives were recruited and trained in the use of the typology. These midwives then viewed the videotapes and coded them according to the typology.

The intraclass correlation coefficient was used to approximate the Kappa statistic in accordance with Fleiss and Cohen (1973). Based on Fleiss's (1981) guidelines for Kappa, the inter-rater agreement was in the middle to upper end of the fair to good range (0.40 - 0.75). This demonstrates that midwives can use the typology with moderate inter-rater reliability.

Recruiting midwives for the reliability study successfully exposed them to infant mental health principles and practices as part of their standard professional development. Interested midwives received additional training in the use of the Newborn Behaviour Observation System (NBO).

Engaging midwives in infant mental health: The newborn behavioural observation system on the postnatal ward – a case study

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The Newborn Behavioural Observation System (NBO), developed by Kevin Nugent, et al, enables clinicians to elicit and share observations of an infant's individual capacities and temperament with parents. It recognizes the imperative of the competent infant's developmental agenda to connect in relationship while harnessing early parental preoccupations and the transition to parenthood.

The use of the NBO as a clinical tool will be illustrated through a case example and video. Emphasis will be given to how the infant-focused nature of the NBO can encourage effective, congruent responses within parents and assist to contain parental concerns. The case study will include aspects of reaction to disability, birth trauma and working with extended family.

Looking and delighting together through the lens the NBO can:

- capture and focus a new parents' desire to understand their baby and illustrate how their infant is reaching out to them
- create a safe space in which parents are invited to hear the "voice" of their infant, their particular vulnerabilities and preferences and gain confidence in managing infant behaviours
- develop an understanding within the parent of how different states can influence an infant's capacity to engage socially, protect sleep or successfully feed.
- create a platform for relationships to deepen between infant and parent and also between clinician and parents

The NBO consists of 18 behavioural observations that acknowledge the domains of autonomic, motor, state organization and responsivity. It recognizes the developmental agenda of the competent infant to connect and the formative energy and psychological transition of the early parental preoccupations.

Engaging midwives in infant mental health: Midwives experience of the nbo and raising the profile of the mother- infant relationship on the postnatal ward.

Valerie Aylesbury

Women's and Children's Health Network, Adelaide, Australia

What can early intervention look like when we begin at the very beginning, meeting the new baby fresh from the womb? We explore the experiences of midwives involvement in the development and introduction of a 'Typology of Looking' on the postnatal ward at the Women's and Children's Hospital. Involvement in the research led to more education of midwives in the NBO and bringing the NBO into postnatal care.

The WCH provides care to over 4800 pregnant women each year and delivers over 5000 babies. In midwifery there is understandably much focus on pregnancy. Length of stay on the postnatal ward is between 1 and 3 days, a short and intensive period of care and transition. The actual baby is finally present and able to be seen.

The focus of midwifery care is being "with woman". The reality is that hospital systems become focussed on tasks and paperwork and risk aversion. Therefore the midwives' experience on the post-natal ward can feel like just 'busyness'.

The aim of the introduction of the typology and NBO on the postnatal ward has been to shift the focus back to the mother, baby and their relationship.

In this paper we report :

- How this has impacted on the midwives' experience of care giving
- Any cultural changes and practice on the PN ward
- Any impact of the NBO specifically on midwifery care
- Feedback from the mothers and families of this initiative

Relationships are forged within the practice of the NBO between both midwives and parents and then the parents and their newborn infant and family. At another level it is relational between researcher, educators and the health team of midwives. In all aspects, this practice-based research has a relational focus with the mother-infant relationship at its heart.

Posters

Changing Faces - What does SAFESTART referral data tell us about the contemporary face of perinatal and infant mental health, and how does it inform service development?

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Background: The Central Coast of NSW has a rapidly expanding population and an increasing number of Perinatal and Infant Mental Health referrals that are complex and require multiple service involvement. Since the inception of the SAFESTART screening and assessment programme, it appears that the face of the Perinatal and Infant Mental Health Client has changed, in line with Perinatal and Infant Mental Health as an emerging construct. Service review is an integral part of maintaining a relevant and effective service, able to meet the needs of consumers.

Aim: This poster presentation aims to analyse SAFESTART referral data for the period March 2015 to August 2015 and identify and illustrate the make-up of referrals to the SAFESTART multi-disciplinary meeting and Perinatal and Infant Mental Health (PIMH) team. Key vulnerabilities will be analysed for frequency of presentation along with demographic variables. From this data, a picture of the contemporary Perinatal and Infant Mental Health client will be developed along with potential foci for service improvement and development, and an analysis of where specialist PIMH teams fit in the current health landscape.

Results and conclusions: Pending

Development of a model of psychological service within a neonatal unit

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Neonatal Units are a unique and complex environment. Having a baby admitted to a Neonatal Unit is often a stressful and unexpected experience for parents and this can compound the already challenging perinatal period for which adverse psychological symptoms are a risk. The Neonatal experience for parents can be associated with experiences of stress, anxiety, depression, sleep disruption and trauma. This can result in compromised parenting capacity and interaction with the infant and other children in both the short and long term. Given that early events and experiences for parents can negatively impact on infant developmental outcomes and life traumatic experiences, need for psychological services within Neonatal Units is evident. Psychologists can have a broad and important impact within Neonatal Units by way of providing evidence-based therapy for psychological disorders and symptoms, developmental assessment of high risk infants, and education to families and other staff working with high risk families. Regional hospitals present additional complexities to consider when providing psychological intervention to families including cultural diversity of patients, families separated from home and social networks for extended periods of time, challenges providing outreach support, and loss of long term developmental follow-up. Greater understanding of the scope of psychology within Neonatal settings is required. Provided is a review of current knowledge of psychological

aspects of Neonatal admissions and best practice models of early psychological intervention and the experience of developing the Clinical Psychologist role within a Neonatal team in a regional hospital setting.

Pregnant woman with treatment resistant schizophrenia on Clozapine

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Clozapine continues to be the gold standard in the management of treatment resistant schizophrenia (TRS) even after many newer antipsychotics being introduced over the last two decades. It is the obvious treatment of choice in TRS. However, the use of clozapine in pregnant women is based on a risk/benefit analysis. Clozapine should be used in pregnancy only if the expected benefit is considered to outweigh the potential risk. We describe a 31-year-old married woman, who had more than 10 years' history of TRS. Her mental state was stable on clozapine 200 mg for the last 5 years. Her functional improvement was such that she was not only able to hold down a job for many years but was also in a stable relationship for the last 4 years. She had not seen any medical professional (including GP and psychiatrist) since relocating to Australia 8 months ago. Her GP referred her to the community mental health clinic attached to a tertiary referral institution requesting specialist advice regarding the use of clozapine in pregnancy, given that the patient was 8 weeks pregnant. In addition to ethical issues, there were many other management difficulties that complicated her care.

Evaluation of the Circle of Security Parenting Education Program (COS PEP): A pilot study

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The Circle of Security Parenting Education Program (COS PEP) is a group program designed to help caregivers provide a secure base and safe haven for their children. Adapted from the longer 20-week COS intervention (Marvin et al, 2002; Cooper et al, 2005), COS PEP offers the core components of the COS protocol in a DVD format. The DVD contains eight chapters aimed at educating parents and caregivers to refocus from behaviour management to enhancing the quality of relationship, and to introduce strategies to enhance parental reflective functioning and manage children's emotions.

COS PEP is popular and widely used. Anecdotal reports about the program have been positive but, to date, there has been no published outcome data regarding its effectiveness. This pilot study evaluated outcomes associated with COS PEP delivered in a community-based setting using a basic pre-post questionnaire design. Participants were 15 mothers with children aged 0–2 years of age, recruited via invitation from staff at a Family Care Centre or in response to a promotional flyer circulated through email networks to local child and family health referral agents.

Results showed the COS PEP intervention to be associated with significant improvements in maternal reflective functioning ($p < .05$), feelings of caregiver helplessness ($p < .05$), parent-child bonding ($p < .05$) and maternal stress ($p < .05$). While there is clearly a need for larger, controlled outcome studies to investigate the effectiveness of COS PEP, the initial evidence provided by this pilot study is promising.

Edinburgh Depression Scale referral criteria during routine antenatal screening: clinical impact of changing the cut-off score from 10+ to 13+.

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Liverpool Hospital (Sydney), since 2001, has routinely screened women attending their first antenatal clinic appointment for psychosocial risks and for current emotional difficulties. Women scoring positive on either of these

have been referred to a weekly Safe Start meeting for triaging. Until 2012 all women who had a psychosocial risk, or who had an EDS score of 10 or more, were deemed 'screen positive' and were referred to this meeting. Due to the

increasing number of referrals, and evidence that a higher EDS cut-off score was valid antenatally, the referral criteria was increased to a score of 13 or more. Those then scoring 10-12, without any psychosocial risks, were instead given a clinic letter, asking them to contact the hospital's Social Work department should they have any emotional concerns. The clinical impact of this change on referral numbers, and on the correct management of women, was evaluated. Records were monitored over an 18-month period, which showed that i) referral numbers dropped by around 20%; ii) none of approximately 140 women who were given the clinic letter contacted the Social Work department; iii) 20 English-speaking women, who had been given the clinic letter due to scoring 10, 11 or 12 on the EDS with no other psychosocial risks, were interviewed. All said that at the time of the antenatal appointment they had not wanted to discuss any emotional concerns or worries, and all said that they were aware that they could have contacted the Social Work department if they had wanted to. The evidence from this change in clinical practice evaluation suggests that increasing the EDS referral score from 10 or more to 13 or more does not miss women who in fact need to then be triaged, and it also results in a meaningful reduction in the service's workload.

Common mental disorders among women, social circumstances and toddler growth in rural Vietnam

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Common mental disorders (CMD) and adverse social circumstances are widespread among mothers of infants and toddlers in resource-constrained settings. These can undermine early childhood development through compromised caregiving and insufficient access to essential resources. The aim was to examine the effect of maternal CMD and social adversities in the postpartum year on toddler's length-for-age index in a rural low-income setting.

A population-based prospective cohort study of women in Ha Nam, Vietnam who completed baseline assessments in either late pregnancy or 4–6 weeks postpartum and were followed up, with their toddlers, fifteen months later. CMD were assessed at both points by psychiatrist-administered Structured Clinical Interviews for DSM IV Diagnoses. Toddler's anthropometric indices were calculated length using WHO Standards. Social adversities were assessed by study-specific questions and locally-validated psychometric instruments. The hypothesised model of factors governing toddler's length-for-age Z score (LAZ) was tested using Path Analysis.

In total 211/234 (90.1%) mother-toddler pairs provided complete data. Baseline prevalence of CMD among women was 33.6% and follow-up was 18.5%. The mean LAZ among toddlers was -1.03 and stunting prevalence (LAZ < -2) was 15.6%. Maternal CMD at baseline were indirectly related to toddler LAZ via maternal CMD at follow-up (regression coefficient = -0.05, 95% CI -0.11 to -0.01). Maternal CMD at follow-up was associated significantly with toddler LAZ (regression coefficient = -0.15, 95% CI -0.28 to -0.05). Poorer quality of marital relationship, mothers' experiences of childhood abuse, and < 30 days dedicated postpartum care were associated indirectly with lower toddler LAZ via maternal CMD.

Maternal postnatal CMD are associated with child growth measured by LAZ in this resource-constrained setting. Social adversities affect child growth indirectly through increasing the risk of maternal CMD. Interventions to reduce stunting in low-income settings will need to address maternal CMD and social adversities in order to improve impact.

Evaluation of circle of security parenting program for women with perinatal mood disorders

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Postnatal depression is the most prevalent mood disorder associated with childbirth and affects up to 20% of childbearing women. This study's aim was to examine the effectiveness of the Circle of Security (COS) parenting program for women diagnosed with a perinatal mood disorder. Circle of Security is a relationship based early

intervention designed to enhance attachment security. The sample consisted of 37 women admitted to a private mental health hospital who participated in 6 groups conducted during 2014. The program included video examples of secure and problematic parent/child interaction, healthy options in caregiving, and animated graphics designed to clarify the central principles. Participants completed self-report questionnaires pre and post program. Aspects of patient functioning that were measured included: maternal attributions about infants (Infant Intentionality Questionnaire); feelings about being a parent and being with their children (Caregiving Helplessness Questionnaire); and how reactive they perceive themselves to be to young children's negative affect (Coping with Toddlers Negative Emotions Scale). An analysis of the data revealed statistically significant results across most measures. The results indicated that participants assigned less negative attributes to their child's behaviour; they felt less helpless about their ability to parent; and rated themselves as less fearful of their children. Furthermore, statistically significant changes occurred when rating the likelihood of responding to toddlers' negative emotions in each of 7 possible ways for 12 scenarios: distress reactions; punitive reactions; expressive encouragement; emotion-focused reactions; problem-focused reactions; minimization reactions; and granting wish reactions. Additionally, post-program evaluations revealed that 100% of participants agreed they were now able to identify their child's needs, and 98% stated that they now viewed their child's behaviour differently. The results suggest that the Circle of Security parenting program has the potential to assist women who have experienced perinatal mood disorders to improve their relationship and interaction with their children.