



When the bough bends, resilience in the perinatal period



The  
Marcé  
Society

Australasian Marcé Society  
for Perinatal Mental Health  
2017 Conference

Brisbane Convention & Exhibition Centre  
26 to 28 October 2017

# PROCEEDINGS

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## Day 1: Friday 27 October 2017

### Session 1B - Workshop

#### **A16: Mother-Infant Dialectical Behaviour Therapy (MI-DBT): The Development of a DBT Group Program that Addresses the Complex Emotional and Relationship Challenges affecting Mothers with Young Infants.**

**Chris Yelland<sup>1</sup> and Sharron Hollamby<sup>2</sup>**

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Descriptive Text: Helen Mayo House is a 6-bed acute inpatient mental health facility that admits women who have severe mental illnesses with their infant children up to the age of 3 years. A recent study of our unit found that a high prevalence of women who were admitted had a diagnosis of Borderline Personality Disorder (BPD) (23.1%), with 46.6% reaching criteria for a potential diagnosis of this disorder on the McLean Screening Instrument for BPD.

Dialectical Behavioural Therapy (DBT) has been found to be an effective treatment for working with people who have a diagnosis of BPD. However, traditional DBT groups do not address the specific and unique challenges affecting women with BPD who have babies and young children. This presentation will discuss how we have adapted DBT to meet the specific needs of this population, not only in order to help the women learn adaptive ways of managing the emotional and relationship issues that are associated with being a mother with BPD, but also in order to prevent the infant from going on to experience their own difficulties with emotion regulation and interpersonal effectiveness. Results of the first four groups will be presented along with case discussion to highlight the gains made by the Mothers and Infants who attended.

### Session 1D - Technology and Genetics

#### **A55: Stepped Care for Perinatal Mental Health Support**

**Jeannette Milgrom<sup>1&2</sup>, Alan W. Gemmill<sup>1</sup>, Jennifer Ericksen<sup>1</sup>, Christopher Holt<sup>1</sup>, Charlene Holt<sup>1</sup>**

**<sup>1</sup>Parent-Infant Research Institute, Melbourne, Australia, <sup>2</sup>University of Melbourne, Melbourne Australia**

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The Parent-Infant Research Institute (PIRI) is leading the implementation of a Mental Health Stepped-Care Model, as advocated in the National Mental Health Plan, in the perinatal period.

PIRI continues to develop e-health tools for stepped perinatal mental health care that enable consumers to readily step-up to higher-intensity services, or transition down to lower-intensity supports, when their needs change. These include electronic screening (developed with COPE); a clinical decision support system (CDSS) for health professionals to use in conjunction with electronic screening; and a suite of evidence-based online psychological treatment programs designed for women with depression and anxiety, both in pregnancy and postpartum (*MumMoodBooster*, *Mum2BMoodBooster*). The *MumMoodBooster* programs are self-paced, highly interactive and embody the key Cognitive Behavioural Therapy elements within a user experience that is designed to be closely comparable to our proven face-to-face treatments for perinatal depression. They

have been validated as effective in Australian populations and are delivered using low-intensity telephone or SMS support. PIRI has also developed, in partnership with other experts in the field, a smartphone app for 'at risk' women with sub-clinical symptoms of depression and anxiety or with significant risk factors (e.g., history of mental health difficulties).

PIRI is leading a research collaboration to implement and evaluate the stepped-care model, including these and other perinatal e-mental health resources. A national website will organise new and existing health promotion tools, resources and supports for easy access. The approach aims to ensure that all parents have ready online access to perinatal mental health resources, tools and mobile apps beginning with those suited to the whole population (focused on fostering resilience, mental health promotion and prevention). The model then enables consumers to 'step-up' to specialised interventions suitable for treatment of moderately severe perinatal depression and anxiety (*MumMoodBooster*, *Mum2BMoodBooster*) or to traditional specialist services, as and when needed.

## **A64: Positively Pregnant: Development and pilot testing of an app for stress management in pregnancy**

**Carol Cornsweet Barber and Bridgette Masters-Awatere**

University of Waikato, Hamilton, New Zealand

This paper will describe the development and pilot testing of an app that seeks to promote mental health and wellbeing among pregnant women. Positively Pregnant (PP), a mobile phone app, has been developed using principles from positive psychology, health promotion, and perinatal mental health. It is an interactive tool for women to reflect on their own strengths, strategies, supports, stressors, emotions, cognitive style, and health behaviours. These self-assessments lead to feedback and recommendations for activities and strategies for self-management, some in the app (e.g., guided imagery, goal setting, journaling) and some in the world (e.g., exercise, social support). The app also includes prompts for conversations with the partner or support person about hopes, plans, and goals, and information about the social and emotional side of pregnancy and early parenting.

Positively Pregnant is currently being piloted in Waikato, New Zealand, with about 60 women. These women are using PP throughout their pregnancy and providing quantitative and qualitative feedback on their experience using the app, as well as completing standardized measures of depression, anxiety, stress, and health behaviours at four points during and after the pregnancy.

One of the advantages of mobile app technology is that it can be tailored to the individual user, so that specialized content or format can be presented to users with particular needs or characteristics. Part of the goal of this study is to solicit feedback from migrant, indigenous, and teen mothers in order to adapt and tailor PP to their needs and interests.

This paper will describe the structure and contents of the app, and present findings from the initial two assessment points, at enrolment in the study (prior to 20 weeks' gestation) and at 24 weeks. We will also present feedback from focus groups of users and plans for modification and development of the app.

## **A72: SMS Messages - Mental Health Promotion and Prevention for Women with Diagnosed Perinatal Mental Illness and their Partners.**

**Cate Rawlinson<sup>1</sup>, Richard Fletcher<sup>2</sup>, Elisabeth Hoehn<sup>1</sup>**

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SMS mental health promotion and prevention messages can be delivered at low cost to parents' mobile phones, can be read when convenient, allow confidentiality, and avoid possible stigma. The SMS4Families research project in regional and rural Queensland is currently testing the feasibility of using mental health promotion and prevention text messages with new mothers diagnosed with perinatal mental illness and their partners. The text messages, delivered to the participant's mobile phones, are aimed at encouraging parents to look after their mental health, support their partner, identify ways to connect with their infant, and provide links to information and resources. New parents experiencing mental illness in regional, rural and remote areas are a particularly vulnerable group as access to resources and services can be limited. Therefore, the use of innovative technology may provide another means of delivering important information, informing parents of available resources, and provide access to support in areas where resources may be scarce.

Research and scoping data identifies mothers in the perinatal period with young children to be prolific users of smart phone technology to communicate and to find information. There is also a growing evidence-base for the use of SMS messages to engage fathers in learning about and seeking help for their mental health and wellbeing in the perinatal period. Results from the SMS4dads pilot study in Newcastle and from the SMS4dads national randomised control trial indicate that many fathers discuss the text messages with their partner, and that these discussions lead to more cooperative parenting practices.

This research aims to progress knowledge in this area by extending the current evidence to women with diagnosed perinatal mental illness and their partners, in regional and rural areas. This paper will discuss the research protocol and participant feedback to date highlighting an innovative, sustainable and scalable methodology.

## **A15: Genomics and epigenomics in Postpartum Depression – methods and technology in research**

### **Dr Divya Mehta**

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Postpartum depression (PPD) is a common debilitating disorder that has long-term detrimental effects. PPD has also been reported to have significant negative consequences on mother-infant bonding, well-being of the infant and socio-cognitive development of the infant. Among other factors, sex-steroid hormone fluctuations such as estrogen may increase risk for depressive symptoms in PPD.

Recent technological advances have provided new insights into the pathogenesis of PPD. This workshop will focus on research interrogating the biological mechanisms and disease trajectory in Postpartum depression, with special emphasis on genetic, and epigenetic methods. Methods will include candidate-based analysis approaches as well as hypothesis-free methods via genome-wide gene expression and DNA methylation profiling. Specifically, different lines of evidence about the estrogen sensitivity theory of PPD and the more generalized role of estrogen sensitivity not just in PPD but also in related disorders will be discussed.

Finally, biological data including novel research findings from genomic, neuroendocrine and brain imaging data will also be presented to provide examples of genomic methods that can be used to elucidate biological mechanisms underlying PPD. Using a systems approach, different types of data will be integrated to provide a holistic overview of the disorder and the biological pathways that are perturbed in PPD. Current status and future directions in PPD research will be interactively discussed.

This workshop is specifically designed for clinicians, scientists and students who would like to get a glimpse of the recent technological advances in genomics and how these methods are currently being applied to Postpartum depression.

## **Session 2A – Workshop**

### **A71: Eating Disorders in the Peripartum and impact on Infant Mental Health and Feeding**

**Susan Roberts<sup>1</sup>, Warren Ward<sup>2</sup>, Megan Huppert<sup>3</sup>**

Eating Disorders are associated with significant physical complications and increased mortality. In pregnancy eating disorders are associated with increased risk of pregnancy complications including unplanned pregnancies, hyperemesis and small for gestational age babies. Pregnancy can both worsen eating disorders due to challenges in changing body shape and also provide the motivation for change. There are also increased risks for postnatal depression, relapse of the eating disorder postpartum, reduction in rates of breastfeeding and significant impact on maternal infant attachment and infant feeding.

This workshop combines the expertise of perinatal psychiatry, eating disorder specialists and Infant mental health specialists in an interactive case based workshop using deidentified cases to promote discussion of identification and management of eating disorders in the peripartum and interventions for Infant Mental Health.

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## Session 2B - Postpartum Psychosis

### A9: Postpartum psychosis in the 19<sup>th</sup> and 20<sup>th</sup> century

#### Philip Boyce<sup>1</sup>

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The Marce society is named after the French psychiatrist, Louis-Victor Marce, who is credited with producing the first substantial treatise on perinatal mental illness. However, there were writers earlier than him that provided rich descriptions of the clinical features and treatments for postpartum psychosis.

In this presentation, I will review some of the major English-speaking contributions that provide rich descriptions of the clinical features and treatments of postpartum psychosis in the 19th and early 20th century.

The clinical profile picture described in these early papers is remarkably consistent; an onset of illness in the first few weeks postpartum with a complex clinical picture with a mix of catatonic features, 'confusion/perplexity' along with florid psychotic symptoms. Among the myriad of treatments provided, one fundamental treatment was to ensure that the women slept.

Postpartum psychosis has no official nosological status; we have to shoehorn a diagnosis using current DSM diagnostic categories. The consistent clinical presentation over time following a specific aetiological factor are strong arguments to support this disorder having its own diagnostic category. This is also essential to further advances in our understanding of this disorder, especially when a clear phenotype needs to be defined for genetic studies.

### A35: CLOZAPINE IN PREGNANCY: MEDICAL, OBSTETRIC AND NEONATAL OUTCOMES OF WOMEN PRESCRIBED CLOZAPINE IN PREGNANCY UNDER THE CARE OF A SPECIALIST ANTENATAL CLINIC

#### DR JASMINE MORDECAI<sup>1</sup>

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Clozapine is an effective antipsychotic medication indicated for the management of treatment resistant schizophrenia. However, it is medication with numerous side effects and stringent monitoring requirements. Little is known in regard to the risk to the mother and fetus when this medication is used in the obstetric setting. This paper presents the findings of a retrospective chart audit of women prescribed clozapine in pregnancy under the care of the King Edward Memorial Hospital Childbirth and Mental Illness (CAMI) Clinic; a state-wide multidisciplinary antenatal clinic for women with severe mental illness established in 2007. A total of 9 pregnancies were identified from the CAMI database where the mother was prescribed clozapine in pregnancy between December 2007 and December 2016. Medical, obstetric, and neonatal outcomes were obtained from the medical record, and compared to Western Australian obstetric and perinatal statistics where possible. It was found that these women are at statistically significant increased risk of obstetric risk factors such as obesity, smoking, and gestational diabetes. Women prescribed clozapine in pregnancy were more likely to experience suspected fetal distress during labour. Statistically significant higher rates of adverse neonatal

outcomes such as resuscitation at birth, and admission to special care nursery were also observed. Clozapine related side effects such as constipation, orthostatic hypotension, and cardiomyopathy also occurred at a rate that was higher than expected when compared to published data of clozapine related side effects in the non-pregnant population. None of the women experienced a psychotic relapse during pregnancy or in the early postpartum period. The results of this audit will provide valuable information for both women and their care providers to assist in informed decision making in cases of maternal clozapine use.

## **A67: Who dropped the baby? Postnatal psychosis case studies.**

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### **Aim**

The aim of this paper is to consider the range of health professionals involved in perinatal care, and identify who should be responsible for informing and identifying risks and symptoms of perinatal mental health issues, particularly postnatal psychosis (PP), to assist with prompt and effective care.

### **Background**

Postnatal psychosis is considered a rare condition with it affecting 1-2 women in every 1000 childbirths, or 600 women per year in Australia. If PP symptoms are not identified early, then often it is not diagnosed until delusions, hallucinations and losing concept of reality has taken hold. This increases the woman's risk of suicide and even infanticide. The woman will then require hospitalisation and treatment with antipsychotics, mood stabilisers and, possibly, ECT. Without accessible mother baby units, this means admission to a general secure public mental health unit, and separation from her baby, adding further distress to the mother, and her family.

### **Method**

This paper examines a series of case studies to determine whether the women diagnosed with PP received the information, diagnosis, treatment and care they needed in a timely manner.

### **Findings**

In these cases, although many health professionals were involved in a woman's perinatal care, there was minimal continuity of care, which may have limited the opportunity for changes in behaviour to be identified. These women lacked access to information about PP and were not assessed for PP until they showed acute symptoms amongst family and friends.

### **Conclusion**

Earlier identification of women at risk of PP and recognition of symptoms would enable women to be more promptly connected with Perinatal Infant Mental Health Services allowing treatment to prevent the more serious symptoms developing and removing the trauma of mother-baby separation. Access to specialised public mother baby facilities would improve treatment options for these women and their families.

## Session 2C – Symposium

### A13: Supporting emotional wellness and treating perinatal anxiety and depression online

This symposium brings together three studies examining the impact of mobile phone monitoring/screening and internet-delivered programs for the detection and treatment of depression and anxiety during the antenatal and postpartum period.

#### PAPER 1 ABSTRACT

### **mummatters: an on-line tool to support emotional wellness during pregnancy and the postpartum**

**Nicole Reilly<sup>1</sup>, Marie-Paule Austin<sup>1,2</sup>**

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#### **Background**

*mummatters* is a free evidence-based online mobile tool that aims to support emotional wellness during the perinatal period. It has been designed as a method for pregnant and postnatal women to self-assess for symptoms of depression (using the Whooley questions) or the presence of psychosocial risk factors (using the Perinatal Risk Questionnaire), and guides them to appropriate support and resources. *mummatters* also encourages women to create a tailored wellness plan and to regularly 'check-in' to monitor their emotional health. Summary reports can be generated directly from *mummatters* for women to share with their health care provider.

#### **Methods**

The *mummatters* evaluation will examine the 'real world' utility of this on-line tool. Data will be collected from consenting women 1-month, 3-months and 6-months after completion of the *mummatters* self-assessment measures.

#### **Results**

Data from the first 200 women enrolled in the *mummatters* evaluation will be presented. This will include an examination of the acceptability, credibility, perceived impact and motivational appeal of *mummatters*, whether it prompts users who receive a 'positive' screen to take some form of action (including clinical review by a health care provider), as well as barriers to action taking.

#### **Discussion**

This study will be the first to report on the acceptability and utility of an online consumer-led tool developed specifically to support emotional wellness during the perinatal period. Opportunities for future enhancements of *mummatters* will also be discussed.

#### PAPER 2 ABSTRACT

### **MUMentum Pregnancy Program: Development and evaluation of an online intervention for antenatal anxiety and depression**

**Siobhan Loughnan<sup>1</sup>, Dr Christine Butler<sup>1</sup>, Dr Jill Newby<sup>2</sup>, Professor Gavin Andrews<sup>1</sup>**

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## **Background**

No evidence-based, low-intensity, online interventions are currently available for women experiencing anxiety and depression during the antenatal period, despite antenatal anxiety and depression being associated with poor postnatal adjustment. The aim of the MUMentum Pregnancy Program is to deliver an accessible, convenient and evidence-based treatment intervention to women experiencing clinical symptoms of anxiety and depression during pregnancy.

## **Method**

A randomised controlled trial was conducted to evaluate the efficacy of an online-delivered intervention in reducing clinical symptoms of anxiety and/or depression experienced during pregnancy. Participants were required to be between 13-30 weeks gestation, fluent in written and spoken English, have access to a computer and internet, and have minimal safety risk issues at application. Participants completed the 3-lesson program over a period of 4 weeks, with baseline, post-treatment and follow-up data collected at Week 1, Week 5 and Week 9, respectively.

## **Results**

Data will be presented on the pregnancy program's efficacy in reducing symptoms of anxiety and depression (pre- to post-treatment), acceptability (i.e. treatment satisfaction) and other maternal outcomes including mother-infant attachment, and quality of life. We currently have 80% of our required sample size.

## **Conclusion**

This study will be the first to report on the efficacy of a short, 3-lesson online-delivered CBT-based intervention specifically tailored to clinical symptoms of anxiety and depression experienced during pregnancy.

## **PAPER 3 ABSTRACT**

### **MUMentum Postnatal Program: Development and evaluation of an online intervention for postnatal anxiety and depression**

**Siobhan Loughnan<sup>1</sup>, Dr Christine Butler<sup>1</sup>, Dr Jill Newby<sup>2</sup>, Professor Gavin Andrews<sup>1</sup>**

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## **Background**

Convenient and accessible, evidence-based interventions that are tailored to the unique issues and challenges of the postnatal period are required in order to improve help-seeking amongst postpartum women experiencing anxiety and/or depression. No evidence-based, low-intensity online interventions are currently available for women experiencing postnatal anxiety and depression, despite anxiety and depression being highly comorbid. The MUMentum Postnatal Program is a 3-lesson, online-delivered, cognitive-behavioural therapy-based intervention that aims to help women manage symptoms of antenatal anxiety and depression in the privacy of their own home, at any time that is convenient to them.

## **Method**

A randomised controlled trial was conducted to evaluate the efficacy of the MUMentum program in reducing clinical symptoms of postnatal anxiety and/or depression. Participants were required to be within 12 months postpartum, fluent in written/spoken English, access to a computer/internet, and self-report minimal safety risk issues. Participants completed the 3-lesson program over a period of 6 weeks, with baseline, post-treatment and follow-up data collected at Week 1, Week 7 and Week 11, respectively.

## **Results**

Data will be presented on the postnatal program's efficacy in reducing symptoms of anxiety and depression (pre- to post-treatment), acceptability (i.e. treatment satisfaction) and other maternal outcomes including mother-infant attachment, parenting confidence, and quality of life.

## **Conclusion**

This study will be the first to report on the efficacy of a short, 3-lesson online-delivered CBT-based intervention specifically tailored to clinical symptoms of anxiety and depression experienced during the postnatal period.

## **Session 2D – Attachment and Bonding**

### **A54: A review of antenatal clients of a perinatal mental health service: the level of bonding, their partners' understanding, and their reasons for feeling distressed.**

**Kay Souter<sup>1</sup>, Stephen Matthey<sup>1,2</sup>, Julie-Anne Murphy<sup>1</sup> and the PIMHS Team<sup>1</sup>.**

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## **Background**

Many studies have looked at the risk factors for perinatal distress, from a statistical point of view, and many others have reported on women's experiences of feeling distressed, their sense of partner support, and bonding in pregnancy. Few, however, have directly asked women what things they themselves consider have contributed to their distress. Though this approach is usually taken within clinical practice, it is done in a semi-structured way, which may leave possible reasons, from the woman's perspective, hidden or unexplored. As part of the evaluation of a perinatal mental health service, women therefore completed a checklist of possible reasons for their distress, which included an item on partner understanding, as well as a maternal-foetal bonding questionnaire.

## **Method**

Pregnant women attending a clinical perinatal mental health service, because they were currently distressed or because they had identified risk factors for later difficulties, completed the Reasons for Distress Checklist (RDC; N=108) as well as Condon's Bonding Questionnaire (N=68). These were completed during the assessment phase. In addition, 28 of these women completed the RDC again at review (~13 weeks later).

## **Results**

Frequency of significant reasons for feeling distressed will be reported, as well difficulty with maternal-infant bonding and perception of their partner's level of understanding. Changes on the RDC between the assessment and initial review will also be investigated. The discussion will in part focus on the benefits and drawbacks of using such standardised instruments in clinical practice, as perceived by the clinicians, especially in respect to the mandated NSW Health measure, the K10.

## **Conclusion**

Apart from providing a fuller picture of issues to be considered when assessing perinatal mental health clients, there are some indications that this project also has managed to partially bridge the usual separation between clinical and research work.

### **A65: The Building Early Attachment and Resilience (BEAR) study: Supporting mums and bubs**

**Dr Kristine Mercuri**

Royal Women's Hospital Melbourne, University of Melbourne, Australia

## **Background**

Infancy is a crucial developmental period during which early experiences including the quality of care-giving influences brain architecture and neuronal functioning and helps to shape capacities central to later psychological and emotional health. Attachment Theory stresses the significance of the infant's relationship

with the primary care-giver and the role of parental capacity to read and process infant affective communication. However parental mental illness, anxiety and history of early adversity and trauma can have a negative impact on this relationship. Pregnancy offers a window of opportunity to provide early interventions for parents at risk. The main aim of this study is to evaluate the efficacy of two attachment focussed interventions aimed at decreasing maternal stress and anxiety and improving emotional interaction and the attachment relationship with their infants, in a quasi-randomised control trial.

### **Bear Study**

Women attending for antenatal services at a tertiary referral women's hospital and referred to mental health services are recruited into the study and randomised to one of 3 treatment groups and a control group: mindfulness-based antenatal program, attachment-based postnatal program, mindfulness-based antenatal program followed by attachment-based postnatal program. Data is collected by self-report and assessment. The primary outcomes are: maternal parenting ability, the infant-parent attachment relationship, maternal mental health and functioning, and infant development. Data collection commenced in 2015 and the aim is to recruit 500 participants. This presentation will outline the design protocol and initial data on the first 100 participants.

### **A36: Screening For Socio-Emotional Problems In Infants: Implementation Of Universal Screening With The Alarm Distress Baby Scale (ADBB) In Primary Care**

**Johanne Smith-Nielsen<sup>1</sup>, Nicole Nadine Lønfeldt<sup>2</sup>, Anotoine Guedeney<sup>3</sup>, Mette Skovgaard Væver<sup>1</sup>**

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In most countries, infant socioemotional development is held under informal surveillance, but a formal screening program is needed to ensure systematic detection and early intervention. However, screening programs are often ineffective, because official screening recommendations are not followed, resulting in low screening prevalence rates.

We examined the feasibility and acceptability of implementing formal screening for socioemotional problems in infants with the ADBB as a part of the regular practice of Danish health visitors (HV). We evaluated the implementation process from when the HVs started using the ADBB to one-year post-implementation. Using a mixed-method approach, the following questions were addressed: Is it possible to obtain acceptable screening prevalence rates within a 1-year period? How do HVs experience using the ADBB? Is the attitude toward using ADBB related to screening prevalence rates/adherence to guidelines?

Screening prevalence rates increased during the first year: 47% ( $n = 405$ ) of the children seen by the HVs were screened 6 months after implementation; 79% ( $n = 789$ ) of the children had at least one ADBB screening 12 months after implementation. Most (92%) of the HVs reported that the ADBB made a positive contribution to their work. At the same time, most (81%) of the HVs reported that the ADBB posed a challenge in their daily work at least to some degree. The majority (78%) of the HVs did not experience a decrease their job satisfaction due to using the ADBB. Finally, we found that attitudes (positive and negative) towards the ADBB, measured 7 months post-implementation, significantly predicted proportion of children screened 12 months post-implementation.

These results indicate that adding the ADBB to a formal screening program is feasible and acceptable and confirm that successful implementation relies on an instrument that adds value/eases the work of the screener as opposed to being a time consuming, complicated burden.

## **A4: Attachment Based Interventions to Achieve Infant sleep (Birth- 3 years); Achieving Outcomes While Promoting Parent-Infant Relationships**

### **Helen Stevens**

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Workshop objective; to encourage participants to consider the experience of the infant and the importance of the parent-infant relationship when supporting families with infant sleep struggles. Socio-emotional experiences with the first three years of life become the underpinning of lifetime neurological regulation. The primary factor that influences experiences is the parent-infant relationship. When the internal world of an infant is not supported by the relationship, then biobehavioural factors such as sleep become dysregulated. With up to 40% of Australian families reporting childhood sleep as problematic, (Quach, Gold, Hiscock et al. 2013) we need to look more towards enhancing parent-infant relationships to address sleep. With a focus on infant cues and parental sensitivity, the experience can result in more patterned and consolidated sleep and increased paternal sensitivity to the infant's experience. Sleep interventions often focus on parental withdrawal to promote sleep, leaving infant needs and cues as a secondary consideration. Typically professionals and parents look towards 'treating the sleep problem' but overlook factors that influence sleep such as negative parental adaptation (Counterline, Teti 2010). By incorporating attachment theory and research and knowledge surrounding infant sleep, early sleep challenges can become a portal to enhance parental awareness through relationship based interventions. Participants will have the opportunity to partake in a component of an e-learning package designed to promote parent-infant attunement time while developing an understanding about current research findings.

*Counterline M.S., & Teti D.M. 2010. Parental adaptation and sleep arrangements in infancy. Infant Mental Health Journal, 31(6), 647-663.*

*Quach J., Gold L., Hiscock H., Mensah FK., Lucas N., Nicholson JM., Wake M. BMJ Open 2013;3,3:e002419. Doi:10.1136/bmjopen-2012-002419*

## **Session 2E – Symposium**

### **A59: Peach Tree: Building resilience through peer support**

**Emma Prior, Jen McCall, Alicia Langlands, Viv Kissane and Rani Farmer**

Peach Tree Perinatal Wellness, Brisbane, Australia

Our presentation will serve a dual purpose. Firstly, it will bring the voice of the consumer to the conference, with speakers sharing their lived experience. Secondly, the session will explore peer support and peer work more generally. Overall, it will demonstrate that peer support has a valuable role to play, alongside clinical interventions, in the prevention of and recovery from perinatal mental illness.

Abstracts for each individual presentation are below.

The presenters are, in preferred order of speaking:

- Emma Prior  
Peer Worker and Communications Advisor, Peach Tree Perinatal Wellness  
Lived experience of postnatal depression, return to work following perinatal mental illness
- Jen McCall  
Peer Worker and Volunteer Coordinator, Peach Tree Perinatal Wellness  
Lived experience of multiple losses, trauma and bereavement, 'rainbow' baby
- Alicia Langlands  
Peer Worker, Peach Tree Perinatal Wellness

- Lived experience of postnatal and antenatal depression, defence force family  
Baby in Mind Accredited Infant Massage Instructor, BNursing student
- Viv Kissane  
CEO and co-founder, Peach Tree Perinatal Wellness  
Lived experience of postnatal depression, loss of family member to maternal suicide
- Rani Farmer  
Lead Parent Educator and Peer Worker, Peach Tree Perinatal Wellness  
Lived experience of postnatal depression, bipolar  
Current student, Masters of Maternal Primary Health Care

## Day 2: Saturday 28 October 2017

### Session 3A – Symposium. Queensland Centre for Perinatal and Infant Mental Health

#### A23: The Perinatal Mental Health and Wellness Project: A Cross-Sectoral Collaboration

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#### Paper 1 – Transition to Parenthood: Collaborative Practice Promoting Perinatal Mental Health

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Adjusting to pregnancy and parenthood can be a complex and stressful period, particularly for parents whose life histories are marked by disadvantage, trauma, illness, grief and loss, problematic family situations, or other serious challenges. Traditional antenatal education focuses on the physical health of mother and baby, but may neglect the importance of attending to the mental health and emotional wellbeing of mothers, fathers, partners, babies and families in this time of enormous change.

The Perinatal Mental Health and Wellness Project at Redcliffe Hospital evolved from an antenatal education session developed by the perinatal mental health service in collaboration with midwives and peer workers, called Emotional Preparation for Parenthood (EPP). As a result of the project EPP has developed into a program called Transition to Parenthood (TtP) that also includes a postnatal class (Postnatal Connections).

This paper outlines how the inclusion of peer support workers (parents with 'lived experience' of perinatal mental illness and recovery) as co-facilitators supports and validates the content of the TtP. Involvement of Peer Support Workers in TtP enables role-modelling of positive help-seeking behaviours and hope for recovery. In addition, the inclusion of Peer Support Workers facilitates honest and open relationships between parents and clinicians, as well as providing partners with much needed support.

The development of a peer workforce is an emerging feature of contemporary mental health care. While peer support for expectant and new parents is demonstrating encouraging impacts on the mental health and wellbeing of at-risk parents (e.g. McLeish & Redshaw, 2015), and there is established credibility for peer support groups across various areas of health (e.g. oncology, cardiology, epilepsy, acquired brain injury, mental health), the role of peer workers in perinatal mental health care has not yet been extensively explored or documented. This paper will highlight how the Perinatal Mental Health and Wellness Project has been able to develop, test and document processes for ensuring safe and effective peer worker involvement, in supporting the mental health and emotional wellbeing of expectant and new parents.

#### Paper 2 – Pathways: Cross-sector Collaboration for Enhanced Care in the Perinatal Period

Belinda Kippen<sup>2</sup> and Sallyanne Keevers

A key objective of the Perinatal Mental Health and Wellness Project has been the mapping of government, non-government and private services involved in the provision of perinatal mental health care in the Redcliffe

area, and the strengthening of referral pathways to ensure the best mental health care for expectant and new parents.

The project embraced a contemporary view of mental health and wellbeing that acknowledges families in the perinatal period have emotional health needs that are on an ever changing wellness/ illness continuum. Project partners recognised that individuals can experience poor mental health and wellbeing with or without experiencing a mental illness, in the same way that it is also possible to live with mental illness and experience positive levels of mental health and wellbeing. With this shared understanding local services (government and non-government, clinical and non-clinical) were asked to think about where their skills and scope of practice might meet the various needs of families. The bringing together of a wide range of services also demonstrated to families that they are part of a wider interconnected community.

The high level of collaboration between government and non-government services has been a unique feature of this work, which has yielded products of outstanding quality and utility. This paper outlines the challenges and successes of this innovative partnership project, and implications for future policy and practice in Redcliffe and elsewhere.

### **Paper 3 – Learnings from the Perinatal Mental Health and Wellness Project**

Emily Herde<sup>1</sup>

Perinatal mental health describes the mental health and emotional wellbeing of parents, from conception until two years after the end of pregnancy. For most families, this is a time of excitement and joy. However, adjusting to pregnancy and parenthood can be stressful.

Funded by the Statewide Maternity and Neonatal Clinical Network and the Queensland Mental Health Commission, the Perinatal Mental Health and Wellness Project trialled an innovative model of service, to support the emotional wellbeing of expecting and new parents, at Redcliffe Hospital Maternity Services. The model's premise was the collaboration of maternity services, mental health services, child health services, peer-led services, and non-government services to deliver four main outcomes:

- antenatal and postnatal education focused on emotional wellbeing in the perinatal period
- 'targeted' peer support groups (for parents experiencing symptoms of perinatal mental health problems)
- strengthening cross-sectoral collaboration to improve referral pathways that support the mental health and wellbeing of parents, infants and families in the perinatal period
- embedding and sustaining a greater focus on mental health and wellbeing within the health system that supports expectant and new parents

Project evaluation was both formative and summative and continued over the life of the project using a continuous quality improvement/ action learning framework. A formal quality improvement activity approved by Prince Charles Hospital Human Research Ethics Committee reviewed participants' mental health and wellbeing, parenting confidence and perceived quality of relationship as measured using the DASS 21, Karitane Parenting Self Efficacy Scale, and Relationship Quality Index.

The discussion of this paper will focus on the critical factors required to successfully implement this evidence-based collaborative model.

#### **A40: Research to practice: A collaborative perinatal and infant mental health day program for mothers with a psychiatric illness and their infants**

Dr. Elizabeth Hoehn <sup>(1)</sup>, Catherine Rawlinson <sup>(1)</sup>, Adrienne Irvine <sup>(1)</sup>, Alexandra Robbins-Hill <sup>(1)</sup>, Dr. William Bor <sup>(2)</sup>, Janette Garvey <sup>(3)</sup>

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## **Paper 1 - Overview of an early intervention collaborative PIMH Day Program for mothers with a moderate to severe mental illness and their infants.**

Catherine Rawlinson – QCPIMH Strategy and Service Development Team Leader

### **Background**

Perinatal mental illness impacts on an infant's earliest neurological, social and emotional development. With more than 15% of Australian women diagnosed with a perinatal mental illness there is an urgent need for the development of responsive perinatal and infant mental health (PIMH) programs. The Queensland Centre for Perinatal and Infant Mental Health (QCPIMH) investigated the impact of a collaborative interagency psycho-educational day program for mothers with a moderate to severe perinatal mental illness with infants under 12 months of age. While the literature proposes that the most efficacious treatment approaches need to address equally the needs of the mother, their infant and their relationship, this program uniquely addresses these needs through a collaborative interagency partnership that benefits all participants including clinicians delivering the program. The outcomes of the research support the hypothesis that a PIMH day program leads to enhanced maternal mental health, mother-infant relationships, parenting knowledge and confidence, clinician knowledge of PIMH and collaborative practice between services.

### **Methods**

The paper will explore the development of a PIMH Day Program delivered by three collaborating services, in two Queensland Hospital and Health Service sites in 2016. Services delivering the program are Adult Mental Health, Child and Youth Mental Health and Community Child Health Services and involved twenty six mother-infant dyads. The project was delivered using a manualised program trialled in a pilot project delivered in Metro North Hospital and Health Service (Brisbane) in 2009. The paper will also identify the program elements that enhanced or modified intervention effectiveness

### **Discussion**

The discussion will focus on the program design, research protocols and overcoming project challenges.

## **Paper 2 - Working together – insights from a collaborative practice model**

Janette Garvey – CNC Perinatal Mental Health Coordinator Townsville Mental Health Service Group

### **Background**

Collaboration across services is increasingly being identified as a more effective response to perinatal and infant mental health with complex issues receiving a coordinated approach to care. The Perinatal Mental Health Action Plan (2008-2010) recommended "the development of a system of care that is effectively networked, collaborative and responsive to the whole family". The day program early intervention model supports access for the perinatal mother and her infant to adult mental health, child health and infant mental health services addressing various needs within a purposeful and coordinated model of care.

In response to the National Perinatal Depression Initiative (NPDI) the Queensland Centre for Perinatal and Infant Mental Health (QCPIMH), Children's Health Hospital and Health Service Queensland, in collaboration with Townsville and Cairns and Hinterland Health and Hospital Services Queensland, conducted a Perinatal and Infant Mental Health Day Program research project in 2016. The research investigated the impact of an intensive step up/step down small group day program for mothers with a moderate to severe perinatal mental illness attending with their infants under 12 months.

### **Method**

This unique family centred program used a partnership approach between Adult Mental Health, Child & Youth Mental Health and Child, Youth & Family Health Services. This partnership allowed a level of expertise and specialist experience to ensure a holistic approach to the mother-infant dyad and broader family. Services and clinicians involved in the research identified increased collaboration and knowledge regarding perinatal and infant mental health and child health. The opportunity for clinicians to have increased contact hours with the mothers and their infants led to earlier identification of mental health and child health issues resulting in



appropriate linkages to ongoing services. It was noted throughout the research that whilst the mothers strengthened their social network amongst other participants the clinicians in Townsville strengthened their professional network between each of the three services leading to long term positive service connections.

### **Discussion**

The discussion will highlight the value of a collaborative interagency model of care and the impact on participating clinicians in their professional development in the theory and practice of perinatal and infant mental health.

## **Paper 3 - The Day Program outcomes – measures, results, learnings and recommendations**

Adrienne Irvine – Project Coordinator

### **Background**

The research hypothesis was that a collaborative PIMH day program was likely to improve maternal mental health and the resulting parent-infant relationship. The purpose of the model of care was to primarily support improvements in the mother's mental health leading to the development of secure attachments and the physical, emotional and social development of the infant. The results of the research highlight an improvement in maternal mental health (scores for depression, anxiety and stress) and parenting confidence. The implications of this are that the day program supported recovery of the mother's mental health and assisted in the development or strengthening of the mother - infant attachment relationship. The positive impacts of this day program were also measured through clinicians responses to their experience in delivering the program and working in direct collaboration with other related services.

### **Method**

The research protocol required the collection of pre and post measures by the clinicians administering the Day Programs, data collation and analysis by research team members, and reporting by the project coordinator. An extensive mixed measure design consisting of quantitative measures and qualitative feedback were used in the study. Measurements that relate to maternal mental health, parenting confidence, parenting stress, parental attachment and interaction with infants and child development were collected pre and post program. Qualitative measures (survey feedback) were collected relating to parent satisfaction with the program, feedback from the partners sessions and participating clinicians questionnaire.

### **Discussion**

The discussion will focus on the selection of measures used in the research, the results of the research and learnings and recommendations for the implementation.

## **Session 3B – Symposium. Perinatal Loss**

### **A21: Respectful and Supportive Care After Stillbirth – What Do We Know and What Needs to Happen?**

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Stillbirth is a profoundly distressing outcome of pregnancy for women and their families. The psychosocial impacts are immense and often enduring. Throughout the world, an estimated 4.2 million women are living with depression following stillbirth. Respectful and supportive care – in both hospital and post-hospital settings – is critical to psychological recovery following stillbirth. Yet, research into best practice care is relatively recent and under-developed. In Australia, systematised approaches to care after stillbirth are rare and parents' needs

are frequently unmet: in our survey conducted for The Lancet Ending Preventable Stillbirths Series, one-third of bereaved parents rated their follow-up care as “poor” or “very poor”.

The implementation of respectful and supportive care after stillbirth across Australian maternity settings is a priority for the Centre of Research Excellence in Stillbirth. This presentation will draw on our review of published research, an analysis of parent and health care provider responses to a large online multi-country survey about stillbirth, and consultation with parents and health care providers to:

1. Provide an overview of what is known about women’s perceptions and experiences of care after stillbirth, highlighting the needs of women, their families and health professionals;
2. Identify current shortcomings in care after stillbirth, highlighting areas of unmet need;
3. Describe a proposed framework for respectful and supportive care after stillbirth that incorporates four main goals of care (good communication; shared decision-making; recognition of parenthood; and effective support) and could be used to support the implementation and evaluation of best practice.

## **A24: Care in Subsequent Pregnancies Following Stillbirth: An International Survey of Parents**

Aleena M Wojcieszek<sup>1,2</sup>, Frances M Boyle<sup>2,3</sup>, Jose M Belizán<sup>2,4</sup>, Jillian Cassidy<sup>2,5</sup>, Paul Cassidy<sup>2,5</sup>, Jan Jaap HM Erwich<sup>2,6</sup>, Lynn Farrales<sup>2,7,8</sup>, Mechthild M Gross<sup>2,9,10</sup>, Alexander EP Heazell<sup>2,11,12</sup>, Susannah Hopkins Leisher<sup>1,2</sup>, Tracey Mills<sup>13</sup>, Margaret Murphy<sup>2,14</sup>, Karin Pettersson<sup>2,15</sup>, Claudia Ravaldi<sup>2,16</sup>, Jessica Ruidiaz<sup>2,17</sup>, Dimitrios Siassakos<sup>2,18</sup>, Robert M Silver<sup>2,19</sup>, Claire Storey<sup>2</sup>, Alfredo Vannacci<sup>2,16,20</sup>, Philippa Middleton<sup>2,21</sup>, David Ellwood<sup>2,22</sup>, Vicki Flenady<sup>1,2</sup>

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### **Background**

The risk of stillbirth and other pregnancy complications is increased for parents with a previous stillbirth. Pregnancies subsequent to stillbirth are also laden with intense anxiety and fear. While it is clear that parents require specialised clinical care and emotional support in these pregnancies, there is little evidence to inform care. This study investigated the frequency of additional care, and parents' perceptions of quality, respectful care, in pregnancies subsequent to stillbirth.

### **Methods**

Data were obtained from a web-based survey of parents. Data were analysed using descriptive statistics and stratified by geographical region. Subgroup analyses explored variation in care by gestational age at index stillbirth.

### **Results**

A total of 2,716 parents from 40 countries responded (female = 2507; male = 204; gender not stated = 5). Additional antenatal care visits and ultrasound scans were provided for 67% and 70% of all parents, respectively, although there was wide variation across geographical regions. Care specifically addressing psychosocial needs was less frequently provided, such as specialist antenatal classes for bereaved parents (3%), visits to a bereavement counsellor (10%), and access to named care provider's phone number (27%). Compared to parents whose stillbirth occurred at 29 weeks' gestation or less, parents whose stillbirth occurred at 30 weeks' gestation or greater were more likely to receive various measures of care in the subsequent pregnancy, particularly the option for early delivery after 37 weeks. Only around half (47-63%) of all parents felt that elements of quality, respectful care were consistently applied, such as listening to parents, spending enough time with parents, and involving parents in decision-making.

### **Conclusions**

Care in pregnancies subsequent to stillbirth appears inconsistent. Greater attention is required to providing thoughtful, empathic, and collaborative care in all pregnancies following stillbirth. Training for health professionals providing care in pregnancies subsequent to stillbirth is needed.

## **A25: Title: Mental Health Status of Mothers with and Without Perinatal Loss**

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### **Background**

Perinatal loss may be devastating for women and their families. To support women in a subsequent pregnancy after loss, the Pregnancy After Loss Clinic at the Mater Mothers' Public Hospital in Brisbane was established. The current study aims to compare the mental health status of women with and without perinatal loss during and after pregnancy.

### **Methodology**

A longitudinal case-control cohort study was conducted with two groups of pregnant women from the Mater Mothers' Public Hospital: those with previous perinatal loss attending the Pregnancy After Loss Clinic, and those without perinatal loss receiving standard antenatal care. The women were assessed using the Mental Health Inventory-38 during the latter stages of pregnancy, and again within the first twelve months after delivering a healthy baby. Prenatally, 55 women with-, and 64 women without- perinatal loss completed the

questionnaire. Postnatally, 23 women with- and 35 women without- perinatal loss completed the questionnaire. Independent-samples t-tests were conducted.

### **Results**

During pregnancy, women with previous perinatal loss experienced more anxiety and less general positive affect than women without perinatal loss. When assessed postnatally, women with and without perinatal loss experienced similar levels of mental well-being and distress.

### **Conclusions**

While women with perinatal loss may experience higher levels of anxiety and lower positive affect during pregnancy than women without perinatal loss, these suboptimal mental health factors resolve after pregnancy to be comparable to their non-loss counterparts. Providing support to these vulnerable women is clearly important for the women's health and in turn, we suggest, may have a positive and ongoing effect on the development of the babies.

## **Session 3C – Forum. Mother Baby Units**

### **A29: Lavender Mother and Baby Unit – Baby steps: A review of the first 6 months of the first Public Mother and Baby Unit in Queensland**

#### **Susan Roberts**

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The Lavender Mother and Baby Unit is the first dedicated Mother and Baby Unit in Queensland. It is a 4-bed unit with capacity to admit mothers with serious mental illness who cannot safely be managed in the community. Opening its' doors on the 27<sup>th</sup> March 2017, this paper will outline the planning, processes and challenges involved in the first 6 months of operation. The paper will include patient characteristics, referral patterns and early outcomes.

### **A46: Are Improvements in Clinical and Parenting Outcomes Maintained Following Discharge from An Inpatient Mother-Baby Unit?**

#### **Nicole Reilly<sup>1</sup>, Elloise Brake<sup>1</sup> and Marie-Paule Austin<sup>1,2,3</sup>**

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### **Background**

Only a small number of studies have reported on post-discharge outcomes for women admitted to an inpatient mother-baby unit (MBU), however none of these studies have been conducted in Australia and none have included measures of parenting confidence or attachment as outcomes of interest.

Aim: This study aimed to examine whether improvements gained during an admission to an Australian MBU are maintained 3 months following discharge.

### **Methods**

Women completed the self-report Edinburgh Postnatal Depression Scale (EPDS), Depression, Anxiety and Stress Scale (DASS-21), Karitane Parenting Confidence Scale (KPCS) and Maternal Postnatal Attachment Scale (MPAS) at admission, discharge and 3-months post-discharge from an inpatient MBU. Information relating to service engagement in the time since discharge was also collected at the 3-month follow-up. Additional clinical and demographic information was extracted from the medical record.

### Results

Scores on outcome measures were examined using repeated-measures ANOVA (N=75). Significant improvements on symptom-based measures observed from admission to discharge (EPDS [M=19.80 vs 8.82,  $p<.001$ ], DASS-21 [M=22.51 vs 7.36, depression; 16.59 vs 7.15, anxiety); 27.47 vs 11.97, stress; all  $p<.001$ ] and in parenting confidence (KPCS [M=32.85 vs 38.21,  $p<.001$ ]) were sustained 3-months post-discharge. However, improvements in total MPAS scores between admission and discharge (M=63.29 vs 75.03,  $p<.001$ ) were not maintained at the 3-month follow-up, and were most significantly impacted by the 'pleasure in interaction' and 'quality of attachment' subscale scores which showed significant decreases at 3 months.

### Discussion

This is the first Australian study to report on post-discharge clinical and parenting outcomes for women admitted to an inpatient MBU. Factors associated with maintenance or deterioration of improvements will be discussed.

## A33: Monash Health: An Integrated Approach to Perinatal Care Complex Case Presentation

Dr Celeste Hoopmann<sup>1</sup>, Dr Zara Zia<sup>1</sup>, Melissa Thompson<sup>1</sup>

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The Perinatal and Infant Inpatient Unit (PIIU) at Monash Health is a specialised, perinatal psychiatry unit providing treatment to mothers and their infants. The unit is located in the South-East of Melbourne and is part of an integrated model with a corresponding outpatient perinatal team. The service also provides care to mothers within the antenatal period who are identified as having mental health concerns. The unit provides treatment for acute episodes of illness with a multidisciplinary team approach and a robust group therapy program. The outpatient services focus on delivering specialised dyadic therapy to enhance mother-infant bonding and wellbeing.

This unique model allows for seamless transition of patient care across varying stages of mental illness. The benefit of this continuity of care is best illustrated through the use of a case example. The presentation will outline the journey of a mother through both inpatient and outpatient perinatal services, highlighting the strengths of this approach to perinatal care.

## A17: Fatigue, Sleepiness, Sleep Quality and Psychological Distress in Women Admitted with their Infants to a Residential Early Parenting Service and Men whose Partners are Admitted

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Residential early parenting services (REPS) are unique to Australia, and provide structured, psycho-educational programs to address maternal mental health problems and unsettled infant behaviours. The aim was to assess fatigue, sleepiness, self-reported sleep quality and psychological distress among women who are admitted with their infants to a REPS, and among the partners of these women.

Women admitted to Masada Private Hospital Mother Baby Unit during a 5-month period were invited to complete surveys on the first day of their admission. Their partners were also invited to complete surveys. The surveys included standardised measures of fatigue, sleepiness, sleep quality, depression, anxiety, stress, irritability and alcohol use.

Surveys were completed by 165 women and 56 men. Clinically significant fatigue was indicated in 90% of women and 50% of men. Compared to normative data, this sample of women and men reported significantly greater sleepiness, poorer sleep quality, and higher stress. Among women, mean scores for depression and anxiety were also significantly higher than normative data. Among men, mean scores for irritability were significantly higher than available norms, and excessive drinking (at least monthly) was reported by 20% of men.

Unsettled infant behaviour may therefore be associated with parental fatigue, sleepiness, poor quality sleep and mental health problems. These may compromise parents' interactions with their partners and infants, as well as their ability to carry out safety-sensitive activities including caring for a child. Amongst women, REPS could be enhanced to include assessment and treatment of fatigue, sleepiness and poor-quality sleep. Services should also consider ways to assess and address the fatigue and mental health of men whose partners and unsettled infants are admitted to REPS.

### Session 3D – Screening and Parenting Capacity

#### A18: Study Protocol for a Comparative Effectiveness Trial of Two Models of Perinatal Integrated Psychosocial Assessment: The PIPA Project

**Nicole Reilly<sup>1</sup>, Emma Black<sup>1</sup>, Georgina Mary Chambers<sup>2</sup>, Virginia Schmied<sup>3</sup>, Stephen Matthey<sup>4</sup>, Josephine Farrell<sup>1</sup>, Andrew Bisits<sup>5</sup>, Dawn Kingston<sup>6</sup> and Marie-Paule Austin<sup>1</sup>**

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#### **Background**

Studies examining psychosocial and depression assessment programs in maternity settings have not adequately considered the context in which psychosocial assessment occurs or how broader components of integrated care, including clinician decision-making aids, may optimise program delivery. There is also limited evidence relating to the diagnostic accuracy of symptom-based 'screeners' used in this context. The Perinatal Integrated Psychosocial Assessment (PIPA) Project was developed to address these knowledge gaps.

**Aims:** The primary aims of the PIPA Project are to examine the clinical- and cost-effectiveness of two alternative models of integrated psychosocial care during pregnancy: 'care as usual' (the SAFE START model) and an alternative model (the PIPA model). The acceptability and perceived benefit of each model of care from the perspective of both pregnant women and their healthcare providers will also be assessed. The secondary aim of the PIPA Project is to examine the psychometric properties of a number of symptom-based screening tools for depression and anxiety when used in pregnancy.

### **Methods**

This is a comparative-effectiveness study comparing 'care as usual' to an alternative model sequentially over two 12-month periods. Data will be collected from women attending the Royal Hospital for Women, Sydney, at Time 1 (initial antenatal psychosocial assessment) and Time 2 (2-weeks after Time 1), and from clinicians at Time 3, for each condition. Primary aims will be evaluated using a between-groups design, and the secondary aim using a within group design.

### **Discussion**

The PIPA Project will provide evidence relating to the clinical- and cost- effectiveness of psychosocial assessment integrated with referral processes in the maternity care setting. It will also address research recommendations from the Australian (2011) and NICE (2015) Clinical Practice Guidelines.

## **A6: When is Parenting “Good Enough”?**

### **Anne Buist**

Austin Health, University of Melbourne

### **Objective**

To investigate the methods used to assess parenting capacity in families with protective issues with mental illness in Victoria, Australia.

### **Methods**

Liaison with Family and Children's Court practitioners, perinatal and forensic psychiatry and Protective services including reviewing documentation where available.

### **Results**

There are no standardized measure or method to assess parenting capacity. Practitioners and services use a variety of residential and outpatient interviews and observation in assessing how mental illness may or may not impact on practical parenting tasks, reflective functioning and ability to protect. The conclusions reached by the practitioner rely on balancing multiple aspects of the assessment with risks of exposure to the parent versus risk of removal, and inevitably includes aspects of experience and subjectivity. Observational assessments would ideally be in home over an extended period of time but residential assessments and those including attachment and reflective functioning add important information towards a valid assessment.

### **Conclusions**

Removal of a child is traumatic for all concerned. Historically this continues to cause significant anguish for individuals and the community in Australia with its background of the Stolen Generation and Forced adoptions. But as abuse is also known to cause trauma, and it and the risk of murder is highest in the first year of life (with the exception of black men in the USA), it must be acknowledged that some families cannot safely parent. Perinatal and court practitioners have an unenviable task to help the court in these assessments and currently are lacking in standardized guides or tools and it is recommended that several different assessments—interview and observational—at the very least are included.

## **A19: A Generic Mood Questionnaire for Perinatal Mood Screening: How it Compares to the EPDS, PHQ-2 / Whooley, and Various Anxiety Measures.**

### **Stephen Matthey**

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While the Edinburgh Depression Scale (EDS; EPDS) is often the measure of choice within perinatal mental health screening programs, it has several significant limitations. Most notable of these include a complex myriad of validated cut-off scores for women from different cultures, and at different perinatal times (antenatal and postnatal); exclusion of women with high levels of distress if the reason is considered to be 'reasonable'; a very high rate of false positives; and a complex scoring system leading to frequent errors.

Investigation of other potential screening measures showed that they also suffered from similar significant limitations, and hence a new measure was developed, the 'MGMQ'. Six studies have now been undertaken comparing the performance of this with the EDS, and also the depression measures of the PHQ-2 / Whooley, as well as several anxiety measures.

One study has been published so far, with two more currently under review. These studies come from Australia (4), Italy and Saudi Arabia, with one postnatal and six antenatal samples (one study having samples at both time points). Sample sizes vary between 78 and 2,292 women, with five being community samples and one being a clinical sample. One study has included the use of the MGMQ and EDS with men (N=107).

The talk will outline the background to the development of the MGMQ, and the main findings from these studies. The discussion will focus on the relative merits of each of the main measures, with reference to the following quote:

*"if we do not take time to reflect on what we are measuring we also run the risk of using a measure because it has a high profile rather than necessarily being the best measure of psychological health"* (Alderdice et al., 2013; p. 436).

### **A38: The Childbirth Fear Questionnaire (CFQ): A new measure of fear of childbirth**

**Nichole Fairbrother** (Department of Psychiatry, University of British Columbia, Canada, nicholef@uvic.ca); **Dana Thordarson** (Registered Psychologist, North Shore Stress and Anxiety Clinic, Canada); **Kathrin Stoll** (School of Population and Public Health, University of British Columbia, Canada); **John Sakaluk**, (Department of Psychology, University of Victoria, Canada)

Fear of childbirth affects as many as 20% of women, and has been associated with a number of negative outcomes (e.g., increased pain during childbirth, prolonged labour, increased risk of cesarean delivery, postpartum mental health difficulties, and poor maternal-infant bonding). Currently available measures of fear of childbirth fail to fully capture women's childbirth-related fears (i.e., important content domains have been excluded). The purpose of this research was to develop a new measure of fear of childbirth (the Childbirth Fear Questionnaire; CFQ) that would address the limitations of existing measures. Participants were 643 pregnant women residing in English speaking countries, and were recruited via online forums. Participants completed a set of questionnaires, including the CFQ, via an online survey. Analysis of the CFQ resulted in 9 factorially-derived subscales, and an Interference scale. CFQ subscales represent fear of: (1) pain from a vaginal birth, (2) embarrassment, (3) medical interventions, (4) insufficient pain medication, (5) cesarean birth, (6) harm to one's infant, (7) the mother or infant dying, (8) body damage, and (9) negative changes to one's appearance and sexual functioning. The 9 CFQ subscales and the Interference scale demonstrated good internal consistency, and convergent and discriminant validity. The CFQ's ability to accurately screen for specific phobia, fear of birth, will also be presented. The CFQ represents the most comprehensive measure of fear of childbirth currently available.

### **A12: The EPDS and 'Whooley' Questions: How Well Do these Measures Identify Current Depressive and Anxiety Disorder during Pregnancy?**

**Nicole Reilly**<sup>1</sup>, Emma Black<sup>1</sup>, Georgina Mary Chambers<sup>2</sup>, Virginia Schmied<sup>3</sup>, Stephen Matthey<sup>4</sup>, Josephine Farrell<sup>1</sup>, Andrew Bisits<sup>5</sup>, Dawn Kingston<sup>6</sup> and Marie-Paule Austin<sup>1</sup>

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### **Background**

The Edinburgh Postnatal Depression Scale (EPDS) has been shown to have good sensitivity and excellent specificity using a cut-off of 13 or more to detect major depression in English-speaking women in the postnatal period. However, few studies have examined the psychometric properties of the EPDS or EPDS-3A (anxiety subscale) when used during pregnancy, despite its now widespread use in antenatal settings. The test performance of the NICE-recommended 'Whooley' questions is also yet to be examined in Australian perinatal populations.

**Aim:** To examine the psychometric properties of the EPDS and 'Whooley' questions when used in pregnancy, to ascertain their value in identifying women experiencing a current depressive or anxiety disorder.

### **Methods**

The test characteristics of the EPDS and 'Whooley' depression questions were examined using the Mini International Neuropsychiatric Interview v6.0 (MINI; mood and anxiety disorder modules) as the gold standard.

### **Results**

669 women attending the Royal Hospital for Women, Sydney, completed the EPDS, 'Whooley' questions and MINI two weeks after their antenatal booking-in appointment (M=17 weeks gestation). Using a cut-off of 13 or more, the EPDS was shown to have good sensitivity (0.70) and excellent specificity (0.97) to detect major or minor depression. A EPDS-3A score of 4 or more detected the presence of anxiety disorder with sensitivity of 0.56 and specificity of 0.77. The two 'Whooley' questions had a sensitivity of 100% and specificity of 79% in identifying depressive disorder, with a third question about the need for help improving specificity (0.96) but decreasing sensitivity (0.60). The sensitivity and specificity of the two 'Whooley' questions to detect any depression or anxiety disorder was 0.63 and 0.81, respectively.

### **Discussion**

This study provides an important contribution to the evidence-base relating to the use of screening and case-finding questions to identify depression and anxiety during pregnancy. Findings will be discussed in light of current recommendations of national and international clinical practice guidelines for perinatal mental health.

## **Session 4A – Symposium. Theme: Watch, Wait and Wonder®**

### **A57: Symposium Overview - Embedding, Evolution and Efficacy of Watch, Wait and Wonder® Intervention in a Community Based Perinatal and Infant Mental Health Service**

**Adaobi Udechuku**<sup>1,2</sup>, **Lucinda Smith**<sup>1,2</sup>, **Belinda Freake**<sup>1,3</sup> **Dr Jessica Kuc**<sup>1,4</sup>, **Denise Guy**<sup>5,6</sup>

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An infant's development is mediated through the relationship with their parent. Parental mental health can adversely impact upon infant's development but treating maternal mental illnesses does not necessarily translate to improved outcomes for infants or the parent infant relationship. The Watch, Wait and Wonder®

Intervention (WWW-I) has been shown to improve infant attachment security and cognitive capabilities, parenting satisfaction in the parenting role, the parent-infant relationship and reduce parenting stress.

The Raphael Service Berwick has almost 4 years' experience of training clinicians and incorporating WWW-I as an option for clinical care. This 5-paper symposium will present the, embedding, evolution and efficacy of WWW-I at the service.

An overview of WWW-I and the process, highlights and challenges of introducing the intervention to the services form the first paper. To illustrate how the intervention is conducted and its ability to bring about change, there are three papers presenting clinical case material, video footage and pre-and post-therapy Parent Infant Relationship –Global Assessment Scale (PIR-GAS) of individual parent-infant dyads. The final paper details the trainer's perspective including training, WWW-I assessment, formulation and treatment planning and supervision. The use of the PIR-GAS and the new 0-5 Classification System will also be discussed.

## **Embedding, Evolution and Efficacy of Watch, Wait and Wonder® Intervention in a Community Based Perinatal and Infant Mental Health Service**

**Adaobi Udechuku** <sup>1,2</sup>, **Lucinda Smith** <sup>1,2</sup>, **Denise Guy** <sup>3,4</sup>

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The Raphael Service Berwick is a community based perinatal and infant mental health service. The service has almost 4 years' experience of training clinicians and incorporating the Watch, Wait and Wonder® Intervention (WWW-I) as an option for clinical care. As part of a 5 paper symposium, this first paper will discuss the process of embedding WWW-I into clinical practice, the evolution over time and the efficacy of the intervention.

7 clinicians have undergone Introductory WWW-I Training and 2 Advanced Training. A total of 27 dyads have been considered for the intervention with 14 commencing, 6 completed cases and 4 still in progress. An important component of our work has been to contribute to the small but growing body of evidence demonstrating the clinical efficacy of the WWW-I through pre and post Parent Infant Relationship –Global Assessment Scale (PIRGAS).

### **This presentation outlines:**

WWW-I and our approach to embed the intervention into clinical practice

The dyads assessed and have commenced WWW-I

Where WWW-I fits amongst other treatment options

Pre and post PIRGAS scores for selected cases

The evolution of both the service and clinicians' approach as we face challenges and successes and

Logistical and service level issues with a growing complement of staff trained in WWW-I

## **Presentation 1 - The Struggle is Real: Parallels in the Watch, Wait and Wonder® Intervention Therapy and Process**

**Belinda Freake**<sup>1,2</sup>

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When a parent is able to regulate their own emotions, it leaves space for them to observe and then help regulate their infant's emotions. When a parent struggles with emotional regulation and has a limited tolerance for their discomfort, they may not be able to observe their infant needs their support. This leaves the infant without containment and therefore dysregulated themselves. Treatment for parents who suffer perinatal mental health issues can support them to contain their affect but this does not necessarily generalise to self-regulating in interaction with their infant. Attachment theory has been well researched and the importance of promoting an optimal parent-infant relationship is central to achieving positive outcomes for infants. The Watch, Wait and Wonder® Intervention(WWW-I) is a dyadic infant-led approach to treating parent-infant relationships.

This component of the symposium will discuss the parallels between the therapeutic process of the WWW-I and the psychotherapy process the infant and his mother go through, simultaneously. The dyad featured is a first-time mother and her son who have had considerable difficulties in their relationship, despite successful treatment of the mother's mental health issues. This is the first dyad the therapist has worked with using the WWW-I. The reflections of the therapist regarding the struggles and successes of the intervention are outlined alongside the struggles and successes of the dyad.

This presentation will include Parent Infant Relationship- Global Assessment Scale pre and post scores, clinical case presentation using video footage, an overview of the therapy and the specific challenges for the therapist and for the dyad.

## **Presentation 2 - Like Father, Like Son? Watch, Wait and Wonder® Intervention in a Father-Son Dyad**

Dr Jessica Kuc<sup>1,2</sup>

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### **Background**

While the significance of the attachment relationship in the mother-infant dyad and its impact on the development and emotional wellbeing of an infant has been evident for decades through the work of authors such as Bowlby and Ainsworth, Less is understood about the consequences of significant dysfunction in the father-infant relationship. Significant cultural barriers exist to the identification and management of father-infant relationship dysfunction and the broader area of paternal perinatal mental health. With the increase in fathers taking on the primary care role, services need to be flexible and responsive in their approach to parent-infant dyadic work.

### **Discussion**

The Watch, Wait and Wonder® Intervention been shown to improve several markers of the health of the parent-infant relationship including infant attachment security and parenting satisfaction in the parenting role. This presentation explores the journey of a father-son dyad through the process of the WWW-I including the assessment of the parent-infant relationship, the indications and considerations for using WWW-I with this dyad, other therapeutic interventions utilised or trialled prior to the decision to begin WWW-I, and the progress of the dyad in therapy thus far.

The presentation includes video footage of the parent-infant relationship assessment, PIRGAS scores, and clinician reflection on the benefits and challenges of this approach to therapy. Consideration will be given to the intergenerational impact of trauma from father to son, and cultural elements of the role of 'father' and the masculine identity as they relate to the process of WWW-I.

### **Presentation 3 - “I Need My Baby More Than My Baby Needs Me” - Using Watch, Wait and Wonder® Intervention in a Mother Sensitive to Rejection.**

Lucinda Smith<sup>1,2</sup>

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This presentation will describe the use of the Watch, Wait and Wonder® Intervention in a parent infant dyad at The Raphael Centre Berwick, using video footage to illustrate aspects of the case and demonstrate change in the parent infant relationship.

The WWW-I is a dyadic infant-led approach to problems in infancy and early childhood, and one of the parent infant psychotherapy interventions available to treat parent-infant relationship (PIR) problems.

The dyad featured is a first time mother and her daughter (21 months old at the time of commencing WWW-I) who have engaged in WWW-I spanning approximately 10 months. The WWW-I followed a number of months of individual treatment for mother including psychological and medication management of postpartum psychosis and significant ongoing anxiety. The mother's concerns around not understanding her daughter, her daughter's tantrums and feeling rejected by her daughter prompted consideration of a specific PIR approach.

As therapy progressed the degree to which the mother felt unwanted and rejected by her daughter became apparent and the challenges this created for the mother to be able to follow the instructions of watching and waiting are explored.

Aspects of the case that will be discussed in further detail include:

- Impact of mother's severe post-partum illness including Mother Baby Unit admission for post-partum psychosis on WWW-I
- Indications in PIR relationship to consider a specific PIR therapy
- Why WWW-I was chosen as appropriate intervention
- Overview of therapy
- Specific challenges for mother, infant and therapist when working with a mother highly sensitive to rejection
- Objective measurement of changes in PIR using the DC:0-3R Relationship Problems Checklist (RPCL) and pre and post therapy Parent Infant Relationship –Global Assessment Scale (PIR-GAS)

### **Presentation 4 - The Trainer's Perspective – Support, Supervision and Sustainability**

Denise Guy<sup>1,2</sup>

<sup>1</sup> Incredible Families, Wellington, New Zealand

<sup>2</sup> Department Psychological Medicine, Otago University, Christchurch, New Zealand

Training in the Watch, Wait and Wonder® Intervention (WWW-I) is a significant undertaking with attendance at Introductory and Advanced courses and supervision through at least 3 cases. The journey for Raphael Service Berwick over the last 4 years has been a commitment to improving outcomes for infants and parent-infant relationships.

WWW-I has a place in perinatal clinical care and clinicians have been engaged in the training process as a result of changes they have observed in the infants and their parents. Training has evolved and the strengths and challenges in supporting clinicians from different disciplines and experiences will be reviewed. Parallel themes of building observational capacity, containment, self regulation, and reflection are apparent. Sustaining the intervention and ongoing training and practice is an active collaboration with Raphael Service Berwick.

Training has also incorporated utilising the WWW-I assessment process to derive Axis II data for formulation and treatment planning. The PIR-GAS has then been used to collect pre-and post data and consideration of this and the future use of the new 0-5 Diagnostic Classification system will be discussed.

## Session 4B – Substance Abuse, Gambling and Screening

### A5: A practical guide for providing multidisciplinary clinical care to women and babies exposed to substance use in pregnancy.

**Julie Blandthorn<sup>1</sup>, Ellen Bowman<sup>1,2</sup>, Meg Hardiman<sup>1</sup>**

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Drug and alcohol use in pregnancy is of significant concern in terms of fetal and maternal health, parenting ability and the long-term impact on the infant and child. The Women's Alcohol and Drug Service at the Royal Women's Hospital provides multidisciplinary specialist clinical services in the care of pregnant women with complex substance use and alcohol dependence.

This interactive workshop will provide a practical approach for clinicians who care for women using substances in the perinatal period and their exposed infants with evidence based research and case studies highlighting shared decision-making processes. The session will be presented by a midwife, paediatrician and social worker which fosters a holistic approach to care.

An outline of the workshop follows.

- Asking the question. The importance of screening all pregnant women for alcohol and drug issues at initial presentation
- Medications and substances in pregnancy
- assessing breastfeeding safety
- bonding, family support, resources
- Neonatal Abstinence Syndrome
- screening and length of stay
- Infant home-based withdrawal
  - when is it safe?
- Hidden impediments to success
- Questions, discussion

### A31: Gambling harm and the Dyadic Relationship: Infants of Parents with Gambling Addiction.

**Monya Gangemi-Murch**

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The presentation will unfold from clinical observations supported by the most recent research on gambling harm and infant studies. It will contribute to new insight of the impact of gambling harm on families, focusing on infants and the dyadic relationship.

There is a vast body of work on the impact of substance misuse on infants and the interventions required by those high-risk families, little has been done to look at the infant-parent relationship and what is like for children to grow up in families where the parent/s are struggling with Gambling Addiction and impact of gambling harm, either on its own or often with the presence of co-morbidity (depression, PTSD), on the family environment, including infant-parent relationship. Therefore there is a need to bring more focus on how parental

psychosocial issues; financial hardship and domestic violence, stemming from gambling addiction can be considered a high-risk environment for the infant/s, which can compromise the child's future outcome. Clinical work can provide considerable evidence of the association between parental difficulties, antenatal depression, gambling harm and the complex needs of these families however, there is at present limited research and guidance for practitioners on how these problems affect parenting, infant-parent relationship and child's outcome, in the presence of gambling harm. It is important to ensure infants visibility for their present and future wellbeing as adults.

#### **A14: Psychosocial assessment and depression screening in private obstetric care**

**<sup>1</sup>Tanya Connell, <sup>2</sup>Donna Waters, <sup>3</sup>Bryanne Barnett**

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There is an increasing move internationally to standardise and make routine the psychosocial assessment and depression screening of all pregnant women.

Approximately 30-40% of pregnant women choose to deliver in the private sector in Australia.

In Australia, including mental health assessment in perinatal clinical care has been deemed good practice in the national clinical guidelines for perinatal depression and anxiety. Little is known, however, about such initiatives in the private hospital sector. The primary aim of this study was to establish what is known about psychosocial assessment and depression screening 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 introducing psychosocial assessment as part of the booking-in process at a regional private hospital in NSW.

This presentation reports on the research findings of the overall study and recommendations for clinical practice.

Access to information on risks to maternal and infant health is considered a fundamental component of antenatal care. The perinatal period provides a unique opportunity to identify and intervene appropriately to enhance resilience, and address risks for and actual mental health disorders, thus promoting better health for women, their infants, partners and the family.

### **Session 4C – Fatherhood and Service Provision**

#### **A30: The effectiveness of a peer to peer model in addressing stigma related to postnatal depression in the maternal and child health services setting**

**Clare Whitcombe**

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Victorian Maternal and Child Health (MCH) services are available for all families with children from birth to school age; they provide a schedule of consultations for parents at key ages and stages, including facilitated groups for new mothers. Recent data on participation in Victoria MCH services show that the families of all 0-1 year olds had attended a MCH service at least once. During the course of providing therapeutic care to new mothers, 'emotional assistance' was requested more frequently than any other form of support.

Within this universal setting *beyondblue* recently undertook a feasibility study to investigate whether a peer to peer storytelling model would reduce various types of stigma related to postnatal depression (PND) and increase help-seeking behaviours amongst mothers in new mothers groups.

The study included a session structure designed by women with previous experience of PND, *beyondblue* resources, a *beyondblue*-trained speaker and online training for MCH nurses. The model was trialed across three Victorian local government areas to explore which components were most/least effective.

An independent evaluation identified the overall effectiveness of the model on addressing different types of stigma and help-seeking behaviours, as well as critical success factors and challenges for delivery of this model within and between groups. These findings, in addition to information from stakeholder interviews, will be used to inform future peer to peer programs and stigma reduction initiatives.

Findings presented in this paper will assist people working in policy and programs related to MCH services, as well as MCH professionals who wish to improve their knowledge of stigma related to PND.

This project is funded under the Commonwealth Government's National Perinatal Depression Initiative.

## **A32: Implementing a Parent-Infant Therapy Group in an Australian Perinatal Service: A Literature Review of Parent-Infant Therapy Groups**

**Dr Zara Zia<sup>1</sup>, Dr Adaobi Udechuku<sup>2</sup>**

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### **Background**

Raphael Services Berwick provide specialist perinatal and infant mental health services to families in the southeast of Melbourne. The majority of the clients suffer from high prevalence perinatal disorders, such as depressive and anxiety disorders. The negative impact of parental perinatal disorders on the infant is well established. Improvements in the parental illness do not guarantee improvements for the infant. Parent-infant therapy can improve infant attachment security and developmental outcomes. Group parent-infant therapy has the benefit of the group process and cost advantages over individual formats. The service aims to implement a parent-infant dyadic therapy group.

### **Objective**

To examine existing models of parent-infant dyadic group therapy to identify an approach that is appropriate in an Australian, community-based perinatal service

### **Method**

A search of online journal databases Ovid Medline, PubMed, Cochrane Library and PsycINFO. Data from existing group programs known to the authors and from direct correspondence with perinatal service providers were also included.

### **Results**

823 articles were identified, 14 met inclusion criteria, 4 Australian and 10 International parent-infant dyadic group programs

The design, process, outcomes measures and efficacy of the 14 parent-infant dyadic groups will be presented. The salient features and limitations relevant to the study aims will be discussed. A proposed parent-infant group for the service will be outlined.

## **A56: Preconception Predictors of Expectant and New Fathers' Mental Health: A Prospective Analysis Spanning Two Cohorts and Two Generations**

**Elizabeth Spry**<sup>12</sup>, **Christopher Greenwood**<sup>12</sup>, **Margarita Moreno-Betancur**<sup>2</sup>, **Jacqui Macdonald**<sup>123</sup>, **Rebecca Giallo**<sup>2</sup>, **Denise Becker**<sup>2</sup>, **Primrose Letcher**<sup>3</sup>, **Jennifer McIntosh**<sup>123</sup>, **Delyse Hutchinson**<sup>1234</sup>, **Stephanie Brown**<sup>23</sup>, \***George Patton**<sup>23</sup>, \***Craig Olsson**<sup>123</sup>

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Recent studies suggest that one in ten fathers experience mental health problems during pregnancy and in the first year postpartum, comparable to rates reported for women. These problems are significant because of their effects on men, their relationships with partners, and care-giving responsiveness to their infants. Understanding who is at risk is important for early intervention, but prospective studies of preconception risk factors are scarce. This study examined the extent to which a history of depression and anxiety in the decades prior to conception predicts the risk of perinatal mental health problems.

Data come from two prospective intergenerational cohort studies that have assessed young people over 25 years from adolescence to parenthood. The Victorian Intergenerational Health Cohort assessed anxiety and depression 9 times from age 14-29 years, and then in the third trimester of subsequent pregnancies to age 36 years (VIHCS; N=295 pregnancies to 214 men). The Australian Temperament Project Generation 3 assessed anxiety and depression 6 times from age 13-27 years, and again at one year postpartum for subsequent pregnancies to age 34 years (ATPG3; N=159 pregnancies to 125 men; data collection on-going).

Men with preconception depressive and/or anxiety symptoms in both adolescence and young adulthood had the greatest risk of mental health problems antenatally (VIHCS: adjusted RR=4.48, CI:1.69-11.91) and one year after the birth of offspring (ATPG3: adjusted RR=2.06, CI:1.19-3.56). At one year after offspring birth, persistence of depressive rather than anxiety symptoms appeared to be driving these associations; preconception depressive symptoms predicted postpartum depressive symptoms (ATPG3: adjusted RR=3.55, CI:2.14-5.90), while preconception anxiety symptoms did not predict postpartum anxiety symptoms.

Men with a history of mental health problems from adolescence are at increased risk of mental health problems during the perinatal period and may therefore benefit from support when planning pregnancies and throughout the perinatal period.

## **A60: Working Out Dads – Engaging and Connecting**

**Le Ann Williams** and **Kirsty Evans**

Tweddle Child and Family Health Service

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All around the world academics and health professionals are talking about the critical first 1000 days and the window from conception to age 2 when a baby's brain is experiencing rapid growth. So time is of the essence. We know that parents play a critical role in teaching their child, providing learning opportunities and the relationships that surround each child and stimulation they receive will literally help shape their brain. However, dads have reported that they often feel like the third wheel as a parent and want to be more involved. Our organisation understands the value of fathering, encourages the involvement of men and promote practices which seek to derive positive benefits of father involvement. Literature suggests changing in fathering practices with men participating more equitably and directly in child rearing. However, there are barriers to including and engaging men relating to hours of service operation, physical environment, marketing targeting mothers and lack of male facilitators. So we thought about how we could engage more dads and devised a program called



Working Out Dads, which is facilitated after hours at a gym and run by men. The early intervention 6 week program combines 1 hour of facilitated discussion and 30 minutes of guided fitness. The program includes pre and post mental health screening, parenting confidence evaluation, handouts and spans the topics of parenting, importance of play, relationships, mental health, fitness and wellbeing. Working Out Dads engages, supports and strengthens the capacity of dads in families. The program connects dads to each other and services in the community, strengths family relationships and importantly helps build the relationships between dads and their babies and young children at a time when brains are being built. Dads are now telling us there is finally a program for them!

## Session 4D – Perinatal Anxiety, Surrogacy and Trauma

### A3: Monash Health: An Integrated Approach to Perinatal Care Complex Case Presentation

Dr Celeste Hoopmann<sup>1</sup>, Dr Zara Zia<sup>1</sup>, Melissa Thompson<sup>1</sup>

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The Perinatal and Infant Inpatient Unit (PIIU) at Monash Health is a specialised, perinatal psychiatry unit providing treatment to mothers and their infants. The unit is located in the South-East of Melbourne and is part of an integrated model with a corresponding outpatient perinatal team. The service also provides care to mothers within the antenatal period who are identified as having mental health concerns. The unit provides treatment for acute episodes of illness with a multidisciplinary team approach and a robust group therapy program. The outpatient services focus on delivering specialised dyadic therapy to enhance mother-infant bonding and wellbeing.

This unique model allows for seamless transition of patient care across varying stages of mental illness. The benefit of this continuity of care is best illustrated through the use of a case example. The presentation will outline the journey of a mother through both inpatient and outpatient perinatal services, highlighting the strengths of this approach to perinatal care.

### A66: Trauma Exposure and Resilience in Perinatal Mental Health

Dr Catherine Acton

Western Health, Australia

#### Background

From research and clinical experience, it is known that the majority of individuals who experience traumatic lifetime events do not go on to develop mental health problems. This study sought to explore differences in reported distress among a sample of women in the perinatal period, with a particular focus upon their lifetime exposure to potentially psychologically traumatizing events.

#### Method

A prospective longitudinal study was conducted, with participants consecutively recruited in public and private maternity hospitals in Melbourne Australia. Structured telephone interviews were completed during their third trimester of pregnancy, and at 6 weeks postpartum. Experiences of traumatic events were assessed by standardized measures, alongside current symptoms of post-traumatic stress, depression, general anxiety, and fear of childbirth, as well as a number of established psychosocial risk factors. Postnatally, symptoms of depression and post-traumatic stress resulting from childbirth were assessed, and qualitative data relating to birthing experiences was collected.

#### Results

A sample of 213 women was recruited. Those who had experienced lifetime trauma that did not involve interpersonal violence, had the lowest levels of perinatal distress of all women, including women with no self-reported history of trauma exposure at all. Women with experiences of childhood maltreatment experienced the greatest levels of perinatal distress, followed by those without childhood maltreatment but who had been exposed to interpersonal violence during adulthood. Thematic analysis of birthing experiences assisted with understanding of proximal events that increased vulnerability to postnatal distress.

### **Conclusion**

Interpersonal violence and early childhood maltreatment increase vulnerability to distress while other types of traumatic exposure may be associated with later resilience during the perinatal period.