The Australasian Marcé Society

2007 Conference

Social Adversity and Resilience for Mothers and Infants in the Perinatal Period

Contents:

President's Welcome

I am delighted to welcome all those with an interest in the mental health and wellbeing of women and their infants in the perinatal period to the biannual Australasian Marcé Conference being held at Surfers Paradise, Queensland.

Australia continues to be one of the world leaders in research and the delivery of psychological care to perinatal women and their infants. This conference will provide delegates with an exciting opportunity to update themselves with what is happening throughout Australia and New Zealand, as well as hearing from some of the leading national and international speakers and researchers who are at the forefront of their fields. The quality of our local and international speakers looks to provide a very stimulating conference, with dynamic and interactive sessions that should not be missed.

We look forward to seeing you at the conference!

Marie-Paule Austin
President, Australasian Marcé Society

Scientific Committee: Marie-Paule Austin
Jane Fisher
Barbara Hayes

The Marcé Society

The Marcé Society is multi-disciplinary and provides a forum for exchange of information and ideas between professionals concerned with the welfare of women and their families around the time of childbirth.

Traditionally, the main focus has been on mental illness related to childbearing. However, the interests of Australasian members often encompass broader areas including the maternal-infant relationship, attachment theory, the psycho-biology of pregnancy, antenatal and postnatal education, psycho-social aspects of obstetrics, perinatal bereavement and all aspects of mental health of women and their families during pregnancy and the postnatal period.

Close collaboration between clinicians and researchers is an important priority of the Australasian Branch.

Membership of the Society is open to all professionals who support the aims of the Society, for example nurses, midwives, psychologists, psychiatrists, general practitioners, obstetricians/gynaecologists, health visitors and researchers in the field. Membership includes 6 annual editions of the journal Archives of Women's Mental Health.

For further information, please see www.marcesociety.com

NAME BADGES/TICKETS
Admission to all sessions and catering is by the official conference name badge – please wear it at all times when at the conference. Tickets are necessary for the Conference Dinner; if you have booked a place, you will find the ticket behind your name tag.

PROGRAM CHANGES
There have been a number of program changes so please check the program in this book carefully. Any last-minute program changes will be shown on the progam on the notice board at the Registration Desk.

PRESENTERS AND CHAIRS
Presenters using data projectors are asked to load their presentations onto the computer in the room where they will be presenting in a break prior to the presentation. If you encounter any problems, please ask for help from the AV technician.

Presenters are asked to convene at the front of the appropriate room with the Chair of their session a few minutes before the start of their session.

POSTER PRESENTERS
Please attach your poster to its board prior the poster session in Cristel's. Please leave your poster up for as much of the conference as possible….posters will be moved to the main conference area after the poster session in Cristel's.

In addition to the formal poster session noted in the program, please remain with your poster during the morning and afternoon tea breaks whenever possible so that you can discuss the material with interested delegates.

MOBILE PHONES AND PAGERS
Please turn these off while in sessions.

SPECIAL DIETARY REQUIREMENTS
There will be ample vegetarian options for all lunches. If you have requested a gluten free diet, please collect your morning and afternoon teas from the registration desk and identify yourself to the hotel staff at lunches.

PARKING
Subject to availability, complimentary car parking is available at the Crowne Plaza.

DELEGATES WITH ACCOMMODATION
Deposits paid when delegates registered for the conference should be credited to your hotel account….please check that this has been done when you check out. We recommend that you arrange for your luggage to be held at your hotel, rather than bringing it to the conference venue, where storage space is very limited and security cannot be provided.

SOCIAL PROGRAM
Delegates will have the opportunity to relax, catch up with old friends, and meet new ones at the **Welcome Reception** at the end of the day on Thursday; this will be held at the Cristels at the Crowne Plaza and is included in the full registration fee. **Symphony Hills Wines** will match a selection of their wines with local cheeses ... prepare for some surprises!

The optional **Conference Dinner** will be held on the Friday evening at **Four Winds Restaurant**, Queensland's only revolving restaurant, 26 floors above the glittering Gold Cast atop the Crowne Plaza Hotel. By night, the vista transforms into a carpet of twinkling lights up and down the Coast as far as the eye can see. A sumptuous buffet will include local fresh seafood, exotic Asian dishes, and delicious desserts. The cost of the dinner is $55 per person (cash bar). Please check at the Registration Desk if you have not purchased a ticket but would like to attend….late bookings may be possible.

CONFERENCE REGISTRATION FEES

- Workshop Registration includes morning or afternoon tea on Thursday.
- Full Conference Registration includes catering throughout the conference and the Welcome Reception.
- Partial Registration includes catering on the chosen day(s); the Welcome Reception is NOT included.
- The student rate inclusions are as above.

DISCLAIMER

At the time of printing, all information contained in this booklet is correct; however, the organising committee, its sponsors and its agents cannot be held responsible for any changes to the final structure or content of the program, or any other general or specific information published here.

Thursday, 7 June 2007

8:00 AM - 6:00 PM *Registration*

9:00 AM - 12:30 PM Workshop 1 Norfolk Room

Chair: Marie-Paule Austin

How should we manage those with current or past history of serious mental illness? (p 50)
Margaret Oates

10:30 AM - 11:00 AM *Morning tea*

1:30 PM - 5:00 PM Workshop 2 Norfolk Room

Chair: Jane Fisher

Interventions for high risk infants (p 50)
Louise Newman

1:30 PM - 5:00 PM Workshop 3 Cypress Room

Chair: Barbara Hayes

Exploring attachment and cultural safety as aspects of enduring resilience from the perspective of perinatal Aboriginal and Torres Strait Islander People (p 49)
C Griffiths, BA Hayes, W Thiele, J deVries, P Glossop, LK Geia

3:00 PM - 3:30 PM *Afternoon tea*

5:30 PM - 6:30 PM Poster Session and Wine and Cheese Tasting Cristels

Posters (abstracts pp 40-47):

- Maternal posttraumatic stress disorder and child interactive patterns over the first two years of life
  Jacqueline Beall, Clara Bookless and Alexander McFarlane
- Austin Health's Parent-Infant Mental Health Initiative (pimhi): a model of care for better management of mothers with a serious mental illness and their infants
  Anne Buist, Susan J Breton and Adaobi Udechuku
- Maternity liaison project: "Working together"
  Lyn Dawson
- Maternal distress: a comprehensive approach for understanding maternal unhappiness
  Elizabeth Emmanuel
- Social supports of depressed and non-depressed new mothers
  Jennifer Ericksen and Jeannette Milgrom
- The National Children of Parents with a Mental Illness Initiative (COPMI)
  Elizabeth Fudge
- Raphael Centres: a community service supporting families
  Suzanne Higgins, Leanne Lewis, Joe-anne Sundblom
- Screening for postnatal anxiety using the EPDS
  Stephen Matthey
- The place and importance of antenatal / postnatal care and pregnancy planning for psychiatrically ill women
  Fyowna Norton
- Outcomes of a Consultation Workshop for staff in a ward for infants under 12 months aimed at improving relationship based care and the emotional well being of parents and infants
  Rosalind Powrie, Nicole Marshall and Jon Jureidini
- Aim and role of early intervention in a maternal mental health service
  Karen Rowan
- Reconfiguring birth and reconstructing bodies: the choice for Caesarean in the absence of a medical reason for a first birth
  Lynne Staff, Jenny Gamble and Debra Creedy

Friday, 8 June 2007

8:00 AM - 8:45 AM Registration

8:45 AM - 10:30 AM Opening Plenary Norfolk Room

Chair: Marie-Paule Austin

8:45am Opening
Marie-Paule Austin

9:00am Keynote Address
Psychiatric causes of maternal death 1997-2005
Margaret Oates

10:00am Education and training and the future of infant mental health
Louise Newman

10:30 AM - 11:00 AM Morning tea

11:00 AM - 1:00 PM Parallel Sessions 1A, 1B and 1C

Session 1A: Severe Postnatal Disorders (Papers)		**Session 1B: Perinatal Interventions Part 1 (Papers)**		**Session 1C: Consumer Views on Self-help and Advocacy (Papers)**	
Norfolk Room Chair: Anne Buist		**Cypress Room Chair: Barbara Hayes**		**Kauri Room Chair: Michelle Fletcher**	
11:00am	Recurrence of affective psychosis following childbirth: a meta-analysis and case studies (p 14) *PM Boyce; J Barton*	11:00am	Three in one: a three part group intervention for high risk mothers and babies (p 10) *Karen Asgill, Bernadine McDonald and Annette Murphy*	11:00am	Women speaking out about thoughts of infanticide (p 11) *Jennieffer Barr*
11:30am	Psychosis and bipolar disorder relapse in the postpartum: exploring the influence of sleep (p 12) *J Bilszta, H Badruddin, R Lestari, and AE Buist*	11:30am	Perinatal distress and mood changes:-a rationale for early intervention (p 27) *Leone Joyce*	11:20am	A cost-analysis and satisfaction evaluation of postnatal support use (p 13) *J Bilszta, J Kamaruddin, R Sugondo and AE Buist*
12:00pm	An investigation of subtypes of postnatal depression (p 33) *Jane Phillips, Louise Sharpe and Stephen Matthey*	12:00pm	PremieHUGS: a specialised mother-infant program following premature birth (p 29) *Bronwyn Leigh, Carol Newnham, Jeannette Milgrom and Nisha Brown*	11:40am	PANDA – Victoria's perinatal depression Helpline – an update (p 26) *Belinda Horton*
12:30pm	Undiagnosed bipolar disorder presenting as PND: a non-puerperal event (p 37) *Beverley Turner*	12:30pm	Emotion Focussed Therapy and postnatal depression (p 30) *Kate Luttick and Belinda Horton*	12:00pm	Connections' Starting Out Program (p 27) *Pam Joseph*
				12:20pm	Advocacy for new mothers with mental illness (p 28) *M Lagan, PM Boyce; J Barton*

1:00 PM - 2:00 PM Lunch

2:00 PM - 3:30 PM Parallel Sessions 2A, 2B and 2C

Session 2A: Forum: Late Termination of Pregnancy - Where Are We Now?	Session 2B: Perinatal Interventions Part 2 (South Australia) (Papers)		Session 2C: Perinatal Resources from Aboriginal and Torres Strait Islander Women (Papers)	
Cypress Room **Chairs:** **Fran Orr/Marie-Paule Austin**	**Norfolk Room** **Chair: Anne Sved-Williams**		**Kauri Room** **Chair: Philip Boyce**	
(p 9) **D*iscussion panel:*** *Ian Kerridge* *Lucy Bowyer* *Cameron Stewart*	2:00pm	Providing a full spectrum of care for women with severe postnatal psychiatric illness (p 36) *Anne Sved Williams, Carol Kelly and Sue Ellershaw*	2:00pm	Ownership and respect – key components of resilience in the perinatal period: three translations by Aboriginal and Torres Strait Islander women of the booklet Emotional Health in Pregnancy and Early Parenthood (p 23) BA Hayes, ME Egan, B Buckby, J McCulley, LK Geia
	2:30pm	Doing the hard yards: mother-infant therapy in the context of abuse (p 30) *Lynly Mader, Mandy Seyfang and Georgie Swift*	2:30pm	Indigenous community perinatal mental health service expansion (p 18) *C Down, J Brooks, and M Mitchell*
	3:00pm	ACORN: a mother infant therapy group programme-from small things big things grow! (p 39) *Neil Underwood, Mandy Seyfang and Jo Press*	3:00pm	Perinatal mental health resources for indigenous families (p 17) *C Down and J Brooks*

3:30 PM - 4:00 PM Afternoon tea

4:00 PM - 5:30 PM Parallel Sessions 3A, 3B and 3C

Session 3A: Workshop: Child protection and the perinatal period	Session 3B: Perinatal Interventions Part 3 (Papers)		Session 3C: Fetal and Child Development (Papers)	
Kauri Room **Chair: Eilis McKensey**	**Cypress Room** **Chair: Debra Creedy**		**Norfolk Room** **Chair: Marie-Paule Austin**	
Child protection and the perinatal period: building resiliency through clinical work (p 48) *Michael Daubney, Sue Roberts and Raeleigh Bryant*	4:00pm	What are the successful strategies for engaging fathers in the perinatal period? (p 32) *Stephen Matthey, Richard Fletcher, Rebecca Reay*	4:00pm	The biological and behavioural effects of maternal trauma and posttraumatic stress disorder on child development (p 11) Jacqueline Beall, Alexander McFarlane and Clara Bookless
	4:30pm	Social adversity and resilience for mothers and infants in the perinatal period; partners involvement is crucial (p 39) *Moira Williamson, Carol McVeigh and Mercy Baafi*	4:20pm	Prenatal anxiety, postnatal symptoms, and the effect of quality of mother-child interactions on child behaviour at 18 months (p 14) *T Burrell, C McMahon, M-P Austin*
	5:00pm	Managing postnatal depressive symptoms using a combined support and exercise program: a pilot study (p 31) *E Mallet and MJ Currie*	4:40pm	Prenatal psychosocial and neuroendocrine factors and the regulation of sleep and feeding in infancy (p 19) *K-A Egliston, M-P Austin, C McMahon, L Leader, D Garrett*
			5:00pm	Does antenatal maternal stress and anxiety influence fetal behaviour and infant development? (p 28) *L Leader, M-P Austin, N Reilly, G Heller*

5:30 PM - 6:30 PM AGM Norfolk Room

8:00 PM Conference Dinner Four Winds Restaurant (Level 26, Crowne Plaza)

Saturday, 9 June 2007

8:30 AM - 9:00 AM Registration

10:00 AM - 11:00 AM Plenary Session Norfolk Room

Chair: Jane Fisher

10:00am The beyondblue National Perinatal Mental Health National Action Plan: the development of guidelines for psychosocial assessment, training and pathways to care in the perinatal context (p 10)
Marie-Paule Austin

10:30am NICE Guidelines on Antenatal and Postnatal Mental Health (Feb 07)
Margaret Oates

11:00 AM - 11:30 AM Morning tea

11:30 AM - 1:00 PM Parallel Sessions 4A, 4B, 4C and 4D

	Session 4A: Workshop: Don't drop the baby	**Session 4B: Impact of Childbirth on Emotional Well-being (Papers)**	**Session 4C: Education for Health Care Providers (Papers)**	**Session 4D: Medication in the Perinatal Period (Papers)**
	Cypress Room Chair: Megan Galbally	**Kauri Room Chair: Justin Bilszta**	**Phoenix Room Chair: Heather Rowe**	**Norfolk Room Chair: Sara Weeks**
11:30am	Don't drop the baby : keeping the infant in mind when working with complex families (p 50) *Patricia O'Rourke and Mandy Seyfang*	Caesarean section and postpartum depression: a review of the evidence examining the link (p 15) *Frances A. Carter, Chris M. A. Frampton and Roger T. Mulder*	Enhancing postpartum emotional care: evaluation of an education program for midwives (p 16) *Debra Creedy, Jenny Gamble and Marnie Griffiths*	Psychotropic treatment of depressive disorders during pregnancy – birth outcome and the neurobehaviour in the newborn (p 35) *Helena Sandahl, Megan Galbally, Anne Buist, Stephen Bowden, Gillian Opie*
12:00pm		Implications of poor care on trauma development following childbirth (p 22) *Jenny Gamble and Debra Creedy*	A coordinated training framework for the Edinburgh Postnatal Depression Scale (EPDS): lessons learnt (p 25) *A Hodgson, J Brooks, and C Down*	Antidepressant use in the antenatal period – can clinical decision making be informed by the evidence? - a literature review (p 38) *Adaobi Udechuku, Anne Buist and Malcolm Hopwood*
12:30pm		A story tells more than its tale: women's accounts of their Caesarean experience (p 35) *Lynne Staff, Jenny Gamble and Debra Creedy*	Overcoming depression: evaluating a best practice model of treating postnatal depression (p 20) *Jennifer Ericksen, Jeannette Milgrom, Bronwyn Leigh, Alan Gemmill, Christopher Holt, Yolanda Romeo and Anne Buist*	Post Natal Depression and breastfeeding-a consumer perspective of the challenges (p 21) *Michelle Fletcher*

1:00 PM - 2:00 PM *Lunch*

2:00 PM - 3:30 PM Parallel Sessions 5A, 5B, 5C and 5D

Session 5A: Workshop: How safe are the drugs we use in pregnancy?	**Session 5B: Edinburgh Depression Scale: Further Developments (Papers)**	**Session 5C: Families and Parenting (Papers)**	**Session 5D: Social Adversity and Perinatal Mental Health (Papers)**
Norfolk Room **Chair: Fiona Judd**	**Cypress Room** **Chair: Jennifer Ericksen**	**Phoenix Room** **Chair: Martha Birch**	**Kauri Room** **Chair: Barbara Hayes**
How safe are the drugs we use in pregnancy? A brief update on the treatment of mood disorders in pregnancy (p 48) *Marie-Paule Austin and Megan Galbally*	2:00pm Using cut-off scores on the EDS/EPDS: does it matter if you get it wrong? (p 33) *Stephen Matthey, Carol Henshaw, Sandra Elliott, and Bryanne Barnett* 2:30pm The Edinburgh Postnatal Depression Scale detects but does not distinguish anxiety disorders from depression: implications for clinical practice (p 34) *Heather J Rowe and Jane RW Fisher* 3:00pm The processes and information used to develop a new resource - 'Using the Edinburgh Postnatal Depression Scale (EPDS) – Translated into languages other than English' (p 32) *Jann Marshall and Kate Bethell*	2:00pm Disability and family sensitive practice (p 37) *Kathryn Thornton* 2:20pm Combining parenting and paid employment: does it make the transition to first time parenthood more complex and therefore more challenging? (p 24) *Suzanne Higgins and Carol Morse* 2:40pm Professional women as mothers: high expectations and depression? Some case studies and questions (p 26) *Mary Hood* 3:00pm Postnatal depression: a crisis of identity (p 22) *Jane Hasler*	2:00pm Perinatal mental health, poverty and regional development: a review of the evidence and its implications for Australian international aid (p 21) *Jane Fisher* 2:30pm Building resilience through government and non government partnership in working with substance using pregnant women: The SUPPS experience from experiment to mainstream practice? (p 16) *Vivienne Cunningham-Smith, Cathy King and Miriam O'Toole* 3:00pm Pathways to care in culturally and linguistically diverse communities: utilising DVD to connect families with services (p 19) *Christina Down, Bernadette Wright and Vilma Palacios*

3:30 PM - 4:00 PM *Afternoon tea*

4:00 PM - 5:00 PM Closing Plenary Norfolk Room

Chair: Bryanne Barnett

Keynote Address: Trauma in infancy – neurodevelopment and attachment
Louise Newman

5:00 PM - 5:30 PM Farewell Drinks

Late termination of pregnancy - where are we at?

- **Fran Orr[1] (chair) and discussion panel: Ian Kerridge[2], Lucy Bowyer[3] and Cameron Stewart[4]**

[1] Consultation-Liaison Psychiatry, Concord Repatriation General Hospital, NSW
[2] Centre for Values, Ethics and the Law in Medicine, Sydney University
[3] Dept of Maternal Fetal Medicine, Royal Hospital for Women
[4] Macquarie University

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When a termination of pregnancy is requested the clinician needs to be mindful of legislation regarding the procedure. There are differences in the law in each state and territory of Australia with regard to abortion. Apart from Western Australia and the Northern Territory reference is not made to the gestational age of the foetus. On the rare occasions where a termination is requested beyond twenty weeks, the decision-making is complex and often distressing for those involved. In 2000 the NSW Department of Health issued a circular that elaborated a framework for termination of pregnancy in NSW public hospitals. If a termination is requested after twenty weeks gestation the treating clinician is advised to involve a multidisciplinary team including experts in foetal medicine, neonatology, psychiatry or specialist mental health and any other relevant specialties.

Following an overview, this symposium will discuss the issues around late termination from the time the request is made. As well as the clinical presentation we will explore the legal and ethical dilemmas regarding such decisions. A panel consisting of a psychiatrist, an ethicist, an obstetrician and fetal medicine specialist, and a legal representative will discuss specific issues with reference to cases presented. There will be time for discussion with the audience.

Three in one: a three part group intervention for high risk mothers and babies

- **Karen Asgill, Bernadine McDonald and Annette Murphy**

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The Benevolent Society's Early Intervention Program (EIP), in operation for the past 17 years, has amassed considerable experience in the delivery of psychodynamically-orientated infant-parent psychotherapy, both in its Home Visiting Program, which offers a long term engagement, and its group programs, including perinatal, art therapy and play groups

The focus of this paper will be the development, over the last 10 years, of the Perinatal Group Program, consisting of a stream of three groups. The first, the antenatal support group, runs for 8 weeks in the 3rd trimester of pregnancy. In the post-natal period, participants are offered a baby massage group (10 weeks) and subsequently, a mother-baby group (10 weeks). The evolution of this three part group intervention will be discussed in terms of its theoretical framework and include clinical material to illustrate content and process. While aspects are currently under evaluation as part of a research project, the Group Program is proving to be a clinically powerful intervention in a high- risk population.

The *beyondblue* National Perinatal Mental Health National Action Plan: the development of guidelines for psychosocial assessment, training and pathways to care in the perinatal context

- **Marie-Paule Austin**

beyondblue National Perinatal Mental Health Program

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The *beyondblue* National Perinatal Mental Health Program was recently established to develop a National Action Plan for the implementation of universal psychosocial assessment in the perinatal context. Psychosocial assessment will particularly involve Midwives, GPs and Maternal and Child Health Nurses who will need training and ongoing supervision. Adequate Pathways to Care will also need to be developed before routine psychosocial assessment can be implemented.

This talk will outline some of the key aspects that are expected to form part of the National Action Plan which is to be submitted in November 2007. There will be time for discussion as we are keen to engage our key stakeholders on this important project.

The biological and behavioural effects of maternal trauma and posttraumatic stress disorder on child development

➢ **Jacqueline Beall[1], Alexander McFarlane[1] and Clara Bookless[2]**

[1] Centre for Military and Veteran Health, University of Adelaide, Australia
[2] Centre for Parenting, Children, Youth and Women's Health Service, Adelaide

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This longitudinal study has investigated the impact of maternal trauma experience and posttraumatic stress disorder (PTSD) prior to conception on the subsequent mother-infant relationship, and the development of the infant's physiological, cognitive, emotional and behavioural development. Forty four middle class mothers were recruited in the prenatal period and followed until the infants were 24-months of age, with over two thirds of the sample having experienced at least one severe trauma in their life time. For many women this included sexual molestation or rape during their childhood or adolescence. Overall, the results demonstrated different outcomes depending on whether the mother had developed PTSD or not. Surprisingly, maternal trauma experience without PTSD was found to be associated with reduced infant-mother interaction and delayed language development, whereas the life time diagnosis of PTSD was associated with disorganized attachment. Furthermore, the mother's trauma experience and level of hyperarousal symptoms post trauma were predictive of the infant's basal cortisol levels at 12-months-of-age suggesting an epigenetic mechanism for intergenerational effect of PTSD.

Women speaking out about thoughts of infanticide

➢ **Jennieffer Barr**

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Little research has reported descriptions of infanticide thoughts. Using a qualitative research design directed by hermeneutic inquiry, the experiences of women living with postpartum depression (PPD) was obtained. Following ethical approval, twelve women who had been diagnosed with a major depression or anxiety disorder following childbirth were recruited. Through in-depth interviews using a conversational approach, women spontaneously raised their concerns about thoughts of infanticide. This collected data included descriptions and meanings about thoughts of infanticide that did not lead to the act. Characteristics of these infanticide thoughts reflected the typical and known features like anger, associated suicide thoughts, and fear that women felt about being alone with the baby in case they spontaneously acted on these thoughts. Women were also asked what happened when infanticide thoughts were present and amongst the description were strategies that these women implemented to inhibit acting on these thoughts. The literature addressing infanticide predominantly focuses on the act and data is often collected retrospectively. The literature also contains case studies of women who have thoughts of infanticide. This research builds on the current knowledge and adds to the descriptions and understandings held about the nature of such thoughts. Findings of this research project enhance the dialogue on why women do not act on thoughts of infanticide.

Psychosis and bipolar disorder relapse in the postpartum: exploring the influence of sleep*

➢ **J Bilszta[1], H Badruddin[1,2], R Lestari[1, 2] and AE Buist[3]**

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[2] Universitas Indonesia, Djakarta, Indonesia
*[3] Women's Mental Health, Austin Health & Northpark Private Hospital, Melbourne**

*This project was funded by a grant from NARSAD: The National Mental Health research Association, awarded to Prof A Buist

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A numbers of studies have shown that sleep deprivation or changes in sleep quality can precipitate mania in non-pregnant individuals. Sleep-wake activity changes have been reported to occur during late pregnancy and the early postpartum period. These changes in sleep schedules are related to alterations in circadian hormones (eg melatonin and cortisol), reproductive hormones, and the physical discomfort associated with pregnancy.

It is well known that pregnancy and the early postnatal period are associated with a significant increase in the incidence of a mood disorder and women with a history of a serious mental illness (eg bipolar disorder, previous postpartum psychosis, schizophrenia and major depression) are at a significant risk of relapse. The reason for is unclear - cessation of medication due to concerns of teratogenicity is one clear risk factor, as are the hormonal changes that occur at delivery. However, these fail to explain all cases of psychosis in vulnerable women and suggest that some other mechanisms may be involved.

Given that pregnancy and the early postpartum period is a time of altered sleep quality, it is possible this phenomenon has an influence on relapse of a mood disorder. To explore this further, this project compared sleep/wake activity and sleep patterns in patients with a history of bipolar disorder/postpartum psychosis to a healthy, control population. Data will be presented from the first 33 women recruited (16 bipolar/postpartum psychosis history and 17 healthy controls). It will include current mental health and psychosocial data, as well as sleep and mood diary recordings from each trimester of pregnancy and the 1st, 4th and 8th weeks postnatal. Preliminary data collected using Actiwatch® Actigraphy Monitor will also be presented. This is the first time this technology has been used to monitor sleep-wake activity in pregnant women with a history of bipolar disorder/postpartum psychosis.

Findings from this study will be considered in relation to clinical presentation and the implications for management and early intervention of at-risk women.

A cost-analysis and satisfaction evaluation of postnatal support use

➢ **J Bilszta[1], J Kamaruddin[1,2], R Sugondo[1, 2] and AE Buist[3]**

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[2] Universitas Indonesia, Djakarta, Indonesia
[3] Women's Mental Health, Austin Health & Northpark Private Hospital, Melbourne

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With the growing acknowledgement of depression as an important health issue, there has been an increase in the research assessing not only the personal and financial costs associated with mental illness but the cost-effectiveness of interventions to treat or prevent recurrence. Whilst there has been extensive economic evaluation of major mood disorders, emotional health associated with pregnancy and childbirth, has received little attention.

Research has suggested that women who are at-risk of, or experiencing, a postnatal mood disorder use more services and supports than women who cope better during this period. However, the cost-implications of this increased use has yet to be fully investigated. Studies completed have had significant limitations including excluding data from partners or other children, did not collect non-medical costs, were limited to high-risk populations and for those that that included a treatment intervention, lacked a before-and-after intervention comparison. With these limitations in mind, this project evaluated postnatal service/support in a naturalistic prospective cohort of women whom had recently delivered.

Data was collected at three time points: 2, 6 and 12 weeks postnatal. It included mental health, service/support use and satisfaction questionnaires. Women involved were divided into two groups on the basis of whether they were considered at risk of a mood disorder (EPDS score of 12 or more at 6-weeks postpartum).

Service/support use data was collected across four domains: demographic/psychosocial history; employment and income; health, education, legal and social service usage and; informal care support usage. For the last two domains information on professional/individual or agency that provided service; location of professional/individual or agency; frequency of use and; duration of each contact was collected. A unit cost (per hour or per session, for example) was determined for each service. Global satisfaction with perinatal services and supports was measured as either i) those services accessed as a total or ii) comparison of responses of participants who were "very satisfied" from those with lesser degrees of satisfaction. This analysis will allow a contrast between those who are very satisfied with those who are satisfied to lesser degrees.

Findings from this study will be considered in relation to implications on clinical practice and resource requirements for women requiring emotional and/or practical assistance during the postnatal period.

Recurrence of affective psychosis following childbirth: a meta-analysis and case studies

➢ **P.M. Boyce[1]; J. Barton[2]**

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[2]*Westmead Perinatal Psychiatry & Clinical Research Unit, Sydney West Area Health Service.*

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The relationship between the psychotic illness and pregnancy has been noted since antiquity. The nature of the specific type of psychotic illness has been the focus of some debate, with the consensus now held that puerperal psychosis is a variant of bipolar disorder; although women suffering from schizophrenia may also experience exacerbation of their symptoms postpartum. The rate of puerperal psychosis has been estimated at one to two episodes per 1000 deliveries. However, this figure does not appear to have been determined through a systematic review of the prevalence rates of puerperal psychosis.

Childbirth and the immediate postpartum period have been considered times of high risk of relapse for bipolar disorder. This presents a myriad of clinical management issues due to the risks associated with the prophylactic treatment of women with mood stabilisers during pregnancy; a strategy utilised for women who have previously experienced puerperal psychosis, or have bipolar disorder, to minimise the risk of additional episodes or prevent relapse. Mood stabilizers are associated with teratogenicity if used in the first trimester of pregnancy, may lead to behavioural toxicity in the latter stages of pregnancy (floppy-baby with lithium) and lithium toxicity is a risk during labour. Breast-feeding is also generally contraindicated for women taking mood stabilisers as they pass though the breast milk.

Women who have had a previous psychotic episode are increasingly consulting with perinatal psychiatrists to plan their clinical management during pregnancy. Such consultations should include a risk-benefit analysis for the women and for the infant, taking into account the risks of the woman not being on mood-stabilizing drugs during the pregnancy and after delivery against the risk to the infant of being exposed to the mood stabilizers in utero. Thorough understanding of the relevant risks of relapse for each woman, and each pregnancy, must be achieved to enable informed decision-making.

The purpose of this paper is therefore twofold; first, to provide accurate estimates of the risk of having an episode of affective psychosis following childbirth; second, is to clarify the unique risk factors for a recurrence of puerperal psychosis or relapse of bipolar disorder following childbirth.

Prenatal anxiety, postnatal symptoms, and the effect of quality of mother-child interactions on child behaviour at 18 months

➢ **T Burrell[1], C McMahon, M-P Austin**

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Background: In the context of emerging evidence of a lasting impact of maternal anxiety in pregnancy on offspring, the present exploratory study aimed to investigate the relationship between prenatal anxiety disorder and toddler temperament and behaviour at 18-22 months. The potential mediating role of concurrent symptoms and caregiving quality were also examined.

Methods: Maternal anxiety in pregnancy was assessed using the MINI to establish whether mothers met diagnostic criteria for past or current anxiety disorders. The A-State scale was used at 18 months to assess state anxiety and both mothers and fathers reported on behaviour using the Child Behaviour Checklist (CBCL). Child behaviour during developmental testing was examined using the behaviour rating scales from the Bayley Scales of Infant Development and maternal sensitivity and child responsiveness were observed during ten minutes of free play.

Results: Women who met diagnostic criteria for an anxiety disorder during pregnancy had toddlers who showed less-optimal orientation and engagement behaviour, as rated by an observer during testing ($p < .05$). . In addition, mothers with higher levels of concurrent anxiety reported their toddlers had more internalising behaviour problems ($p < .05$) Maternal intrusive caregiving behaviour was related to lower levels of toddler activity during free-play, however neither prenatal anxiety status nor concurrent and anxiety were related to the quality of maternal caregiving behaviour. Study findings must be interpreted with caution given the small sample size. Nonetheless some findings suggest interesting directions for future research with larger samples.

Caesarean section and postpartum depression: a review of the evidence examining the link

- **Frances A. Carter, Chris M. A. Frampton and Roger T. Mulder**

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Objective: To examine the evidence for an association between caesarean section and postpartum depression.

Methods: Medline and PsychInfo databases were searched. All studies on caesarean section which evaluated maternal mood between 10 days and 1 year following delivery were reviewed. Nine methodologically superior studies, including the only randomised controlled trial (RCT), were analysed separately. The nine studies that provided adequate summary statistics were combined in a meta-analysis.

Results: Of the twenty-four studies that have examined the association between caesarean section and postpartum depression, five found a significant adverse association, fifteen found no significant association, and four found mixed results. With only one exception, methodologically superior studies found either no significant association or mixed evidence for an association between CS and PPD. Meta-analyses of suitable studies failed to find evidence for a significant association between caesarean section and postpartum depression. Possible reasons why different studies have obtained different results are critically evaluated.

Conclusion: A link between CS and PPD has not been established.

Carter FA, Frampton, CMA, Mulder, RT. Caesarean section and postpartum depression: A review of the evidence examining the link. *Psychosomatic Medicine*. 2006; 68 (2):321-330.

Enhancing postpartum emotional care: evaluation of an education program for midwives

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Midwives are expected to provide holistic women-centred care (Australian College of Midwives Inc, 2004) yet birthing women consistently report inadequate emotional support. This paper reports on a single group pre-post test pilot study of an educational intervention to enhance the counselling skills of midwives (n = 13). The educational intervention was assessed in regards to attitudes, reported counselling skills and processes as well as knowledge. Participants also evaluated workshop content and processes, quality of facilitation and overall satisfaction. Repeated measures analyses revealed a shift in respondents' attitudes about working with women who have emotional health problems and disorders. Respondents felt more positive in working with women who have emotional health problems and disorders after attending the workshop in comparison to before. Respondents also reported improved self-perceived competence in the use of treatment techniques (i.e. counselling and relaxation) with women suffering from depression and anxiety. Respondents self-perceived competence in the used of treatment techniques (i.e. counselling and relaxation) with women suffering from depression and anxiety were higher after attending the workshop. The presentation will outline the content of the workshop, substantive results and explore some of the challenges encountered.

Building resilience through government and non government partnership in working with substance using pregnant women: The SUPPS experience from experiment to mainstream practice?

➢ **Vivienne Cunningham-Smith[1], Cathy King[2] and Miriam O'Toole[3]**

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Since 2002 in the Illawarra area of NSW, a small service has been building its expertise in developing an intersectoral maternal substance misuse service. This service is known as SUPPS or the "Substance Use in Pregnancy and Parenting Service". SUPPS is a cross sectoral multidisciplinary team which includes 2 non government Family Support Services who work side by side with their colleagues from maternity, paediatric, drug and alcohol, child and family, statutory child protection and mental health services.

This service has moved from a small discrete team approach to having been recognised as exemplary practice in the NSW Child Death Review 2006, the NSW State Health Baxter Awards and formed the basis for a statewide report on best practice models in maternal substance misuse. The team has gone through many stages of development with the approach heading into mainstream practice in health in the most recent months. This has not been without its challenges especially in the area of professional, statutory and organisational difference.

This paper will present the development of an integrated cross government / non government approach , warts and all , and walk the listener through the machinations of mainstreaming this model into a hospital and wider health and child protection system which is ever changing. The paper will draw upon the Churchill Fellowship Report* on international best practice in this field as well as the 2 independent evaluations of client outcomes and studies of client satisfaction. It will discuss its planned evolution in working with Indigenous families and the way forward to embed this unique approach into large bureaucratic systems at the local and state level. The paper will present its listeners with key models of best practice which they can implement in their local areas given the varied range of services provided across Australia and between urban, rural and remote areas. It will also provide them with a toolkit of what to expect in achieving a multi government and non government team approach and how to get over the many hurdles experienced when bringing together vastly differing professionals and service systems.

* Ms Kerry Moore undertook a Churchill Fellowship in 2005 to study international models of working with substance using pregnant women to build upon the practice of SUPPS.

Perinatal mental health resources for indigenous families

➢ **C Down and J Brooks**

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Australia's Indigenous population experiences twice the rate of mental health problems of non-Indigenous Australians. The broader issues of grief and displacement that underlie all issues of mental health are greater for Indigenous people and are reinforced by current adversities including significantly high levels of poverty, unemployment, physical and emotional health problems and inequality in the provision of and access to appropriate health and social services. Within these social complexities, Indigenous women face significant risk when dealing with the adjustments required during pregnancy and postpartum. Addressing the needs of the Indigenous communities in Australia requires innovative and collaborative ways of combining western and traditional methods to build community capacity within Indigenous populations.

Over the last 3 years the SPRG has been working to enhance the knowledge of perinatal mental health issues amongst Indigenous Health Workers and to foster the capacity of Indigenous Health Workers to provide support to Indigenous women and their families experiencing perinatal mental health issues.

Workshops have been held with Indigenous Health Workers in rural and metropolitan locations to provide information on perinatal mental health and to generate discussion about culturally appropriate resource development and highlight areas of specific importance for Indigenous perinatal mental health. Key recommendations in regards to culturally appropriate content and mode of information delivery were gained from these workshops.

Three Indigenous specific perinatal mental health resources have subsequently been developed, and are currently being distributed and utilised by Indigenous Health Workers in WA. This paper presents the development, content and uses of these resources.

Boodjarri Business: Maternal Mental Health Resource for Aboriginal Health Workers is a 34-page colour booklet, containing valuable information for those working with Indigenous families.

A training module for Aboriginal Health Workers has been developed containing practical information, skills and resources based on the *Boodjarri Business* booklet. A DVD developed in collaboration with Indigenous communities and co-presented by an Aboriginal consumer provides a unique and valuable addition to resources available nationally.

Indigenous community perinatal mental health service expansion

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There is a recognised need to raise awareness of mental health issues in Australian Indigenous communities and provide culturally appropriate services for these communities. Although literature specific to Indigenous perinatal mental health is limited, there is sufficient evidence to support the development of culturally appropriate mental health services for Indigenous Australian families during the child-bearing years.

In collaboration with the WA Indigenous Mental Health Service, the WA SPRG has developed a perinatal mental health service framework to extend and support existing services in rural WA. An implementation steering committee was established with key Indigenous stakeholders to guide service development and a local steering committee was recently formed to guide process issues as they arise.

By June 2007, an Indigenous Community Liaison Officer and 2 Indigenous Mental Health Workers will have been employed to provide this new perinatal mental health service. These positions will be embedded within an existing local service to ensure the necessary infrastructure and supports are available. Perinatal specific training is being provided by the SPRG and the State Indigenous Mental Health Service is providing cultural support for these positions.

One of the overarching aims of this initiative is to bridge the cultural and geographical gap between Indigenous families living in rural Australia and mainstream perinatal services. This Indigenous perinatal mental health service will thus play a major role in information provision and education for local community members and services, and facilitate engagement with metropolitan services as necessary. The service will also act as an advocate for the local perinatal client group and liaise with local and metropolitan services as appropriate. Finally, the service will coordinate the provision of support groups for women who are pregnant or who have had a baby in the last 3 years.

The service is currently being trialed over a 3-year period with plans to maintain the service at the pilot site and obtain further funding for expansion to other rural locations. A thorough evaluation process has been built into the trial and findings from the baseline evaluation will be available for presentation.

Pathways to care in culturally and linguistically diverse communities: utilising DVD to connect families with services

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Australia is a multicultural society, with emerging communities that include refugee and migrant populations. It is well documented that factors relating to language, religion, culture, tradition and the refugee experience itself place these groups at high risk of mental illness, particularly depression.

The need to gain more information on the experience of emotional adjustment during the perinatal period for these populations was identified by SPRG, as essential in order for mainstream services to provide culturally sensitive pathways to care and to build capacity within the communities. Appropriate perinatal specific resources and services could then be developed.

Iraqi, Sudanese and Ethiopian populations were selected to participate in focus groups. The participating women had arrived in Australia in the last ten years and had a child aged three years or younger who was born in Australia. Key questions were developed in consultation with bilingual workers and group discussions addressed issues pertaining to the comparison of experiences during pregnancy and postpartum between country of origin and Australia and recommendations for support and intervention. The discussions were recorded on audiotape, translated, transcribed and key themes extracted. Participants were invited back for a second focus group in order to validate findings and provide feedback.

This paper will present the key issues identified by women including:
Perceived gaps and barriers in existing pathways to care.
Recommendations for the provision of culturally appropriate interventions and resources by mainstream perinatal services including consumer based service models.
Development of three consumer information DVDs which highlight experiences encountered by women from these communities during the perinatal period, and guidance on how to best access support (in appropriate language) and accompanying information pamphlet.

Prenatal psychosocial and neuroendocrine factors and the regulation of sleep and feeding in infancy

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Background: Experimental studies with animals suggest that maternal prenatal stress induces long-lasting disturbances in the regulation of offspring sleep and feeding behaviours. Emerging data from human studies points to links between maternal prenatal distress and behavioural, emotional, and cognitive development in offspring, but little is known about the impact of prenatal factors on infant sleep and feeding. The present study used a prospective design to

investigate the impact of maternal prenatal psychological distress and neuroendocrine parameters on infant sleep and feeding at 6 weeks and 6 months postpartum.

Participants: Data was collected from 68 women taking part in a prospective study at the Royal Hospital for Women, Sydney. The women had singleton, uncomplicated pregnancies, and none were diagnosed with a chronic psychiatric disorder.

Measures: Self-reports assessing maternal depression, anxiety, and perceived stress were administered during the third trimester of pregnancy and at 6 months postpartum. Blood samples were collected during the third trimester to test for the maternal stress hormones CRH, ACTH, and cortisol. Mothers completed infant activity diaries for one 24-hour period at both 6 weeks and 6 months postpartum to record patterns of infant sleep and feeding.

Results: Preliminary analyses indicated that mothers with higher antenatal depression scores and higher antenatal plasma cortisol levels have infants who sleep less at 6 weeks postpartum. A positive association between cortisol and total time feeding at 6 weeks was also found. Similar trends were noted at 6 months postpartum suggesting that antenatal factors may have lasting effects on child development.

Overcoming depression: evaluating a best practice model of treating postnatal depression.

- **Jennifer Ericksen, Jeannette Milgrom, Bronwyn Leigh, Alan Gemmill, Christopher Holt, Yolanda Romeo and Anne Buist**

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The overall aim of this project is to implement and evaluate best-practice care pathways for postnatal depression and to improve service relationships between primary and secondary mental health settings. This project is a randomized trial, in which we aimed to allocate a total of 105 participants, between 3 quality care pathways (35 in each). This project evaluates General Practitioner (GP) management alone and in combination with 2 adjunctive treatments consisting of a 7-session overcoming depression treatment program delivered by either a Psychologist or a Maternal and Child Health Nurse (MCHN). A training session was provided individually to each General Practitioner. Maternal and Child Health Nurses were also trained to deliver the 7 session Overcoming Depression© program. To identify mothers at risk of depression the EPDS (Edinburgh Postnatal Depression Scale) was administered by a Maternal and Child Health Nurse (MCHN) or GP. The Beck Depression Inventory (BDI) was used to provide a clinical assessment of depression severity and was the main post-treatment outcome measure.

Over the project period of 18 months, 1124 mothers were screened by Maternal and Child Health Nurses in Melbourne municipalities, Banyule, Nillumbik & Whitehorse. This yielded 117 mothers who scored $\geq$ 12 on the Edinburgh Postnatal Depression Scale and were eligible for the study. Whilst the potential participants into the study exceeded our target of 105, only 44 of these mothers were referred to the program with 17 mothers accepting participation into the study. Qualitative data capturing reasons as to why mothers declined treatment will be reported. Qualitative and Quantitative data will be presented on outcomes of the program including health professional satisfaction, GP and MCHN training, depression treatment outcomes and knowledge of diagnosis, PND treatment and management.

Perinatal mental health, poverty and regional development: a review of the evidence and its implications for Australian international aid

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The World Health Organization's Making Pregnancy Safer Initiative aims to address the economic, sociodemographic, health status and health service factors associated with mortality and morbidity related to pregnancy. The most prominent risks to life are identified as those directly associated with reproduction including pregnancy illness and complications of childbirth. There is, however, very limited consideration in these initiatives of mental health as a determinant of maternal mortality and morbidity.

Most research into the prevalence and determinants of compromised mental health in women during pregnancy and after childbirth has been conducted in the rich industrialised countries of the world. The prevalence estimates of 10% - 15% of women experiencing Major Depression in advanced pregnancy and the postpartum year are cited widely. Ethnographic studies in developing countries documented culturally prescribed and socially structured peripartum customs, which provided dedicated care, an honoured status, relief from normal responsibilities and social seclusion for mother and newborn. They argued that in cultures where these rituals were observed there was little evidence of postpartum depression.

A systematic review of the emerging evidence indicates that contrary to this conclusion, mental health makes a substantial contribution to maternal mortality and morbidity in resource poor countries including in the Asia Pacific region. Although only limited data are available, suicide is a notable cause of maternal mortality. Depression during pregnancy and after childbirth is two to three times more common in women living in low income countries. Prevalence is highest among the poorest women with least access to health services. Risk factors include lack of reproductive choice and unwanted pregnancy, crowded living conditions, critical coercion, intimidation or violence in intimate relationships, gender disparities in access to education and employment, cultural preference for male children and poor physical health, in particular iron deficiency and anaemia.

The Australasian Marcé Society is well positioned to contribute health and social research expertise to building local evidence and contribute to service development in the low income countries of the region.

Post Natal Depression and breastfeeding-a consumer perspective of the challenges

➢ **Michelle Fletcher**

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Women with PND often struggle with other issues which complicate the journey. One of them is breastfeeding and the emotional rollercoaster which goes along with it. For women with PND, medication, treatment options and the lack or mismanagement of information while trying to maintain breastfeeding can compromise the relationship with the infant.

I would like to share, from a consumers point of view, how these factors impact an emotionally vulnerable woman/family and provide clinicians and caregivers with vital information to better understand those pieces of information which are non verbal. The presentation will feature a range of options for care providers to better understand and enrich the medical relationship and the bond between mother, child and extended family.

Through sharing my journey and that of other women that I have counselled over the years I would like to share some excellent resources and helpful strategies.

Implications of poor care on trauma development following childbirth

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Childbirth is a significant and potentially traumatic event in the lives of women. This paper reports the satisfaction and care related factors associated with PTSD at 4-6 weeks and 3 months postpartum for 412 women recruited antenatally and followed up to 3 months after the birth. There was a consistent and statistically strong relationship between variables measuring aspects of satisfaction with care associated with PTSD at 4-6 weeks and 3 months. At 4-6 weeks postpartum there was a statistically significant association between PTSD and the overall poor quality of care [$\chi^2(4)$ 49.089, <.001]. Other variables identifying specific aspects of quality of care were also examined. Statistically significant associations were found between variables assessing women's feelings in labour and PTSD at 4-6 weeks. They included feeling worried, frightened or anxious when labour first began; not confident in labour; out of control; frightened; helpless. Similar results were found at 3 months postpartum. The contribution of poor care to the development of these negative feelings will be outlined. Implications for research and practice will be discussed.

Postnatal depression: a crisis of identity

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Postnatal depression (PND) has historically been 'medicalised' and seen as a condition generally not associated with social factors. However, it appears that the expectations society places on a woman when she has a baby and those she places on herself at this time are significant in their contribution to her emotional wellbeing. These expectations are interwoven with her sense of identity, of which gender plays a major part.

By recognising these psychosocial factors as a major factor associated with PND, necessary steps can be made to change not only the cognitive processes of both women and men, but also the practice of everyday life. The greater interest within Western society in PND has led to more 'cases' being identified, however relatively little has been done to actively address the experience of PND from a sociological standpoint.

Placing women's feelings in the context of their lives brings to life PND so that we can begin to recognise the extent to which the condition is tied to the white, middle-class model of motherhood. Postnatal depression needs to be reconceptualised as an understandable reaction experienced by many women when they become mothers. A large number of these women feel a profound sense of loss and grief for the perceived loss of the identity they had before they had children.

This qualitative study involved interviews with twenty women who have previously experienced postnatal depression within the last 3 years. The aim of the study was to collect in-depth and detailed narratives that shed light on the relationship between traditional gender identity and PND. 'Traditional gender identity' in this context refers to the adoption of roles, values, beliefs and practices that reflect normative definitions of masculinity and femininity. Findings are significant in that they provide a better understanding of the way that gender identity can contribute not only to PND, but also to postnatal wellbeing. The study also contributes to the field of gender studies, in particular, theories and ideas about identity formation and the concept of an 'authentic self'.

Ownership and respect – key components of resilience in the perinatal period: three translations by Aboriginal and Torres Strait Islander women of the booklet *Emotional Health in Pregnancy and Early Parenthood*

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The achievements of the *beyondblue* National Postnatal Depression Program (2001-2005) made several landmarks recommendations in the emotional and mental health of perinatal women. The following recommendations were adopted as the three parallel processes for the National Action Plan developed by the National *beyondblue* Perinatal Mental Health Program (2006-2007):
Implementing psychosocial assessment of pregnant women and new mothers Australia-wide;
Training relevant health professionals in recognition and management of depression and related difficulties;
Establishing models of care appropriate to the various settings covered by the National Action Plan with a focus on prevention and early intervention.

Underpinning all of these processes are the particular cultural needs and approaches of Australia's Aboriginal and Torres Strait Islander women. One of the Queensland strategies as part of the *beyondblue* National Postnatal Depression Program (2001-2005) was the translation of the Edinburgh Depression Scale (EDS) into contemporary, locally understood language at three sites in North Queensland: Townsville; Mt Isa; and Palm Island. After each site-specific screening package was translated and developed, each of the Reference Groups expressed the desire to translate the booklet -- *Emotional Health in Pregnancy and Early Parenthood (*which was distributed nationally to all women) – into their own language and to accompany it with their own symbols and artefacts. The women at each site expressed a sense of ownership of all the materials generated which was based on respect for their connection to country; respect for their choice of language for the experiences of perinatal emotional and mental distress; and their compassion for perinatal Aboriginal and Torres Strait Islander women who often experience cumulative loss in the journey of childbearing. Ownership and respect will be explored in relation to resilience.

Combining parenting and paid employment: does it make the transition to first time parenthood more complex and therefore more challenging?

➢ **Suzanne Higgins[1] and Carol Morse[2]**

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This doctoral study examined the experience of first time parent couples when the mother returned to the paid workforce. Such parents are now more likely to be two-income than ever before. Sixty-five percent of employed women in couple families have dependant children, and in couple families with children under 5 years of age, 52% of mothers are employed.

A community based sample of 141 participants (69 couples plus 3 women) were recruited into this longitudinal study for the purpose of comparing single and two-income first time parent couples. Their infants were aged between 3 and 15 months on enrolment.

A number of variables were measured including marital satisfaction, worker spillover, stress levels, emotions (anger and anxiety) parenting satisfaction and division of household labour. Data was collected on 4 occasions over a 10 month period of time using valid and reliable measures collated into a booklet. Both men and women completed their booklets which were administered by mail.

This presentation will discuss the findings on stress, anger and anxiety, parenting satisfaction and couple relationship.

This reasonably well-educated sample group was mostly aged in their 30's and described themselves as semi-professional or professional in occupation. The majority were born in Australia and had lived together for around four years upon enrolment in the study.

In general this sample group reported being less satisfied with their couple relationship than the validation means although not to the level which would indicate relationship breakdown, the group as a whole appeared less stressed than the validation sample means and this was particularly evident for men in the current study. Men and women reported being more anxious and angry than norms for the scale used although two-income participants, as a group, reported being more anxious and angry than single-income participants.

It would appear that this sample of Australian first-time parents demonstrated a transitional process over a 10-month period, when some were combining parenting and paid work. They did not appear to be experiencing undue hardship although some evidence of stress existed for some groups of participants.

A coordinated training framework for the Edinburgh Postnatal Depression Scale (EPDS): lessons learnt

➢ **A Hodgson, J Brooks, and C Down**

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Effective training and support in the screening, diagnosis and management of depression during the perinatal period, with an understanding of local referral pathways is central to effective intervention for women and their families. Screening for perinatal depression using the Edinburgh Postnatal Depression Scale (EPDS) is routinely implemented in WA antenatally and at six-weeks and three-months postpartum, generally by general practitioners, child health nurses or midwives.

Given the geographic extremes of rural and remote WA and associated difficulties of a rapid staff turnover and limited access to available resources, there are significant challenges in providing effective training and support for clinicians working with women during the perinatal period. Such challenges are not unique to WA.

Following consultation with multidisciplinary staff from a range of services throughout the state, and closely aligned with the key recommendations of the *beyondblue* National Postnatal Depression Program (2005), a 4-hour EPDS educational module and Train the Trainer framework was developed. This centrally coordinated and systematic approach to training promotes consistency in the use of the EPDS as a screening tool and builds capacity and skills amongst local health care professionals.

Since its inception in 2005, over 30 clinicians from throughout WA have attended a two-day workshop providing training in the delivery of the 4-hour module, and received a comprehensive training package, including required training materials.

Outcomes thus far indicate a positive response, with the 30+ trainers having now provided the module to over 150 clinicians from a variety of clinical backgrounds and agencies. Initial evaluation results indicate strong acceptance of the module format, with marked improvement between pre- and post- module scores.

The Train the Trainer framework appears to be successfully addressing the difficult issue of how to provide localized education and support to clinicians in remote areas of Australia. Whilst staff time constraints and geographic distance provide some difficulties, different ways of working with and around such problems are continually being developed and will be discussed in this paper.

Professional women as mothers; high expectations and depression? Some case studies and questions

- **Mary Hood**

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This paper will consider some questions about the impact of early childhood knowledge and professional status on women as mothers. Do expectations of perfection in meeting the child's need's and of managing one small household, while being in good control of the self, more often lead to disappointment and depression when not achieved? How does this interact with the original attachment styles of the women and sociological factors such as age of the first time mother? Case studies will illustrate this discussion.

PANDA – Victoria's perinatal depression Helpline – an update

- **Belinda Horton**

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PANDA, the Post and Antenatal Depression Association, is a Victorian, statewide, not for profit association working for women and their families affected by antenatal and postnatal mood disorders. PANDA is committed to a community where post and antenatal mood disorders are recognized, and the impact on women and their families is minimized through acknowledgment, support, education and referral.

PANDA began in 1985 when two women with postnatal depression (PND) were introduced to each other by their Maternal and Child Health Nurse. They and other women found it helpful to talk each other so they continued to meet regularly to share their personal experiences, benefiting from the mutual support. Collectively the women decided to establish a support group and over time the organization of PANDA was established to cope with the demand for the need for the group.

In the last 22 years PANDA has built on its consumer roots to become a significant telephone Helpline dedicated to supporting women and their families with antenatal and postnatal mood disorders. PANDA receives calls from women experiencing mild through to severe distress and depression as well as calls from their partners, family and friends. All callers talk to staff and volunteers who have been personally touched by antenatal or postnatal mood disorders, thus providing powerful peer to peer support. PANDA provides an accessible, acceptable and confidential helpline service.

This paper describes developments in PANDA's service delivery including tools for the biopsychosocial assessment of risk and the causative factors and symptoms associated with antenatal and postnatal mood disorders. The mapping of quality pathways to care for women and their families, including short term intensive service coordination, and the vital need for ongoing support and follow up are discussed. The education provided to empower women and their families to become informed consumers of medical, community and mental health services is a significant part of PANDA's services.

The paper also describes PANDA's program for the recruitment and training of consumers as volunteer Telephone Support Workers that ensures the quality and consistency of service delivery and duty of care for the volunteers.

Connections' Starting Out program

- **Pam Joseph**

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Throughout 2006 and into 2007, Victorian Child Protection, Family Services and Out-of-Home Care services prepared for the implementation of the Children, Youth and Family Services Act 2005. The Act represents a clear articulation of the centrality of the child's needs when working with vulnerable families, and a sense of 'the child as client'.

What does this mean for services that seek to work with children and their families primarily through engagement with parents?

For Starting Out, a program traditionally geared to working directly with young women who are pregnant and/or parenting, with the primacy of the child's needs often assumed rather than stated, what changes in service delivery are required in order to respond to the current policy environment? What are the consequences for our work with mothers and their infants?

The paper will use a Program Evaluation model to follow the journey of this program as it grapples with these issues, to identify some of the challenges, achievements and dilemmas confronted.

Perinatal distress and mood changes: a rationale for early intervention

- **Leone Joyce**

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The Waikato District health board early intervention maternal mental health service was developed 5yrears ago in response to a recognized need and gap in the services for the women and their families of the waikato region, new zealand. Although there has been a continual demand for services there are limited resources and the service has had to triage the incoming referrals to ensure the best outcome for the clients.

The perinatal period is known to be a time of rapid physical and emotional change and therefor becoming a stressful life event for many families. Increased anxiety and emotional mood changes often rob the mother father and their infant of the vitality needed to form a healthy attachment bond which may lead to further problems.

Identifying and differentiating the prodromal symptoms at their earliest manifestation and clarifying the issues of contention can make a difference for the affected family. Unmasking the emotional turmoil of perinatal distress is a task that is often met with much resistance because of the social stigma and negative perception associated with mental ill health. A failure to acknowledge and assess anxiety levels and social distress when screening for depression during the perinatal period may heighten the susceptibility to a depressive episode. Conversely to ignore or minimize the emotional distress of this period, expecting the mother to "pull herself together" can be devastating and lead to misunderstanding and further distress. Skill and

expertise is needed in order to differentiate the real issues of contention as very often sleep deprivation, baby feeding problems and/or physical health issues present as a false positive when using a screening tool.

I therefore propose that an Early Intervention Maternal Mental Health service can preempt further distress and reduce the risk of developing a mental health disorder by providing specialist, empathetic, therapeutic options for the family in the perinatal period.

Advocacy for new mothers with mental illness

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Being a mother is said to be the hardest but most rewarding job in the world. Mothers with serious mental illness face the same challenges and more, but often experience little of the rewards. Additionally they face the challenge of accountability, not only to their baby, but also to social service agencies and health care workers to prove that they can be a competent and caring mother. The measure of being a "good enough" and competent mother is in fact a problematic and subjective one, relying upon the input of multiple health and welfare care providers whose opinions are often not in agreement and rely on subjective assessment. New and ever developing welfare and child protection legislation, make the socio-legal system challenging to negotiate for the health care providers, let alone the mother of a young baby already trying to cope with serious mental illness and parental responsibilities.

There are currently inadequate resources and knowledge to facilitate the expansion of the role of perinatal mental health care providers to adequately advocate for their patients within the legal and welfare systems. There is also a predominant focus on child custody at the expense of addressing the fundamental mental health issues that have contributed to a child being removed from its mother in the first place. Several recent case studies will be presented to highlight the complexity of these issues in current perinatal health care provision.

Does antenatal maternal stress and anxiety influence fetal behaviour and infant development?

- **L Leader[1], M-P Austin[2], N Reilly[2], G Heller[3]**

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Aim: To examine the effects of maternal anxiety in pregnancy on fetal behaviours and infant development at 18 months.

Method: We measured maternal anxiety, using the STAI (trait and state), stress using the perceived stress Scale (PSS) and a Life events stress (LES) scale and depression using the

Edinburgh Scale (EPDS), at 30-32 (time 1) and 36-36 wks of gestation (time 2). Fetal heart rate (HR) responses to repeated vibro-acoustic stimulation were assessed at 36-38 wks. Infant development was evaluated by an independent observer at 18 months of age using Bayley Scales of Infant Development (BSID).

Results: Regressions which attempted to explain fetal heart rate changes by maternal stress and anxiety measures were performed in 108 mother-fetal diads. The dependent variables used were: Mean HR (bpm) during baseline, standard deviation of HR (bpm) during baseline: maximum HR change (bpm) following the first 3 stimuli, time to maximum HR change following 1st 3 stimuli (seconds).

The explanatory variables used were the EPDS and STAI-trait total score at times 1 and 2, STAI-State total score at time 2, PSS total score, life event stressors at time 2, fetal weight; maternal ACTH, cortisol and CRH at time 1.

Each of the time 1 explanatory variables was regressed against each of the time 1 stimulation outcomes, and similarly for time 2. No significant results were found, i.e. none of the maternal anxiety and stress measures, including blood hormone levels, were found to be predictive of fetal response to repeated vibro-acoustic simulation

Seventy-one infants were tested using the BSID scales. Infants whose mothers had STAI scores >45 at both times 1 and 2 had a significantly lower Mental Developmental Index (MDI 111.47 v 116.75 p=0.001) and a lower Behavioural Rating Scale (103.22 v 108.14 p=0.056). The Psychomotor Development Index (PDI) was similar for both groups

Conclusions: Results suggest that maternal anxiety in pregnancy does not impact on fetal behaviour as measured by heart rate responses to repeated vibro-acoustic stimulation. However maternal anxiety does seem to have a significant impact on infant development.

PremieHUGS: a specialised mother-infant program following premature birth

- **Bronwyn Leigh, Carol Newnham, Jeannette Milgrom and Nisha Brown**

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A premature birth is often associated with multiple traumatic experiences for both mother and baby. Mothers may experience significant loss of control, grief/loss issues and may struggle to adjust, often contributing to depression, anxiety and trauma symptoms. Premature infants also endure multiple traumas of an emotional, social and medical nature, which may leave them vulnerable to developmental complications.

PremieHUGS is an 8-week group program for mothers and their premature infants. The objective of the group is to provide maternal support, focus on the mother-infant relationship and potentially enhance early infant development, all of which promote resilience for mother and baby.

PremieHUGS is a newly developed program being run through the Parent-Infant Research Institute and Infant Clinic, Austin Health. Little research has been evaluated in this area. A description of the program and preliminary results from the pilot of this very unique and important program will be presented.

Emotion Focussed Therapy and postnatal depression

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This presentation presents a discussion of the emotional processes involved in postnatal depression based on the results of a phenomenological exploration of the nature and content of emotion process and emotion schemes in women experiencing postnatal depression (PND). A Process Experiential Emotion Focused Therapy (PEEFT) Framework is used to investigate the affective component of PND, and its interaction with other important aspects such as cognition, behaviour, motivation and physiology (Greenberg & Watson, 2005).

Whilst a significant amount of research has been conducted in the area of depression, there have been no studies within the PEEFT framework conducted specifically on PND and its related emotions or emotions schemes. Further still there has been minimal research into the affective component of PND, leaving PND inadequately understood. The purpose of this study was to examine the emotion schemes present in women experiencing PND and any dominate themes that may be present.

Three women assessed as having PND participated in the current study. The participants were interviewed on two occasions using a quasi therapeutic interview procedure in order to elicit in-depth descriptions of their emotional experiences of PND. Analysis of the data using an empirical phenomenological approach identified depression related descriptives interpreted then in order to derive main thematic categories. Diagrams of emotion schemes were then drawn. The main thematic categories for all participants were then synthesised and emotion scheme components were compared.

The major themes common to all three participants were identified with core emotion schemes being centred around feelings of failure and not being good enough, rejection and being alone, and abandonment and loss. The impact of previous emotional experiences, re-activated with the loss and stress associated with motherhood as dysfunctional emotional responses, is discussed within a family of origin and Family Therapy framework.

The findings help to increase understanding of PND and to lay the foundations for further investigation into treatments for PND particularly outcomes research into the effectiveness of PEEFT to help develop more functional emotional responses to transform dysfunctional ones and make sense of experience in new ways.

Doing the hard yards: mother-infant therapy in the context of abuse

- **Lynly Mader[1], Mandy Seyfang[1, 2] and Georgie Swift[1]**

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Two case studies will be presented that describe the processes involved in building parental capacity of parents who have been abused themselves as children and who are experiencing a mental health crisis and severe social adversity. The presentation will focus on the ways of containing and managing the symptomatology of both the adult and infant. The establishment of therapeutic relationships that accommodate a necessary alliance with other systems such as

child protection agencies will be explored. Aspects of ethical case deliberation and the therapist's experience of this kind of work will be mentioned. The processes used to increase parents sensitivity and responsiveness to their infants cues whilst also developing their own reflective capacity will be discussed and illustrated through use of video. The work is situated within a perinatal and infant mental health service within a large hospital environment and tracks the progress of mothers and their infants from acute care to the community. The case studies chosen will highlight the similarities of the work despite a difference in initial point of referral.

Managing postnatal depressive symptoms using a combined support and exercise program: a pilot study

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Background: PANDSI is a non-government organisation offering support for women and their families affected by perinatal depression.

Objectives: Determine if (1) a program of facilitated support combined with physical exercise improves the psychological health of clients experiencing postnatal depressive symptoms and (2) explore the feasibility and acceptability of the program.

Methods: PANDSI conducted two 10-week programs combining one hour of exercise and one and a half hours of facilitated support sessions covering topics such as goal setting, motivation, self-care and self-esteem. Free childcare was provided and clients paid $100 to participate. Outcome measures were pre and post program scores on Edinburgh Postnatal Depression Scale (EPDS) for depressive symptoms and a participant satisfaction survey to measure the feasibility and acceptability of the program.

Results: 22 clients enrolled, and 19 completed the program at least once with 4 clients attending both programs. Pre-program, all 22 clients were attending a health professional as well as PANDSI and 12 were taking antidepressant medication. Post-program EPDS scores were lower for 20 attendees compared to pre-program scores. 2 clients reported reducing/ceasing antidepressant medication. All clients found the program to be satisfactory in respect to access and acceptability. The free childcare facility made this a particularly accessible course for the majority of clients. Data from a third program to be run early in 2007 will be available for presentation at the conference.

Conclusions: This pilot study suggests that a combined program of exercise and support is useful in the management of postnatal depressive symptoms and is highly acceptable to participants. The aim now is to test the effectiveness of the program in preventing and/or ameliorating a range of perinatal mental health conditions using a cohort study design.

The processes and information used to develop a new resource - 'Using the Edinburgh Postnatal Depression Scale (EPDS) – Translated into languages other than English'

➢ **Jann Marshall and Kate Bethell**

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The Edinburgh Postnatal Depression Scale has been translated into many languages and tested with diverse population samples in a variety of countries with women and their partners in the perinatal period. Data collected over the past five years about the country of origin and use of interpreters of women having babies in Western Australia were used to identify the languages most relevant for translation of the EPDS. The resource manual was developed to collate information about the use of translated versions of the EPDS.

Part one of the new resource contains 18 translated EPDS versions which have been validated with different populations and at different timing of administration. A systematic review process was conducted with the primary objective of identifying all published validation studies using translated versions of the EPDS in the perinatal period. The research quality varies across studies. Contact was made with many of the researchers who translated and validated EPDS versions and extra information was included from our contact with the authors. For each translated EPDS, the resource provides information recording the methods used for the translation and back-translation. As a guide for the use of these questionnaires, recommended screening cut-off scores, 'Notes' and summaries of the validation research studies were recorded.

Part two of the resource includes another 18 non-English EPDS translations. Thirteen new translated EPDS versions were commissioned as direct translations of the English EPDS by registered translators in Australia using a standard format template. Five more non-validated translations were obtained from various sources. Each of these were checked by translators specifically for accuracy and irrelevant information. All the recommended cut-off scores for non-validated EPDS translations should be used with caution and carefully compared with clinical judgment.

Information in the resource includes the names of the countries where the 36 languages are spoken in different countries of the world and aspects for cultural consideration as reported from the research literature.

What are the successful strategies for engaging fathers in the perinatal period?

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Involving men in perinatal services designed to promote adjustment to parenthood, for women and men, is generally seen as being a worthwhile goal. There is increasing evidence that partner involvement can have positive impacts on the mother's well-being, her adjustment to parenting as well as her recovery from conditions such as postnatal depression. However, the way in which such involvement is encouraged and the success of the strategies they employ has varied across programs and studies. This paper reviews the small amount of published evidence for the

results of such strategies designed to engage men, as well as providing some unpublished clinical evidence on this topic. Based on these findings, the authors suggest 7 strategies for the possible successful involvement of fathers in perinatal programs.

Using cut-off scores on the EDS/EPDS: does it matter if you get it wrong?

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The Edinburgh Depression Scale (EDS/EPDS) is the most widely used self-report instrument for the screening of probable depression in the antenatal or postnatal period. Validated cut-off scores on this measure are often used for the purpose of helping in the decision as to who, from a universal screening/assessment program, should be offered an intervention. It is also used within research projects to report on the rate of high scorers ('rate of probable depression'), and whether this rate changes from pregnancy to postpartum. It is therefore important that the correct validated cut-off scores are applied, particularly in the latter scenario.

This paper will provide examples of the many studies that use different cut-off scores to the validated ones, and discuss the implications of this practice. In particular it will examine whether using unvalidated scores has any meaningful impact on findings, and discuss possible reasons for the increasing lack of rigour in this use of the EDS/EPDS. In addition, examples of different formatting of the scale will be given, and whether the accuracy of scoring it can be improved by adjusting the formatting in a way approved by John Cox, the scale's primary author.

Finally clear recommendations will be given regarding the use of cut-off scores, for women and men from English-speaking backgrounds, and for women from non-English speaking backgrounds.

An investigation of subtypes of postnatal depression

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There has been a suggestion that women who become depressed for the first time post-natally (De Novo) might differ from postnatally depressed women who have a history of prior depression (Cooper & Murray, 1995). The current study aimed to determine whether there were any identifiable phenomenological differences between these two groups of women.

One hundred and sixty women with infants under 12 months were recruited from the Karitane Residential Family Care Unit in Sydney. Participants completed a semi-structured, diagnostic interview for current and lifetime mood disorders, from which they were allocated to one of four groups: (i) 'De Novos', (ii) 'Recurrents', (iii) 'No depression controls' (no current or lifetime history of depression) and (iv) 'History of depression controls' (history of non-postnatal depression, but

not currently depressed). Participants also completed questionnaires relating to negative attitudes (general and maternal specific), personality style, infant temperament, life stressors and adult romantic attachment style. It was hypothesised that 'De Novos' would display more maternal-specific negative attitudes than 'Recurrents' and non-depressed controls; and that 'Recurrents' would display more general negative attitudes, a more insecure adult attachment style and a more vulnerable personality style compared to 'De Novos' and non-depressed controls.

Results of ANCOVA analyses showed there were no significant differences between 'Recurrents' or 'De Novos' in terms of symptom severity or dysfunctional attitudes (general or maternally specific), suggesting that PND is characterised by a negative cognitive style, irrespective of whether the depression develops for the first time or as a recurrence of a previous depressive disorder. However, while 'History of depression controls' were no different from 'Recurrents' in terms of generally negative attitudes, they demonstrated more positive maternally specific attitudes. There were no differences between 'Recurrents', 'De Novos' or 'History of Depression controls' in terms of personality vulnerability, however all three groups were revealed to be more vulnerable than 'No Depression controls'. This paper will consider results from this study in relation to previous literature and will discuss implications for the provision of specifically tailored treatments for PND.

The Edinburgh Postnatal Depression Scale detects but does not distinguish anxiety disorders from depression: implications for clinical practice

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Objectives: Postpartum anxiety disorders are problematic and poorly investigated compared with depression. This study aimed to establish prevalence of diagnosable anxiety and depression in women admitted to residential early parenting programs with infants aged up to 12 months using a structured clinical interview, and to compare with scores on the Edinburgh Postnatal Depression Scale (EPDS).

Method: Consecutive cohorts of English speaking women admitted with their under one year old infants to Masada Private Hospital Mother Baby Unit (MPHMBU) and Tweddle Child and Family Health Service (TCFHS) in Melbourne, Australia were invited to complete the Composite International Diagnostic Interview (CIDI), which yields diagnoses of common mental disorders including anxiety and depression. EPDS scores were extracted from the medical record and compared with diagnoses for anxiety and depressive disorders on the CIDI.

Results: Of the 145 women (78.4 % recruitment rate) who participated, 138 (95%) provided complete data of whom 35 (25%) had at least one anxiety disorder diagnosed. Fifteen (11%) had generalized anxiety disorder, 17 (12%) had a specific phobia, 4 (3%) had panic disorder and 7% had social phobia. Thirty seven women (27%) had a depressive disorder and 15 (9.3%) had both anxiety and depression diagnoses. Of the 64 women scoring over 12 on the EPDS, 10 (16%) had an anxiety disorder, 15 (23%) had a depressive disorder, 13 (20%) had both anxiety and depression and 26 (41%) had neither.

Discussion: High rates of diagnosable anxiety as well as depression were present in this sample.

The EPDS detected women with clinically significant anxiety but not depression and women with neither diagnosis, as well as women with diagnosable depression. The presumption that EPDS scores over 12 indicate probable depression appears to be an oversimplification. Current national initiatives recommend that women with EPDS scores over 12 be treated for depression, which may lead to inappropriate treatment in some cases.

Psychotropic treatment of depressive disorders during pregnancy – birth outcome and the neurobehaviour in the newborn

- **Helena Sandahl[1,2], Megan Galbally[1,2], Anne Buist[2, 3], and Stephen Bowden[2], Gillian Opie[1]**

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This paper presents the findings of the first completed part of the Victorian Pregnancy Register (VPR). The VPR is a larger longitudinal study on in-utero exposure to psychotropics in which child development in aspects of cognition, motor, speech and language, behavioural adjustment and temperament will be assessed until the children enter school. The objective of the present study was to investigate the effects of maternal use of selective serotonin reuptake inhibitors (SSRIs), serotonin and noradrenaline reuptake inhibitors (SNRIs), and noradrenergic and specific serotonergic antidepressants (NaSSAs) during pregnancy on birth outcome and the neurobehaviour in the newborn. We used a prospective, case control study design. Participating were 27 women treated with an SSRI, an SNRI or a NaSSA in pregnancy, and 27 individually matched controls. Maternal and infant data were collected in pregnancy, after delivery, and at one month postpartum. The results suggest that in-utero exposure to an SSRI, an SNRI, or a NaSSA lead to a range of complications and symptoms commonly associated with serotonin withdrawal or toxicity. Are these symptoms and complications transient? How useful are maternal verbal reports of symptoms in the newborn? These and other questions will be discussed in this presentation.

A story tells more than its tale: women's accounts of their Caesarean experience

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Caesarean section (CS) rates continue to escalate in Australia and over 30% of Queensland women currently experience birth by CS. More than 80% of women who experience CS have a repeat CS and less than 20% of QLD women who plan a vaginal birth after CS achieve one. Research regarding CS is prolific, but predominantly relates to risks, benefits, rates and mode of birth following a CS. Considerable investigation has focussed on maternal preference for CS and maternal involvement in decision-making for a CS.

A glut of opinion pieces saturate the medical literature, mainly focussed on the right of women to choose CS, and the ethical dilemma faced by obstetricians when a woman requests a CS in the absence of a medical indication. Yet despite the commonness of CS, women's accounts of their CS experience remain conspicuously absent in the literature: almost no research has investigated what it is like for women to undergo a Caesarean. A telephone interview using a two-part questionnaire (structured and semi-structured) was used to explore 103 women's experiences of CS. The aims of the study were to 1) discover why CS was performed, 2) explore the experience of undergoing CS surgery, and 3) to discover whether women's preference for a subsequent birth was influenced by their CS experience. The focus of this presentation is the second aim of this project - women's own accounts of their experience of CS.

Providing a full spectrum of care for women with severe postnatal psychiatric illness

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Helen Mayo House (HMH) is a 6 bed inpatient unit in Adelaide, South Australia which offers psychiatric care for women with severe postpartum psychiatric illness. Whilst for 20 years the Unit has used and continues to use a systemic approach to the care of women and a biopsychosocial orientation, over time there has been a significant evolution towards:

Mother-infant work as a predominant psychotherapeutic mode of practice
A focus on the discharge planning process and provision of an appropriate discharge care plan.
Teaching in the community about perinatal and infant mental health.

Recognising the importance of prevention and early intervention, the SA Department of Health has provided project funding for teaching (Becoming Attached) and patient community follow-up, Staying Attached.

In this presentation, the work of the unit will be described, with a focus on the following:

General structure of the unit, including staffing, theoretical orientation and practical considerations of space
Mode of assessment and management whilst an inpatient
Types of therapy undertaken
Discharge planning with a focus on the modes of community work employed and discussion of the project, Staying Attached. This is a partnership model with Anglicare, an NGO, who are the fund-holders, under which women admitted through HMH may be referred for community follow-up by Anglicare workers for up to 3 years. Preliminary data from this project will be presented.

Disability and family sensitive practice

➢ **Kathryn Thornton**

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Parenthood is usually embarked upon with dreams and aspirations for the child. Adapting to the "real" as opposed to the "imagined" child is one of the early processes of parenting. This process is more challenging when the "real" child has a disability. Parents may have to let go of their hopes and dreams and may be daunted by the future both they and their child have to face.

Many parents with a child with a disability find themselves involved with early intervention services that assert that they are family centred, however, the reality is that few achieve this goal. Often little thought is given to the impact the disability is having on the relationships within the family or the stressors on individual family members. Practices may place members in conflict with each other and/or result in the exclusion of some family members. As family functioning is a significant factor that impacts on the outcomes for the child it is important that services consider the impact of the interventions they are advocating on all members.

In a series of interviews conducted with parents of children who were, or had been, involved in early intervention programs a number of issues were identified that had negative impacts on the family. These included difficulties associated with both parents attending appointments and planning meetings, lack of counselling at the time of receiving the diagnosis, role confusion – parent or therapist -, unrealistic expectations by therapists and lack of information. Other stressors identified as impacting on family functioning included financial and marital difficulties, difficulties meeting the needs of siblings, doing things as a family and isolation.

Some factors identified that would have been, or would be, helpful included good case management, information packs both about the disability and useful strategies, and the opportunity to interact with others on a similar journey. Information and access to services such as respite care were identified as beneficial for family functioning.

Family sensitive practice is crucial for the wellbeing of both the child and the family. This paper will provide participants with the opportunity to reflect on their current practices and consider ways of enhancing their service provision for families in which a child has a disability.

Undiagnosed bipolar disorder presenting as PND: a non-puerperal event

➢ **Beverley Turner**

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Post-natal depression is a frequent presentation in psychiatric practice, and each case is managed according to its unique characteristics. This paper will discuss a number of clinical presentations of post-natal depression, non-puerperal in onset, which have been the first presentation of an underlying bipolar disorder which had not previously been diagnosed. It highlights the issue of difficulty in diagnosis in bipolar disorder, and the importance of accurate diagnosis, to facilitate correct pharmacological management.

Antidepressants use in the antenatal period – can clinical decision making be informed by the evidence? - a literature review

➢ **Adaobi Udechuku[1], Anne Buist[2] and Malcolm Hopwood[3]**

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Depressive disorders occur commonly during the childbearing years. Antenatal depressive symptoms have a prevalence rate of 26% with 10-16% reaching caseness for a depressive disorder. Antenatal depression is now recognised as the most significant risk factor for postnatal depression. Antidepressants are effective in the treatment of depressive disorders with newer antidepressant agents providing greater clinical flexibility. Recent studies reveal that 70% of antenatal depression is untreated and ceasing antidepressants places women at high risk of relapse. The literature on the use of antidepressants in the antenatal period is growing but varying study designs and methodology provided inconsistent results. Clinicians managing women with antenatal depression continue to be faced with the dilemma of balancing the risk to the mother against the risk to the developing foetus. When considering the use of an antidepressant achieving the optimal balance requires information based on the best available evidence to address three key questions:

What is the risk to the mother of untreated antenatal depression?
What is the risk to the foetus/neonate/child of untreated antenatal depression? and
What is the risk to the foetus/neonate/child of antenatal antidepressant use?

A database search of MEDLINE, from 1966 - December 2006 was performed using MeSH terms depression, pregnancy, pregnancy complications, neonatal, foetal, infant, child, birth outcomes, antidepressants agent, drug therapy and limited to English language and human studies. Various study types were identified, where available, study designs with the highest NMHRC level of evidence were reviewed revealing that:
Untreated antenatal depression represents a risk to mothers
Studies of foetal/neonatal/child outcomes of untreated antenatal depression provide conflicting results
Results from studies of antidepressant use in the antenatal period are not uniform, demonstrating an association with adverse outcomes, no association or even an association with positive outcomes.

In this paper, the current evidence and its limitations are critically appraised and then integrated with clinical risk: benefit assessment and decision-making.

ACORN: a mother infant therapy group programme-from small things big things grow!

➢ **Neil Underwood[1], Mandy Seyfang[1, 2] and Jo Press[3]**

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This presentation will provide the particulars of an innovative group programme for mother and their infants, where there are significant mental health issues for the mother and significant struggles within the mother infant relationship. The group programme incorporates a supported playgroup time where music is used in distinctive ways to support the attachment relationship. This is followed by a parent only time where the use of journaling and digital images are key tools for supporting parent's reflective functioning. The use of therapeutic letters to build preferred story lines and to help hold and deepen reflection will also be outlined. This programme will highlight the importance of supporting and developing the attachment relationship between mothers and their infants in the context of significant adversity. Preliminary results will be presented and future directions for this work described.

Social adversity and resilience for mothers and infants in the perinatal period; partners involvement is crucial

➢ **Moira Williamson[1], Carol McVeigh[2] and Mercy Baafi[1, 3]**

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From an exploratory study that looked at the functional status of fathers following birth, the authors have gained insight into the effect of birth and the postnatal period on the transition of men to fatherhood.

It is well documented in the literature that health professionals focus on the adaptation of women to pregnancy, birth and motherhood and the impact that this transition may have on the mother and baby dyad. In comparison the research exploring the transition of men to fatherhood is a fairly recent phenomenon.

This presentation will discuss the findings from a study that explored the functional status of new fathers who were surveyed 6, 12 and 24 weeks after the birth of their baby. Of 205 men surveyed 128 (63%) responded to week 6 survey, 101 (50%) responded to the 12 week survey and 84 (41%) responded to the 24 week survey. Over 90% of the respondents were satisfied with fatherhood and the changes that had taken place in their lives since becoming a father.

The results from the analysis of these surveys will be discussed. Highlights from the fathers written comments about a range of effects of a new baby on their relationship with their partners and new baby will also be disseminated. The support of fathers is crucial for the wellbeing of their partners and new baby.

Maternal posttraumatic stress disorder and child interactive patterns over the first two years of life

➢ **Jacqueline Beall[1], Clara Bookless[2] and Alexander McFarlane[1]**

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It has been hypothesised that symptoms of posttraumatic stress disorder (PTSD) may result in the lack of an appropriate emotional connection between parents and infants (Lyons-Ruth & Block, 1996; Yehuda et al., 2001). The current study aimed to investigate the impact of maternal trauma experience on the mother's emotional interactions with her infant using three different measures across the first 19 months of the infant's life, namely; 1) infant withdrawal (modified ADBB; Guedeney & Fermanian, 2001); 2) dyadic emotional availability (EA scales, Biringen, eta l., 1998); 3) and infant attachment status (SSP; Ainsworth et al., 1978). Forty mother-infant dyads were followed from 37 weeks gestation. It was hypothesised that maternal trauma and PTSD would be associated with increased rates of infant withdrawal at three months, which in turn would be associated with reduced dyadic emotional availability at 13 months and insecure attachment at 19 months.

The hypothesis that maternal PTSD would be associated with infant withdrawal at 3 months was only partially supported. Infant withdrawal was found to be related to partial PTSD but not full PTSD. Infant withdrawal was not related to ongoing or concurrent maternal mental health problems. Infant withdrawal negatively correlated with total EA ($r = -.315$, $p<.05$), and both child responsiveness ($r = -.314$, $p<.05$) and child involvement ($r = -.358$, $p<.05$). These correlations indicate that earlier infant withdrawal was associated with less dyadic emotional availability, particularly with lower levels of child interactions. A significant difference, $\chi^2(2, N = 39) = 7.81$, $p<.05$) was found using EA as a dichotomous variable. No significant differences were found using Chi-square analysis of A-B-C, secure-insecure, and organised-disorganised attachment groups and withdrawal. However, twice as many avoidant infants were withdrawn at three months compared to ambivalent and secure infants. Overall, these results only partially support the hypothesis that early infant withdrawal would be related to later EA and insecure attachment and suggest a weak continuity of infant behaviour across early development with withdrawn infants at 3 months of age being less interactive with their carers at 13 months, and more avoidant at 19 months.

Austin Health's Parent-Infant Mental Health Initiative (pimhi): a model of care for better management of mothers with a serious mental illness and their infants

➢ **Anne Buist[1], Susan J. Breton[2] and Adaobi Udechuku[2]**

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Austin Health's Parent-Infant Mental Health Initiative **(pimhi)** aims to increase the awareness and capacity of Area Mental Health and Child and Adolescent Mental Health Services to better manage mothers with a serious mental illness and their infants. **pimhi's** service consists of 3 complementary aspects: consultation, education and training, and liaison network development.

The objectives are to:

- Assess the needs of target stakeholders involved in treating women who suffer from serious mental illness and their infants.
- Assess what works and what difficulties there are in access and delivery (consults and focus groups with women who had been involved with our, local and rural services).
- Map the available services and how to access them
- Build service capacity
- Provide primary and secondary consultations
- Initiate training of Mental Health practitioners
- Improve linkages with relevant CAMHS

Funded by DHS**, pimhi** commenced in 2006. It is a new model of care designed to provide a service to target stakeholders and women and their infants in the North East Metropolitan areas and the Hume Regional areas of Victoria. The **pimhi** team works closely with the existing services at the Austin including the Austin Parent Infant Program (APIP, the Mother-Baby Inpatient Unit), the Infant Clinic, and Parent and Infant Research Institute (PIRI).

Maternity liaison project. "Working together"

➢ **Lyn Dawson**

Maternal Mental Health Team, Auckland, New Zealand

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Introduction: This poster will give an overview of a six month Maternal Mental Health liaison project within the maternity services of Waitemata District Health Board in New Zealand.

Rationale: It is expected that this role will benefit pregnant women who have had, or who develop mental health problems. Closer liaison between services and a better understanding of each others' roles will help to bridge gaps between maternity services and a Maternal Mental Health team.

Background: This project has been developed to identify the gaps in services and to improve access for women to appropriate services. This group of women is specifically those women who are pregnant and who have/ had mental health problems.
The liaison project is led by a community mental health nurse for six months with the following areas to identify:

Goals:
Identify and document the mental health needs and gaps in service provision for women admitted to WDHB maternity service.
Identify and document the parameter and scope of a maternal mental health liaison service.
To develop a service user pathway for this liaison service.
Identify learning needs for maternity providers and establish education packages in conjunction with midwifery educators.

Method: Over a period of 6 months, the project leader will meet with all the maternity stakeholders to discuss the role.
Surveys have been posted out to LMCs to capture a wide variety of thoughts around their knowledge of MH , and their thoughts about how this role may develop.
Consumer involvement has occurred as has cultural involvement.

Awareness of the catchment areas of Waitemata District Health Board has occurred as the socio economic areas vary greatly, which will impact on service delivery.

Outcomes: The findings of the Project will be presented in detail on the poster and how the findings will then be implemented into the Maternity and Mental Health services with the view to service improvement.

Maternal distress: a comprehensive approach for understanding maternal unhappiness

- **Elizabeth Emmanuel**

School of Nursing and Midwifery, Griffith University Logan Campus, Queensland

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Background: 'Maternal distress' is a common experience for many women during pregnancy and following childbirth, although it is not well understood and accepted within the broad framework of maternal unhappiness. For these women, distress is sometimes simply struggling with daily living and life circumstances which then impacts on their ability to make a smooth transition to motherhood. Health professionals frequently deal with such women in their daily practice although there is little formal recognition for them within the current framework on maternal unhappiness. A more coherent and integrated approach is needed to encompass the broad range of maternal emotional responses. 'Maternal distress' offers a new way to conceptualise the maternal experience of unhappiness, although the concept has not been developed.

Aims: This paper is a concept synthesis of 'maternal distress' based on Walker and Avant's approach to discover new dimensions from old concepts using steps and cycles through the examination of the literature on maternal unhappiness until theoretical saturation is reached.

Methods: Steps to concept synthesis were undertaken. This included a search of major databases covering the last 50 years; assessment of common related concepts such as postnatal depression, posttraumatic stress syndrome, anxiety disorders, dysphoria and maternal unhappiness; classification into clusters and examining for a hierarchical structure; . identification of the new concept 'maternal distress'; verification of the new conceptualisation; and examination of its fit into existing theory within maternal unhappiness.

Analysis and discussions: 'Maternal distress' is an innovative way of conceptualising maternal unhappiness. Previous literature characterised and presented maternal unhappiness in a manner that tended to fragment the maternal experience leading to a lack of coherence. The new concept of MD is more appropriate because it is holistic, encompasses a broad range of response along a continuum and is reflective of the real experience.

Conclusions: 'Maternal distress', as a concept provides a more comprehensive approach to maternal unhappiness. Integrating such a concept into practice will help health professionals desist from problematising women's responses and allow for a more compatible women centred model of care.

Social supports of depressed and non-depressed new mothers

➢ **Jennifer Ericksen and Jeannette Milgrom**

Parent-Infant Research Institute and Infant Clinic, Department of Clinical and Health Psychology, Austin Health, Melbourne

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This study aimed to identify the relationships between postnatal depression, anxiety, automatic thinking, coping style and social support. A group of 366 depressed new mothers and a contemporaneous control group of non-depressed mothers took part. The number of social supports for each woman was measured using the Social Supports Questionnaire, and women's evaluation of those supports was measured with the Social Provisions Scale.

Having fewer social supports was associated with increased depression, anxiety and negative thinking, all of which were strongly inter-correlated. Depressed women not only reported having fewer social supports but also evaluated their supports less positively.

Poor social support evaluation was strongly associated with maladaptive ways of coping. Greater levels of perceived social support were associated with fewer avoidant behaviours, self-blaming and less wishful thinking.

These results are consistent with a role for the number of social supports influencing depression levels, which is mediated by the woman's negative automatic thinking. This negative thinking leads women to evaluate their supports poorly.

The National Children of Parents with a Mental Illness Initiative (COPMI)

➢ **Elizabeth Fudge**

Australian Infant Child Adolescent and Family Mental Health Association (AICAFMHA), Adelaide

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The Children Of Parents with a Mental Illness (COPMI) initiative has been funded by the Australian Government since late 2001 with the overall goal of promoting better mental health outcomes for children of parents with a mental illness. Key areas of work have included

- the development of good practice principles and guidelines by services and people working with children of parents with a mental illness around Australia;
- increased accessibility for children of parents with a mental illness and their families, and to people working with them, of appropriate resource materials in line with the good practice principles and guidelines; and
- the provision of information to Government to enhance policy development regarding children of parents with a mental illness and their families.

The initiative has been undertaken by the Australian Infant Child Family and Adolescent Mental Health Association and is soon to enter a new three year phase in line with the directions of the COAG mental health New Early Intervention Services for Parents, Children and Young People initiative. Children of parents with a mental illness have been identified within the COAG 2006 Mental Health documents as a key population group at risk of poor social and emotional well-being.

The poster presentation will summarise key achievements to date and plans for the next phase of the national COPMI initiative. The COPMI initiative focuses on children from 0 to 18 years and their families. However, the poster will deal predominantly with strategies and outcomes for young children and their families and those who work with them, in keeping with the Marce conference theme of social adversity and resilience for mothers and infants.

Raphael Centres: a community service supporting families

➢ **Suzanne Higgins[1], Leanne Lewis[2] and Joe-anne Sundblom[3]**

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[2]St John of God Raphael Centre, Berwick
[3]St John of God Raphael Centre, South West Victoria

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The St John of God Raphael Centres are perinatal mental health services with a relatively short history. These specialised services provide support, counselling, education, assessment, referral and information for parents and health professionals in the community. Service is provided during the ante-natal or postnatal phase and is available regardless of where families birth. Mostly the services are provided without charge but a nominal charge may apply to families that can afford to self fund.

There are 4 such services to date, Berwick, Southwest and Geelong in Victoria and the initial Service in Subiaco. The oldest service, Subiaco, has been functioning for 4 years while the youngest, Southwest, is just over 12 months old. These community based services are funded out of Social Outreach and Advocacy Program monies under one of the six priority areas, Mental Health.

Parenthood transition provides a range of challenges for many couples including fragile mental health or a degree of distress associated with this life phase. There may not be a diagnosed mental illness but the level of distress may be sufficient for the couple or individual parent to seek assistance in developing skills to minimise the distress across the transitional phase. Some services available in communities have rigid eligibility criteria or rigid service delivery guidelines. This poster presentation will illustrate a model which is currently applied in 4 geographical areas resulting in slightly different applications for individual communities.

Screening for postnatal anxiety using the EPDS

➢ **Stephen Matthey**

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

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Background: The Edinburgh Postnatal Depression Scale (EPDS) has been well validated for women for screening for major or minor depression in the postnatal period. However, given the prevalence of postnatal anxiety disorders in the absence of depressive disorders, screening for anxiety as well as depression is required. Several investigators have conducted factor analysis on the EPDS and found that three items (items, 3, 4 & 5) load on an anxiety factor. This study

therefore investigated the Receiver Operating Characteristics of these three items to screen for anxiety orders in the postnatal period.

Method: 238 women and 218 men (English-speaking) completed the EPDS and underwent a diagnostic interview (DIS) for anxiety and depressive disorders at 6 weeks postpartum. The interview was conducted blind to participants' EPDS scores. This poster will report the respondents' optimal cut-off scores on the three anxiety items (EPDS-3A) to screen for the anxiety disorders of Panic, OCD, and Generalised Anxiety Disorder (without the 6-month time criterion).

Results: 7.6% of the women, and 3.2% of the men, met diagnostic criteria for an anxiety disorder. The range of possible scores on the EPDS-3A is 0-9. The optimal cut-off scores on this EPDS-3A for women and men will be discussed, as well as the overlap with the optimal cut-off scores for probable depression.

Clinical Implication: The findings from this study will enable services that currently use the EPDS to screen for the presence of both probable depression *and* probable anxiety disorders.

The place and importance of antenatal / postnatal care and pregnancy planning for psychiatrically ill women

- **Fyowna Norton**

Parent Infant Mental Health Initiative (pimhi,) Werribee Mercy Hospital Melbourne

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This presentation aims to discuss the importance of specialised care during the perinatal and postnatal period for psychiatrically ill women and their families and the effect of interventions on their psychiatric stability and the mother/infant relationship.

pimhi 'Parent Infant Mental Health Initiative' is a innovative program established across Victoria, specifically aimed at providing appropriate interventions to mothers with serious mental illness and their infants in order to improve outcomes, particularly in their capacity to function as parents in the first critical 12months.

Women with severe mental illness such as major depression, schizophrenia and bipolar disorder pose significant management challenges when planning for childbirth, pregnancy and the post partum period. There is a lack of information about effective interventions aimed at decreasing illness relapse as well as promoting the mother infant relationship, parenting skills and thus the emotional development of the infants.

The Western Victoria Region *pimhi* Initiative has established a number of strategies to address this through the group of women who are clients of the Area Mental Health Services in this region.

To be specifically presented is information, statistics and outcomes generated from the Mother/Infant Psychiatric Outpatient Clinic. Established in late 2006, this clinic specialises in psychiatric assessment of the mother/infant relationship, psychosocial assessment, pharmacotherapy and pharmacology relating to pregnancy and breastfeeding. Since it's inception it has seen many clients with the major percentage of these falling into the antenatal category. Further analysis 4 weeks post initial assessment and post birth has been conducted on the relevance and appropriateness of interventions provided by the clinic.

The Initiative is also undertaking ongoing data collection on the actual number of Area Mental Health Services clients who are pregnant or who have an infant less than 12 months of age. We are seeking to understand demand and use this data to enable further planning.

These, with a number of other strategies and actions including education/training and clinician capacity building will be presented.

Outcomes of a Consultation Workshop for staff in a ward for infants under 12 months aimed at improving relationship based care and the emotional well being of parents and infants

- **Rosalind Powrie, Nicole Marshall and Jon Jureidini**

CYWHS, Womens and Childrens Hospital, Adelaide

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Aims: The workshop was held to explore and develop ideas and strategies to improve relationship based care and integrate an infant mental health focus more fully on the ward. This workshop was the culmination of an increasing awareness of structural, environmental and process difficulties in caring for the emotional health and well being of infants who are admitted for a wide range of problems.

Methods: Two half day workshops were conducted for 23 staff (nursing, medical, allied health and mental health) using an external facilitator who had been briefed by a core planning group. The facilitator used case scenarios and small group discussions to elicit information from each group regarding existing barriers as well as strengths of the ward in caring for infants and their parents. Information was summarized and broad themes were identified. These were –the importance and quality of relationships between staff, parents and infants, decision making and communication in diagnosis and management, assessment and care pathways, education and training and the physical environment of the ward. It was recognized from the outset that the workshop outcomes needed to be fedback and reviewed by departmental heads and managers to support further action plans and to increase awareness of the issues. This took place in early 2007.

Results: There were very positive responses from all participants about the usefulness of the workshop and a very strong consensus and support for re-orienting care to promote attachment and identify perinatal and infant mental health problems earlier. Refurbishments are underway to more comfortably accommodate parents staying on the ward and further environmental changes are planned to make a more “baby and family friendly” space.Staff were encouraged to apply for two service wide scholarships to undertake the Graduate Diploma in Infant Mental Health and a ward nurse has been a successful recipient. More regular supervision and training in infant mental health is occurring with a re-structuring of nursing shifts. The use of volunteers to assist parents in the ward is being developed and medical teams are reviewing issues of continuity of care and the need for a primary care team for each infant.

Aim and role of early intervention in a maternal mental health service

➢ **Karen Rowan**

Early Intervention Maternal Mental Health Service, Mental Health & addictions service, Waikato District Health Board, New Zealand

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The aim of an Early Intervention Service is to identify, intervene and reduce the risk of escalating maternal mental health problems in the perinatal period. A time which is known to be a period of rapid physical, psychological and emotional change therefore often becoming a stressful life event for many families. Increased anxiety and emotional mood changes often rob the mother, father and their infant of the vitality needed to form healthy attachments which may complicate the clinical picture and lead to further problems later on.

Identifying and differentiating prodromal symptoms at their earliest manifestation and clarifying the issues of concern can help to modify the potential stress for the family.

Psychosocial intervention during the perinatal period requires skill and expertise, as the presenting issues may mask an underlying problem and the use of screening tools in isolation may give a false positive result. Troubled interpersonal relationships and limited social supports do affect the mother's mood, which may remain fragile until the situation is remedied.

An Early Intervention Maternal mental Health Service can provide timely, specialist, Empathetic and therapeutic assessment and treatment options for women and their families in the perinatal period.

Reconfiguring birth and reconstructing bodies: the choice for Caesarean in the absence of a medical reason for a first birth

➢ **Lynne Staff[1], Jenny Gamble[2] and Debra Creedy[2]**

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Research regarding Caesarean section (CS) is prolific, but predominantly relates to risks, benefits, rates, and choice for mode of birth *following* a CS. Although maternal request for a CS has been increasingly investigated, it almost always relates to a prior birth experience. In this mixed method investigation, 103 women who had a CS in the last five years were interviewed in depth about their CS experience, ten of whom chose a CS in the absence of a medical reason for a first birth. This study explored: a) the reasons behind the choice for CS in an uncomplicated first pregnancy; b) the experience of CS; and c) the choice of birth mode in a subsequent pregnancy.

All participants feared vaginal birth. Birth was reconfigured, in that women believed the vagina was unnecessary to have a baby. Participants modified their body (through CS) so that their baby could be born. Plans for CS were kept secret from family and friends. Doctors did not explore the reasons behind a woman's request for a CS, and supported women's fear of vaginal birth. Women minimised the severity and likelihood of risk occurring with CS and emphasised those of vaginal birth. Most felt the birth of their baby was less emotional than they had imagined it would be. Despite four women suffering significant complications, they all minimised the severity of these, yet two would never have another baby as a result. Nine women had, or would have another CS, and one woman had a VBAC. This paper discusses the experiences of their CS, using their narratives.

How safe are the drugs we use in pregnancy? A brief update on the treatment of mood disorders in pregnancy

➢ **Marie-Paule Austin[1]and Megan Galbally[2]**

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[2] Mercy Hospital, Melbourne

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The use of medications in pregnancy has attracted significant media and research attention as we become more aware of the sequelae that may be associated with medication use in pregnancy, in particular the mood stabilizers and the newer antidepressants. While cautionary statements have been recently released about the use of SSRIs in late pregnancy, there is still a paucity of data available to guide clinicians in their decisions.

We will review the most recent findings in this area including:

- examining risks of using & not using Pharmacological therapies in pregnancy for mother & offspring
- Mood Stabilisers & Antidepressants in Pregnancy: with particular focus on the recent literature examining 1st and 3rd Trimesters exposure
- a brief discussion of the physiological changes in pregnancy that affect psychotropic medication will be given to better understand the interplay between changes in pregnancy, psychiatric illness and psychotropic medication

We will then present a clinical case to examine possible ways forward in terms of medication treatment guidelines for mother and infant in the perinatal period.

Child protection and the perinatal period: building resiliency through clinical work

➢ **Michael Daubney[1], Sue Roberts[2] and Raeleigh Bryant[3]**

[1] Private Practice, Brisbane,and Logan Child and Youth Mental Health
[2] Private Practice, Gold Coast
[3] Contact House Brisbane North, The Abused Child Trust

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Social adversity and resilience for mothers and infants in the perinatal period raises multiple issues including child protection, perinatal mental health, parenting, and clinical dilemmas. Infants are at high risk regarding child abuse and its adverse sequelae. The delicate balance of managing the demands of the mental health needs of the mother, child protection obligations, promoting resilience and safety in the broader family and community context and therapeutic possibilities to improve the attachment relationship will be discussed. While it can be true that coordinating psychotherapy and a child protection role may involve an ongoing conflict, a contrast to this viewpoint will be provided, emphasising the intrinsic therapeutic value of behaving assertively as a child (and caregiver) protection advocate.

Clinical interventions occur within the context of confidentiality, legislation, boundaries, therapeutic alliance, reunification issues and the attachment relationship. The clinical issues will be discussed from infant mental health, adult mental health, and systemic perspectives. The value and potential challenges of working collaboratively with child protection agencies will be debated, with clinical vignettes illustrating specific dilemmas that may occur.

An added dimension to the forum is the experiences from public and private practitioners. Issues that will be discussed include that of risk assessment, and its role/limitations within the therapeutic setting, how resiliency may be conceptualised from a therapeutic and welfare stance, and the context for therapeutic assessments. Psychiatric considerations in the caregiver will be considered alongside the developmental implications for early intervention within child therapy practice.

In this workshop experienced clinicians will consider the components of a possible "best practice model" for therapists working in this area. The workshop will include an overview of the relevant literature. Participant contribution will be supported by a panel representing different professional backgrounds and perspectives.

Exploring attachment and cultural safety as aspects of enduring resilience from the perspective of perinatal Aboriginal and Torres Strait Islander People

- **C Griffiths[1], BA Hayes[2], W Thiele[3], J deVries[4], P Glossop[5], LK Geia[2]**

[1] *Sydney South West Area Health Service*
[2] *School of Nursing Sciences, James Cook University, Townsville*
[3] *St John of God Health Services, Adelaide*
[4] *Wuchopperen Health Service, Cairns*
[5] *Perinatal & Infant Programs, George Street Health Centre, Sydney*

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Many of the recent public health and perinatal interventions have demonstrated that Aboriginal and Torres Strait Islander childbearing women and their families draw strength from their cultural heritage and an enduring sense of strong connectedness with family and land that provides a buffer for many of the adversities they experience from generation to generation (Geia, 2007). The overall aim of this workshop is to explore processes and pathways to assist new Aboriginal and Torres Strait Islander mothers, fathers and families to name and claim the practices which will be effective for them to nurture and build the social and emotional wellbeing (Connection or Attachment) for their babies and the protection of Cultural Safety.

The underpinning imperative is that Aboriginal and Torres Strait Islander Peoples are rich in their own language, symbols and rituals which are very diverse around family, country and birthing. Thus, participants are requested to bring some symbolic token of their own heritage, which pertains to establishing Attachment and maintaining Cultural Safety, to establish personal connections within the Workshop. The Workshop is presented as a whole so, in order to honour that holism, participants are requested to be committed to the full half-day.

Interventions for high risk infants

- **Louise Newman**

The NSW Institute of Psychiatry, Sydney

Parents with backgrounds of adversity, particularly trauma and abuse, often find psychological parenting challenging and their infants frequently present with insecure and disorganized attachment relationships. Interventions for traumatised parents require attention to the emotional needs of parents as well as their interaction with their infants. This workshop will review approaches to psychological intervention and psychotherapy for high risk infants and parents and will present results of recent research. It will also suggest and describe modifications of available psychotherapy programs making them more suitable for this group.

How should we manage those with current or past history of serious mental illness?

- **Margaret Oates**

University of Nottingham, United Kingdom

Issues to be discussed will include the following:
• risk identification
• working with psychiatry and maternity services
• proactive management
• resources
• parenting capacity

Don't drop the baby: keeping the infant in mind when working with complex families

- **Patricia O'Rourke**[1] **and Mandy Seyfang**[1, 2]

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[2] University of South Australia

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This presentation will bring into sharp focus the infant and small child's experience in the context of early trauma. It will provide an expanded sense of the infant /toddlers' experience in a care-giving environment marked by issues of drug and alcohol, mental health and domestic violence. The importance of 'holding' at all levels of the therapeutic system will be illustrated and our response to this highlighted. We will share our experiences over the last 12 months working individually in the play room with a 3 year old child whose mother has a dual diagnosis of mental health and drug and alcohol issues. An overview of this infant's early experiences, how he came to therapy, some examples from the work and shifts noted to date and reflections on our work will be detailed. Our hope is that this will contribute to a more child-focused response to complex situations.

Marie-Paule Austin

Associate Professor Marie-Paule Austin is a Perinatal Psychiatrist at the Royal Hospital for Women in Sydney, and holds a conjoint appointment with the University of NSW. She was a key researcher on the beyondblue Phase 1 Postnatal Depression project and is now Director of the beyondblue phase II Perinatal Mental Health Initiative which is developing a National Action Plan for the implementation of universal psychosocial assessment, training and pathways to care in the perinatal period.

Over the last 10 years A/Prof Austin has established a model of antenatal psychosocial screening and early intervention which has informed the Integrated Perinatal Care model used across NSW. She has published over 80 papers in the field of mood disorders and postnatal depression. She is President of the Australasian Marce Society, represents the Royal ANZ College of Psychiatrists on the National Perinatal Maternal Morbidity Committee and is on the International Marce Society Executive.

Mercy Baafi

Mercy is the Senior Midwifery Educator at the Wollongong Hospital. She is an Honorary Teaching Fellow, University of Wollongong, School of Nursing, Midwifery and Indigenous Health and has a considerable input into the Master of Science (Midwifery) degree.

Jacqueline Beall

Jacqueline Beall is a registered psychologist and has recently completed a PhD entitled “The biological and behavioural effects of maternal trauma and posttraumatic stress disorder on child development”. Jacqueline has a strong interest in the intergenerational transmission of biological and psychological resilience to trauma. Her clinical interests are in the area of attachment and child maltreatment. Jacqueline is based at the Center for Military and Veterans Health, University of Adelaide and is currently involved with a multidisciplinary team working on a feasibility study to investigate the intergenerational effects of military service.

Justin Bliszta

Dr Bilszta is a Research Associate with the Dept of Psychiatry, Austin Health. His previous role was as National Project Manager for the beyondblue National Postnatal Depression Program. His current interests include screening and detection strategies for perinatal depression, issues related to satisfaction and cost-analysis of periantal health services & postpartum psychosis and bipolar disorder in pregnancy.

Philip Boyce

Philip Boyce is Professor and Head of the Discipline of Psychological Medicine at the University of Sydney. He is based at Westmead Hospital. Currently he is working with a small Perinatal Psychiatry Service. His current interests are in the psychotic disorders, especially the management of women with bipolar disorder and the relationship between cognitive impairment, schizophrenia and parenting skills.

He is a former President of The Marcé Society,

Janette Brooks

Janette Brooks is the Research Officer for the State Perinatal Mental Health Strategy in Western Australia. Prior to this position Janette was the Project Manager for the beyondblue National PND Program in WA and a Research Officer with the Australian Indigenous HealthInfoNet. Upon completion of her Masters Degree in Clinical Psychology Janette became the proud recipient of the beyondblue Sherryl Pope Memorial Scholarship and is subsequently a year and a half into her PhD candidature. Both her Masters and PhD research have focused upon the psychological well being of multiple birth mothers during the perinatal period.

Anne Buist

Anne Buist is the Professor of Women’s Mental Health, University of Melbourne and runs parent infant units at the Austin and Northpark hospitals. She has 20 years clinical and research experience in perinatal psychiatry, including leading the $4 million beyondblue National PND program 2001-5.

Tracy Burrell

Tracy Burrell is currently completing training as a Clinical Psychologist at Macquarie University, and has a particular interest in women’s health and child and family work. She has been involved in the Stress and Pregnancy study, a collaborative project of the Black Dog Institute and Macquarie University, investigating the relationship between antenatal stress and fetal and child development. Continuing her interest in the area of stress and reproductive health, she is currently at the School of Public Health and Community Medicine at the University of New South Wales, coordinating a study of women’s experiences of stress while undergoing Assisted Conception procedures.

Raeleigh Bryant

Ms. Raeleigh Bryant is Regional Manager of The Abused Child Trust, Brisbane. Previous to this she was Senior Occupational Therapist, Logan Beaudesert Health District. She has extensive experience in treating traumatized children and families. A particular clinical interest is working with infants and parents and she was the founding coordinator of the Better Beginnings Infant Program at Logan.

Frances Carter

Dr Carter is a senior clinical lecturer at the Christchurch School of Medicine and Health Sciences, Otago University, New Zealand. She has been an investigator on randomized controlled trials evaluating the effectiveness of psychological interventions for eating disorders, depression during pregnancy and anxiety disorders.

Debra Creedy

Professor Debra Creedy is a registered nurse with a Honours degree in psychology, a Masters of Education by Research and PhD. She is the Professor and Dean of Health at Griffith University. Professor Creedy's main research interests relate to women's mental health, in particular postnatal depression, and evidence based practice and clinical innovation. Professor Creedy has over 110 publications in book chapters, international journal articles and conference proceedings. She is a Fellow of the Australian & New Zealand College of Mental Health Nurses and an executive member of Australian & New Zealand Association for Medical Education. She is a member of the Australian Council of Deans of Health Sciences.

Vivienne Cunningham-Smith

Vivienne Cunningham-Smith has had over 24 years experience in the non government child and family, youth and community development sector as well as 12 years in the government health sector in Primary Health Care, HIV/AIDS, Sexual Health and Drug and Alcohol Services. Viv is currently the Senior Manager Barnardos South Coast which provides integrated Early Intervention child and family services. Viv taught welfare for over 10 years focussing upon community development and theory and ran her own Social Work planning and management consultancy business particularly assisting small non government organisations in development of strategic and business plans, policy and procedure documents and in conflict resolution.

Michael Daubney

Dr. Michael Daubney is currently Clinical Director Child and Adolescent Psychiatry, Logan Beaudesert Health District and also treats patients in Private Practice. His clinical interests include treating traumatized children and families and Infant Psychiatry. In Private Practice he treats children, adolescents and adults who have experienced trauma in their childhood.

Lyn Dawson

My name is Lyn Dawson. I am a nurse working in Auckland's Maternal Mental Health team at Waitemata District Health Board.
I have worked in mental health for 16 years and worked in a variety of different areas, in different roles.
For the last year I have been employed as a project leader to scope a maternity liaison project. My poster presents some of the findings.
I am originally from England (grew up in Blackpool) but I have lived in New Zealand for the last 8 years with my husband and two children.

Christina Down

Christina Down is State Co-ordinator Perinatal Mental Health for the WA State Perinatal Mental Health Unit. Her current role includes coordinating establishment of a perinatal service for Indigenous women in Carnarvon, WA. Christina's areas of research include exploring perinatal mental health pathways to care in CALD Communities. She has clinical experience in Community Nursing, Acute Admissions/Consultation liaison and as program manager/senior clinician for psychotherapy services. Her qualifications include; Ba Hons Nursing, Post Graduate Diplomas in Mental Health Nursing and Business/Management, Masters in Psychotherapy. Christina is WA representative on the Perinatal Mental Health Beyondblue National Pathways to Care and Policy Working Party.

Margaret Egan

My name is Margaret Egan. I am a Gungallita/Yullinga aboriginal woman, I have great respect for Aboriginal and Islander culture. I was employed by Mt Isa Hospital as an Aboriginal Liaison Officer for 19 years. I met Lynore Geia and Professor Barbara Hayes, in 2002, when invited to be a member of the Reference Group for the "beyondblue National Postnatal Depression Program – Indigenous Women's Initiative Program". Barbara and Lynore came to Mt Isa to meet all the stakeholders and they were well accepted by the whole community. I was very fortunate to be fully involved and employed with the Program until its conclusion. My interest in Post Natal Depression comes from personal and professional experience working with women who had babies and were depressed but didn't have anywhere to go or anyone to talk to about their feelings; these women wouldn't seek professional help as they were afraid their babies would be taken. That is still a common occurrence.

Kerry-Ann Egliston

Kerry-Ann is currently completing her PhD at Macquarie University's Centre for Emotional Health. Working with a team from Sydney's Black Dog Institute, Kerry Ann is investigating the relationship between maternal antenatal stress and anxiety and the development of individual differences in infant cognitive, emotional, and behavioural functioning.

Elizabeth Emmanuel

Dr Elizabeth Emmanual is currently working as nurse lecturer at Griffith University, Logan Campus, Brisbane. Presently teaching nursing undergraduates. Clinical expertise in mental health nursing and midwifery. Previous positions held at the Mater mothers Hospital and Logan Hospital. Focus of interest –maternal distress, maternal role development in the early postpartum, maternal satisfaction.

Jennifer Ericksen

Jennie Ericksen is the Coordinator of the Parent-Infant Research Institute, Infant Clinic based at Austin Health. She is a clinical psychologist specialising in early childhood assessment, parent support and skills training, cognitive behaviour therapy, service planning and implementation. She has worked with in a variety of specialist children's services Currently she works with families during the child's first two years of life. She has a strong interest in training other health professionals, and is project manager on a number of PIRI research projects. Current research interests include Toward Parenthood© and antenatal preparation for parenthood program, Beating the Blues Before Birth© an antenatal group treatment program for depression and Community HUGS© program a therapeutic playgroup to promote attachment in mothers and their infants after postnatal depression.

Jane Fisher

Jane Fisher is Associate Professor and Coordinator of Education and Training at the Key Centre for Women's Health in Society at the University of Melbourne. She has been Consultant Clinical Psychologist to the Masada Private Hospital Mother Baby Unit since 1996 and has a long standing interest in the links between women's reproductive health and mental health.

Michelle Fletcher

Michelle Fletcher is a Kindergarten teacher, pastor, mother of 3 and wife of 1. She presently sits as Chair of the Beyond Blue Consumer Reference Group for Post Natal Depression and is Deputy Chair of Blue Voices, the Consumer Representative Group for Beyond Blue. 10 years ago, after a second episode of PND, Michelle founded the Tasmanian PND Support and Information Service which is a small volunteer operation manning a phone line and visiting service which provides support and information to families suffering PND and related parenting stresses. She is passionate about meeting opportunities for spreading the message that PND is part of the journey not the destination and for supporting women and families to be the best that they can be and find their own empowering path to healing and beyond.

Richard Fletcher

BSc. Dip. Ed. (Sydney), Grad. Dip. Infant Mental Health (NSW Institute Psychiatry), M.Med. Sci. (Newcastle) Following his plumbing apprenticeship Richard studied science at Sydney University and taught science in NSW, Kenya and the United States before joining TAFE to work with marginalised groups. He pioneered domestic violence prevention within Health Promotion and Men's and Boys' Health as areas of study. He has lectured on Health Research and Male Health Studies to teachers, nurses, occupational therapists, and medical students. He is currently completing his PhD on father's attachment to infants and children.

Elizabeth Fudge

Elizabeth is currently the Project Manager for the Children Of Parents with a Mental Illness (COPMI) initiative being undertaken by the Australian Infant Child Adolescent and Family Mental Health Association for the Australian Government.

Elizabeth worked as a speech pathologist and manager in education, community health and hospital settings where she was involved in health promotion and early intervention programs. Since completing her MSc. in Primary Health Care she has undertaken project management in the area of continuity of care for individuals and families.

Megan Galbally

Dr Megan Galbally is a Consultant Psychiatrist and Head of Unit at Mercy Hospital for Women in Victoria. Megan is the Chief Investigator for the Victorian Pregnancy Register for Women on Psychotropic Medication, which is a longitudinal study of the neurodevelopmental effects of psychotropic medications taken in pregnancy on infant and child outcomes. This study has been the recipient of the Neuroscience Research Grant and the Pat and Toni Kinsman Postnatal Depression Award. Megan also has an interest in parent-infant psychotherapy and recently published a study of clinicians' attitudes to practice and training. Megan has been a member of the executive committee of the Australasian Marce Society since 2004 and Treasurer of the Perinatal and Infant Special Interest Group within the Royal Australian and New Zealand College of Psychiatrists since 2005.

Jenny Gamble

Dr Jenny Gamble is Convenor of the Master of Midwifery Program at Griffith University. She is on the Qld Maternity Services Steering Committee established to implement the recommendations of the independent review of maternity services. Jenny is a Steering Committee member of beyoneblue's National Perinatal Mental Health Program.

Her research focuses on childbearing women's emotional health including fear of birth, acute trauma symptoms, depression and the link to caesarean section.

As Queensland President of the Australian College of Midwives she is committed to strengthening the midwifery profession to better meet the needs of childbearing women and their families.

Lynore Geia

My name is Lynore Geia. I am a woman born on Palm Island, 60km off the coast of Townsville. I am of the Kalkadoon nation of North West Queensland and of the Kaurereg Nation of the Western Islands of the Torres Strait. Since I was 16 years old on Palm Island, my interest and professional career as a nurse and midwife has involved working mainly with Indigenous mothers and babies: as community health nurse in a remote Aboriginal community; and as the manager of the Aboriginal birthing centre called "the Congress Alukura of the Grandmothers Law", in Alice Springs for four years. I first met Professor Barbara Hayes in 2001 at James Cook University (JCU) and, in 2002, after I completed my Masters of Public Health & Tropical Medicine I joined the "beyondblue National Postnatal Depression Program – Indigenous Women's Initiative Program". Barbara is now my first supervisor as a PhD candidate at JCU as I explore intergenerational perceptions of child-rearing practices on Palm Island.

Patricia Glossop

My name is Patricia Glossop. I am a Registered Nurse and Registered Midwife and have qualifications in Child & Family Health, as a Lactation Consultant and have a Master in Infant Mental Health. My current position is as Perinatal & Infant Program Coordinator with Sydney South West Area Health Service. I am also currently involved with Chryne (Charlie) Griffiths in the development of Aboriginal & Torres Strait Islander Child Development and Infant Mental Health Training, the development and facilitation of Aboriginal Circle of Security parenting camps, and the development of an Aboriginal Edinburgh Depression Scale. I am is President of The Australian Association of Infant Mental Health (AAIMHI), NSW, a Member of World Association of Infant Mental Health and a member of the Australasian Marce Society.

Chryne Griffiths

My name is Chryne Griffiths (Charlie). I am an Aboriginal Perinatal & Infant Mental Health Worker. I have a Graduate Diploma Infant Mental Health, a Master in Social Administration, and a Bachelor of Arts in Welfare. I work with the Aboriginal Antenatal/Postnatal Home Visiting Team and the Infant Child & Adolescent Mental Health Service in Campbelltown, NSW, and my speciality is working with Aboriginal families antenatally & postnatally. I am currently involved in the development of Aboriginal and Torres Strait Islander perinatal and infant mental health workshops for staff working with infants and their parents. I am also involved in the development of attachment-based parenting programs for Aboriginal parents. My burning ambition is to get the information re Perinatal Infant Mental Health out there to the broader community.

Jane Hasler

BA (Honours); Grad. Dip. Comm.; RN
Jane lives in Sydney with her husband and their eight children.

She completed her general nursing training at Manly hospital in 1983 and worked as a registered nurse and nurse educator for a number of years. She has worked in the mental health arena for the last three years which included supporting women experiencing postnatal depression (PND). Jane is currently starting up seminars for pregnant women and their partners to better equip them for 'life after birth'.

Jane completed a Graduate Diploma in Communication at UTS, majoring in Journalism, in 1996. She completed a BA Honours at Griffith University in Gender Studies in 2001 and is currently in the final year of her PhD candidature at Sydney University.

Jane believes PND is an understandable reaction in relation to the concept of identity and argues that society needs to address PND mainly from a social standpoint rather than generally medicalising this experience.

Barbara Hayes

My name is Barbara Hayes. I am fourth generation Anglo-Irish Australian and New Zealand background: water, country and a heritage of 'noblesse oblige' are part of our family tradition. I am a mental health nurse, a paediatric nurse a midwife and have a commitment to partnerships towards better health for all mothers, babies and families, especially those of Australia's Aboriginal and Torres Strait Islander Peoples through improved evidence based practice, teaching and research. I have been privileged in the last eighteen years to be involved in university education for the health of Aboriginal and Torres Strait peoples in northern Australia. The beyondblue National Postnatal Depression Project (2001-2005) was the opportunity to work at a deeper level with three groups of Aboriginal women accompanied by Lynore Geia and Margaret Egan. Standing at the interface of two cultures and honouring both was a life changing experience for me.

Suzanne Higgins

RN, PhD.

Dr Suzanne Higgins is a nurse with General, Midwifery, Maternal & Child Health and Mental Health qualifications. Her career has spanned almost 30 years working in a variety of general nursing areas, community health and mental health. Over the past 15 years her passion has been working with families particularly in their transition to parenthood. Her doctoral thesis examined the 'Experiences of first time parent couples as they combined parenting and paid work'. She established the first Victorian Raphael Centre (a perinatal mental health service) in July 2003 at St John of God Hospital Geelong which she still manages. She is married with 3 children.

Anthea Hodgson

Anthea Hodgson is the Education and Training Officer with the State Perinatal Mental Health Unit, Western Australia. Her qualifications include Diploma in Mental Health Nursing; Bachelor of Nursing; Masters in Psychotherapy (in progress) and Certificate in Gestalt Therapy. Her current role includes coordinating the roll-out of the EPDS 'train the trainer' program, and other training initiatives focussing on the perinatal period. She has clinical experience in acute adult inpatient care, Community Mental Health Nursing in adult and CAMHS, and in Nursing Staff Development. She has a particular interest in attracting and retaining graduate nurses in the mental health field.

Mary Hood

Dr Mary Hood has an extensive career in the public sector focussing on children and families, including positions within child protection settings, social welfare agencies, university and early intervention programs in Adelaide and the United States. This has included therapeutic, supervisory, consulting, formal educational and training roles. She now has opened a private practice at the Attachment and Relationship Centre and is interested in applying attachment approaches to child-carer relationships on the pre-school years.

Belinda Horton

Since completing her undergraduate degree in occupational therapy (OT) in 1986 Belinda was involved in many aspects of OT practice. Following the birth of her first child in 1992 Belinda maintained an active involvement in Nursing Mothers' Association of Australia (NMAA) (now Australian Breastfeeding Association) as a volunteer Breastfeeding Counsellor, Group leader and Research Officer. Other professional development activities have included regular attendance at conferences and seminars and initiating involvement in activities at all levels of NMAA, while also maintaining close contact with women in the groups and through telephone and face-to-face counselling.

During this time, Belinda completed studies in a Master of Health Science in Occupational Therapy, which provided an opportunity for Belinda to explore interest in maternal and family health and postnatal depression (PND) from the perspective of occupational therapy.

In 1998 - 1999 Belinda completed studies in the Australasian Lactation Course which equipped her to successfully sit the International Board of Lactation Consultant Examiners exam in July 1999, resulting in her becoming an International Board Certified Lactation Consultant (IBCLC) which she practived privately until 2004. Belinda went on to complete the Graduate Diploma in Family Therapy in 2001 (LaTrobe University) and has practiced family therapy counselling for 6 years in a postnatal depression program in Melbourne. In February 2004 Belinda joined PANDA as Director. Belinda co-authored the PND and Breastfeeding booklet with ABA at the beginning of this year.

Pam Joseph

Pam Joseph is the Program Manager at Starting Out, a program of Connections Child Youth and Family Services in Melbourne. Pam's initial qualifications were in nursing (general, midwifery and Maternal and Child Health) but at the age of 40 she headed back to uni to compete a Bachelor of Social Work, while working at the Department of Human Services in an agency funding and partnerships role.

At Starting Out, Pam leads a multidisciplinary team of professionals, peer support workers and volunteers who share a passion for working with young people who are pregnant or parenting, and their children.

Leone Joyce

Leone Joyce, Te Awamutu, New Zealand. I have 3 children, and 4 grandchildren. After registering as a General Obstetric Nurse in 1961 I began a very interesting eclectic career in nursing. In 1983 I Registered as a Psychiatric Nurse became a Nursing Tutor for 4yrs then completed my Plunket Training with the aim of volunteer nursing
overseas, but the the death of my husband in 1992 changed this. I have worked for Health Waikato as a Community Mental Health Nurse for 15 years, with the last 8 years as Maternal Mental Health Nurse.
I am curently completing my Masters Nursing.(Mental Health).

Cathy King

Cathy King is a clinical psychologist with the Child and Adolescent Mental Health Service. Cathy is currently working in the Integrated Perinatal Care Project to implement state strategies at a local area for the universal screening of women in the perinatal period and the development and support of clinical pathways. Cathy has worked for many years with vulnerable and disadvantaged individuals and families in a number of government and non-government agencies.

Maureen Lagan

Maureen Lagan is a clinicial nurse specialist, currently working in the area of Perinatal Psychiarty and Mental Health at Westmead Hospital Hospital NSW. I am a RGN, RPN and have a Bachelor Health Sciences Nursing. I am a member of the Australian College of Mental Health Nurses.

My clinical experience in psychiatry nursing has been accrued over the past two decades. I have worked in acute hospital and community settings. For the past two years I have worked consistently with Mothers, Infants, families who are challenged by coping with the complex and demanding role of parenthood but also the complexities of a psychiatric illness and diagnosis.

In addition, I have worked with welfare and child protection agencies and various NGO's during processes of child protection and maternal rehabilitation.

Leo Leader

Leo Leader is a senior lecturer in the School of Women's and Children's health at the University of New South Wales. He is also a senior consultant obstetrician and gynaecologist at the Royal Hospital for Women in Randwick, Sydney.

He has a long-standing interest in fetal behaviour, fetal habituation and the effects of maternal stress and anxiety on fetal behaviour and infant outcome and development.

Bronwyn Leigh

B.A. (Hons), DPsych (Health)
Dr Bronwyn Leigh is a clinical health psychologist who works with women, infants and families through the Infant Clinic, Austin Health. She is involved in a range of research studies related to maternal mood and prematurity through the Parent-Infant Research Institute. Her doctoral thesis explored risk factors for antenatal depression, postnatal depression and parenting stress and the relationship between them. Bronwyn's areas of specific interest include perinatal maternal mood disturbance, adjustment to parenthood, adjustment following a premature birth, perinatal loss, mother-infant interaction and maintaining intimacy between couples in the transition to parenthood. Bronwyn is also an honorary psychologist to the Bonnie Babes Foundation.

Leanne Lewis

Leanne is a Social Worker and accredited Mental Health Professional with work experience in England, Scotland, and Australia. Originally from Perth, Leanne has worked as a relationship counsellor and has facilitated Domestic Violence groups for perpetrators and victims. She has also worked in psychiatric triage and at the W.A AIDS council. Leanne established a specialist pregnancy loss/termination counselling service in 1999 and became increasingly interested in women's mental health during the perinatal period. She moved from Perth to Melbourne in 2005 to establish the Raphael Centre at St John of God Hospital in Berwick. She has two boys – 10 years and 5 years.

Liz Mallet

Liz is a support worker with PANDSI (Post and Antenatal Depression Support and Information Inc) a community organisation operating in Canberra. Before moving to Australia Liz served in the British Army. Australia afforded her an opportunity for a career change and she became a counsellor. She joined PANDSI in 2005. She also tutors at University of Canberra and consults to beyondblue committees. Liz has a personal interest in exercise and its benefits and in 2006 designed an exercise and support program for women with PND. This is the topic of her presentation to the Marce Conference.

Anne Manne

Anne Manne is the author of Motherhood; How should we care for our children? Allen & Unwin, 2005. She has been a columnist and feature writer for The Australian and The Age, while longer essays have appeared in The Australian's Review of Books, Quadrant Magazine, Arena Magazine, Arena Journal, Monash University Journal People and Place, and The Monthly. She is one of the contributors to Cries Unheard; A New Look at ADHD, Common Ground 2002, edited by child psychiatrist George Halasz. Prior to writing full time she taught in the Politics Departments of Melbourne and Latrobe Universities. She lives in Melbourne and is a mother of two.

Jann Marshall

Dr Jann Marshall works as a Senior Medical Adviser in policy and planning in the Child and Adolescent Community Health Division of the Department of Health in Western Australia. The nature of her work is varied, focusing on providing advice and assistance to support children, families and communities. Jann has worked and lived in many cultures and advocates for cross-cultural awareness and the specific needs of culturally and linguistically diverse communities to ensure that they are addressed in policy and practice. A request for advice from a midwife and a psychiatrist in Perth led to the development of the new resource.

Stephen Matthey

Dr Stephen Matthey is a Senior Clinical Psychologist, and the Research Director, for the Infant, Child & Adolescent Mental Health Service in the Sydney South West Area Health Service. He gained his undergraduate psychology degree from England; his Clinical Masters degree, as well as his Ph.D., from the University of Sydney.

He has published around 50 papers in peer-reviewed journals on a range of topics, including: child and adult treatment; educational psychology; cross-cultural psychology; perinatal mental health; psychological assessment; questionnaire development; statistics; brain injury; fathers; parenting programs, and the evaluation of clinical services. He is passionate about playing soccer & supporting Chelsea; his motorbike; and trying to improve on the violin. And is equally passionate about the absurdity of most OH&S notices !

Bernardine McDonald

Formally a critical care nurse and midwife, Bernardine McDonald has worked as a Clinical Psychologist with the Benevolent Society's Early Intervention Program for six years, working with groups and in home-based, long-term, parent infant psychotherapy. In addition to the inner worlds of mothers and babies, Bernardine has an abiding interest in the nature and impact of trauma, the borderline spectrum and the interface of mind and body.

Annette Murphy

Annette Murphy supplemented her degree in Occupational Therapy with training in both Couple and Family Therapy. She has worked with families for the past 20 years and currently works with the Benevolent Society as a group work co-ordinator and co-facilitates therapeutic antenatal and mother baby groups. She also works in private practice as and Individual, Couple and Family Psychotherapist.

Louise Newman

Dr Louise Newman is the Director of the New South Wales Institute of Psychiatry and a Child and Adolescent Psychiatrist with expertise in the area of infancy and early childhood development. She is undertaking research into the prevention of child maltreatment and interventions for parents who have experienced early abuse. Dr Newman's' current academic work is looking at early attachment relationships in infants up to 3 years of age and the importance of supporting parents with histories of trauma. Prior to studying medicine, Dr Newman completed undergraduate degrees in Psychology, Philosophy and Gender Studies and she has a longstanding commitment to the promotion of women's mental health. Dr Newman is currently the Chair of the NSW Branch of the College of Psychiatrists, and Chair of the College Faculty of Child and Adolescent psychiatry. She has been the Chair of the RANZCP workforce committee and sits on the NSW government Implementation Committee that oversees the reform of the mental health system. She is the Convenor of the Alliance of Health professionals for Asylum Seekers and is The Royal Australian and New Zealand College of Psychiatrists' spokesperson on asylum seekers and child mental health issues. She is involved in advocacy for the human rights of asylum seekers and particularly for children affected by the Australian Government policy of mandatory detention.

Fyowna Norton

Fyowna Norton is the Western Victorian Co-ordinator of a new statewide program called pimhi – parent infant mental health initiative.

pimhi addresses the importance of specialised care during the perinatal period for psychiatrically ill women and their families and the effect of interventions on their psychiatric stability and mother infant relationship.

Fyowna has studied English, Genetics and Social Work. She has been a social worker for 10 years working within diverse and multidisciplinary fields such as Child Protection and Economic Development. She also runs her own business in the fitness industry.

Margaret Oates

Dr Margaret Oates is Consultant Perinatal Psychiatrist and Honorary Senior Lecturer at the University of Nottingham. She is a founding member and past president of Marcé Society, Chair of Royal College of Psychiatrists Perinatal Section and Lead Clinician, Trent Strategic Health Authority, Perinatal Mental Health Managed Care Network. Dr Oates is a Central Assessor for the Confidential Enquiries into Maternal & Child Health and responsible for the assessment of psychiatric causes of maternal death and leads a Perinatal Mental Health Service in Nottingham including a Mother and Baby Unit, Maternity Liaison Service and a Community Outreach Team.

Miriam O'Toole

Miriam O'Toole has 18 years experience working in the Drug and Alcohol Field as a psychologist. Fore several years she developed research into this field through the University of Wollongong. She is currently managing outpatient services in the Wollongong region and supervising psychologist in training.

Suzanne Payne

Suzanne Payne is the Nurse Unit Manager Of Antenatal Services and Community Midwives Program in the WOMENS & BABIES /CHILD & ADOLESCENCE HEALTH STREAM at Wollongong Hospital. Suzanne has worked in Maternity for 7 years after receiving a Masters In Science (Midwifery). She has been part of the Mentoring for Midwives program since it's inception at Wollongong Hospital in 2002 and has been published in Midwifery Matters in 2005 and presented at Midwifery conferences in 2004 and 2005. Suzanne's goal is to ensure that all women are given the opportunity to receive evidence based care no matter what their needs are , round pegs do not always fit into square holes.

Jane Phillips

BA (Hons: Psych)

Jane Phillips works as a Research Officer at Karitane, an organisation in NSW providing parenting services for families with children aged 0-5 years. In this role, Jane works alongside clinical staff at Karitane to facilitate and conduct child and family health research and to evaluate the clinical services provided at Karitane. Jane's previous research work includes involvement in the evaluation of the 'Integrated Perinatal and infant Care' (IPC) initiative in South Western Sydney and the 'beyondblue' National Postnatal Depression Program. Jane is a registered psychologist and she is currently studying a combined Doctorate of Clinical Psychology/PhD at the University of Sydney.

Rosalind Powrie

Dr Rosalind Powrie is a child, infant and perinatal psychiatrist and Head of the Perinatal and Infant Mental Health Team at the Womens and Childrens Hospital CYWHS Adelaide. She took up this appointment recently after having worked in community child and adolescent mental health for over 20 years. She is a trainer in the Parent and Infant Mental Health project (PIMHIC), is a tutor in the Graduate Diploma in Infant Mental Health (NSW Institute of Psychiatry) and is currently a member of the Beyond Blue Pathways to Care working Party Working Party. She has trained and taught widely and maintains and interest in childhood and infant trauma and cultural issues and mental health.

Rebecca Reay

Rebecca Reay BAppSc (OT), Acc OT, PhD (candidate) Med Sc (research).

Rebecca currently works as a research officer with the Academic Unit of Psychological Medicine, Mental Health ACT. She conducts research, training and clinicial supervision in perinatal mental health. Rebecca has a special interest in interpersonal psychotherapy, group interventions and working with couples. Rebecca coordinated the ACT component of the beyondblue National Postnatal Depression Program. In addition, she is involved in the Perinatal Mental Health Consortium National Action Plan as a subcommittee member.

Susan Roberts

Dr. Susan Roberts is a Perinatal Psychiatrist in part-time private practice. She has worked in this area for the last 10 years. She has a strong interest in the impact of maternal mental health on parenting and regularly performs mental health assessments for the Department of Child Safety. She believes in forging strong multidisciplinary links in the community for the management of women with perinatal mental health problems.

Karen Rowan

I am a registered social worker and member of ANZASW. After graduating in 1995 I worked in the acute admission ward at a Tokanui Hospital, North Island, New Zealand. When Tokanui closed I began working with the Adult Community Mental Health Service. In 2002 the opportunity arose for me to become part of the Early Intervention Maternal Mental Health Service, I have found the work pleasurable, challenging and varied. I am particulary interested in children whose parents have mental health problems and the effect of these illnesses on the children. However the most satisfying part of my job is walking beside women as they become well, watching their parenting skills improve and the family reunited to continue on their life journey together as a family unit.

I have 3 adult children and a precious grandchild who adds another dimension to my life, which in turn adds another dimension to my professional career.

Heather Rowe

Dr Rowe is a health scientist with a background in genetics, psychology and health promotion. She is on the academic staff of the Key Centre for Women's Health in Society in the School of Population Health at the University of Melbourne, where she is involved in postgraduate teaching and higher degree supervision. Her research interests in perinatal mental health include the impact of reproductive technology on women's mental health, reproductive decision-making and the postnatal care of women who are experiencing psychological distress. Her current research projects involve the development and evaluation of psycho-educational interventions for the promotion of postnatal mental health.

Helena Sandahl

Dr Helena Sandahl is a clinical psychologist and investigator at the Mercy Hospital for Women, Heidelberg, and a research fellow with the Key Centre for Women's health in Society, School of Population Health, The University of Melbourne. She specialises in child, adolescent and family psychology. To date, her main research activities have been within the field of perinatal mental health. Other areas of interest include the question of diagnosis in developmental disorders, and the ethics of clinical practice and research.

Mandy Seyfang

Mandy Seyfang is a family therapist and occupational therapist, working at Helen Mayo House, a mother infant mental health service. Her role there is as an infant mental health speicalist and she works predominately to support the attachment relationship between mother and infant. She also lectures at the University of SA in Health Sciences programmes and provides training in the community in a private capacity.

Lynne Staff

Lynne has been a midwife for 24 years and has worked in the public and private sectors, home birth and midwifery education. She helped establish the Nambour-Selangor Private Hospital Maternity Unit in 1997, where she still works. She is passionate about ensuring that women's perspectives of their birthing experience are made known because women's accounts of their experiences are so invisible in the literature relating to birth. She is a novice researcher and hopes to continue on to a PhD.

Joe-Anne Sundblom

Joe-Anne began her working life as a nurse in Victoria moving to WA to do midwifery. During the 1980's as a midwife Joe-Anne worked for several years as Nursing Coordinator for a large general/midwifery hospital and later as Nurse Unit Manger of a rural Victorian midwifery unit. Since leaving nursing, in 1993, Joe-Anne completed tertiary study in psychiatric disability support and disability services management. She has also completed a diverse range of study in specialist counselling and support and community mental health promotion. Initially working in a Family Services Agency in foster care placement, then as a community mental health worker, at Aspire a Pathway to Mental Health, a psychosocial rehabilitation and recovery support service. Since early 2006 Joe-Anne has been the manager of the St John of God Raphael Centre South West Victoria which is a perinatal mental health support service.

Anne Sved-Williams

Dr Anne Sved Williams is a Clinical Senior Lecturer at the University of Adelaide and Director of Perinatal and Infant Mental Health Services at the Womens and CHildrens Hospital in Adelaide, which includes the inpatient unit of Helen Mayo House where she has worked for 20 years. She has developed teaching packages in the perinatal/infant mental health area and these have been used in many parts of Australia. Having worked as a GP prior to psychiatric training, she has also worked extensively in primary care psychiatry, both in educational and consultation-liaison roles, and has a significant interest in the integration of hospital and community care.

Wendy Thiele

My name is Wendy Thiele: I trained as an Occupational Therapist (OT) and Art teacher and I'm currently the National Training Coordinator for the beyondblue Perinatal Mental Health Initiative.

I spent most of my pre-school years in a remote Aboriginal community in Eastern Arnhemland. My father was a teacher and was later involved in Aboriginal education in the Northern Territory so the family travelled to many Aboriginal communities throughout the NT during my primary years.

My husband has a background in Aboriginal affairs in Central Australia (Ernabella) and South Australia and time spend with him and my two wonderful children; a daughter 16 and son aged 13 is precious. In my spare time I like to quilt and love smelling the roses in my garden.

Kathryn Thornton

Prior to working as a psychologist with Hunter New England's Perinatal Psychiatry Service Kathryn worked as school teacher, school counsellor and researcher. She has a Graduate Diploma of Infant Mental Health from the NSW Institute of Psychiatry. She has an interest in, and works, with parents with major mental illness and their children and also co-facilitates groups that focus on the relationship between mothers and their infants or toddlers. Attachment theory informs her work. Kathryn enjoys providing education and supervision to individuals and organizations. Her presentation at this conference is the result of work she undertook for an in-service education session for the staff at the Special Education Centre at the University of Newcastle.

Beverley Turner

Dr Bev Turner is a child and family psychiatrist in private practice in Sydney. About a third of that practice is in the treatment of perinatal issues. She also provides a regular psychiatric service at Redbank House in Westmead, in a clinic for children who have been permanently removed by the court from their parents' care, and a general child psychiatry service to rural NSW on a fortnightly basis.

Adaobi Udechuku

Dr Adaobi Udechuku is Consultant Psychiatrist to the Parent Infant Mental Health Initiative and the Postnatal Depression Initiative Austin Health, Melbourne, Victoria.

Moira Williamson

Moira is currently senior lecturer at the University of Wollongong, School of Nursing, Midwifery and Indigenous Health. She coordinates the Master of Science (Midwifery) program and research in this area. She has worked as a midwife for more than 28years with a wide range of experience in clinical, educational and managerial positions.

Mrs Helen Allison	Mt Druitt Community Health	NEW SOUTH WALES
Mrs Chandra Ambrose	St.John Of God Hospital	NEW SOUTH WALES
Ms Karen Asgill	The Benevolent Society	NEW SOUTH WALES
Dr Marie-Paule Austin	Prince of Wales Hospital	NEW SOUTH WALES
Mrs Mercy Baafi	Wollongong Hospital	NEW SOUTH WALES
Dr Meryl Bacon	Maternal Mental Health, Auckland DHB	AUCKLAND
Ms Hilda Badruddin	Austin Health	VICTORIA
Ms Helen Baker	Infant-Parent Counselling and Consultancy Service	QUEENSLAND
Professor Bryanne Barnett	Sydney South West Area Health Service	NEW SOUTH WALES
Doctor Jennieffer Barr	Queensland University of technology	QUEENSLAND
Ms Jodi Barton	Westmead Perinatal Psychiatry and Clinical Research Unit	NEW SOUTH WALES
Mrs Judith Baxter	Mater Private Hospital	NEW SOUTH WALES
Dr Christine Bayly	Royal Women's Hospital	VICTORIA
Ms Jacqueline Beall	University of Adelaide	SOUTH AUSTRALIA
Ms Carol Bennett	Beyondblue	VICTORIA
Ms Linda Benz	Gold Coast Hospital Acute Care Team	QUEENSLAND
Dr Tuni Bhattacharyya	SSWAHS	NEW SOUTH WALES
Dr Justin Bilszta	Austin Health	VICTORIA
Ms Martha Birch	PIMHS Liverpool NSW	NEW SOUTH WALES
Dr Gaynor Blankley		VICTORIA
Ms Nicole Blount	PANDSI	ACT
Ms Kerryn Boland	Office for Children - The Children's Guardian	NEW SOUTH WALES
Professor Philip Boyce	Westmead Hospital	NEW SOUTH WALES
Ms Debbie Brewis	QEC	VICTORIA
Mrs Kirsty Brislane	St John of God - Raphael Centre	VICTORIA
Ms Helen Brodribb	Healthscope Tasmania	TASMANIA
Ms Raeleigh Bryant	The Abused Child Trust	QUEENSLAND
Professor Anne Buist	Austin Health & Northpark Private	VICTORIA
Ms Tracy Burrell	Black Dog Instititute/Macquarie University	NEW SOUTH WALES
Ms Ruth Callaghan	NSW Dept Community Services	NEW SOUTH WALES
Dr Frances Carter	Otago University	CHRISTCHURCH
Dr Helen Cooney	Auckland District Health Board	AUCKLAND
Professor Debra Creedy	Griffith University	QUEENSLAND
Ms Vivienne Cunningham-Smith	Barnardos South Coast	NEW SOUTH WALES
Mrs Tanja Dalton	Connections	VICTORIA
Dr Michael Daubney	LoganBeaudesert Health Service	QUEENSLAND
Ms Virginia Davies	North Coast Area Health	NEW SOUTH WALES
Ms Lyn Dawson		AUCKLAND
Mrs Joanne deVries	Wuchopperen Health Service	QUEENSLAND
miss Christina Down	State Perinatal Mental Health Unit WA	WESTERN AUSTRALIA
Mrs Joanne Duffy	Postnatal Depression Support Association Inc (PNDSA)	WESTERN AUSTRALIA
Mrs Jill Durkin	Toowong Health Service	QUEENSLAND
Dr Belinda Edwards	Lyell McEwin Hospital	SOUTH AUSTRALIA
Ms Kerry-Ann Egliston	Black Dog Institute	NEW SOUTH WALES
Dr Elizabeth Emmanuel	Griffith University	QUEENSLAND
Mrs Jennifer Ericksen	Austin Health Repatriation General Hospital	VICTORIA
Ms Many Fairclough	Queensland Health	QUEENSLAND
Ms Shelley Fallowfield	QEC	VICTORIA
A/Professor Jane Fisher	The Key Centre for Women's Health in Society	VICTORIA
Dr Jo Fitz-Gerald		VICTORIA
Mrs Rhonda Fitzpatrick	North Coast Area Health Service	NEW SOUTH WALES
Mrs Michelle Fletcher	Beyond Blue	TASMANIA
Ms Shirley Floyd	Raphael Centre - Berwick	VICTORIA
Ms Sophia Franks	Mercy Hospital for Women	VICTORIA
Ms Maureen Frilingos	Royal Hospital for Women	NEW SOUTH WALES
Ms Elizabeth Fudge	AICAFMHA	SOUTH AUSTRALIA

Dr Megan Galbally	Mercy Hospital for Women	VICTORIA
Dr Jenny Gamble	Griffith University	QUEENSLAND
Mrs Heather Gilbert	Alfred Psychiatry Research Centre	VICTORIA
Ms Patricia Glossop	George Street Health Centre	NEW SOUTH WALES
Mrs Chryne Griffiths	Sydney South West Area Health Service	NEW SOUTH WALES
Mrs Rosemary Hagan	King Edward Memorial Hospital	WESTERN AUSTRALIA
Dr Kwi Won Han	Austin Hospital	VICTORIA
Dr Catherine Hapgood	Waitemata District Health Board	AUCKLAND
Ms Jane Hasler	University of Sydney	NEW SOUTH WALES
Professor Barbara Hayes	James Cook University	QUEENSLAND
Dr Suzanne Higgins	St John of God Raphael Centre	VICTORIA
Ms Christine Hill	Epworth Freemasons Maternity Unit	VICTORIA
Ms Margaret Hodge	Connections	VICTORIA
Ms Anthea Hodgson	North Metropolitan Health Service	WESTERN AUSTRALIA
Ms Sue Holley	Princess Alexandra Hospital and District Health Service	QUEENSLAND
Ms Jan Holmes	Whangarei Hospital	WHANGAREI
Dr Mary Hood	The Attachment and Relationship Centre	SOUTH AUSTRALIA
Ms Belinda Horton	PANDA	VICTORIA
Ms Dianne Hurt	John Hunter Hospital	NEW SOUTH WALES
Dr Mark Huthwaite	Maternal Mental Health Serice, CCDHB	WELLINGTON
Ms Mary Hyland	Austin Hospital	VICTORIA
Ms Susie Ingram	Child and Family Health	NEW SOUTH WALES
Mrs Carmel Jarvis	QE2 FAMILY CARE CENTRE	ACT
Ms Kerrie Jennings	John Hunter Hospital	NEW SOUTH WALES
Ms Christine Jones	St John of God Hospital	WESTERN AUSTRALIA
Ms Pam Joseph	Connections' Starting Out Program	VICTORIA
Ms Leone Joyce	Waikato District Health Board	HAMILTON
Professor Fiona Judd	Royal Women's Hospital	VICTORIA
Ms Janine Kalisch	The Queen Elizabeth Hospital	SOUTH AUSTRALIA
Ms Juneta Kamaruddin	Austin Health	VICTORIA
Dr Barney Kann		QUEENSLAND
Dr Kristin Kerr	Royal Prince Alfred Hospital	NEW SOUTH WALES
Mrs Angela Kershaw	Tweddle Child and Family Health Service	VICTORIA
Ms Cathy King	South East Sydney Illawarra Area Health Service	NEW SOUTH WALES
Dr John King	Monash Medical Centre	VICTORIA
Dr Nick Kowalenko	Royal North Shore Hospital	NEW SOUTH WALES
Dr Miriam Kuttner	The Delta Centre	VICTORIA
Mrs Maureen Lagan	Westmead Perinatal Psychiatry and Clinical Research Unit	NEW SOUTH WALES
Ms Kathryn Laidlaw	Westmead Perinatal Psychiatry and Clinical Research Unit	NEW SOUTH WALES
Dr Leo Leader	University of New South Wales	NEW SOUTH WALES
Dr Bronwyn Leigh	Austin Health	VICTORIA
Ms Ria Lestari	Austin Health	VICTORIA
Dr Tom Levien	Werribee Mercy Hospital and Monash Medical Centre	VICTORIA
Ms Leanne Lewis	Raphael Centre - Berwick	VICTORIA
Mrs. Kerry Lockhart	St. John of God Health Services	NEW SOUTH WALES
Ms Kate Luttick	PANDA	VICTORIA
Ms Lynly Mader	Adelaide Womens and Children's Hospital	SOUTH AUSTRALIA
Mrs Liz Mallet	PANDSI	ACT
Ms Anne Manne		VICTORIA
Ms Fiona Martin	Capital and Coast Health	WELLINGTON
Dr Stephen Matthey	Sydney South West Area Health Service	NEW SOUTH WALES
Ms Cheryl Mayes	Caring for Newborn and Beyond	NEW SOUTH WALES
Dr Eilis McKensey	HUNTER NEW ENGLAND HEALTH	NEW SOUTH WALES
Dr Jan McKenzie	University of Otago	CHRISTCHURCH
Ms Karen McKinnon	Barnardos South Coast	NEW SOUTH WALES

Ms Clare Miller	Auckland District Health Board, Maternal Mental Health	AUCKLAND
Ms Nicky Miller	Family Services Illawarra	NEW SOUTH WALES
Ms Christine Minogue	The Nurtured Way	NEW SOUTH WALES
Ms Barbara Minto	Monash Medical Centre - Mother Baby Unit	VICTORIA
Mr Michael Mitchell	Statewide Indigenous Mental Health Service	WESTERN AUSTRALIA
Ms Annette Murphy	The Benevolent Society	NEW SOUTH WALES
Ms Carol Newing	Northern Sydney Central Coast Health	NEW SOUTH WALES
Dr Louise Newman	The NSW Institute of Psychiatry	NEW SOUTH WALES
Ms Fyowna Norton	Werribee Mercy Hospital	VICTORIA
Professor Margaret Oates	University of Nottingham	UNITED KINGDOM
Mrs Judy Olsen	Logan Child and Youth Mental Health	QUEENSLAND
Ms Tricia O'Neill	North East Psychiatric Services	VICTORIA
Ms Patricia O'Rourke	Children, Youth and Women's Health	SOUTH AUSTRALIA
Dr Fran Orr	SSWAHS	NEW SOUTH WALES
Dr Larry Osborne		VICTORIA
Ms Miriam O'Toole	South East Sydney Illawarra Area Health Service	NEW SOUTH WALES
Dr Estela Papier		VICTORIA
Ms Suzanne Payne	South East Sydney Illawarra Area Health Service	NEW SOUTH WALES
Ms Jane Phillips	Karitane	NEW SOUTH WALES
Dr Rosalind Powrie	CYWHS Womens and Childrens Hospital	SOUTH AUSTRALIA
Ms Jennifer Quinlan	st john of god hospital	VICTORIA
Mrs Kaberi Rajendra	Counties Manukau DHB	AUCKLAND
Dr Jonathan Rampono	King Edward Memorial Hospital	WESTERN AUSTRALIA
Mrs Rebecca Reay	Academic Unit of Psychological Medicine	ACT
Ms Nicole Reilly	Black Dog Institute	NEW SOUTH WALES
Ms Helen Richards	QE2 FAMILY CENTRE	ACT
Dr Susan Roberts	Fertility Gold Coast	QUEENSLAND
Ms Karen Rowan	Waikato District Health Board	HAMILTON
Dr Heather Rowe	University of Melbourne	VICTORIA
Ms Serena Ryan	Statewide Indigenous Mental Health Service	WESTERN AUSTRALIA
Ms Ayse Salih	Royal Women's Hospital	VICTORIA
Dr Helena Sandahl	Mercy Hospital for Women	VICTORIA
Mrs Jill Scanlan	University of Southern Queensland	QUEENSLAND
Ms Leanne Scoines	Department of Child Safety	QUEENSLAND
Dr Jo Selman	Rosebud Mother Baby Unit	VICTORIA
Ms Mandy Seyfang	Adelaide Womens and Children's Hospital	SOUTH AUSTRALIA
Ms Katie Shafar	Positive Parenting Services	VICTORIA
Ms Sheryl Sidery	Royal Hospital for Women	NEW SOUTH WALES
Ms Lucinda Smith	Raphael Centre - Berwick	VICTORIA
Ms Nancy Smith	QE2 FAMILY CENTRE	ACT
Dr Sandra Smith		NEW SOUTH WALES
Ms Deborah Soady	Logan Child Youth Mental Health	QUEENSLAND
Ms Maureen Speedy	Waikato Family Centre	HAMILTON
Mrs Lynne Staff	Nambour-Selangor Private Hospital	QUEENSLAND
ms vicki stephenson	nambour selangor private hospital	QUEENSLAND
Ms Penny Stevens	Maternal Mental Health Service	TAURANGA
Ms Paula Storey	Royal Hospital for Women	NEW SOUTH WALES
Mr Ruben Sugondo	Austin Health	VICTORIA
Mrs Joe-Anne Sundblom	Raphael Centre South West Victoria	VICTORIA
Dr Anne Sved-Williams	Children, Youth and Women's Health	SOUTH AUSTRALIA
Dr Klara Szego	Werribee Mercy Mother Baby Unit	VICTORIA
Dr Enno Taemets	Belmont Private Hospital	QUEENSLAND
Ms Catherine Teague	Tweddle Child and Family Health Service	VICTORIA
Ms Wendy Thiele	St John of God Health Services	SOUTH AUSTRALIA
Mrs Kathryn Thornton	Hunter New England Health	NEW SOUTH WALES
Ms Kiaran Thorpe	Flinders Medical Centre	SOUTH AUSTRALIA
Ms Marianne Trebett	TeRawhiti Community Based Mental Health Centre	AUCKLAND

Ms Rebecca Tucker	Flinders Medical Centre	SOUTH AUSTRALIA
Dr Beverley Turner	Redbank House	NEW SOUTH WALES
Dr Adaobi Udechuku	Austin Health	VICTORIA
Mrs Rhonda Upton	Child Youth and Family Health	QUEENSLAND
Ms Lyn Wardlaw	Northland District Health Board	WHANGANEI
Dr Elizabeth Webster	Private Practice	QUEENSLAND
Dr Hilary Weeks	Mensana Clinic	AUCKLAND
Dr Sara Weeks	Mensana Clinic	AUCKLAND
Mrs Sue Wentworth	Gold Coast Hospital Acute Care Team	QUEENSLAND
Ms Ros West	Child and Adolescent Community Health Sercice	WESTERN AUSTRALIA
Ms Doreen Westley	Doreen T. Westley & Associates	QUEENSLAND
Ms Mary Wickham	Northcoast Area Health Service	NEW SOUTH WALES
Ms Michelle Wickham	John Hunter Hospital	NEW SOUTH WALES
Ms Moira Williamson	University	NEW SOUTH WALES
Dr Deborah Wilson	Canterbury District Health Board	CHRISTCHURCH
Mrs Angela Wood	Postnatal Depression Support Association Inc (PNDSA)	WESTERN AUSTRALIA
Mrs Alice Yianni	Banyule City Council	VICTORIA
Ms Nikki Zerman	Tweddle Child and Family Health Service	VICTORIA

Marce 2007 Conference Evaluation Form

Please take a few minutes to complete the following so that we can deliver high quality and relevant conferences in the future.

Name/Organisation (OPTIONAL):

First, how did you hear about the 2007 Conference?

O Email **O** Word of Mouth **O** Mail **O** Website **O** Notice board

O Other (please specify):

Was the conference cost

O Excellent **O** Good **O** Fair **O** Poor Value

Comments:

Were the conference topics appropriate?

O YES **O** NO

Comments:

Was the time for each presentation appropriate?

O YES **O** NO

Comments:

Was there enough time for discussion and questions?

O YES **O** NO

Comments:

How often should the Marce Conference be held?

O Annually **O** Every 2 years **O** Every 3 years **O** Other - please specify:_____

Comments:

What for you were the highlights of the conference?

What for you were the low points of the conference?

How do you think the conference could have been made better?

Should the Marce Conference include a dinner?

O YES **O** NO **If yes**, what cost would be acceptable to you? Up to $_____

Do you have any suggestions for future Marce conferences? – Speakers, topics, location, conference length etc. (Please use the back of this page if needed.)

Thank you for completing this form. Please return it to the registration desk or mail to
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