Panda

Post and Antenatal Depression Association Inc.

Foreword

The Post and Antenatal Depression Association (PANDA) of Victoria is pleased to compile this written submission to the Parliament of South Australia's Social Development Committee Inquiry into the impact of childbirth experiences in South Australian hospitals and Postnatal Depression (PND) on South Australian individuals, families and the community.

PANDA is a Victorian, statewide organization that is considered to be an association of expertise on issues related to post and antenatal mood disorders. Over time PANDA has increasingly become involved in other state and national issues, via networks and contacts from other state bodies to comment on the issues of PND.

Throughout Australia there is historically limited coordinated planning of the support services and resources available to address many of the issues this Inquiry is focusing on. It is PANDA's belief that the needs of families with infants and the issues related to Postnatal Depression need an Australia wide focus.

This submission aims to:

- provide an overview of post and antenatal mood disorders, particularly PND,
- address a number of the terms of reference as appropriate, with the exception that it does not comment specifically on issues related to South Australia, and
- provide detailed information about PANDA as a Mutual Support Self Help organization.

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Post and Antenatal
Depression Association Inc.

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Lisa’s Story

‘My baby’s birth was quick, easy, drug free and exciting.

During my stay in hospital I experienced the ‘baby blues’, but that was to be expected I told myself. I soon made use of the ‘No Visitors’ notice on my door.

The staff was very supportive, but I became more and more tearful and easily upset. I miss my home, I told myself. I miss my husband. Things will be better when I am at home. For two weeks things were fine. My mother in law stayed with us.

When my husband returned to work and my mother in law went home, I was alone and I was scared. I was afraid of my baby, afraid to go out and afraid to stay at home. I spent the afternoons pacing the lounge-room floor with my baby in my arms. I left the phone off the hook most of the time. I loved my baby dearly, but there was something missing.

The simplest decisions became increasingly more difficult to make. I felt as if a large black cloud was hanging ominously over my head. Everything was dark. The sun never shone.

I stared out the window and the trees looked different. The street was unfamiliar. Our house felt very impersonal – it looked dirty, shabby and gloomy to me. The nights were worse. I would lie tensely waiting for my baby to wake.

I would go to the supermarket and feel strangely disoriented. Everything looked distorted; even people’s voices sounded distant and flat. Venturing out was a frightening experience and one I repeated as infrequently as possible.
I was sure I would get better. All that was required was a little willpower.

As the weeks and months went by, I could no longer stay at home alone. My mother had to come every day. I watched her worried face, I saw my husband looking so lost, alone and afraid for me, and then guilt was added to the turmoil of emotions I was grappling with.

I finally decided to tell my GP how I felt. He would help me, I thought. I tried to tell him how I felt, but it was too hard. Instead I complained that my baby was not feeding and sleeping well. I went back every week worried about my baby’s health. Each week he reassured me that my baby was fine. Maybe, if he had asked about me, I would have told him that something was wrong and that I was scared, but he never did. I kept trying to tell him how I felt but the words just wouldn’t come out. Each week I left his office and cried all the way home’.

By Lisa Fettling

Article commissioned by (and copyrighted to) Women’s Health Victoria for “Health Sharing Women” magazine, November 1998 issue.

Section 1: Postnatal Depression

Postnatal Mood Disorders

The arrival of a new baby is usually a happy event but it can also be a stressful time during which many adjustments have to be made by the new parents. Many women and their partners are not aware that mood changes are common after childbirth and can vary from mild to severe. In fact in the year after childbirth a woman is more likely to need psychiatric help than at any time in her life.

There are three recognised mood disorders in the postnatal period that can be viewed along a continuum.

At one end of the continuum is the **Baby Blues**, affecting about 80% of new mothers and occurring between the third and tenth day after birth. Symptoms include tearfulness, anxiety, mood fluctuations and irritability. The ‘blues’ are transient and will pass with understanding and support.

At the other end of the continuum is **Postpartum Psychosis**. This affects 1 in 500 mothers, usually in the first 3 to 4 weeks after delivery. Postnatal psychosis is a serious condition. The mother herself may be unaware she is ill as her grasp on reality is affected. Symptoms include severe mood disturbance (either marked elation or depression or fluctuations from one to the other), disturbance in thought processes, bizarre thoughts, insomnia and inappropriate responses to the baby. There is risk to the life of both mother and baby if the problem is not recognised and treated. Postnatal psychosis requires a hospital stay. With appropriate treatment women suffering from postnatal psychosis usually fully recover.

Between the ‘blues’ and psychosis lies **Postnatal Depression** (PND). Most women find adjusting to life with a new baby very difficult, but 15 – 20% of women develop PND. Many women do not know that PND can occur unexpectedly after delivery and typically blame themselves, their partners or their baby for the way they feel. Some try hard to ‘snap out of it’ without understanding that women with PND have little control over the way they are feeling. It is very important for women to learn to recognise the signs and symptoms of PND so that they can ask for help as early as possible.

What we know about Postnatal Depression

Postnatal depression (PND) can be a devastating and debilitating illness that can persist and affect not just a new mother but everyone around her. We know that:

- PND can be mild, moderate or severe.
- symptoms of PND can begin:
  - during pregnancy (antenatal depression)
  - suddenly after birth
  - gradually in the weeks or months following delivery.
- PND occurs in all cultures.
- it is not a modern condition. Each generation calls it something different. What we call PND today may have been called a 'nervous breakdown' fifty years ago.
- symptoms can emerge at any time during the first year after birth but most cases have their onset in the first four months.
- PND can happen to child bearing women of all ages.
- it can happen after miscarriage or stillbirth, normal or traumatic delivery, or caesarean delivery. Pregnancy is the common factor.
- PND happens not only after a first baby. It can occur after a third or fifth baby. Sometimes it happens after a first baby only. Sometimes it happens with a third baby, but not with the first two. Sometimes it happens after each pregnancy.
- a woman who has had PND has a 50% chance of recurrence with a subsequent pregnancy.
- if a woman becomes pregnant again before recovering from PND, the condition will continue through the pregnancy and may worsen. Women should delay another pregnancy until they have recovered completely. It is wise to wait at least a year after discontinuing medication before falling pregnant again.
- the early signs of PND are recognizable and help and interventions are available.

Symptoms of PND

The severity of PND depends on the number of symptoms, their intensity and the extent to which they impair normal functioning. PND tends to be characterized by a combination of the following symptoms:

- **Sleep disturbance unrelated to baby's sleep needs** - most women with a young baby fall asleep as soon as they are able to. Women with PND often lie awake for hours feeling anxious while the baby sleeps. Some women have trouble falling asleep, staying asleep or wake early in the morning.
- **Appetite disturbance** - women may feel totally uninterested in food and say "I force myself to eat because I am breastfeeding, but I don't taste anything". Sometimes women overeat in an attempt to control their anxiety.
- **Crying** - a woman may feel sad and cry without apparent reason. Tears come easily, sometimes without reason. Some women say "I want to cry but can't. I am crying on the inside."
- **Inability to cope** - daily chores seem insurmountable. A woman may feel like running away from it all.
- **Irritability** - a woman with PND may snap at her partner without cause. Partners often say "I can't do anything right. If I fold nappies she complains I do it the wrong way. If I don't help, I'm being unsupportive."
- **Anxiety** - she may feel a 'knot in the tummy' most of the time and panic without cause. Some women experience heart palpitations so severe that a heart attack is feared. She may be anxious about her own health or her baby's even after reassurance that nothing is wrong. Many women describe anxiety as their most obvious symptom and reject the term postnatal depression. They deny being 'depressed'. The term 'postnatal disorder' might more accurately describe the way some women feel.
- **Negative obsessive thoughts** - a woman may be afraid to let her partner go to work in case he has a car accident or be afraid to leave the baby with a friend in case something happens to him/her. It can be very difficult for her to switch off her constant negative thoughts and worries.
- **Fear of being alone** - many women go out a lot because they are afraid of being alone at home or express the need for someone to be with them at home. Some women fear being alone with their baby.
- **Memory difficulties and loss of concentration** - a woman may forget what she wanted to say mid-sentence or be unable to concentrate on simple tasks. Decision making, reading, watching television or a movie, or engaging in a conversation can be very difficult.
- **Feeling guilty and inadequate** - a woman may feel she is a 'bad mother' even when those around her comment on what a good job she is doing. She may be unable to take pleasure or satisfaction from anything she does, including her baby.

- **Loss of confidence and self-esteem** - a woman who enjoyed her job may panic at the thought of going back to it. No longer is she sure she is able to do it. A woman who enjoyed entertaining may panic at the thought of visitors. She may feel unable to prepare a meal when she enjoyed doing so before the baby was born.

Some women sum it all up by saying "There is no joy in anything any more", and “I feel like I have lost myself”.

Causes of PND

PND can happen to any woman, but some women are more vulnerable than others. There can be the presence of some risk factors that include a previous experience of PND, a family or personal history of psychiatric illness (depression, bipolar disorder, schizophrenia, PND), or stressful life events eg. a death in the family, age and difficult marital or family relationships.

Experts call PND a multi factorial problem with biological, psychological and social factors all playing some part. A different combination of factors is probably responsible for each woman’s unique experience of PND.

The factors thought to be responsible are:-

- Biological
  - genetic predisposition to developing depression
  - hormonal, ie sudden drop in pregnancy hormones after delivery can affect brain chemistry
  - nutritional deficiencies
  - difficult pregnancy
- Psychological
  - difficult or traumatic birth, perhaps involving unexpected interventions eg emergency caesarean
  - relationship difficulties with partner or parents
  - traumatic / abusive childhood
- Social
  - lack of family, marital and community support
  - social isolation

Early identification of PND

It can be very difficult to identify and diagnose PND in the early stages of its development for some of the following reasons:

- Many women suffering from PND do not seek help themselves. Many do not know what PND is or how to recognise the signs. What couples know or believe of PND comes largely from the media. Rarely does the media portray PND accurately. The media typically portrays PND as a severe illness, which very often leads to child abuse or a mother killing her baby, or dismisses it as an understandable reaction to the stresses of life with a new baby. Most popular books on pregnancy and parenthood ignore or trivialise PND.

- For some the stigma associated with depression prevents them asking for help. It is very hard for a woman with PND to admit that she is not coping and to ask for help. Our society puts great pressure on mothers to 'cope'. Motherhood is portrayed as intuitive and fulfilling. Often new mothers pretend to 'cope' because they are ashamed to ask for help. Symptoms are consequently masked.
- Many women fail to recognise PND in the early weeks because they often attribute how they feel to other parts of their lives and they assume that things will get better. Many of the women who contact PANDA have babies who are three-to-four months old. This is when babies usually start to settle, and sleep for longer periods, and the mother has largely adjusted to being home. Often women will at this time say to us, 'I blamed tiredness for the way I feel, but now she sleeps and I still can't. Something is wrong'.
- A woman might also blame herself or her partner for not feeling the way she expected to feel. Often couples will seek relationship counselling when PND is the underlying problem.
- Furthermore, even the most caring health professional can miss PND. Many do not know what to look for.

Partners

Living with a woman experiencing PND is difficult. Partners need a lot of support too and are known to be at risk of developing depression themselves. They often feel confused, lost and helpless. They can be the target of their partner's distress and irritability as she attempts to make sense of what is happening to her. Not only is he expected to stop being the 'cause' of her distress, he is expected to know how and when to listen to her, support her, and to know exactly the right things to say.

The partner's workload can increase enormously as he attempts to continue working to provide their single income but he may also need to take on more of the household work and the care of the children if his partner has not been able to manage during the day. In addition to this he may be feeling very anxious about how is partner is coping at home with the baby, especially if she rings during the day, and also trying to manage his own distress and frustrations as to why his partner is not getting better. He may be feeling very isolated and lonely.

It is important that partners be included by the support services and health professionals treating women with PND. Partners are much more supportive if they understand what the problem is and what they can do to help, as well as needing support and encouragement themselves.

Interventions

If a woman does not feel the way she expected to feel after having a baby it is very important that she talk to her GP or Maternal and Child Health Nurse. It could simply be that she is having trouble adjusting to the changes in lifestyle that occur when a baby is born and to the demands that a new baby makes. If she is suffering PND it is important that she receive appropriate help as soon as possible. PND is not something to be ashamed of. It should be seen as one of the many complications of pregnancy and delivery. With appropriate help and accurate information women with PND do recover.

All women with PND need emotional support from family and friends. Some women find psychological treatments helpful especially if they have experienced traumatic events in their childhood or more recently, including a traumatic childbirth experience.

Antidepressant medication can be a vital treatment for many women. Unfortunately there are many misconceptions about antidepressants and many women who could benefit from them refuse to take them because they are afraid the medication is harmful. Sometimes partners prevent the mother from taking medication if they have strong views on their risks. Antidepressants are not addictive and some can be safely taken while pregnant or breastfeeding.

Antidepressants work to correct the chemical imbalance in the brain that are thought to be responsible for symptoms of depression and anxiety. The doctor's provision of accurate information about the medication and careful monitoring of their effectiveness and symptom reduction is vital. Finding the correct medication and becoming settled on a therapeutic dose can sometimes be a trial and error process, during which time the mother requires ongoing support. It is important to understand that women cannot 'snap out of' depression any more than they could 'snap out of' diabetes!

What helps?

early identification of the symptoms of PND,
provision of accurate information about PND and interventions,
emotional support from family, friends, services,
practical help with housework & childcare,
psychological help with counselling, cognitive therapy,
support groups,
medical assessment and monitoring by GP, psychiatrist,
antidepressant medication,
hospitalization, ideally in a mother-baby unit,
lifestyle changes – diet, exercise, rest.

Section 2: Addressing the Terms of Reference

Terms of Reference

The Terms of Reference that this submission will be addressing include:

2. The relationship between birthing experiences and PND
3. Interventive and preventative services to minimize the occurrence and harm of PND
4. Health implications of PND
5. Alternatives for antenatal and postnatal care and support
6. Any other related matters - PANDA

The relationship between birthing experiences and PND

The expectations of a mother-to-be of a calm, natural and fulfilling labour and childbirth, surrounded by supportive people with a sense of control and being heard can be central to her emerging sense of herself as a good mother. She may also be expecting a straightforward and successful breastfeeding experience. Should this type of labour or postnatal period not eventuate the new mother can feel less than a good mother, combined with the emotional and physical scars that remain.

Many women who experience PND express feelings of distress following labour and/or childbirth. The degree of distress that they feel is determined by the combination of their experience and what the experience means to them. For some women their labour or childbirth may have required a minor degree of intervention for which they were not prepared, that triggered deep responses related to past experiences or interacts with their personality. Other women can experience extreme levels of intervention and are able to come to terms with it fairly rapidly.

Postnatal Depression has become increasingly recognized as a valid and important postnatal mood disorder but there is less recognition for the trauma that can result from the process of childbirth. A difficult and traumatic childbirth experience has been identified as a potential trigger for the development of **Post Traumatic Stress Disorder**. This can be as a response to exposure to events that involve actual death, serious injury or any perceived threat, as a victim or a witness. Childbirth is seen as a trauma of significance to cause PTSD. A woman who has felt traumatised by childbirth may re-experience it as intrusive dreams, flashbacks and stress response to events that symbolise the trauma. She may exhibit persistent behaviours of avoidance and increased arousal.

Risk factors for PND and PTSD associated with childbirth can include: (Swalm)

- poor support from partner, family and or staff during labour
- unplanned pregnancy
- previous stillbirth – Turton et al found that 21% of women with a history of stillbirth experienced PTSD during the 3rd trimester of the next pregnancy
- previous trauma such as childhood sexual abuse – some aspects of labour and delivery might remind her of previous sexual assault
- high trait anxiety resulting in women being more prone to anxious responses
- perceptions of not being in control during labour and not knowing what's going on
- inadequate pain relief can be extremely traumatic
- the mother's fear for the well being of her baby or herself following interventions or a life threatening situation can be very traumatic. These fears and anxieties can interrupt the mother's ability to be available to and bond with her baby.

Some of the characteristics that can be evident include:

- a tendency to blame staff or self for things that went wrong and not being able to resolve it;

- secondary trauma symptoms may be present in partners and attending staff, bystanders might not be too helpful if they have been traumatized too.

As Swalm states it is important for professionals and lay persons to have some understanding of the differences between PND and PTSD because the treatment for the two disorders can be different

RECOMMENDATIONS

- Centre/service for routine postnatal debriefing – including criteria for referral to this service eg all deliveries with a certain level of intervention and the mother is offered a referral to this service.

  > “Things do go wrong: we need to improve the way we manage the emotional sequelae of negative events” (Swalm)

- Routine antenatal screening for pre-existing trauma such as child abuse, previous childbirth trauma, history of illness or previous hospitalization, to identify possible impact of childbirth, and to prepare the mother
- Trained antenatal midwives who can observe signs within a mother’s behaviour of previous trauma during childbirth – overly anxious or volatile, demanding behaviour, significant lack of self assuredness
- Educate midwives and obstetricians of the link between PTSD and PND and childbirth
- Increased understanding of PTSD symptoms as separate from PND, with the possibility of implementing some form of measurement of PTSD symptoms.

Interventive and preventative services to minimize the occurrence and harm of PND

The issues that are inherent in this term of reference are very broad and for the purpose of addressing them this submission will focus on the separate issues of the occurrence of PND and the harm associated with it. The nature of services as focussed on intervention or prevention is not always clear and will be discussed as strategies, encompassing both. Much of the background to these strategies is included in the body of this submission.

It is worth noting that the ideal range of services that could be established are best targeted specifically at PND. Not only does this acknowledge the importance of PND to funding bodies and to the community, it also ensures that there is an adequate level of skill in the identification and management of PND. As we know women with PND can be easily overlooked.

Strategies to prevent/minimise the occurrence of PND

Greater community understanding of the normal transition to parenthood and PND

Greater emphasis on preparation for parenthood for couples

Opportunities for couples expecting a baby to reflect on their expectations, and relationship and psychological impact

Improved community infrastructure for families – transport, readily accessible local community services

Strategies to prevent/minimise the harm of PND

Education of all new parents about the identification of PND

Community awareness of PND, its onset and symptoms

De-stigmatisation of PND

Early identification of parenthood transition difficulties

Early diagnosis of PND – routine screening

Access to well funded and skilled support and therapeutic services to ensure recovery

Access to skilled medical assessment and interventions

Recommendations:

- Programs to educate the community (schools, health promotion etc) about parenthood transition and what is PND
- Services to facilitate preparation for parenthood
- Education of health care professionals about PND symptoms and diagnosis
- Routine evaluation of PND risk factors in the antenatal period
- Routine screening for PND in the early postnatal period
- Adequately costed and targeted PND services

Health implications of PND

Incidence of PND

Women who experience depression after having a child are known to experience higher levels of distress in terms of symptoms and relationship difficulties, particularly marital, than non-childbearing women with depression (Milgrom, 1999 report of O'Hara et al 1990). Milgrom goes on to say that:

> *"While the incidence of depression postnatally may be similar to that in the general population, depressive symptomatology, chronicity of symptoms and increased risk of future depression after childbirth may be worsened. It is possible that this is the result of the interaction between depression and factors such as the need to recover physically from a complicated labour, the transition and stressors associated with early parenthood, personal vulnerability factors, changing demands on the marital relationship and the presence of an infant."* (Milgrom, 13)

Within the complexity of PND as described in the statement from Milgrom it is well known that PND can have long term and destructive effects on the mother, her infant and children and on the marital and family relationships. The nature of these effects will depend on the number and severity of the symptoms and the length of time that the mother's depression goes unidentified or inadequately treated. With early identification and skilled treatment and support most women with PND will recover, their recovery can mean an enhancement of their life skills and emotional development.

Impact on the mother:

As with general depression PND can impact enormously on the mother's physical well being – the changes in her diet, sleep and activity levels can result in her being less well nourished, exhausted and overly or less active than usual. Combined with on going depression and high levels of anxiety this will in turn reduce the body's immunity and ability to fight infection. Eventually the emotional distress of depression and anxiety may be expressed in increasing physical symptoms that might be felt as pain, headaches, chest pain or difficulty breathing.

There are also long term implications for the mother's mental health as a result of PND, particularly if there is inadequate treatment. Pitt (1968, as reported by Milgrom) found that without treatment 30% of women experiencing severe PND are still very unwell one year after the baby. Fifty percent of women with PND can continue to experience symptoms 2 years after diagnosis. In addition, women who have experienced PND are twice as likely to experience future depression over a five-year period, compared to women who have experienced depression unrelated to childbirth.

Impact on the mother-infant relationship:

PND can interfere with the behavioural and emotional interactions that are now recognized as being necessary for a successful mother-infant relationship. Mothers with depression tend to less sensitive to the needs of their babies and can be less responsive to their communications.

Attachment between mother and infant and resultant parenting may be disadvantaged

Severe PND has been claimed to contribute to child abuse and neglect

Impact on Infant Development:

Difficulties in mother-infant interaction may compromise many aspects of the infant's development – increased fussiness or withdrawal, brain pathways development, cognitive and social skills

PND can impact on the child's later cognitive and language development, social competence, behavioural and parenting difficulties

Impact on family relationships:

Negative impact increases with duration of the PND

Marital relationship may be threatened by the stressors of PND – mother's distress and intense needs within relationship, father's struggles to know how to support his partner and resultant conflict

Parent-child relationships may also be damaged due to mother's withdrawal or volatility, parental conflicts, inconsistent parenting

Extended family relationships may become stressed due to lack of understanding of PND, unhelpful and conditional support

RECOMMENDATIONS:

- Early identification of transitional difficulties
- Early identification and diagnosis of PND
- Immediate access to PND specific services
- Education of the community and health professionals about the impact of PND on family relationships and child development, and strategies to minimise this

Alternatives for antenatal care and support

It is essential to educate those health professionals who are in regular contact with pregnant women about PND. Skilled primary health care services must be able to view childbearing women holistically. It is important that they are able to recognise the signs of PND, especially since we know that women are masking their symptoms and ill health. They need knowing the right questions to ask will help to reveal PND in those women who are ashamed of the way they feel and they attempt to hide their symptoms behind a mask of normality.

These health care services particularly include Midwifery services, Obstetricians and Shared Care General Practitioners across the public and private sectors.

Antenatal Education

> Relatively few antenatal educators introduce women in their classes to the possibility that they might develop PND. Probably every woman attending antenatal classes, whether she is aware of it or not, knows someone - a relative, a friend or a neighbour – who has been affected by PND. It is likely that one woman from every antenatal class will develop PND.
>
> Many women with PND, and their partners, are angry that their antenatal classes did not prepare them for the possibility of PND. Many complain that their classes emphasised preparation for delivery rather than preparation for parenthood. They feel that if they had been taught to recognise the early signs they would have sought help earlier and so minimised the distress their families experienced. One woman has told PANDA:
>
> *"We were told that one of us would need an emergency caesarean, but we were not warned that one of us would experience the nightmare that is PND. Nobody told us it could happen."*

Aims of PND Education in Antenatal Education

Education about PND for expectant couples and health professionals would significantly reduce the trauma this illness causes. Antenatal educators are in an ideal position to educate couples about PND. Information about PND during the antenatal period would:

- help to dispel the myths and misconceptions about PND, helping to de-stigmatise PND;
- give new mothers permission to ask for help if they do not feel the way they expect to feel after having a baby, encouraging women to take control over their own mental health in the postpartum period;
- inform expectant couples that the symptoms of PND are recognizable and that help is available, which aids in earlier recognition and interventions.

Women who have learnt about PND in antenatal classes, and then go on to develop symptoms, don't panic, but recall the topic being discussed and know where to go for help.

Strategies to incorporate PND into Antenatal Education

PND can be presented as one of the complications that can arise following pregnancy and delivery. Couples are told a great deal about the physical changes they can expect when having a baby. The emotional changes accompanying the antenatal and postnatal periods deserve the same attention.

Great care needs to be taken in presenting material about PND. A matter-of-fact approach, avoiding unnecessary detail, will satisfactorily prepare couples for the possibility of PND. The challenge is to alert well women, many of whom will never develop PND, to this condition without alarming them.

Couples in antenatal classes need to know that:

- PND can happen to any new mother;
- PND is not anyone's fault;
- The early signs are recognisable; and
- Help is available.

Presentations in Antenatal Education can take various forms:

- A woman who developed PND remembers her antenatal educator saying:

  'Don't let anything get in the way of you enjoying your baby. Sometimes things don't go according to plan. If you have breastfeeding problems or you don't feel the way you expected to feel, ask for help. There is so much help available; all you need do is ask. Start with your maternal and child health nurse or your doctor.'

- One woman found it helpful to be told:

  'Bringing home a new baby should be a happy and exciting time. For some of you, pregnancy has meant developing gestational diabetes. Some of you will develop mastitis in the early weeks. Others will develop symptoms of depression. All these conditions are complications of pregnancy. All are treatable. All of you will go on to enjoy your babies.'

- Another women gratefully remembers her antenatal educator saying:

  'You will be told a lot about the physical changes to expect during pregnancy, but emotional changes are also a part of pregnancy and the time after delivery. I want to talk to you about these changes. One in ten women develop PND after delivery. Let's talk about what the symptoms are and how important it is to let your maternal and child health nurse and your doctor know if you don't feel yourself, so they can help make this time with your new baby special and rewarding.'

It is also important that antenatal educators:

- Women with risk factors should be encouraged to talk with their doctor or midwife before the birth of their baby. Just as women are asked whether they have a family history of multiple births or diabetes they should be routinely asked in the antenatal period if they or anyone in the family (mother, sister) has suffered from a mental illness. A woman who is at greater risk of developing PND should be encouraged to speak to her doctor.

- Include partners, whenever possible, in discussions about PND. If both parents-to-be understand what PND is the early signs will be detected more quickly. The father is often best able to detect early symptoms. Often he does this before his partner realises, or admits, that something is wrong. Couples that know how to recognise

PND are less likely to blame each other or the baby when symptoms emerge. Obviously, the sooner PND is diagnosed the better off the whole family will be.

- Encourage couples to think about a support network for when the baby is born. This might include their doctor, a maternal and child health nurse, a friend who might help with older children, someone who can help with meals, and support groups for a variety of problems (for example, PANDA and Australian Breastfeeding Association).
- Acknowledge the pressure on new mothers to 'cope', and convince women that if PND happens to them it will not be their fault and help is available.
- Differentiate PND from the adjustment difficulties most couples have in the early months. It is important to give couples realistic expectations of life with a baby so the transition to parenthood is more gentle. Couples with high expectations will find adjusting to life with an infant more difficult than those who expect initial difficulties like sleepless nights or colic. Couples should be given permission to find the early months difficult and they should be encouraged to ask for help. But they also need to understand that PND is different. It should be made clear that while most couples have trouble adjusting to life with a baby only 10-20% of women develop PND. Adjustment difficulties will pass. Without help, PND may not. Antenatal educators should be specific about the differences between adjustment and signs of PND. A woman who is woken by her baby every two hours for several weeks will understandably be tired and irritable. A mother who is tired and irritable because she is too anxious to sleep and lies awake all night while her baby sleeps could have PND.
- Understand that an antenatal class is not the best place to explore treatment options for PND. When women attend antenatal classes they are well. Giving too much detail about treatment options may result in couples denying that PND could ever happen to them. Couples should be told as much as they need to detect early signs and ask for help. If they do develop symptoms, they will then know enough to recognise PND as an illness and not as a sign that she has failed to be ‘a good mother'. Treatment options should be taken up in detail with a health professional when a diagnosis of PND is made.

Proposal for restructuring Antenatal Education:

Discussions about PND could be incorporated into antenatal education more easily if classes emphasised parenthood rather than delivery. Antenatal classes could be called ‘parenting classes’ and run from the seventh month of pregnancy to the third month postpartum.

Practical aspects of pregnancy and delivery could be dealt with in the first half. The second half of the classes could be devoted to issues such as feeding, infant care, and the emotional changes which women and men experience at this time, which would range from adjustment difficulties through to PND.

Following delivery, couples would be more receptive to discussions about the realities of life with a baby. Those having problems would take comfort from knowing that classes continue through the early week’ postpartum. The transition from the antenatal to the postnatal stages would be more gradual. The class would act as a support group during the most difficult early weeks. The cohesive atmosphere that often develops in a group would help to make it

OK to talk about PND during this time. Women would realise that PND can happen to them, and like many physical complications of pregnancy could occur unexpectedly. Any woman with symptoms would be identified and helped. It would be more relevant and of more help to couples to discuss mood changes when they are being experienced.

RECOMMENDATIONS:

- Improved education of all providers of antenatal care and support about psychosocial childbirth and PND diagnosis and interventions
- More clearly defined standards for antenatal care that consider the mother and infant holistically – eg evaluation of risk factors, screening, continuity of care
- Stronger focus of antenatal education programs on preparation for parenthood and the recognition of PND

Alternatives for postnatal care and support

While there is enormous scope for innovative and new services for women during the postnatal period the greatest priority for women with PND is to enhance existing services to enable a greater availability of services and improved rates of identification of women at risk of developing or who are experiencing PND.

Accessible and available community based services:

Maternal and Child Health Services

Maternal and Child Health Services perform many roles that are vital to the physical and emotional well being of both mothers and babies. Over many years new mothers have developed relationships with their Nurse that has allowed them to drop into the centre, ring up for simple questions and support and to receive services that were flexible and accessible. It was within the context of this support and accessibility to their Nurse that new mothers who were experiencing postnatal distress would express her feelings and share her symptoms.

In recent times there have been several changes to the way the Maternal and Child Health Services are functioning that will increasingly limit the availability of the Service to all new mothers, and particularly to mothers with PND. While many of these changes have been positive, there have been several of these changes that are concerning when we look at what is known about PND and how it is best managed. For example:

- There is a trend to move Maternal and Child Health Services from local neighbourhood centres into larger centralized centres. This means there is less opportunity for women to walk to their local centre to see their Nurse or to become involved in the New Mothers' Groups.

  The previous co-location of the Maternal and Child Health Service within other community centres would encourage the mother to access other support services such as occasional care, women's health services and social networks.

  For women who are already isolated, particularly with limited access to transport this removal of a vital support service from the local neighbourhood is very significant.

- Increasingly there has been the installation of telephone voicemail messages and answering machines on the contact lines for the Maternal and Child Health Nurses. As a result a mother ringing in distress will connect to a voicemail, is expected to leave a message, which will be returned when possible. The single effort that she might make to seek help may not result in the support she needs. The 24 hour support helpline is available but the mother often has to keep ringing to get through and she will not speak to a Nurse that she will see.

- Restrictions placed on the length of time allocated to appointments can make it more difficult for the new mother to feel that their Nurse has the time to give her should she open up about her difficulties.

- The Key Age and Stage visits schedule (4 weeks, 8 weeks, 4 months etc) restrict the new mother's access to the Maternal and Child Health Nurse to a schedule of visits that are determined by the age of her baby. While many Nurses may be able to see the mother in between scheduled visits this is more dependent on the mother making contact with her Nurse when her feelings of distress are becoming less manageable and requesting an additional appointment. Prior to these changes the mother's visits to the Nurse were spaced more evenly during this very early stage of new motherhood (eg. every second week), resulting in the Nurse being able to monitor the mother's well being and an increased likelihood that she will be seen when her symptoms are emerging.
- First time mothers groups that are facilitated for new mothers by the Maternal and Child Health Nurse from the local area are intended to meet the important requirements of increasing the mothers' knowledge about infant care and child development, and establishing a social network. Sometimes a mother who is experiencing distress or PND may not feel comfortable to share her feelings, she may feel different and a failure in comparison to the other mothers and she may cease attending the group. It is important that an atmosphere of honesty and acceptance is established within these groups to ensure women with PND are comfortable to attend as they are a crucial way of monitoring at risk women.

  The exclusion of mothers with new babies who are not first time mothers is also an issue as they are equally at risk of PND and would benefit from the positive outcomes of a group run routinely in their local area.
- The first time mothers' groups would be enriched by the addition of a focus on the new mothers' transition to and expectations of motherhood. The Transition to Motherhood Workshop (Appendix 3) allows women to collectively reflect upon their expectations and experiences and to gain some insight into the transitional issues and how they relate to PND.
- Some Maternal and Child Health Services implement a schedule of routine screening for the presence of symptoms of depression. The Edinburgh Postnatal Depression Scale (Appendix 2) was intended to be used as a screening tool to assess whether a mother is experiencing some symptoms of PND. Its greatest value is in the conversation that follows the scoring of the scale as it allows the mother a safe opportunity to discuss her responses and share her feelings.

General Practitioners

General practitioners (GPs) are the most accessible health professionals for mothers with young children. Most women visit regularly. A doctor thus has many opportunities to assess the emotional well being of women with young children. It is vital that GPs know how to recognise and where appropriate treat PND.

Recent changes to Victorian Health Services have meant that there is now even more pressure on GPs than there was several years ago to identify signs of PND in their patients:

- We once relied solely on maternal and child health nurses to recognise signs of PND in new mothers. Due to the common changes to this service many women say they have little time to tell their maternal and child health nurse how they feel.
- New mothers are being discharged from public hospitals within two-to-three days of giving birth, with minimal follow-up. Private hospitals, under pressure from health funds to keep costs down, are also discharging earlier. Research is now showing that women who leave hospital less than three days after giving birth are at increased risk of developing PND.
- Specialist Mother-Baby units in Victoria, which treat mothers with PND, are also experiencing increasing demand so accessing a bed when the mother needs it can be very difficult. There are three units in public hospitals, at Monash Medical Centre, the Austin Hospital, and at the Mercy Hospital for Women. There are also a number of Mother-Infant Units within private hospitals that also experience high demand.

For all these reasons general practitioners are more than ever being relied on to recognise and treat PND.

What should General Practitioners look for:

General practitioners need to be aware that women with PND typically pretend they are well. If a woman has symptoms of mastitis she can be relied on to ask for help. It cannot be assumed that a woman with symptoms of PND will ask for help. Women often feel that their symptoms are in some way their ‘own fault’ and will hide their feelings behind a brave façade. Many feel that to admit to ‘not coping’ is to admit to being a ‘bad mother’. It should never be assumed that a woman is well because she looks and sounds well.

Some women present the baby as the problem. Very often PND underlies an apparent sleeping or feeding problem. Doctors need to consider PND when a new mother comes in often and is worried about her baby's sleeping or feeding pattern.

Doctors need to recognise veiled cries for help, and focus attention on the mother. ‘How are *you* sleeping?’ ‘How is *your* appetite?’ The well-known paediatrician, Dr Christopher Green, made this point well, in an interview in 1996 with Caroline Wilson on Melbourne Radio 3AW, when he said, ‘I never used to diagnose PND. I never used to see it in the patients I looked after. Then I did start seeing it, and the reason for that was that I started looking for it. It’s a lot more common than we realise’.

GPs need to listen to what women are saying. For women, giving birth is a major physiological, psychological and social stress. Women need to be ‘given permission’ to find the early months difficult and to ask for and accept help. GPs need to create an atmosphere conducive to women talking about how they feel. To do this, it might be as simple as saying, ‘The early weeks are tough aren't they? Lots of my patients tell me life with a baby is not what they expected. How are you finding it?’ A new mother needs to know that her doctor is as interested in her emotional wellbeing as in her baby.

GPs should check the emotional health of new mothers. Women accept that six weeks' after delivery they see their obstetrician or GP for a check up to ensure that they have physically recovered from the birth. Emotional checks should be introduced at six weeks, three months and six months after delivery, to ensure that women are emotionally well. These checks could coincide with immunisations. Alternatively, forward appointments could be made with a GP when a baby is born. Changes to the medicare system have also created more opportunity for GPs to take the time with distressed patients.

GPs should ask new mothers how they are finding life with a baby. If GPs take every opportunity to check, and the woman does not have PND, she will leave feeling that her GP cares. If she does have PND, she will be treated early.

GPs can use a formal scale, the Edinburgh Postnatal Depression Scale, to screen for PND. The Scale covers basic symptoms and indicates whether a woman may have PND. It is most useful when used in conjunction with other indicators: how a woman sounds, how she relates to her child, how she looks, and so on and must be followed up with an assessment interview with the mother.

But it is often better, because less formal, to get the same result by asking questions in a more relaxed way. 'Many of my patients tell me they have trouble sleeping with a new baby in the house. Are you sleeping OK?' GPs can treat women with PND themselves, and most women are treated by their GP. But if the illness is complicated or severe, GPs may choose to refer their patients to psychiatrists or psychologists with a special interest in PND.

Psychiatrists

Many of the issues discussed in relation to GPs apply to Psychiatrists. It has only been in the later stages of the 19th century that Psychiatry recognized PND as a separate and valid mental illness. Many women with PND are referred to Psychiatrists if they are presenting with complex symptoms and needs for intervention or if their GP does not feel able to manage their treatment. Accessing affordable and available psychiatry services is an ongoing difficulty.

Psychiatrists can have an enormously successful impact on the treatment of a woman with PND when they view the woman holistically and take the time to understand the impact of PND on her life and to allow her time to talk.

Therapeutic intervention services:

Women with PND need to be assessed as to what therapeutic services they require to ensure the best possible recovery outcome. Such services may include counselling services for individual, couples or family, support services such as in home support, attending PND Support Groups, access to natural therapies and admissions to Mother and Baby Units. When there is the presence of an unwell mother and a young infant it is not acceptable for these services to have two – three month waiting periods. These services must be adequately funded.

Mutual Support Self Help service eg PANDA

Section 3 provides a description of PANDA as a Mutual Support Self Help organization that provides a model of operation that could be applied to the South Australian community.

RECOMMENDATIONS:

- Role of Maternal and Child Health Service (MCHS) – important to retain accessibility, availability and flexibility of this service to ensure adequate opportunities for the mother with PND to be identified
- Support Groups - MCHS runs New Mothers' Groups in Victoria that focus on information delivery and social connections. Ideal to increase focus of these groups to include Transition to Motherhood Workshops© and more extensive PND education
- Use of routine screening of the presence of PND symptoms such as the Edinburgh Postnatal Depression Scale (EPDS) by Maternal and Child Health Nurses and GPs.
- Adequate funding and planning of PND services – counselling, support groups, Mother and Baby Units, to prevent waiting lists and delayed interventions
- Extensive networks of PND Support Groups and their facilitators to enhance mutual support
- Strengthening of MSSH services such as PANDA to ensure viability and growth

Section 3: PANDA

The History of PANDA

PANDA began in the early 1980's when two women with postnatal depression (PND) were introduced to each other by their Maternal and Child Health Nurse. Each found it helpful to talk to the other so they continued to meet regularly to share their personal experiences. They increasingly found that there were more women who were interested in sharing their personal experiences and who benefited 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 response to the lack of information about PND PANDA held an information session at which the guest speaker was a psychiatrist specialising in the treatment of PND. A woman who had recovered from PND and a man whose partner had experienced PND also spoke. Several hundred women and their families attended the first information session, eager to learn more about PND and to meet others going through similar experiences. PANDA was strengthened as a direct result of the interest shown during that evening.

PANDA became an incorporated association in 1985, under the Associations Incorporated Act (1981). PANDA's early structure was reliant upon the availability of women who had recovered from PND to train and commit to voluntary service in either facilitating support groups or providing 24 hour telephone support service from their homes. The early volunteers worked from their homes and received demanding support calls at any time during the day or night. PANDA at this time also relied on funds raised by its volunteers.

Over time the nature of PANDA's services became unsustainable as the resources available in volunteers who were able to facilitate the support groups, support unwell women and their families or to bear the demands and intrusion of the telephone support line diminished. This trend paralleled the overall reduction in volunteer resources within the community. A review of PANDA was conducted in 1999-2001 that resulted in a more sustainable model of operation with minimal recurrent funding from the Department of Human Services. This model saw the establishment of a telephone support Helpline that was office based and available during business hours only, answering machines that provided information to support after hours callers and the cessation of facilitation of support groups by PANDA volunteers, replaced by a database of support groups run throughout Victoria by other facilitators.

In the years that followed PANDA's establishment it has continued to provide services to families and the mental health sector despite periods of difficulties that have threatened its viability. After several re-locations, restructures and the enormous commitment of many staff and volunteers PANDA has now consolidated its position in the mental health sector and is well placed to move forward. 2005 sees PANDA's 20 year anniversary of incorporation and plans are underway to celebrate this throughout the year and to launch a refreshed image of PANDA.

The Mental Health Sector

The National Standards for Mental Health Services were introduced across Australia in January 1997, after an extensive national consultation process. The standards are outcome-oriented with an emphasis on the end result for clients and their carers. They reflect a strong value base related to human rights, dignity and empowerment.

The National Standards have been used to derive a set of Standards for Psychiatric Disability Support Services (PDRSS Standards) in Victoria. The PDRSS Standards have been derived following consultation with the Psychiatric Disability Support Service sector and govern PANDA’s operations. They are based on the following Principles:

- The promotion of optimal quality of life for people with mental health disorders and/or problems;
- A focus on consumers and a positive outcome for them;
- An approach to consumers and their families which recognises their unique physical, emotional, social, cultural and spiritual dimensions;
- The recognition of the human rights of people with mental illness;
- Equitable access to appropriate services when and where they are needed;
- Community participation in service development;
- Informed decision-making by individual consumers;
- Continuity of care and support through clinical and community services;
- A systematic approach which emphasises comprehensive, coordinated and individualised care and support;
- Accountability to consumers, their families, staff, funding bodies and the community; and
- Equally valuing the various models and components of mental health care.

PANDA has developed it Operations Manual with regard to the above principles, to assist in providing consistently high quality services.

Mutual Support Self Help Principles

There are many services throughout Australia that are or could be categorized as Mutual Support Self Help. These services are based on a holistic view of mental health that recognizes the importance of sharing knowledge gained by people who have experienced the impact of mental illness in their lives. This forms the basis of the information, support and education delivered in MSSH services.

The target group for these services is people who are affected by a mental illness – individuals, carers and family members. PANDA was founded on these principles and continues to incorporate these components.

The concept of **mutual support** underpins these services and refers to the positive effects of people with similar problems, solutions and experiences, working together in order to support each other. This may involve people identifying and sharing their knowledge and experiences about the impact of mental illness in their lives that contributes to the overall understanding of the issues for themselves, their families and carers and the broader community.

The concept of **self help** refers to the ability of individual people to take control over their own lives that have been affected by mental illness. People have access to information, referral and support to assist them to learn and understand the effect of mental illness in their life, in order to improve their understanding and quality of life.

Mutual Support Self Help Key Service Requirements:

- Provide access to information and support to service users by telephone or personal contact and provide information by post or electronically.
- Provide opportunities for people experiencing the impact of mental illness in their lives (participants, families or carers) to meet and share experiences, receive input about the experience of mental illness and develop skills that support them and their families and carers.
- Provide easily accessible information, education, support and referral services to people with mental health problems and conditions and/or their carers, in order to improve their quality of life.
- Promote community awareness of the incidence and effects on people of mental health problems or conditions, and treatment, care and support available.
- Provide education about the experience of mental illness and the community supports that are available.
- Provide community education that focuses upon the promotion of mental health and the prevention of mental illness.

PANDA in the 21st Century

PANDA is a community based not for profit, self help organization and services the state of Victoria. In keeping with its founders' commitment to mutual support self help services PANDA provides information to any person who is affected by post and antenatal mood disorders including partners and extended family members, and to any person who wants more information about these conditions.

Increasingly PANDA produces and distributes accurate information about post and antenatal mood disorders to health professionals and the wider community, to ensure that those affected receive appropriate help as early as possible. This includes conducting professional development and training for health care workers.

PANDA's Infrastructure

Following is a brief outline of PANDA's infrastructure:

- Premises: PANDA sub-leases premises from the Mental Health Foundation of Australia in Richmond, Melbourne.

Staffing:	Director	25 hours per week
	Volunteer and Education Coordinator	20 hours per week
	Telephone Counsellor	20 hours per week
	Administration Worker	21 hours per week
	Bookkeeper	7 hours per week
	Total:	2.4 EFT
Volunteers:	Telephone Support Workers	10 volunteers (ideal)
	Guest Speaking Volunteers	3 volunteers
	Committee of Management	8-10 volunteers

- Information Technology: Network of server and 6 computers
  Printer, fax and photocopier
- Telecommunications: Commander Telephone System, able to support Helpline
- Resources: Database of services in metropolitan and rural Victoria that are specifically focused on the needs of families experiencing post and antenatal mood disorders psychiatrists, general practitioners, counsellors, support groups.

  Infocom Software allowing access to generic community resource directories

  Office equipment and resources
- Literature: Handouts and information packs that are distributed to individuals, health professionals and the community about many aspects of post and antenatal depression. Library of books and videos.

- Team Meetings:
  - Staff meetings (weekly)
  - Volunteer Team meetings (monthly) incorporates ongoing training
  - Staff supervision meetings (fortnightly)
- Network participation:
  - Mutual Support Self Help Network
  - beyondbabyblues Network (beyondblue)
  - Victorian Association of Telephone Support Services
  - CEO Network (Vicserv)
  - PND Group Facilitators Network
- Ambassador:
  - Leah Hudson

PANDA’s Services

Responding to continually increasing community needs PANDA has evolved into a valuable and critical service, well utilized by the wider community and health professionals. PANDA’s services include:

1. **Telephone support, information and advocacy –** PANDA’s telephone and referral service is staffed by specifically trained volunteers and supervising staff. Many of these volunteers have experienced antenatal or postnatal depression, in keeping with Mutual Support Self Help principles. On average PANDA receives 200 calls through the Helpline per month, with an increasing prevalence of calls of very high needs (presence of severe PND, suicide risk or at risk infants), of calls from male partners and extended family members and large numbers of callers reacting specifically to current media coverage of PND related issues.
2. **Information packs** distributed to women, their families, friends and general community members. Increasingly health professionals are requesting information about post and antenatal depression.
3. **Resource and referral information about local services** throughout Victoria – the statewide database includes PND groups, health professionals, psychologists, counsellors and support services in the callers’ local areas. These professionals have a specific interest and expertise in working with women experiencing post and antenatal depression and their families. Sometimes this may necessitate PANDA staff or volunteers making contact with these services on behalf of the woman, due to her degree of illness.
4. **Assistance setting up PND Support Groups –** PANDA encourages a ‘whole of community’ response to post and antenatal depression. The outcome of community meetings, specific training or an apparent community need may be a collaborative effort to establish a new support group for women experiencing PND. PANDA provides information to prospective support group facilitators and ongoing secondary consultation. PANDA also facilitates a peer support and education network for PND Support Group Facilitators from throughout Victoria.
5. **PANDA’s website –** although still in an early establishment stage PANDA’s website is an increasingly valuable means for the community and health professionals to access information about post and antenatal depression, interventions, research and supports. Plans to upgrade this website are underway in 2004. On average there are approximately 3000 visits to this website per month.
6. **Information, education and training seminars –** training can be developed for professionals and community groups according to specific requirements for information and skills.
7. **Guest speakers –** PANDA staff and volunteers are available to speak to professional and community groups.

PANDA’s Funding

PANDA is funded primarily by the Victorian Department of Human Services, Mental Health Unit. Funding is given under the Psychiatric Disability Rehabilitation Support Services under the Mutual Support Self Help services.

The Funding Service Agreement entails approximately $128,000 recurrent funds to meet the targets of 2,500 contacts per year (helpline, website), 20 health promotion activities and 50 volunteers involved throughout one year. Increasingly PANDA’s contacts are in excess of these targets. These funds are used to fund staff salaries.

In light of the current climate of limited government funds PANDA is attempting to secure significant alternative sources of donations and sponsorship. PANDA is reliant upon a number of fundraising events that are organized by external groups, such as dinner dances. These funds are essential for PANDA to be able to grow beyond the current funding base.

PANDA’s Governance

PANDA staff, volunteers and operations are managed by a Committee of Management. It is the aim for the members of this voluntary body to bring a broad range of skills and roles that enhance the functioning of PANDA and oversees its adherence to its Constitution and funding accountabilities.

Holders of positions on the Committee of Management are elected for a one year term and include a Chairperson, Deputy Chairperson, Secretary, Treasurer and Public Officer.

General Committee members are elected to fill a nominated portfolio to which they bring particular skills or interest, for example financial management, fundraising, sponsorship, business development, promotion of PANDA and PND and managing PANDA’s sector profile and relationships.

The Service Coordinator attends and reports to the monthly meetings on the day-to-day functioning of PANDA and items of concern for discussion. There are processes for decision making and the responsibility for PANDA lies with the Committee of Management.

PANDA’s staff and the Committee of Management are also supported by a Liaison Officer within the Mental Health Unit of the Department of Human Services, as a contact for funding and service needs. Importance is placed on the maintenance of this relationship.

PANDA’s Objectives:

PANDA’s objectives are to:

- provide support, information, referral and advocacy to women who experience post and antenatal mood disorders and their families, who contact PANDA’s telephone helpline;
- build professional and community awareness of post and antenatal mood disorders by provide training, education and resources to health care professionals, the wider community and policy making bodies about the issues related to post and antenatal mood disorders.

Summary of Recommendations

The relationship between birthing experiences and PND:

- Centre/service for routine postnatal debriefing – including criteria for referral to this service eg all deliveries with a certain level of intervention and the mother is offered a referral to this service.
- Routine antenatal screening for pre-existing trauma such as child abuse, previous childbirth trauma, history of illness or previous hospitalization, to identify possible impact of childbirth, and to prepare the mother
- Trained antenatal midwives who can observe signs within a mother's behaviour of previous trauma during childbirth – overly anxious or volatile, demanding behaviour, significant lack of self assuredness
- Educate midwives and obstetricians of the link between PTSD and PND and childbirth
- Increased understanding of PTSD symptoms as separate from PND, with the possibility of implementing some form of measurement of PTSD symptoms.

Interventive and preventative services to minimise the occurrence and harm of PND:

- Programs to educate the community (schools, health promotion etc) about parenthood transition and PND
- Services to facilitate preparation for parenthood
- Education of health care professionals about PND symptoms and diagnosis
- Routine evaluation of PND risk factors in the antenatal period
- Routine screening for PND in the early postnatal period
- Adequately costed and targeted PND services

Health implications of PND:

- Early identification of motherhood transitional difficulties
- Early identification and diagnosis of PND and establishment of a holistic care plan
- Immediate access to PND specific services
- Education of the community and health professionals about the impact of PND on family relationships and child development, and strategies to minimise this

Alternatives for antenatal care and support:

- Improved education of all providers of antenatal care and support about psychosocial childbirth and PND diagnosis and interventions
- More clearly defined standards for antenatal care that consider the mother and infant holistically – eg evaluation of risk factors, screening, continuity of care
- Stronger focus of antenatal education programs on preparation for parenthood and the recognition of PND – for example the re-structured Antenatal Education format

Alternatives for postnatal care and support:

- Role of Maternal and Child Health Service (MCHS) – important to retain accessibility, availability and flexibility of this service to ensure adequate opportunities for the mother with PND to be identified
- Support Groups - MCHS runs New Mothers' Groups in Victoria that focus on information delivery and social connections. Ideal to increase focus of these groups to include Transition to Motherhood Workshops© and more extensive PND education
- Use of routine screening of the presence of PND symptoms such as the Edinburgh Postnatal Depression Scale (EPDS) - MCHS
- Adequate funding and planning of PND services – counselling, support groups, Mother and Baby Units, to prevent waiting lists and delayed interventions
- Extensive networks of PND Support Groups and their facilitators to enhance mutual support
- Strengthening of MSSH services such as PANDA to ensure viability and growth

Appendix 1: Philosophies of PANDA

PANDA’s Vision

PANDA is committed to a community where post and antenatal mood disorders are recognised and the impact on women and their families are minimised through acknowledgement, support and education.

PANDA’s Mission

PANDA’s mission is to:

- Support and inform woman and their families who are affected by post and antenatal mood disorders; and
- Educate health care professionals and the wider community about post and antenatal mood disorders.

PANDA’s Values

PANDA values:

- being a mutual support self help organisation
- maintaining privacy and confidentiality
- being a recognised body of knowledge, information and resources about the issues related to post and antenatal mood disorders
- providing support and practical strategies in a non-judgemental, non-intimidating manner
- that women with post and antenatal mood disorders can recover with adequate support and timely interventions, allowing them and their families to successfully build healthy and strong family relationships
- using our resources to research post and antenatal mood disorders and gather the highest quality information about it.

PANDA’s Beliefs

PANDA’s beliefs govern the way it works in the community and with women and their families. They are:

- that all people are important and PANDA’s consumers, staff. volunteers and colleagues should be treated with respect and dignity
- that it is important for PANDA to instil hope, that change and growth are possible
- that consumers should be empowered to make informed decisions about their management based on quality information and support
- that consumers and their families are in the best position to determine what helps them and what they can do
- that most of the time, people are doing the best they can
- that services are best delivered to people within their own communities

Principles of Practice

PANDA's Committee of Management, Staff and Volunteers are committed to the following principles of practice:

Commitment to Social Justice

> **Equity –** a fair distribution of economic, social and cultural resources of the community across all members of the community.
>
> **Access –** ensuring fair and equal access to all PANDA services for all people and their families affected by post and antenatal mood disorders throughout Victoria. PANDA's services are available to all eligible people regardless of gender, race, ethnicity, age, disability, religion or sexuality.
>
> **Participation –** maximising the opportunities for all people and their families affected by post and antenatal mood disorders to participate in the services offered by PANDA staff, volunteers and Committee of Management so as to achieve personal development and support.
>
> **Rights –** developing fairer, more comprehensive rights, including civil, political, social and economic rights, which are equally enforceable by all people regardless of their income and social background.

PANDA's Duty of Care

PANDA owes a duty of care to anyone who is a part of the organisation. A duty of care is breached when a person behaves unreasonably in a situation. Failure to act can also be seen as an unreasonable act. Each situation should be viewed taking into account all circumstances.

Factors to be considered are:

- The risk of harm and the possibility of risk occurring
- The type of injuries that may occur and how serious they are
- Precautions which could have been taken
- Any other factors relevant to a particular situation

Privacy and Confidentiality

Staff, volunteers and Committee of Management will respect the confidentiality of information obtained in the course of any contact with callers or their families and not inappropriately share information with other staff members, volunteers or Committee of Management or networks outside the organisation.

Appendix 2: Edinburgh Postnatal Depression Scale

The Edinburgh Postnatal Depression Scale (EPDS) is a simple self-report scale, consisting of 10 statements relating to symptoms of depression. Mothers select one of four responses in relation to each statement, indicating their mood during the previous 7 days. It is easy to complete and also to score, and it can be administered at any time during the first 12 months postnatally.

It was developed for routine use by health professionals working with mothers in the first postnatal year. It has been found to be acceptable to the mothers and it has been validated in relation to standard psychiatric measures. It is important to remember that the scale is not a diagnostic tool, nor does it replace or override clinical judgement – a careful clinical assessment is necessary before the presence of depression can be confirmed and its severity determined. This may involve referring the mother to other services.

The value of the scale lies in the fact that it allows women to think about their feelings and it should be administered in a situation where they have the opportunity to discuss these feelings with an appropriately skilled health professional. It can serve as an invitation for both the mother and the health professional to engage in a conversation about how the mother has been feeling. It is very important that the health professional who is administering the scale has the time to discuss the mother's responses and make appropriate referrals and crisis management plans when needed. This also provides the opportunity to distinguish between depression and the normal emotional changes, mental and physical challenges and demands of the baby that occur in the postnatal period.

Scoring

Each response has a value between 0 and 3 and scores for the 10 statements are added together to give a score out of 30. The resultant score would provide some indication of the presence of symptoms of depression and anxiety and that it is important for the health professional to address these with the mother. A repeat score two weeks later almost certainly indicates the presence of symptoms of depression and the need for referral and assessment.

> Scores of 9 or less – no symptoms and probably not depressed:
>
> > Clinically there is no cause for concern and the mother is reassured.
>
> Scores of 10 – 12 – possibility of depression:
>
> > The responses on the scale need to be discussed with the mother, especially those scoring more highly. The need for referral can be determined.
>
> Scores of 13 + - depression likely:
>
> > Scores over 13 and particularly where there are thoughts of self harm need to be discussed with the mother to determine the nature and severity of the problems. She needs to be referred to services for clinical assessment and management, crisis intervention if required and ongoing counselling and support. It is important to be aware of the need to ensure the safety of the mother and the baby.

Considerations for application:

Many women calling PANDA’s Helpline line admit to deliberately supplying false positive answers for fear of being seen as bad mothers, insane, or that their child/ren will be placed into protective care.

Informed discussion and history taking by the health professional should always accompany the use of the EPDS, some would argue that it should replace the use of the EPDS.

The scale may be most effective introduced at the second consultation, for example, and used as a stimulus for discussion.

Women also report it useful to use at home with partners and extended family as a starting point for discussion about their PND – but only after they themselves have had the opportunity to work through the indicators and the implications for their own status.

The Edinburgh Postnatal Depression Scale

This short questionnaire will help us to know how you have been feeling since you have had you baby. Please **UNDERLINE** the answer that comes closest to how you have felt IN THE PAST 7 DAYS, not just how you feel today.

NAME:
DATE:

1. I have been able to laugh and see the funny side of things
    - As much as I always could
    - Not quite as much now
    - Definitely not so much now
    - Not at all
2. I have look forward with enjoyment to things
    - As much as I always did
    - Rather less than I used to
    - Definitely less than I used to
    - Hardly at all
3. I have blamed myself unnecessarily when things went wrong
    - Yes, most of the time
    - Yes, some of the time
    - Not very often
    - No, never
4. I have been anxious or worried for no good reason
    - No, not at all
    - Hardly ever
    - Yes, sometimes
    - Yes, very often
5. I have felt scared and panicky for no very good reason
    - Yes, quite a lot
    - Yes, sometimes
    - No not much
    - No, not at all
6. Things have been getting on top of me
    - Yes, most of the time I haven't been able to cope at all
    - Yes, sometimes I haven't been coping as well as usual
    - No, most of the time I have coped quite well
    - No, I have been coping as well as ever
7. I have been so unhappy that I have difficulty sleeping
    - Yes, most of the time
    - Yes, sometimes
    - Not very often
    - No, not at all
8. I have felt sad or miserable
    - Yes, most of the time
    - Yes, quite often
    - Not very often
    - No, not at all
9. I have been so unhappy that I have been crying
    - Yes, most of the time
    - Yes quite often
    - Only occasionally
    - No, not at all
10. The thought of harming myself has occurred to me
    - Yes quite often
    - Sometimes
    - Hardly ever Never

Appendix 3: Transition to Motherhood Workshop

Transition to Motherhood Workshop : "Nobody told me being a mother was going to be like this" ©

PANDA established this workshop to support mothers in managing the significant differences in their expectations of what motherhood was to be like and their actual experience of it. We know that by putting a range of simple things in place to better take care of themselves, many women's quality of life increases dramatically. It is suitable for all new mothers.

Aims of the workshop:

- To provide a space for new mothers to openly explore their experiences of becoming a mother and how it has impacted on their lives.
- To provide clear information about ways new mothers can care for their own emotional and physical wellbeing.
- To encourage new mothers to look beyond society's and their family's expectations of motherhood and to create their own realistic expectations of themselves as a mother.

Structure of the workshop:

1. Warm up: Life before motherhood. The participants are asked to introduce themselves, how they are feeling and to identify one or two things that they enjoyed doing before they became a mother.

2. Introduce the story of a mother who has recovered from PND and her experience of transition to motherhood – PANDA volunteer Guest Speaker.

3. Focus on how different cultures and societies mark the transition to motherhood and some of the myths, followed by a visualization using visual aids and discussion.

4. A second visualisation focusing on the dreams the participants had of motherhood and then the reality of motherhood. Following discussions focus on identifying achievable goals from the dream, depending on their responses.

5. Information is provided about the Postnatal Depression continuum, symptoms and recovery. Discussion follows about self help and support of others experiencing PND. Information about PANDA services.

6. Time is then spent in discussing self care and taking time for themselves, using the concepts of a walking group.

7. The participants are then encouraged to take part in a hand massage as a form of relaxation and self care.

8. The workshop concludes with a review of how the participants are feeling and reflection on any new ideas they have gained that they might put in place to care for themselves, to improve their emotional and physical wellbeing.

Participants are then asked to complete an Evaluation form and to stay on for refreshments.

References

Published literature:

Bishop, L. 1999 *Postnatal Depression Families in Turmoil*. Halstead Press

Milgrom, J, Martin, P. and Negri, L. 1999 *Treating Postnatal Depression, A Psychological Approach for Health Care Practitioners*. John Wiley and Sons.

National Health and Medical Research Council. *Postnatal Depression: A systematic review of published scientific literature to 1999*. NHMRC.

Nicolson, P. 1998 *Posnatal Depression Psychology, Science and the Transition to Motherhood*. Routledge

Victorian Government Department of Human Services 2003 *Psychiatric Disability Rehabilitation and Support Services Guidelines for Service Delivery*. DHS

Unpublished literature

Assorted PANDA literature and information

Delphin Swalm, King Edward Memorial Hospital, Western Australia – *Childbirth and Emotional Trauma Why it's important to Talk Talk Talk*. Information on website of TABS